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

April 15, 2021

Good morning, Chairwoman Brownley, Ranking Member Bergman and Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect VA programs and services. With me today is Dr. Amanda Johnson, Director, Women's Reproductive Health.

We are providing views on H.R. 234, H.R. 344, H.R. 958, H.R. 1448, H.R. 1510, H.R. 2093 and two drafts bill. In addition, per the request of committee we've provided views on H.R. 9016 from the 116th congress. The above bills are related to health programs and services for Veterans, including mental health services.

The Secretary has prioritized ensuring that VA welcomes all our Veterans, including women Veterans, Veterans of color and Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) Veterans; and that Diversity, Equity and Inclusion are woven into the fabric of the Department.

Today, more women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans enrolled over the past 5 years. To address the growing number of women Veterans who are eligible for VA health care, VA is strategically enhancing services and access for women Veterans by investing $75 million in a hiring and equipment initiative in 2021, providing funding to hire over 400 women's health personnel nationally, to include primary care providers, gynecologists, mental health providers and care coordinators. Funds are also available for programs that have not traditionally been offered by VA such as pelvic floor physical therapy and lactation support.

Each of the 170 VA medical centers (VAMC) across the United States now has a full-time Women Veterans Program Manager tasked with advocating for the health care needs of women Veterans. Mini residencies in women's health with didactic and practicum components have been implemented to enhance clinician proficiency. National VA satisfaction and quality data indicate that women who are assigned to Women's Health Primary Care Providers have higher satisfaction and higher quality of gender specific care than those assigned to other providers. VA provides many services for women Veterans, from gynecology, maternity care, infertility services, mental health services and military sexual trauma assistance.

VA and the Congress are closely aligned in what we want to accomplish for Veterans, their families and the Nation. In the few instances where we are not in consensus, it is generally a matter of details. We see these bills as opportunities to collaborate, and in cases of disagreement, VA is willing to provide technical assistance to mitigate those issues in order to resolve disagreement. VA supports several of the bills on today's agenda, but we do have concerns with others, as we outline in this testimony. We stand ready to work with the Committee to further explain our views, and where possible, provide technical assistance to remedy those concerns. The specifics of the bills on today's agenda and our detailed views follow below.

H.R. 234 Korean American VALOR Act

VA estimates that enacting this bill would result in costs of $40.3 million for FY 2022; $205.9 million over the 5-year period from FY 2022 through FY 2026; and $399.6 million over the 10-year period from FY 2022 through FY 2031.

Currently, 38 U.S.C. § 109 provides for reciprocal medical services with other nations in some situations. Specifically, § 109(c) is similar to this bill in that it gives health care eligibility to World War I and World War II members of the Czech and Polish Armed forces. Consequently, there is established precedent for providing health care eligibility.

However, VHA does have concerns about full equity. The Department has not been able to consider the costs and feasibility of providing health care to all other allies of other conflicts who then became citizens of the United States. While VHA understands the desire to reward the service of those who served in the Republic of Korea's Armed Forces while supporting the United States Armed Forces in Vietnam, the legislation must be viewed in the context of numerous other allies that have supported the United States during other conflicts.

In addition, we have concerns about considering expanding health care eligibility to persons who served in Armed forces of other Nations before we can fully address the possibility of expanding eligibility to Veterans in priority groups not covered within our current Veteran population. As to proof of service, currently section 109(c)(2) requires applicants to provide certification from certain foreign governments of the service at issue. There is no similar provision in the Korean American VALOR Act. It's not clear how easy or difficult it would be for VHA to verify the service in question. For these reasons, VHA is unable to support this bill, as written at this time.

H.R. 344 Women Veterans TRUST Act

The Women Veterans Transitional Residence Utilizing Support and Treatment (TRUST) Act directs VA to conduct an analysis of the need for women-specific programs that treat and rehabilitate women Veterans with drug and alcohol dependency. The TRUST Act also directs VA to carry out a pilot program for 5 years

that would provide drug and alcohol dependency programs that treat and rehabilitate women Veterans.

