LEGISLATIVE HEARING ON H.R. 4720, THE MEDAL OF HONOR PRIORITY CARE ACT; H.R. 4887, THE EXPANDING CARE FOR VETERANS ACT; H.R. 4977, THE COVER (CREATING OPTIONS FOR VETERANS EXPEDITED RECOVERY ACT); H.R. 5059, THE CLAY HUNT SUICIDE PREVENTION FOR AMERICAN VETERANS ACT; H.R. 5475, TO IMPROVE THE CARE PROVIDED BY VA TO NEWBORN CHILDREN; H.R. 5484, THE TOXIC EXPOSURE RESEARCH ACT; AND H.R. 5686, THE PHYSICIAN AMBASSADORS HELPING VETERANS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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Wednesday, November 19, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:00 p.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [chairman of the subcommittee] presiding.

Present: Representatives Benishek, Roe, Huelskamp, Wenstrup, Walorski, Brownley, Brown, and Kuster.

Also present: Representatives Bilirakis and Walz.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Dr. BENISHEK. The subcommittee will come to order.

Before we begin I would like to ask unanimous consent for my friends, colleagues, and members of the Full Committee, Gus Bilirakis and Tim Walz from Minnesota to sit on the dais and participate in today's proceedings. Without objection, so ordered.

Good afternoon and thank you all for joining us today to discuss seven important legislative proposals that would impact the provision of healthcare to our Nation's veterans through the Department of Veterans Affairs.

The seven bills on our agenda today are H.R. 4720, the Medal of Honor Priority Care Act, and H.R. 4887 the Expanding Care for Veterans Act, H.R. 4977 the Creating Options for Veterans Expedited Recovery or the COVER Act, H.R. 5059 the Clay Hunt Sui-

cide Prevention for American Veterans Act or SAV Act, and H.R. 5475 to improve the care provided by VA to newborn children, and 5484 the Toxic Exposure Research Act of 2014, and H.R. 5686 the Physician Ambassadors Helping Veterans Act.

From increasing care available to newborn children of women veterans, to expanding and improving mental health treatment options, to providing priority access to Medal of Honor recipients, these seven measures address a wide range of critical issues facing our veterans, their families and the VA healthcare center.

I am proud to join Chairman Miller and Congressman Walz and Congresswoman Duckworth in cosponsoring H.R. 5059 the Clay Hunt SAV Act. With an estimated 22 veterans each day committing suicide, it has never been more important for us to take aggressive action to ensure that VA and DoD's mental health and suicide prevention programs are operating seamlessly, at the fullest strength to care for servicemembers and veterans struggling with mental illness and thoughts of suicide.

I am also proud to sponsor H.R. 5484 the Toxic Exposure Research Act of 2014, which I introduced to improve the research and treatment available to veterans and their family members who have experienced negative affects of toxic exposure.

H.R. 5484 would direct VA to select a medical center to serve as a national center for research on diagnosis and treatment of health conditions of descendents of Veterans exposed to toxic substances while serving as members of the Armed Forces.

The National Research Center will be required to employ at least one licensed clinical social worker to coordinate access to care for impacted individuals to VA, as well as appropriate Federal, State, local, social and healthcare programs, and to provide case management services.

Secondly, H.R. 5484 would direct VA to establish an advisory board to advise the National Research Center to determine which health conditions and the descendants of individuals who were exposed to toxic substances while serving in the Armed Forces result from such exposure, for purposes of determining those descendants eligibility for VA medical care, and A study and evaluate claims of service-related exposure to toxic substances by current and former members of the armed services.

H.R. 5484 will also authorize DoD to declassify documents, other than those that would materially and immediately threaten national security related to any known incident in which not less than 100 members of the Armed Forces were exposed to a toxic substance that resulted in at least one case of disability.

Finally, it would direct VA, DoD and the Department of Health and Human Services to jointly conduct a National outreach and education campaign to communicate information on toxic exposure incidents, resulting health conditions, and potential long-term impacts.

When a service member volunteers to serve our Nation in the United States Military, it is with the full understanding that they may be exposed to high-pressure situations and the strains of combat. But not many are aware that their service may also expose them to harmful chemical toxins they have the ability to impact

not only their health, potentially the health of their children and grandchildren as well.

Wounds that result from exposure from toxic chemicals can have lifelong and generational affects, the impacts of which we do not yet fully understand.

Therefore, it is imperative that we take every available step to recognize, research and treat toxic exposure issues that arise during our veterans military service and thoroughly evaluate the long-term affects this exposure can have on a veteran and on his or her family.

H.R. 5484 is not perfect and I recognize that some of today's witnesses have particular concerns about a provision in the bill that would allow the advisory board to study and evaluate claims of service connected exposure. I understand those concerns and appreciate those who have brought them to my attention.

I look forward to working closely with the VA, VSOs and other stakeholders in the coming days to make any amendments that may be necessary to clarify, and strengthen the intent of that provision and others on today's agenda.

Together we will ensure that these bills and all legislation advanced through this subcommittee are appropriate, effective, meaningful and most importantly contribute to the fulfillment of the promise made by President Lincoln to care for our Nation's servicemembers, veterans and military families.

