

**STATEMENT OF  
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BEFORE THE  
SUBCOMMITTEE ON HEALTH  
HOUSE COMMITTEE ON VETERANS' AFFAIRS**

**July 9, 2013**

Good Morning Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) health programs and services. Joining me today is Susan Blauert, Deputy Assistant General Counsel.

We do not yet have cleared views on H.R. 1612, a bill that would direct VA to convey a parcel of land to Tuskegee University. We will forward views and any estimated costs to you as soon as they are available.

**H.R. 1443 Tinnitus Research and Treatment Act of 2013**

Section 2 of H.R. 1443 would require VA to recognize tinnitus as a mandatory condition for research and treatment by VA Auditory Centers of Excellence. Section 3 of the bill would require the Secretary to ensure that research on the prevention and treatment of tinnitus is conducted at VA facilities. Required research would include an assessment of the efficacy of multidisciplinary tinnitus treatment modalities on different subsets of patients; studies on the underlying etiology of tinnitus in Veteran populations that occur as a result of different causal factors, including blast-related tinnitus, where there is no measurable hearing loss, versus other forms of noise-induced tinnitus, where there is hearing loss; and a study of the underlying mechanisms between hearing loss and tinnitus, including cases in which one or the other condition is present, but not both. VA

would be required to ensure VA cooperation with the Hearing Center of Excellence established by the Department of Defense (DoD) to perform further research on tinnitus.

This bill appears to be consistent with existing programs and operations within the Veterans Health Administration. Therefore, we do not believe this legislation is necessary.

VA Audiology Clinics currently provide tinnitus treatment through VA's Progressive Tinnitus Management Program, a five-level program that provides education and treatment services to Veterans tailored to the degree of the disabling effects of tinnitus. Basic tinnitus intervention involves group educational counseling focused on providing Veterans with the knowledge and skills to self-manage their tinnitus. This group counseling involves interdisciplinary collaboration between audiology and psychology. For those Veterans who do not obtain relief from hearing aids or group educational counseling, VA offers treatment, including a comprehensive assessment and individualized counseling. If none of the above services are beneficial, VA begins treatment involving individualized management including relaxation techniques, cognitive behavioral therapy, drug therapy, sound-based therapy, and combined techniques. VA has also developed patient education materials and clinical training materials to advise clinicians on how best to identify, diagnose, and treat tinnitus and other auditory conditions.

VA's National Center for Rehabilitative Auditory Research (NCRAR), a VA Rehabilitation Research and Development Center of Excellence, has active research projects underway on the efficacy of multidisciplinary tinnitus treatment (e.g., Progressive Tinnitus Management) as referenced in Subsection (1) of Section 3 of the bill. NCRAR is also collaborating with the VA Audiology Program to develop and evaluate Progressive Tinnitus Management at VA medical centers.

VA has active research projects underway addressing the underlying etiology of tinnitus, as well as the mechanisms underlying the co-occurrence of hearing loss and tinnitus, as referenced in Subsections (2) and (3) of Section 3.

VA is also collaborating with DoD on the development of the Defense Center of Excellence for Hearing Loss and Auditory System Injuries, as mandated by Congress in section 721 of Public Law 110-417. The Center will develop a registry of information to track the diagnosis, surgical intervention, or other operative procedure, or treatment, and follow up for each case of hearing loss and auditory system injury incurred by Servicemembers while on active duty. This registry will also facilitate an electronic data exchange with VA. The law further requires the Center to collaborate with NCRAR and VA to ensure coordination of ongoing auditory system rehabilitation benefits and services by VA.

VA believes that implementation of H.R. 1443 would be cost-neutral, if enacted, because VA already complies with the provisions of the bill.

