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FOR THE

SUBCOMMITTEE ON HEALTH

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

PENDING LEGISLATION

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Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Subcommittee. No group of veterans understand the full scope of care provided by the VA better than PVA's members—veterans who have incurred a spinal cord injury or disease. Most PVA members depend on VA for 100 percent of their care and are the most vulnerable when access to health care, and other challenges, impact quality of care. These important bills will help ensure that veterans receive timely, quality health care and benefits services.

H.R. 91, the "Building Supportive Networks for Women Veterans Act"

PVA supports H.R. 91, the "Building Supportive Networks for Women Veterans Act," a bill to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces. The bill would provide VA with the authority to extend the program using the same measurements and eligibility requirements. PVA supported the original program established by the "Caregivers and Veterans Omnibus Health Services Act of 2010" and has been pleased to see it continue.

In surveys conducted after the program, participants consistently showed better understanding of how to develop support systems and to access resources at VA and in their communities. The OEF/OIF women veterans at these retreats are most often coping with effects of severe Post-Traumatic Stress and Military Sexual Trauma. They work with counselors and peers, building on existing support. If needed there is financial and occupational counseling. To be eligible, women veterans must have been deployed in OEF/OIF, and have completed at least three sessions of counseling in the past six months.

The program, managed by the Readjustment Counseling Service, has been a marked success since its inception in 2011. The results have been overwhelmingly positive for women veterans, who experience consistent reductions in stress symptoms as a result of their participation. Other long lasting improvements included increased coping skills. It is essential for women veterans that Congress make this program permanent. We believe the value and efficacy is undeniable.

H.R. 95, the "Veterans' Access to Child Care Act"

PVA supports H.R. 95 the "Veterans' Access to Child Care Act." This legislation would make permanent the provision of child care assistance to veterans receiving certain medical services from the Department of Veterans Affairs.

PVA believes child-care is a critical avenue for veterans to access health care, vocational rehabilitation, education, and employment services. There is no denying that when heads of households have access to reliable child care their participation in their own health care and wellbeing increases.

A VA report from 2015, *Barriers for Women Veterans to VA Health Care*, discussed nine primary barriers, one of which was child care. Forty-two percent of women surveyed for the report said they had difficultly securing child care in order to seek VA health care services and would find on-site child care to be useful. PVA urges Congress to make this program permanent in order to care for veterans who would otherwise not be able to access VA.

Similarly, for veterans seeking mental health care, GAO has identified several barriers that deter veterans, including stigma, lack of understanding of the potential for improvement, lack of child care or transportation, and work or family commitments. Timely access to mental health care is imperative to preventing suicide, obviating long-term health consequences, and minimizing the disabling effects of mental illness.

While the permanent presence of child care services is the right thing to do, it is also economic. Ensuring veterans have timely access to health care decreases the compounding costs that come with treating an injury or mental illness later down the line. A trustworthy child care option alleviates stressors for the veteran, and encourages they maintain their contact and treatment plan with their VA providers. The extended pilot program is set to expire on December 31, 2017. PVA urges Congress to continue this vital service.

H.R. 467, the "VA Scheduling Accountability Act of 2017"

PVA supports the "VA Scheduling Accountability Act of 2017," requiring all VA medical facilities to certify compliance with scheduling laws and directives. This legislation would require each facility director to annually certify compliance with VHA Directive 2010-027, or any successor directive that replaces it. The aim is to increase transparency of scheduling practices at VA. In May 2013, VA waived the annual certification requirement. This legislation makes permanent the requirement for each VA medical center report its scheduling compliance certification. If a facility director is unable to certify compliance the director will then submit a report to the Secretary of VA explaining why the facility is out of compliance and what steps are being taken to achieve compliance. In turn, the Secretary will report to the House and Senate Committees on Veterans' Affairs a full list of the facilities that have or have not certified compliance. Lastly, if a facility does not make a certification, their leadership would then be prohibited from receiving any award or bonus during the following year the certification was not made.

While PVA supports this bill it is unclear how this legislation will resolve the underlying problems with scheduling at VA medical facilities. Preferred date metrics do not properly measure how long a veteran waits for an appointment. A GAO report from April of 2016, "Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care" highlighted inaccurate recording of appointment request and wait times for that appointment in the scheduling system. Using the request date as the starting point is flawed because VA uses an arbitrary time goal of 30 days for all appointments, a standard used by no other health care system. The overwhelming best practices for measuring timeliness is clinical need of the requested care, and in consultation with the patient. The usefulness of this legislation is unclear as long as VA's wait time metrics remain flawed and vulnerable to manipulation. Compliance

with the certification does not guarantee better scheduling practices and improved health care access for veterans.

H.R. 907, the "Newborn Improvement Act"

PVA supports H.R 907, the "Newborn Improvement Act." This bill would amend Section 1786 of title 38, United States Code, to authorize hospital stays of up to 42 days for newborns under VA care. The current provision allows a maximum stay of seven days. As the average stay for a healthy newborn is two days, any newborn needing additional coverage is likely to be facing complications immediate after birth or a severe infant illness.