Thank you to all of our witnesses for being here this afternoon.

With that, I now yield to Ranking Member Brownley for any opening statement she may have.

[THE PREPARED STATEMENT OF CHAIRMAN DAN BENISHEK APPEARS IN THE APPENDIX]

OPENING STATEMENT OF RANKING MEMBER JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chairman and I appreciate you holding this legislative hearing today.

As you know, the purpose of today's hearing is to explore the policy implications of seven bills before us, which cover a wide range of important topics that would expand and enhance VA's healthcare programs and services for our Nation's veterans.

I look forward to hearing the views from our panelists and appreciate the hard work that their testimony demonstrates. While I am disappointed in the Department for not furnishing views on my bill, I understand that the VA is prepared to answer questions on the bill's provisions. We hold these legislative hearings to ensure that the committee is as fully informed as possible on important veterans' health issues. We rely on this input to make sound and well-educated decisions on whether to forward a bill from this subcommittee.

Among the seven bills on the agenda today the subcommittee is considering my bill, H.R. 4887, the Expanding Care for Veterans Act, which would expand complementary and alternative medicine and mental healthcare options for our Nation's veterans.

As ranking member of the House Veterans' Affairs Subcommittee on Health, I believe that we must find more and better ways to provide our veterans with the healthcare they need.

There are many organizations throughout the country that are achieving very positive results using complementary and alternative medicine to treat mental health issues. My bill would require the VA to do a better job of evaluating what works. And when it does, find a way to provide these therapies to our veterans who are in need.

Specifically, the Expanding Care for Veterans Act would expand research and education on and delivery of complementary and alternative medicine to veterans. It would establish a program on integration of complementary and alternative medicine within the Department of Veterans Affairs medical centers. It would steady the barriers encountered by veterans and receiving, and administrators and clinicians in providing complementary and alternative medicine services furnished by the Department of Veterans Affairs, and establish a program on the use of wellness programs as a complementary approach to mental healthcare for veterans and family members of veterans.

Complementary and alternative medicine is intended to enhance, reinforce and sometimes replace traditional mainstream therapies. For instance, in my congressional district Reins of Hope assisted psychotherapy program helps to improve mental health, self esteem, communication skills and interpersonal relationships.

This subcommittee held a hearing in February in my District and I was very pleased that the Reins of Hope was invited to testify because of the successes highlighted at that hearing and through subsequent VA contact with the program, VA has decided to expand services with the Reins of Hope.

Throughout the 113th Congress the VA Committee has held hearings at which we have heard from veterans about the need to expand, complementary and alternative medicine in order to improve care for our veterans, and reduce wait times for mental health visits.

I am hopeful that my bill can move forward and appreciate the support that many of the VSOs have shown for my bill.

Thank you, Mr. Chairman, and I yield back.

[THE PREPARED STATEMENT OF HON. JULIA BROWNLEY APPEARS IN THE APPENDIX]

Dr. BENISHEK. I am honored to be joined today by several of my colleagues on our first panel.

Joining us to discuss legislation they have sponsored is Representative Tim Walberg from the 7th District of Michigan, representative and committee member Gus Bilirakis from the 12th District of Florida, representative and committee member Tim Walz of the 1st District of Minnesota, Representative Doug Collins from the 9th District of Georgia, and Representative John Culberson from the 7th District of Texas. Thank you all for being here this afternoon.

Representative Walberg, we will begin with you, please proceed with your testimony.

STATEMENT OF HON. TIM WALBERG

Mr. WALBERG. Chairman Benishek, Ranking Member Brownley and members of the subcommittee, I thank you for the opportunity to speak this afternoon in support of my legislation H.R. 4720, the

Medal of Honor Priority Care Act of 2014. I also thank you for the good work that you and all of the subcommittee here does for the benefit of our veterans.

As the members of this committee are well aware, the Congressional Medal of Honor is the highest award for valor which can be bestowed upon an individual serving in the United States Armed Forces, and is awarded to soldiers who have displayed conspicuous gallantry and intrepidity at the risk of life above and beyond the call of duty.

The Medal of Honor is a distinguished award given to a select few. Less than 3,500 have been awarded, and of those only 79 are living recipients. When one looks at the recent major conflicts in Iraq and Afghanistan, only 16 have been awarded.

My State of Michigan is honored to have two living recipients of this award, Corporal Duane E. Dewey and Private First Class Robert E. Simanek, both received the decoration for their heroic action in the Korean War. And hearing of their harrowing stories of bravery has reminded me of the sacrifice American soldiers are willing to make to protect their comrades and their country.

Medal of Honor recipients deserve our utmost appreciation and I believe a small portion of our servicemembers who have gone above and beyond the call of duty and have earned the highest honor in our Nation's Armed Forces, have earned the right to be placed in the top priority group to receive their healthcare benefits.

All veterans deserve access to the healthcare they have earned. But as you all know, the VA uses a priority system to determine eligibility for these healthcare services. Some of the factors that will affect the soldiers priority group ranking are whether the soldier has a service connected disability, whether they are former prisoners of war, the time and place of service, as well as income level.