#### **H.R. 1702 Veterans Transportation Service Act**

VA supports this legislation which would permanently extend the Secretary's authority to hire qualified drivers to transport any person to or from a Department facility or other place in connection with vocational rehabilitation or counseling required by the Secretary pursuant to chapter 34 or 35 of title 38, or for the purpose of examination, treatment, or care. The Veterans Transportation Service (VTS) depends on paid drivers to provide transportation services. Section 111A of title 38 of the United States Code (U.S.C.) currently provides authority for use of paid drivers until January 9, 2014.

Through the VTS program, VA provides funding to local VA facilities for mobility managers, transportation coordinators, and vehicles to complement the existing services that volunteers already provide. The service provides Veterans with transportation to and from their VA health care appointments, improving both access to care and continuity of care for many who would otherwise be limited in mobility. In 2012, VTS provided Veterans with more than 199,000 one-way trips totaling more than 9.7 million miles. The average length of a one-way trip is over 48 miles—a considerable distance and a prohibitive one for those with poor health if transportation were not available. Veterans with prostheses or those who use wheelchairs have particularly benefited from the VTS program.

Veterans Service Organizations such as Disabled American Veterans are invaluable in providing volunteers for VA's Volunteer Transportation Network. However, with increasing numbers of transportation-disadvantaged Veterans, there simply are not enough volunteers in all regions of the country to serve the level of need. Furthermore, volunteer drivers are generally precluded from transporting Veterans who are not ambulatory, require portable oxygen, have undergone a procedure involving sedation, or have other clinical issues. Some volunteers, for valid reasons, are reluctant to transport non-ambulatory or very ill Veterans. Without paid drivers, many Veterans would not have transportation to get to their medical appointments to receive the care they need.

VA was grateful for enactment of the temporary authority to ensure we could continue to use paid drivers in the VTS program. The temporary nature of the authority, however, has impacted expansion of VTS, as VA facilities have been cautious in adding staff in light of the expiration that would occur early next year without legislative action. This has understandably dampened our ability to expand the program. Permanent authority will provide this beneficial program with the stable foundation it merits.

VA is unable to provide an accurate estimate of the cost savings associated with this bill at this time. However, since VTS became operational, savings have resulted from the use of paid VA drivers over Beneficiary Travel Special Mode transportation. VA paid drivers are a less expensive option than Special Mode transport. VA is closely examining the cost data across locations where VTS is implemented and will provide this information for the record as soon as we are able.

#### **H.R. 2065 Safe Housing for Homeless Veterans Act**

H.R. 2065 would amend 38 U.S.C. 2012(c)(1), which requires that Grant and Per Diem (GPD) grantees or eligible entities comply with specified fire and safety rules. In place of the current section 2012(c)(1), H.R. 2065 would impose a new requirement that would limit per diem payments to grant recipients or eligible entities who submit an annual certification (that has been approved or verified by the "authority having jurisdiction or a qualified third party") that the building where the entity provides housing

or services is in compliance with codes “relevant to the operations and level of care provided.”

VA does not support H.R. 2065. We are concerned it would fundamentally shift VA’s role in inspecting and overseeing GPD facilities and would shift some of the costs of facility inspections from VA to the GPD grantee. Currently, VA ensures that GPD facilities meet the requirements of the Life Safety Code (LSC) of the National Fire Protection Association through on-site inspections of each facility by staff from the local VA medical center. The inspection team includes representatives from the local VA medical center, who are responsible for ensuring that general operating requirements as noted in GPD regulations are met. The inspection team members are responsible for the review of the project in the following areas: clinical, facilities management, security/law enforcement, and nutrition and food services. The facilities management portion of the inspection includes a requirement for VA staff to evaluate compliance with the LSC. These projects must pass an initial inspection prior to per diem being awarded. Any deficiencies (e.g., nutrition, security, clinical, safety) noted by the inspection team must be corrected by the GPD-funded organization before the project can become operational. A completed initial inspection is signed by the VA medical center Director, approving the placement of Veterans within the project. The inspection packet is then reviewed by the Veterans Integrated Service Network (VISN) Homeless Coordinator for completeness and sent to the GPD National Program Office. GPD providers are also subject to annual re-inspection. The annual inspections are conducted in the same manner as the initial inspection. VA is concerned that merely requiring a certification of compliance with the LSC would remove an essential component of VA’s GPD facility inspection process making homeless Veteran transitional housing less safe and secure.