The current seven day coverage is in a non-department facility for eligible women veterans who are receiving VA maternity care. Beyond the seven days, the cost of care is the responsibility of the veteran and not VA, even if complications require continued care beyond the coverage period. Post-natal health is critical to newborn health which directly impacts the lives and wellbeing of veterans and their families.

H.R. 918, the "Veterans Urgent Access to Mental Health Care Act"

PVA supports H.R. 918, which would provide urgent mental health care to former members of the military who are not otherwise eligible to receive care in the VA due to having an other-than-honorable discharge status. The Secretary's recent announcement that VA will be pro-actively offering mental health care services in urgent situations demonstrates the importance of the issue and passage of supporting legislation.

The scope of this bill is appropriately limited to former military members who are facing an imminent mental health care crisis and have already begun the review process of their discharge status. Those undergoing review have specifically alleged that the circumstances leading to their other-than-honorable discharge were a direct or indirect product of the physical or mental wounds of war. The scope is also properly limited to those who deployed, participated in or experienced combat operations or hostilities, or were the victims of sexual assault, battery or harassment.

H.R. 1005, "to improve the provision of adult day health care services for veterans"

PVA supports H.R. 1005, a bill that would provide "no cost" medical model adult day health care (ADHC) services to veterans who are 70 percent or more service-connected disabled. By authorizing the Secretary to enter into agreements with state veterans homes the bill would provide ADHC to those veterans who are eligible for, but do not receive, skilled nursing home care under section 1745(a) of title 38, USC. Currently, VA pays State Homes a per diem for

ADHC. The per diem rate covers around one-third the cost of the program. H.R. 1005 is an extension to the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Pub. L. 109-461), which provides "no cost" nursing home care at any State Veterans Home to veterans who are 70 percent or more service connected disabled. This means there are veterans making a choice between 100 percent free nursing home care or expensive, out of pocket ADHC. The payment to a state home under this legislation would be 65 percent the amount payable to the state home if the veteran were an inpatient for skilled nursing care.

Adult day health care is a crucial service that allows veterans to remain in their homes and communities and delay entry into traditional nursing care. While a veteran may need long-term services and supports, it is not always necessary those services be received in an institutional setting. Rather, a veteran can receive comprehensive medical care and socialization without the disruption of permanently leaving their home. The program is staffed by a team of multi-disciplinary healthcare professionals who evaluate each participant and customize an individualized plan of care specific to their health and social needs. ADHC is designed to promote social stimulation and maximize independence while also receiving quality of life nursing and personal care services.

Additionally, we know the wellbeing of a caregiver directly impacts the quality of care they provide to their veteran. ADHC gives caregivers the ability to meet other professional and family responsibilities. Especially for those caregivers whose veteran was injured before 9/11 and is not eligible for the VA Comprehensive Caregiver Program. ADHC offers critically needed support. Delayed institutional care for the severely disabled is a rare jewel in health care; it is the least costly care for the taxpayer while at the same time, the highest quality care for certain populations. And perhaps the most important benefit, ADHC for disabled veterans allows spouses, children, parents, friends and communities more time together.

H.R. 1162, the "No Hero Left Untreated Act"

PVA has no official position on H.R. 1162, the "No Hero Left Untreated Act." This legislation would establish a pilot program with the Department of Veterans Affairs (VA) to use Magnetic eResonance Therapy technology, or MeRT technology. This therapy, while not yet FDA approved, is used to treat post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), chronic pain, and opiate addiction. The legislation would establish a one-year pilot program on MeRT technology for fifty veterans at two VA medical centers.

VA currently offers veterans access to repetitive transcranial magnetic stimulation (rTMS). This treatment is FDA approved to address treatment-resistant depression, a comorbid condition in

PTSD, TBI, MST, and chronic pain and opioid addiction. While it is functionally similar to MeRT there is no existing evidence that MeRT is superior to rTMS for treating any disorder.

H.R. 1545, the "VA Prescription Data Accountability Act of 2017"

PVA supports H.R. 1545, the "VA Prescription Data Accountability Act of 2017." In 2016, the "Comprehensive Addiction and Recovery Act" (CARA) required providers at the Veterans Health Administration (VHA) to participate in their respective state's Prescription Drug Monitoring Program (PDMP). Prescribers must check patient records in the state databases before prescribing pain killers. The pharmacists are responsible for recording when they fill those prescriptions.