Currently, Medal of Honor recipients are in priority group 3. And as the VA Web site itself points out, veterans who meet the qualifications of priority group 1 receive expedited service. Moving Medal of Honor recipients to priority group 1 will allow this small group of outstanding individuals who have received expedited—to receive expedited care as well as other benefits, such as medication without copayments.

I would be remiss in not pointing out that the idea to initially look into this legislation came from a veteran who lives in my District and works with the veteran community. This bill would not affect a large population of veterans, but I believe we have a duty to ensure these veterans have access through the VA when they need it.

I am proud to have support of 13 of my colleagues from both sides of the aisle, as well as support from the VFW, Vietnam Veterans of America, IAVA, and the American Legion and AMVETS.

I thank the Chair for permitting me to appear before the subcommittee today and ask for your support, thank you.

[THE PREPARED STATEMENT OF MR. TIM WALBERG APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Walberg.

Mr. BILIRAKIS. please go ahead.

STATEMENT OF HON. GUS BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it very much.

Chairman Benishek, Ranking Member Brownley and Members of the Health Subcommittee. Thank you for holding this very important hearing and providing me an opportunity to testify on my bill.

The importance of exploring complementary alternative treatments for veterans with mental health concerns cannot be understated. As we all know, the cost of wars and the price for freedom are paid for through the valor of brave men and women. These individuals selflessly put themselves in harms way for the freedoms we enjoy on a daily basis.

Statistics show that 20 percent, around 1 in 5 veterans who serve in Iraq and Afghanistan have been diagnosed with post traumatic stress. We must responsibly ask our questions. We must ask ourselves, are we doing enough when it comes to addressing mental health in our veterans population? I don't think so.

Recent data has shown that everyday in this country an estimated 22 veterans take their own lives, very sad. It is sad and alarming that more servicemembers have died from suicide than overseas in Iraq and Afghanistan. Many of these tragic suicides are the result of depression, homelessness and a lack of available resources to assist in their transition into civilian life.

My bill H.R. 4977 the Creating Options for Veterans Expedited Recovery Act, COVER we call it, will help remedy this tragic problem, and provide additional therapies to our Nation's wounded heroes.

The COVER Act will establish a commission to examine the Department of Veterans Affairs current evidence-based therapy treatment model, for treating mental illnesses among veterans.

Additionally, it will analyze the potential benefits for incorporating complementary alternative treatments available within our communities. Under the COVER Act the commission will conduct a patient-centered survey within each veterans integrated service network.

The survey will examine the preferences and experiences of veterans with regard to their interactions with the Department of Veterans Affairs. Instead of presuming to know what is best for Veterans, we should simply ask them, don't you think? We can work with them on finding the right solution that best fits their unique needs.

The scope of the survey will include as follows the experience of a veteran when seeking mental or medical assistance within the Department of Veterans Affairs, the experience of veterans with non-VA medical facilities, veterans experience with healthcare professionals treating them for mental health illnesses, the preferences of a veteran on available treatments for mental health and which they believe to be the most effective, the prevalence of prescribing prescription drugs within the VA as remedies for treating mental health illnesses, and outreach efforts by the VA Secretary on available benefits and treatments.

Additionally, the commission will be tasked with examining the available research on complementary alternative treatments for mental health. They will also identify what benefits could be at-

tained with the inclusion of such treatments for our veterans. Some of these alternative therapies include among others; accelerated resolution therapy, training and care for service dogs, music therapy, yoga, acupuncture therapy, mediation and outdoor sports therapy.

Finally the commission will study the potential increase and benefit claims for mental health issues for veterans returning from Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn. The VA must have the necessary resources and infrastructure to handle an increase in veterans you either, earn benefits to address the mental and physical ailments.

Once the commission has successfully completed their duties, a final report will be issued and made available. The commission outlining its recommendations and findings based on their analysis of the patient centered survey, alternative treatments and evidence-based therapies.

The commission will also be responsible for creating a plan implementing those findings in a feasible, timely and cost effective manner. I am happy to have the support from the veterans service organization, particularly the Iraq and Afghanistan Veterans of America, the American Legion, and Vets First who provided letters of support prior to this hearing. I am almost finished, Mr. Chairman.

With the collaboration of our Nation's greatest heroes, Congress and the VA, we can increase access to quality care for veterans across the country and help better meet their needs when asked—when seeking care.

Thanks again for allowing me to testify on behalf of the COVER Act today and I urge all of my colleagues to support this important piece of legislation and show our veterans, our true American heroes, with action and not just promises that we have them covered.

Thank you so much and I yield back.

[THE PREPARED STATEMENT OF MR. BILIRAKIS APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you.

Mr. Walz, you have five minutes for your statement.

STATEMENT OF HON. TIM WALZ

Mr. WALZ. Yes I do thank you very much.

Thank you Chairman Benishek and Ranking Member Brownley, and thanks for your leadership and dedication to our Nation's heroes.

I am grateful for the opportunity both to have served on this committee for 8 years and what appears to be my last hearing. I am honored to tell you about an important piece of legislation to help rid our community of veteran suicide.

H.R. 5059 is the Clay Hunt Suicide Prevention for American Veterans Act. It is an example of how we get things right on Capitol Hill. The legislation is named in honor of Iraq and Afghanistan war veteran suicide prevention advocate and my friend Clay Hunt.