VA currently provides a comprehensive range of services to meet the needs of women Veterans who experience substance use concerns. The proposed legislation specifically references a Women Veterans Therapeutic Transitional Residence Program. This program is a Compensated Work Therapy – Transitional Residence (CWT-TR) program which is part of VA's broader continuum of Mental Health Residential Rehabilitation Treatment Programs (MH RRTP). The MH RRTPs are a core part of VA's continuum of treatment services for Veterans with Substance Use Disorder (SUD). During FY 2019, nearly 90% of the 33,636 Veterans served in an MH RRTP had a SUD diagnosis. At the end of FY 2020, VA offered 68 Domiciliary SUD (DOM SUD) programs and 41 CWT-TR programs. Across DOM SUD and CWT-TR programs, 45 offered separate and secure units for women Veterans with over 600 beds available to meet the needs of women Veterans.

The CWT-TR programs referenced in the proposed legislation are unique programs in VA with authority defined by 38 U.S.C. § 2032 and 2042. These programs are primarily focused on transition to the community with a required focus on vocational rehabilitation. In reviewing the proposed legislation, we believe that the CWT-TR programs may not be the appropriate program of focus given the defined intent to address the substance use treatment needs of women Veterans.

Regarding the availability of mental health residential services for women Veterans to address SUD, there is no universal approach to providing care; rather VA provides a range of residential treatment options responsive to the unique needs of the women Veterans that we serve. The preferences and needs of the individual Veteran are always honored with programs: 1) for women Veterans only; 2) with separate residential space and gender specific programming in addition to mixed gender programming; and 3) with primarily mixed gender programming. Data suggest we have sufficient mental health residential capacity for women Veterans, but we continue to look for ways to improve the care that we provide. The number of programs with separate and secured units has continued to increase. Often these programs also provide extensive gender specific programming in addition to mixed gender services.

As an integrated health care system, VHA is uniquely situated to address the needs of women Veterans diagnosed with a SUD as it provides a comprehensive continuum of evidence-based substance use treatment, including individual and group therapy, primary health care support, medications, online tools and mobile apps. Every VAMC in the country has a SUD specialty outpatient clinic where women Veterans with SUDs can obtain individual care, group care or both. In addition, because of the integrated nature of VA care, VA can address co-occurring medical, mental health and psychosocial needs, to include supports for employment and housing. In general, the percentage of women Veterans receiving any SUD specialty care is equivalent (or slightly higher) to that of male Veterans except for Opioid Treatment Programs which are more commonly used by male Veterans.

Currently about 37% of VA facilities offer women-only outpatient SUD or PTSD-SUD treatment, and all VA facilities offer individual SUD or SUD-PTSD treatment for women Veterans. In addition, the Seattle VAMC is conducting a Quality Improvement Project utilizing a 14-week series based on the Women's Recovery Group model. Progress on implementing this model is expected this year.

VA currently captures a significant amount of information on the services available for women Veterans to treat SUD as specified by the proposed legislation and does not believe there is a need for a separate report. Further, some of the information specified by the legislation cannot be captured and the scope of services to be captured by the proposed report is unclear.

In summary, VA is concerned with the current language in the proposed legislation regarding the proposed pilot program. VA has several programs currently operating similar to those referenced and would develop the program based on the finding of the analysis of the need for women-specific programs that treat and rehabilitate women Veterans with drug and alcohol dependency. Further, it is not clear that a pilot program would be needed, rather VA could continue its current efforts to expand access to residential treatment for SUD for women Veterans. Of note, VA has submitted proposed legislative text for consideration to update current authority for domiciliary care to ensure consistency with the domiciliary program's current mission to address the mental health and substance use residential treatment needs of Veterans.

For the above reasons, VA does not support this legislation as currently written. Given much is already in place for serving Women Veterans with SUDs, it may be better to evaluate more thoroughly what we already have in place, rather than developing pilot sites as delineated in the proposed legislation. We look forward to additional discussions on how best to address concerns and fill gaps in programs and services for women veterans.

H.R. 958 Protecting Moms Who Served Act

The Protecting Moms Who Served Act would require VA to carry out the maternity care coordination program described in VHA Handbook 1330.03, *Maternity Health Care and Coordination*. GAO would also be required to develop a report on the maternal mortality and severe maternal morbidity among pregnant and post-partum Veterans, with a focus on racial and ethnic disparities in maternal health outcomes for Veterans.