However, data for hundreds of thousands of non-veteran patients seen at VA is unable to be shared due to a technical oversight in the law. Current statute authorizes VA to send prescription data for two groups; veterans, and dependents of veterans. Yet there is a third group of patients who receive prescriptions through VA; non-dependent, non-veteran, VA beneficiaries. These patients include CHAMPVA enrollees, descendants of veterans with birth defects from toxic exposure, VA health employees, some active duty service members, and those receiving care through sharing agreements with academic affiliates. To complicate matters, VistA cannot differentiate between dependents and other non-veterans. VHA is only sending data for veteran and dependents. Approximately 10 percent of VHA's patient population are dependents or non-veteran, non-dependents who receive prescriptions from VHA. H.R. 1545 would rectify this oversight by stipulating the prescription data of all those covered by VHA, regardless of patient group, be submitted to the appropriate PDMP.

The United States is in the midst of an opioid epidemic. PDMPs are critical to ensuring safe prescribing practices and prevent inappropriate pushing of narcotics by providers. Forty-nine states and the District of Columbia have PDMPs. VA has been authorized to share prescription data with PDMPs since 2011 and last year, CARA required VHA to participate. The effectiveness of Opioid Safety Initiatives is dependent on the availability of all prescription data. This loophole allows for these non-dependent, non-veterans, to access prescriptions within VA and a community setting, with neither entity the wiser. VA's 2017 projection of non-veteran patients is 715,000. These patients must have the same safety protections as anyone else. VA would be better able to mitigate the potential consequences of opioid use.

While PVA strongly supports H.R. 1545, we are concerned that PDMPs may not be capturing another group; veterans who travel to different states to receive their specialized care. It is our understanding that each VA Medical Center (VAMC) only shares prescription data to the state PDMP in which the VAMC is located. There is little clarity at this point if state PDMPs can share with other states. Some have established regional Memoranda of Understanding,

communicating information with neighboring states. But there are veterans, particularly veterans with a spinal cord injury or disease (SCI/D) who regularly travel across multiple state lines to one of the 24 SCI Centers across the country. There has yet to be any assurance that the prescription data of an SCI/D veteran who receives care at an SCI/D center in Minneapolis, but lives in Wyoming, will be shared. We urge the committee to make sure these specialized patient populations are benefiting from the opioid safety measures in the same way as non-traveling veterans.

H.R. 1662

PVA has no official position on H.R. 1662, a bill that would ban smoking at all VA facilities within five years. While we understand the intent of this legislation and applaud its intent, we would offer one note of caution. Many veterans smoke as a form of stress relief. It also serves as a form of social interaction for veterans who are inpatients for extended periods of time. We have seen this to be particularly true with veterans who often spend many months as inpatients in VA's spinal cord injury centers. Smoking serves as a form of mental health treatment for some of these veterans, albeit not an optimal one. While it makes perfect sense to eliminate all smoking inside VA facilities, we believe that the legislation should consider the impact this prohibition will have on the many veterans who cannot simply give up the habit.

"Veterans Affairs Medical Scribe Pilot Act of 2017"

PVA supports the draft "Veterans Affairs Medical Scribe Pilot Act of 2017." This legislation would allow for a pilot program to increase the use of medical scribes to maximize the efficiency of physicians at medical facilities of the Department of Veterans Affairs. A medical scribe helps to decrease the burden of data entry on the part of the medical provider. They accompany a provider to document the physician-patient interaction, and enter it into the Electronic Health Record (EHR) at that time. The physician later reviews and approves the data entry. This dynamic allows for the physician to spend more uninterrupted time interacting with the patient, and less time dictating notes. Multiple studies have indicated that medical scribes increase physician-patient satisfaction. Further, because the physician is relieved of data entry, they are able to see more patients, thus impacting wait times. In a time when VHA is struggling to hire and retain physicians, allowing for medical scribes to help existing providers carry the patient volume is essential.

PVA would once again like to thank the Subcommittee for the opportunity to submit our views on the legislation considered today. Enactment of much of the proposed legislation will significantly enhance the health care services available to veterans and their families. I would be happy to answer any questions that you may have.

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2017

Department of Veterans Affairs, Office of **National Veterans Sports Programs & Special Events** — Grant to support rehabilitation sports activities — $275,000.

Fiscal Year 2016

Department of Veterans Affairs, Office of **National Veterans Sports Programs & Special Events** — Grant to support rehabilitation sports activities — $200,000.

Fiscal Year 2015

Department of Veterans Affairs, Office of **National Veterans Sports Programs & Special Events** — Grant to support rehabilitation sports activities — $425,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations, which in some cases are U.S. subsidiaries of non-U.S. companies.

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Prior to joining PVA, Sarah was an organizer for the North American Indian Center of Boston, where she worked to increase urban Indian access to health care and mental health services. For seven years she was an outdoor educator and expedition guide for Keewaydin Temagami in northern Ontario, Canada. She taught business English for Ford Motor Company in Bogota, Colombia, as well as high school philosophy and social studies. She has organized awareness campaigns around issues of sexual assault and harassment on college campuses.

Sarah was raised in Medina, OH. She attended Northeastern University in Boston, MA, and received a Bachelor of Art degree in American History and Native American Studies. She lives in Washington, D.C.