Clay epitomized what it meant to live a life of service, both as a Marine and as a civilian. He helped countless veterans overcome their demons, but tragically took his own life in March of 2011. The legacy left behind however will live on for generations. Clay's mom,

Susan, is on the Hill today and if you get a chance, you may see her around. Make sure you thank her for what their family has given.

The bill you see before you was the result of strong partnerships with our veteran service organization, strong bipartisan effort here in Congress and relentless shown by Clay's parents to get this thing done. This bill is what you get when you have folks sitting around a table, trusting one another and working to get it right for our Nation's veterans.

I want to extend a special thank you to two Air Force veterans for helping to get this done. Thanks should go out to Ms. Christine Hill of Chairman Miller's staff and Tony DeMarino from Ms. Duckworth's staff for their incredible work.

Our premise for this bill was simple, suicide occurs because many veterans return to their community and then disconnect from it. So we wanted to create a bill that would get the communities involved and coordinated. We also knew it would be important to increase the capacity and efficiency of the VA care to deal with over a million veterans returning from war. Specifically, this bill establishes a pure support and community outreach pilot program to assist transitioning servicemembers with accessing VA mental health services. It requires the VA to create a one-stop interactive Web site to serve as a centralized source of information regarding all mental health service for veterans.

Three, it addresses the shortage of mental healthcare professionals by authorizing the VA to conduct student loan repayment pilot program, aimed at recruiting and retaining psychiatrists.

It requires the DoD and the National Guard to review the staffing requirements for directors of psychological health in each State. And it requires a yearly evaluation conducted by a third party, of all mental healthcare, and suicide prevention practices programs at DoD and VA find out what is working and what is not working, and make recommendations for getting rid of those that don't and improving those that do.

It establishes a strategic relationship between the VA and the National Guard to facilitate greater continuity of care between the National Guard and the VA.

And finally, it authorizes the Government Accountability Office report on the transition of care from PTS and TBI between the DoD and VA. One veteran lost to suicide is too many. With many of our warriors returning from war, all too often our heroes return only to face a war of their own.

While there is no bill that will completely end veteran suicide, this comprehensive bipartisan measure is a step in the right direction. I am proud to have worked with Chairman Miller and his staff, Representative Duckworth, a combat veteran herself, Iraq and Afghanistan Veterans of America, and the VFW introduced this bipartisan piece of legislation.

I also want to thank Senator McCain for taking up the Senate companion and making sure that this is on a track to end up on the President's desk. I urge my colleagues to support this measure so we can pass it quickly into law and start addressing an issue that all of us know happens all too often.

And with that, Mr. Benishek, I yield back and thank you.

[THE PREPARED STATEMENT OF MR. TIM WALZ APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Walz.

Mr. Collins, please go ahead.

STATEMENT OF HON. DOUG COLLINS

Mr. COLLINS. Thank you, Mr. Chairman and Ranking Member Brownley, and the distinguished members of the subcommittee, for my opportunity to testify on my piece of legislation, H.R. 5475 to amend title 38 of the United States Code to improve the care provided by the Secretary of Veterans Affairs to newborn babies. And just also as a current active Air Force reservist, I appreciate this committee and also the words spoken to those who come back as one who has come back from Iraq as well and the need for that I appreciate that very much.

The model of the Veterans Administration basically comes straight from Abraham Lincoln's second inaugural. And he got the idea straight from scripture. So the challenge for us is to care for him who shall have borne the battle and his widow and for his orphan isn't a new one.

Since September 11th, 2001 more than a quarter of a million women have answered the call to serve, they have faced terrorism in the deserts and the mountains of Iraq and Afghanistan, so in the 21st century we must also consider she who have borne the battle, when she returns, what of her children?

The finest military in the world is powered by men and women in their physical prime. The young women who decide to serve this country in the Armed Forces aren't immune from the same questions that all young women face about whether they pursue a career, a family or both. Yet they are offered a healthcare system that for so many years has been designed to serve men.

With an increasing number of female veterans, the VA must expand its care and services to meet their needs. Maternity care tops that list of needs. And I have offered one way that we can help. In 2010 Congress passed and the President signed the Caregivers and Veterans Omnibus Health Services Act 2010, to provide short-term newborn care for women veterans who receive their maternity care through the VA. It was signed into law on May 5th, 2010 and this legislation authorized up to 7 days for newborn care.

On January 27th, 2012 the VA published a regulation officially amending VA's medical benefits package to include up to 7 days of medical care for newborns delivered by female veterans who were receiving VA maternity care benefits. The rule which became effective December 19th applied retroactively to newborn care provided to eligible women that on or after May 5th of 2011.

Since this 7 day authorization was enacted by Congress in 2010, we have learned more about the unique challenges facing female veterans and the changing trends and these veterans seeking maternity and newborn care from the VA. According to the study published in the women's health issue journal this year from 2008 to 2012 the overall delivery rate by female veterans utilizing VA maternity benefits increased by 44 percent, and a majority of the women using VA maternity benefits had service connected disability.