We are glad to report that VA is already fulfilling the goals of this bill, with robust support right now for Maternity Care Coordination. As a result of this duplication, VA does not support this bill. However, we welcome further discussion and to working with staff on issues related to maternity care to ensure that disparities can be identified and addressed in a timely manner. VA has built a strong Maternity Care Coordination program and currently has Maternity Care Coordinators (MCC) covering every health care system. MCCs support pregnant Veterans throughout pregnancy and the post-

partum period. Additionally, MCCs help Veterans navigate health care services both inside and outside of VA, access care for their other physical and mental health conditions, connect to community resources, cope with pregnancy loss, connect to needed care after delivery and answer questions about billing for pregnancy care. A key component of the MCC's role is to screen pregnant Veterans for conditions such as post-partum depression and intimate partner violence and then ensure the Veteran is connected with appropriate treatment and services.

Section 2(a)(2) of the proposed legislation would direct VA to provide training and support to community maternity care providers. VA is already using several methods to accomplish this goal. VA currently provides training through the Women's Health Education team to community maternity providers. Women's Health has developed multiple modules to train community providers about the unique needs of women Veterans. VA also provides information to community maternity providers about the needs of women Veterans through participation in the American College of Obstetrics and Gynecology (ACOG) Committees, participation in the Armed Forces Section of ACOG, scholarly presentations at national specialty and subspecialty medical conferences and through peer-reviewed publications in specialty medical journals.

VA defers to the Congress regarding GAO's report on maternal mortality and severe maternal morbidity among pregnant and postpartum Veterans as it relates to action taken by that office.

H.R. 1448 PAWS for Veterans Therapy Act

The Puppies Assisting Wounded Service members (PAWS) for Veterans Therapy Act would authorize VA to provide service dogs to Veterans with mental illnesses who do not have mobility impairments. The PAWS Act also would direct VA to carry out a pilot program for 5 years on service dog training therapy. With regards to piloting a grant program; the legislation spells out what type of agencies should be eligible for these grants and requires VA to develop metrics to determine whether Veterans who are paired with a service dog through these grants (a) improve in psychosocial functioning and (b) improve in their dependence on narcotics medication. The legislation also requires the Government Accountability Office (GAO) to evaluate the pilot program.

VA understands the appeal of having VA provide service dogs for Veterans. However, the vast majority of reputable service dog organizations provide service dogs at no cost to Veterans (costs are covered by charitable contributions), thus it has not been necessary for VA to provide dogs or grants in the administration of the service dog veterinary health insurance benefit pursuant to 38 C.F.R. 17.148. Instead, VA provides veterinary health insurance through a contract to individual Veteran patients who obtain a service dog through an Assistance Dog International or International Guide Dog Federation accredited organization, as opposed to unaccredited organizations. For these reasons, VA does not support providing grants to organizations that provide

service dogs and service dog training to Veterans with post-traumatic service disorder (PTSD).

The inclusion in the bill of the accreditation requirement (see section 3(c)) is critical because in administering service dog benefits, VA must ensure that tested and proven criteria regarding service dog training and behavior are in place to allow VA to have reasonable confidence that dogs are well trained, healthy and not likely to pose a threat of harm to Veterans, their families and others who might come into contact with the dog.

The PAWS Act does not give VA a role in determining when a service dog needs to be replaced for health or training problems and instead leaves that decision to the service dog organization and the Veteran. See section 3(c)(3). VA has serious concerns about this omission. A reputable service dog organization should not have concerns about a funding agency having a role in protecting Veterans. VA knows from experience, as do service dog training organizations, that once people bond to a dog, they are very reluctant to give it back even if its behavior or health are a serious problem. Unfortunately, VA has first-hand experience with this issue and has experience with service dog training organizations taking advantage of it to avoid having to replace a service dog with another dog at considerable expense.