Presently, the cost of inspecting a GPD facility for compliance of the LSC currently falls on VA. Ostensibly, section 2(a)(1) of H.R. 2065 would shift the cost of LSC compliance to the GPD provider. Because section 2(a)(1) merely specifies that the annual certification must be “approved or verified by the authority having jurisdiction or a qualified third party,” the concern is that a GPD provider would receive certifications of

compliance from individuals or entities who are not truly qualified to certify compliance. Under the current statute and regulations, VA officials inspect and determine whether GPD facilities comply with the LSC. VA inspectors are directly accountable to the Department, and there are no concerns about the suitability or qualifications of third parties providing “certifications.” However, VA notes that many of the concerns addressed by section 2(a)(1) could be resolved through regulation.

Furthermore, VA does not agree with the suggestion in section 2(a)(1) that the “International Building Code and International Fire Code” are a suitable alternative to the LSC. VA is not aware of any single standard that is comparable to the LSC. The LSC is unique in that it is organized with chapters that address each occupancy type, has specific infrastructure requirements for existing as well as new facilities, and also provides operational requirements. The LSC accomplishes by itself what it would require multiple other codes to accomplish. For example, if the International Code Council (ICC) Family of codes was utilized, it would require use of the International Building Code, International Residential Code, International Fire Code, and International Existing Building Code in order to encompass the same scope as the LSC.

While a different set of standards (other than the LSC) could be utilized to provide a comparable set of fire and safety requirements, VA believes that introducing another set of codes and standards would not benefit Veterans or VA in any material way. It would also not likely result in increasing the number of facilities that could be approved for the GPD program, and it could create an added burden for VA by potentially requiring VA staff to be trained on two sets of codes and standards instead of one.

It should also be noted that VA facilities receive accreditation from The Joint Commission, which requires compliance with the LSC. VA uses the LSC for all VA facilities (including accredited facilities) to establish consistency across the country for minimum life safety requirements, code interpretation, and fire safety training for VA staff. Finally, section 2(b)(2) could be an extremely burdensome and costly reporting requirement. Although section 2(b)(2) gives little guidance on the extent and scope of these reporting requirements, it requires an evaluation of all facilities receiving per diem

payments. Since VA has an active and robust cadre of GPD Liaisons, individuals at the local VA medical center who liaise with GPD grantees and ensure compliance with inspection findings, VA does not believe these potentially burdensome reporting requirements are necessary.

If enacted, this bill would be cost neutral to VA; however the cost to VA's community-based providers could be substantial.

**Draft bill entitled the “Long-Term Care Veterans Choice Act”**

The draft bill would allow Veterans, for whom VA is required to provide nursing home care by law, to request a transfer to homes designed to provide non-institutional long-term supportive care for Veterans, who are unable to live independently and prefer to live in a family setting. VA would pay the expenses by a contract or agreement with the home. One condition upon the transfer would be the Veteran's agreement to accept home health care services furnished by VA.

VA supports the Medical Foster Home (MFH) concept, where eligible Veterans who would otherwise need nursing home care could get, when clinically appropriate, long-term care in a more personal home setting. VA endorsed this idea in its fiscal year 2014 budget submission. Our experience has shown that VA-approved MFHs can offer safe, highly Veteran-centric care that is preferred by many Veterans at a lower cost than traditional nursing home care. While endorsing the MFH concept, VA cannot today offer a complete evaluation of the text of the draft bill. We have been working with the Subcommittee on technical assistance and look forward to further discussion.

Mr. Chairman, thank you for the opportunity to present VA views on these bills, and we will be glad to answer any questions you or the other Members may have.