Unless Congress extends the authorization for newborn care coverage provided by the VA, these veterans will face difficult financial decisions and complexity in navigating insurance options at the same time their newborn is fighting for their life.

That is why I introduced H.R. 5475. This legislation extends the authorization of care from 7 to 14 days, and provides for an annual report on the number of newborn children who received such services during the fiscal year.

Improved data on trends and female veterans utilizing newborn care will help Congress and the VA better meet the needs in years to come. You see this is also a little personal for me. I know what it is like to be the parent of a little baby who needed intensive medical care for an extended period the moment she was born.

It is my hope that any new mother who has given selflessly to her country wouldn't have to worry about Congress standing in her way as she tries to give selflessly to her our own child.

Our goal should always be to provide the mother with prenatal care she needs to give the newborn the best chance of healthy delivery with no postnatal complications. There are significant needs and challenges female veterans face when returning home from the battlefield, from homelessness to sexual and physical abuse, not to mental health conditions such as post traumatic stress disorder.

This legislation won't solve those challenges but 5475 will give a little peace of mind knowing that a newborn will get some extra help from the VA and Congress and that we are committed to her and her family.

In a focus group conducted, one Marine said, I essentially say that I gave my reproductive years to the Marine Corps and those are the years you can serve. You know you do sacrifice and you say, well, mission first before family mission. Type of thing and the more I think about it, you know, the VA probably should address that part of womanhood and have that understanding.

There are a multitude of ways the VA must adapt to better meet the needs of female veterans. By increasing the authorization in care, we can ensure Congress is not standing in the way of VA seeking to do just that.

Absent legislative change, the VA cannot provide more than 7 days care. I believe this is unacceptable. In closing, we owe it to our female veterans to expand the healthcare services that the VA can provide them and their children. Female veterans face unique challenges and barriers, including very limited newborn care coverage.

While the majority of female veterans who receive maternity care from the VA are able to return home with newborns within current 7 days time frame, some cannot due to newborn complications. It is these veterans and children that need our help today. And expanding this coverage will give them a little more peace and security.

Mr. Chairman and Ranking Member, I do appreciate the opportunity to talk about this and I thank you for the opportunity to discuss this legislation.

I yield back.

[THE PREPARED STATEMENT OF MR. DOUG COLLINS APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Collins.

Mr. Culberson, please proceed with your statement.

STATEMENT OF HON. JOHN CULBERSON

Mr. CULBERSON. Mr. Chairman, thank you. I deeply appreciate the time today, Chairman Benishek, Ranking Member Brownley, and I want to thank the members of the subcommittee; you have coauthored this legislation with me that I present to you today.

I want to thank in particular my colleagues from Texas, Representative O'Rourke and Representative Walz, thank you for coauthoring this with me. Representative Huelskamp has signed on with me, as well as Representative Ann Kirkpatrick.

It is a straightforward, very simple, commonsense idea. When I was visiting the Texas Medical Center back in August, my district just abuts the medical center. It is the largest collection of hospitals in the United States. 155,000 people come in and out of the Texas Medical Center every day. And a radiologist whom I was visiting with that day, Dr. Beth Edeiken-Monroe told me that she repeatedly tried to volunteer her time at the VA hospital and they turned her away. And I just couldn't believe it.

In talking to her and other doctors, all of a sudden, I started getting doctors from up and down the hallway coming to talk to me when they found out not only that I was a Congressman, but I have the privilege of chairing the VA Military Construction Appropriations Subcommittee. So this is—you know, helping our veterans is near and dear to my heart as it is to you all. And I was just dumbfounded, every single doctor I talked to and nurse, I started getting these stories from all over the medical center that they had made repeated efforts to go down and volunteer at the VA hospital because they recognized there was a shortage of help for our veterans that they had heard about the waiting lists, and they were concerned. And they didn't want any veteran to wait any longer than absolutely necessary, they wanted to get them in as quickly as possible to get care.

And so they were willing to help for free and the VA turned them away, said, no, it is too complicated, we have got this hurdle and that hurdle you have to jump through, and we have this problem and that problem and turned them away.

So I frankly was just outraged and concerned. And this very straightforward, simple piece of legislation is designed to make it easy to compel the VA to move rapidly to get any doctor who is licensed, doesn't have a disciplinary problem with their State licensing board, to get them in the door of the hospital right away and help see our Veterans. Make sure they get the care that they need.

It is designed also to address one the concerns the VA had. They said well, if we allow doctors to volunteer, what if they only they volunteer only a few hours a year. So there is a 40-hour minimum in here. The doctors of course want to make sure they provided the same medical liability protection that other doctors have under the Tort Claims Act. The VA already has a procedure for that. So any doctor who comes in and volunteers—this would apply not only to doctors, but healthcare professionals, nurses or other healthcare professionals that want to participate. They are given the same tort claims protection that other VA physicians are given.

So it is a very straightforward, simple idea. I talked to Secretary Bob about this yesterday. He supports this legislation and would like to see it enacted. I have the support also of the Texas Medical Association, believes this is a very straightforward and simple idea. And that is why I present it to you today.

I sincerely want to thank Dr. Beth Edeiken-Monroe, the folks at the Texas Medical Center, particularly MD Anderson Hospital which has done such extraordinary work in eliminating cancer, working to make it a treatable disease. And they are just a wonderful group of people and they just want to help.