It is unclear from a reading of the Act whether VA would have oversight of the service dog training programs administered by the grant recipients. If enacted, VA would need a mechanism to determine if the dogs, trainers and facilities are of satisfactory quality. VA cannot support the award of grants to service dog organizations on behalf of Service members and Veterans without allowing sufficient oversight, including additional accountability mechanisms. VA understands the pilot is aimed at creating a therapeutic treatment modality that will help Veterans currently suffering from and in treatment for PTSD and post-deployment mental health conditions. As such, the service dog would be adjunctive to other mental health treatment. Therefore, it is essential that the program be administered appropriately and as part of a comprehensive mental health treatment program for Veteran participants.

The legislation would require VA to develop metrics to determine whether Veterans who are paired with a service dog through these grants improve in psychosocial functioning and dependence on narcotics medication. VA does not believe that this data would be meaningful as VA recently completed a service dog PTSD study that found no differences on three primary outcome measures of quality of life, mental functioning and physical functioning. Richerson, J & Saunders G. Office of Research and Development, Veterans Health Administration, *A Randomized Trial of Differential Effectiveness of Service Dog Pairing Versus Emotional Support Dog Pairing to Improve Quality of Life for Veterans with PTSD,* Study, viewed 05 January 2021 (https://www.research.va.gov/REPORT-Study-of-Costs-and-Benefits-Associated-with-the-Use-of-Service-Dogs-Monograph1.pdf). Also, narcotic medications are not typically prescribed for PTSD, rather they may be prescribed for co-morbid conditions (such as chronic pain).

Section 4 of the Act authorizes the Secretary to provide a service dog to a Veteran pursuant to 38 U.S.C. 1714(c)(3) regardless of whether the Veteran has a mobility impairment. The Secretary's authority to provide a Veteran diagnosed with a mental illness, including PTSD, with a service dog already exists in 38 U.S.C. 1714(c)(3) and is not conditioned upon the Veteran having a diagnosis of a mobility impairment. Separate authority exists in 38 U.S.C. 1714(c)(2) for the Secretary to provide a Veteran diagnosed with a mobility impairment with a service dog. Thus, Section 4 of the Act neither provides the Secretary with any additional authority nor does it confer upon the Veteran an additional benefit.

H.R. 1510 VCR Act

The Veterans' Camera Reporting (VCR) Act requires VA, through collaboration with VA's Office of Operations, Security and Preparedness; VHA; and VA's Office of Construction and Facilities Management to submit a report analyzing the policies, use and maintenance of cameras deployed by VA for patient safety and law enforcement at VAMCs. While VA supports this bill, VA recommends adding language to the bill regarding the importance of protecting patient privacy.

HR 2093 Providing Benefits Information in Spanish and Tagalog for Veterans and Families Act

The draft bill would require VA to make all VA fact sheets available in English, Spanish, Tagalog and the 10 most commonly spoken languages in the United States. VA would also be required to establish and maintain a publicly available website that contains links to all fact sheets from each Administration and submit a report to Congress regarding the fact sheets an VA's Language Access Plan.

While VA agrees with the intent of the language (ensuring no barrier to Department services), the bill is too prescriptive and may require translations that are not required based on Veteran need. As a result, VA cannot support the bill as currently drafted.

We assure the Committee that VA is preparing to meet the broader language needs of the changing Veteran and family member population in a way that ensures clear, accurate and compassionate content. VA wants to ensure the Department translates its material into languages based on insights gained from human-centered design (HCD) research with Veterans. HCD methodologies must include interviews with Veterans and their supporters as well as employees who will use the products or system, synthesis of the insights obtained, prototyping and testing solutions with users, incorporating feedback and iterating and adapting the products or systems accordingly. User experience must be measured before and after product and system implementation to assess impact. The Department can use HCD insights to determine which language translations are necessary and required, and which products or systems would provide the most positive impact.

VA also seeks to ensure that the bill is not written to require the Department to stand up a standalone website, but rather, will allow VA to determine the best integrated customer experience for Veterans, their families, caregivers, survivors and employees based on HCD research and insights. VA believes that Veteran experiences should be made more easily accessible from the VA.gov site and VA is currently in a multi-year Web Brand Consolidation Strategy to reduce the number of new, standalone websites. This strategy was based on insights from HCD research whereby Veterans sought to have an easy-to-navigate digital "front door" and identified VA.gov as a strong brand to serve as this front door.