To think of a time when veterans are—it is just appalling and unacceptable that our veterans have to wait to get in to see a doctor at the VA. We just want to make sure that we have all hands on deck to help our men and women in uniform get the medical treatment that they deserve, that they have earned, and that is all this legislation does.

And I would recommend it to your favorable consideration.

Thank you very much.

[THE PREPARED STATEMENT OF MR. JOHN CULBERSON APPEARS IN APPENDIX]

Dr. BENISHEK. Thank you, Mr. Culberson.

Unfortunately there is a vote call on the floor so we are going to have to—not adjourn, but recess the subcommittee for a short time. Hopefully we will be back by about 3:05.

So all the members are welcome to come back after. We are going to resume, but we will do the rest of our panels after that.

So we are in recess for the time being. Thank you.

[Recess.]

Dr. BENISHEK. I call to order the Veterans' Affairs subcommittee on Health hearing for the VA committee.

We missed a couple of people unfortunately because the vote was right in the middle of our hearing, which is always frustrating, but we will just begin with the second panel.

Joining us on the second panel is Christopher Neiweem, the legislative associate for the Iraq and Afghanistan Veterans of America, Brad Adams, staff attorney for Swords to Plowshares, Aleks Morosky, the deputy director of National Legislative Service for the Veterans of Foreign Wars of United States and John Rowan, the National president for the Vietnam Veterans for America.

Thank you all for being here this afternoon and for your hard work and advocacy on behalf of our veterans. I appreciate you being here to present your views of your members.

Well, we will begin with Mr. Neiweem.

Mr. NEIWEEM. you have 5 minutes.

STATEMENT OF CHRISTOPHER NEIWEEM

Mr. NEIWEEM. Chairman Benishek, Ranking Member Brownley and distinguished members of the subcommittee, on behalf of Iraq and Afghanistan Veterans of America, we would like to extend our gratitude for the opportunity to share with you our important views and recommendations on the legislation under consideration today.

IAVA supports each bill on the docket of this afternoon's hearing. However, we would like to use our time for remarks to focus on

H.R. 5059 the Clay Hunt Suicide Prevention for American Veterans Act or Clay Hunt SAV Act.

This comprehensive piece of legislation is a very important first step to addressing and beginning to curtail the tragic statistic reported by VA that 22 veterans are lost by suicide each day. Combatting veteran suicide is IAVA's top priority in 2014. In IAVA's 2014 member policy survey, over 47 percent of our respondents told us they knew a veteran who served in Iraq or Afghanistan who had attempted suicide and over 52 percent knew two or more veterans that had been lost to suicide.

The SAV Act has many key provisions, and I will briefly speak to some of them now. Firstly, it requires independent evaluations of all DoD and VA mental health programs and suicide prevention programs. Simply put, these independent evaluations, will examine which programs are working and which programs may not be effective and need to be curtailed, reformulated or eliminated.

Secondly, the bill instructs the VA to launch a new Web site to serve as a centralized resource to provide veterans with information regarding all of the mental health resources available to them and how to access those services. This includes a listing of where to find those services and a listing of key staff contacts that are available to field questions and address concerns.

Further, the formal strategic relationships the bill requires VA and the DoD to enter into with the Chief and the National Guard Bureau and regional state commands will assist in referral of mental health resources to Reserve and Guard troops with service-connected disabilities.

Too often Reserve and Guard forces return home from deployment without a firm pipeline of support to assist with their reintegration into their community. Additionally, the SAV Act aims to bolster the VA's psychiatric workforce through a 3-year pilot program that provides student loan relief for eligible psychiatrists that want to serve veterans at the VA. This incentive would put VA on par with other Federal entities that already offer student loan repayment incentives, and is a great opportunity to promote their recruitment of talented, dedicated, young professionals in the VA's ranks.

The last section of the bill that I would like to focus these remarks on is the Community Outreach Provision which creates a pilot program that will marshal government and nonprofit resources collectively. This will create trained veteran peer networks that will assist fellow veterans in their transition after service.

Additionally, the program will include the participation of community organizations, educational institutions and State and local governments. The SAV Act will improve policy in many categories to address the issue of veteran suicide.

Mr. Chairman, in VA's written remarks they state they support the intent of the Clay Hunt SAV Act, but want to slow down the bill's progress and help recraft certain portions of the bill. The Department has known for months that this bill would move forward in either November or December, yet it failed to raise one objection until now, the very last minute. In fact, just yesterday, Clay Hunt's mother, Susan, met with VA Secretary, Bob McDonald, who informed her that he absolutely supports the bill.

While quick improvements at a markup are acceptable, we do not want to see forward progress on the Clay Hunt SAV Act slowed because the Department wants to move at a glacierly pace on this bill. The time to move forward, Mr. Chairman, in our view is now, so we can get this to the floor and get it passed before we all go enjoy the holidays, that unfortunately with this statistic we know 22 veterans today we will lose to suicide and will not move forward to enjoy the holidays as we will.

Mr. Chairman, we value the VA again. I appreciate the opportunity to offer our views on these important pieces of legislation. I look forward to continuing to work with each one of you and your staffs to improve the lives of Iraq and Afghanistan veterans and their families.

I look forward—I appreciate your time and attention and I look forward to any questions you have of me.

Thank you.

[The prepared statement of Mr. Neiweem appears in the Appendix]

Dr. BENISHEK. Thank you for your testimony. And I certainly agree with you about the glacier-like attitude there.

Mr. Adams, you may begin your statement.

STATEMENT OF BRAD ADAMS

Mr. ADAMS. Chairman Benishek, Ranking Member Brownley and members of the subcommittee, thank you for inviting me to speak today.

Thank you also to the sponsors and cosponsors of the Clay Hunt SAV Act for pursuing this important issue.

My name is Bradford Adams, I am an Army Veteran. I served in Afghanistan. I am now an attorney at a veterans service organization called Swords to Plowshares.

Swords to Plowshares has been providing direct services to the veteran community in San Francisco for 40 years, including long work with the homeless veterans population and veterans struggling with mental illness. I work with veterans who are at risk of suicide, who have attempted suicide, and unfortunately sometimes I work with veterans who complete suicide despite our best efforts.

I want to discuss the specific provision of the Clay Hunt SAV Act and how it can be made stronger. Section 3 addresses an important problem. The problem is that there are a large number of at-risk veterans who are shut out of VA care. This happens because they have been discharged for some kind of misconduct. And when servicemembers are discharged for misconduct, the VA has the authority to deny them eligibility for VA services if the VA feels that their misconduct was so severe that it amounts to overall dishonorable service.

The VA can do this and does do this even when that misconduct is a direct result of mental health trauma acquired in service. This happens too often and it needs to stop.

I will give you an example of a servicemember who has not completed suicide, because I want to focus on the people that this bill can still help. Terrence Harvey was a combat infantryman. He served the 82nd in the first Gulf war, he cleared bunkers in Iraq and walked the highway of death in Kuwait. When he came back

he started showing signs of severe PTSD and after a few months he attempted suicide in the service. He wasn't getting the care he needed. He asked his command for leave to be with his family. When his command said no, he went anyway. When he came back, they discharged him for misconduct.

He still struggles with PTSD. He has been in and out of psychiatric hospitalization, including this past year. He has lived on the streets, which is where Swords to Plowshares found him. And he has attempted suicide again. That was misconduct and Terrence needed to be separated from the service, but the VA is wrong to deny him access to its care because of that one misconduct they believe overshadows his service and renders him ineligible for VA benefits.

That policy on the VA's part is unfair and it is unsafe, both for Terrence and for people around him. Terrence does not deserve to die by suicide. And his daughter who killed herself age 16 did not deserve to live with a father with untreated combat PTSD.

This will not be comprehensive suicide prevention bill as long as Veterans like Terrence are being shut out. Section 3 deals with this by asking the DoD to fix it. Section 3 instructs the DoD to take mental illness into account when veterans ask for discharge upgrades. The DoD should do so. But this is not a direct solution to the problem of suicide. The direct solution will deal with this through the VA itself. This is because it is the VA, not the DoD who decides eligibility for veterans' services. The VA does not need the DoD's permission on this, to grant eligibility for people like Terrence.

Every day the VA evaluates servicemembers like Terrence and decides whether their misconduct was so severe and so dishonorable they should be shut out from care by the VA. It is it the VA's call. This is where the problem is and that is where it can be fixed.

There is a straightforward legislative solution to this. The VA already has the authority to let servicemembers like Terrence in, they already have procedures and policies for doing so, and they have already made their own criteria, not Congress' criteria for making that decision.

If Congress doesn't like the results of that decision, they can simply give new criteria for the VA to implement, no additional costs, or procedures, or time.

There are two shortcomings to this criteria that I would like to draw to your attention. First, they don't fully account for mental health conditions. If the veterans misconduct was the result of the a mental health problem like it, was for Terrence, the VA will excuse that misconduct only if the severity arose to the level of criminal insanity. This doesn't help Terrence. Terrence had severe life-threatening PTSD, but he wasn't insane so it doesn't help him.

Second, it doesn't account for combat deployment. There is nothing in VA regulation or policy which says that its staff must take into account a combat deployment when deciding if someone is eligible for VA services. Clearly that has to stop.

The committee should give the VA two instructions on this. First, when someone has served in combat or has a mental health condition acquired in service, only severe misconduct should render them ineligible for VA services.

Second, while the VA is making up its mind about this, it should provide tentative eligibility for two essential services, medical care and housing services. That is the basic services that someone in a mental health crisis needs.

The current backlog means that waiting for this decision can take 1 to 3 years. That is too long to wait. This is an opportunity to make sure veterans like Terrence are under VA care. I hope the committee will take this opportunity to fix that. Thank you very much.

[The prepared statement of Mr. Adams appears in the Appendix]

Dr. BENISHEK. Thank you for your impassioned testimony there, Mr. Adams. Good job.

Mr. Morosky, you have 5 minutes.

STATEMENT OF ALEKS MOROSKY

Mr. MOROSKY. Chairman Benishek, Ranking Member Brownley and members of the subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States and our auxiliaries, I want to thank you for the opportunity to present the VFW's stance on legislation pending before this subcommittee.