Additionally, VA has undertaken multiple efforts to offer translation of key information in Spanish and Tagalog. For example, VA has translated key caregiver materials and COVID-19 related materials for Veterans into both Spanish and Tagalog since October 2020, including key information web pages: Coronavirus Frequently Asked Questions (https://www.va.gov/coronavirus-veteran-frequently-asked-questions/); COVID-19 Vaccines at VA (https://www.va.gov/health-care/covid-19-vaccine/); and VA's Public Health Response (https://www.publichealth.va.gov/n-coronavirus/) all of which are sourced from the www.VA.gov home page. VA also currently provides Spanish translations of 1,600 health sheet pages online at https://www.veteranshealthlibrary.va.gov/ to Veterans and caregivers.

Since 2008, VA has also translated most benefits-related fact sheets into Spanish and some into Tagalog. For example, 78% of Veterans Benefits Administration fact sheets have been translated into Spanish and 8% have been translated into Tagalog (https://www.benefits.va.gov/benefits/factsheets.asp). VA will continue to work with VA's Office of the Chief Technology Officer to continue exploring additional opportunities to meet the needs of Limited English Proficiency Veterans, families, caregivers and survivors. Applying an HCD approach, VA will also continue to gather insights, perspectives and concerns from Veterans, their families, caregivers, survivors and other partners.

Translation costs vary by language, vendor and the amount of words on the document. If this bill passes, VA encourages the Congress to also include authorization and appropriation of funds.

H.R. ___ - Sgt. Ketchum Rural Veterans Mental Health Act of 2021

The draft bill, *Sgt. Ketchum Rural Veterans Mental Health Act of 2021*, would require VA to establish and maintain three new centers for the VA's Rural Access Network Growth Enhancement (RANGE) Program. The Act also would require GAO to conduct a study to access whether VA has sufficient resources to serve rural Veterans who need mental health care.

VA supports this legislation as services to rural Veterans living with serious mental illness are critical, and in many states these services have been eliminated or significantly reduced for rural citizens. VA also offers the following recommendations:

- Under section 2(a) the meaning of "centers" is unclear. We recommend the phrase "three locations" or "three new RANGE programs."

- Under section 3, the focus of GAO's review is expansive. As section 2 focuses on Veterans with a serious mental illness, VA recommends amending section 3(a)(1) to require the study be of the "health care needs of rural veterans living with serious mental illness and/or substance use disorders."

- VA recommends referring to PRR Centers as Psychosocial Rehabilitation and Recovery Centers (PRRC).

We estimate that enacting this bill would result in costs of $965,100 for FY 2022; $4.825 million over the 5-year period from FY 2020 through FY 2026; and $9.651 million over the 10-year period from FY 2020 through FY 2031.

H.R. ___ - To clarify the role of doctors of podiatric medicine in VA

This draft bill would amend 38 U.S.C. § 7306 and result in modifications to compensation payable to the "Podiatric Medical Director" in VHA. For the reason stated below, VA supports this bill in part and recommends certain technical clarifying changes. This position is currently paid under the equivalent pay scale for the Senior Executive Service (SES) and under this change will instead be paid like other podiatrists in VHA using the three-component pay system of base/longevity pay, market pay and performance pay. Market pay assessments and pay for performance will now be included in the total compensation of the position.

These proposed changes to the position will have no immediate impact on the current incumbent and can be made without formal competition. However, a market assessment for compensation and establishing performance goals would need to be completed, resulting in an increase in total compensation for this position. VA notes this assessment addresses the market component only. This position would be paid entirely under the 38 U.S.C. § 7431 scheme and will no longer fit into 38 U.S.C. § 7404(c) (eligibility for certain SES awards—awarding of ranks and SES performance awards).

After reviewing the qualification standards, there is a conflict with the requirements as noted in the standards and the use of the degree Doctor of Podiatric Medicine (DPM) within the proposal. VHA determined that those who have a DPM "or equivalent" degree as eligible for employment; however, this proposal eliminates the use of equivalent degrees. While a noted conflict, equivalent degrees have not been conferred since the late 1960's. The proposed bill would also expand eligibility to podiatrists for certain senior positions in the Office of the Under Secretary for Health (USH), which conforms with prior changes to the law to expand eligibility for medical

leadership positions to podiatrists. This bill would have minimal impact on VHA; however, VHA would recommend that instead of further specifying positions for inclusion within 38 U.S.C. § 7306, a preferred modification of the proposal would be to eliminate the current restrictions on discipline-specific requirements for leadership positions within the USH office. This would allow for continual coverage of positions and titles despite changes that occur over time and to modernize VHA's organizational structure such that leadership positions may be filled by a broad range of clinical leaders. VA will be glad to work with the Committee on appropriate technical changes.

VA estimates that enacting this bill would result in costs of $15,000 for FY 2022; $83,000 over the 5-year period from FY 2022 through FY 2026; and $170,000 over the 10-year period from FY 2020 through FY 2031.

H.R. 9016 DOULA for VA Act of 2020 (116th Congress)

The Delivering Optimally Urgent Labor Access (DOULA) for Veterans Affairs Act of 2020 would require VA to establish a 5-year pilot program to provide doula services to covered Veterans through eligible entities by expanding VA's Whole Health model. The pilot program would measure the impact that doula support services have on birth and mental health outcomes of pregnant Veterans.

A doula, also known as a birth companion and post-birth supporter, is a non-medical person who assists before, during and after childbirth by providing physical assistance and emotional support to the pregnant Veteran and their family. While VA has found a growing body of evidence to suggest that continuous one-to-one emotional support provided by support personnel, such as a doula, is associated with improved outcomes, VA does not support this bill as written. We welcome additional discussions with Congress about doula services to determine how best to address concerns, some of which are outlined below.

There is currently no standard credentialing, certifying or licensing body to support doulas and ensure that they meet minimum standards of experience or training to provide assistance and emotional support to birthing and postpartum individuals. It is VA's view that it is essential that when doula care is provided to pregnant and postpartum Veterans, especially those who may be most vulnerable in terms of racial disparities and/or mental health comorbidities, that care is understood to meet minimum standards of quality and safety. The language in the bill specifies that the pilot program include "traditional and community-based doulas" which raises concerns that people with little or no experience or training could be part of the pilot.

For purposes of maternity care in the community, a qualified provider is a licensed medical practitioner operating within the scope of their license and not identified on the List of Excluded Individuals and Entities by the Department of Health and Human Services. For this reason, care provided by doulas, who are largely not licensed is not covered.

There are other aspects of the bill that make it difficult for VA to support as written. The bill would direct that VA establish a “Doula Service Coordinator” at each site where the pilot program is implemented to facilitate care between doulas and Veterans. The bill specifies that the Doula Service Coordinator facilitates payment to entities and performs tracking of outcomes by receiving reporting from the doula after each session of care that the doula provides to the Veteran. It is not clear that such a position would, in fact, support the Veteran, but rather support the doula.

VA consistently provides high quality mental health care tailored to the unique needs of Veterans. VA shares the sponsors’ concerns about promoting maternal health outcomes, promoting health equity and combating racial bias in health care settings. VA also shares the goal of improving maternal, mental health and infant care outcomes and is committed to understanding severe maternal morbidity and mortality among Veteran users of VA care. The Office of Women’s Health is actively working with researchers to identify all cases of severe maternal morbidity and mortality among Veterans. As part of this research, cases of severe maternal morbidity and mortality will be subjected to thorough chart review by subject matter experts to identify areas where VA can better intervene to reduce maternal morbidity and mortality and improve outcomes.

VA wishes to ensure that individuals receiving maternity care from VA have the ability and support to develop and follow their own birthing plan. Care from certified nurse midwives and deliveries at accredited birthing centers are covered by a VA maternity benefit. This is significant because using certified nurse midwives has broad support from experts in the provision of maternity care as a vehicle for providing safe and respectful maternity care to all women and especially women of color. We look forward to continued discussions on how to improve maternal health outcomes for Veterans.

This concludes my statement. I am happy to answer any questions you or other Members of the Subcommittee may have.