The bills we are discussing today are aimed at improving healthcare for veterans and servicemembers and we thank the committee for bringing them forward.

H.R. 4720, the Medal of Honor Priority Care Act: The VFW supports this legislation which would elevate medal of honor recipients from VA priority group 3 to priority group 1. The 79 living medal of honor recipients are held in the highest esteem by the veterans and military community. Accordingly, we believe it is entirely appropriate to grant them priority group 1 status as a small, but meaningful symbol of our appreciation for their heroic actions.

H.R. 4887, Expanding Care for Veterans Act: The VFW supports this legislation which would expand VA research, education and delivery of Complementary and Alternative Medicine treatments, also known as CAM.

All too often, the VFW hears stories from veterans who were prescribed ineffective medications to treat their mental health conditions, and powerful addictive medications to treat pain. While drug therapies may be the best solution for some, we recognize that CAM therapies are often a better, safer alternative for others. While already in use on a limited basis throughout the department, we believe that VA should continue to expand access to alternative treatments.

H.R. 4977, Creating Options for Veterans Expedited Recovery or COVER Act: The VFW supports this legislation which would establish a commission to survey veterans and examine the efficacy of VA mental healthcare and CAM in order to identify ways to improve outcomes.

With more than 1.4 million veterans receiving specialized VA mental health treatment each year, VA must ensure that such services are safe and effective.

H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act or the SAV Act: The VFW is proud to support the Clay Hunt SAV Act, which is aimed at Combatting veteran suicide. This

widely known crisis is one that weighs heavily on our Nation, especially on those of us who have served in uniform.

When a veteran or servicemember becomes so hopeless they decide to take their own life, it is equally as devastating as life lost in combat. We would like to thank Representative Walz and Chairman Miller for bringing forth this bipartisan legislation. The SAV Act contains numerous provisions that would have a significant impact on preventing veteran suicide.

We would offer a meaningful change to the way unfavorable discharges are reviewed by the Department of Defense in cases where servicemembers were likely suffering from undiagnosed mental health wounds. It would require VA and the National Guard Bureau to enter into strategic partnerships to ensure guardsmen don't fall between the cracks as they transition from duty. This legislation would also establish a VA community outreach program focused on successful active duty to veteran transition through peer support.

The VFW believes these key provisions along with others contained in the bill will go a long way towards addressing the crisis of veteran suicide.

H.R. 5475: The VFW supports this legislation which would expand VA's authority to provide healthcare to a newborn child whose delivery is furnished by VA from 7 to 14 days post birth. According to the Centers for Disease Control and Prevention, newborn screenings are vital to diagnosing and preventing certain health conditions that can affect a child's long-term health. The VFW understands the importance of high quality newborn healthcare and its impact on the lives of veterans and their families. We believe that VA should be authorized to do what is needed to ensure that newborn children whose delivery was furnished by VA receive the proper post-natal healthcare they may need.

H.R. 5484, Toxic Exposure Research Act of 2014: The VFW supports this legislation which would establish an advisory board to assist VA in determining the association between adverse health conditions and exposure to toxic substances. It would also establish a national center for research to study the health affects of toxic exposures on the descendants of individuals who were exposed to such substances during their military service.

The VFW does have concerns, however, with section 4, which would authorize the advisory board to determine whether a veteran who submits a claim has a health condition that would qualify them for VA healthcare or compensation benefits.

Since the VA already has an established process for adjudicating disability claims, creating a new process for the unique purpose of deciding toxic exposure claims could add confusion to the disability evaluation system.

We suggest that the advisory board's role in this process be limited to whether its research found that a health condition is associated with exposure to toxic substances. Such a process should serve to inform veterans of the advisory board's findings, not to determine a veterans eligibility for VA benefits.

That being said, the VFW strongly believes that veterans should not have to wait decades before their illnesses associated with toxic exposures are recognized, and that more research is needed to de-

termine what affects those exposures may have on their descendants.

Mr. Chairman, this concludes my statement and I look forward to any questions you and other members of the subcommittee may have.

[THE PREPARED STATEMENT OF MR. ALEKS MOROSKY APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you very much, Mr. Morosky for your testimony.

Mr. Rowan.

STATEMENT OF JOHN ROWAN

Mr. ROWAN. Good afternoon, Mr. Chairman, Ranking Member Brownley, distinguished members of the panel.

First of all, Vietnam Veterans of America supports all the bills before you today and we want to be on the record for that. However, I do want to speak on a couple. First of all, we want to thank the chairman for his support of H.R. 5484. I will get into that secondly.

I want to say a couple of words on the Clay Hunt SAV Act. Unfortunately I have been around in this business long enough and I am old enough to remember when Swords to Plowshares was created. And the problems they talk about today with suicide is still with the Vietnam vets. Sixty percent of veterans committing suicides today are my generation, over 50, they are the Vietnam vets primarily. It is still a problem for us. It was a problem for us when we came home and it is still a problem for us today. It is becoming more of a problem unfortunately as the veterans get older.

So a lot of this effort is great and I am glad we are working on trying to save this younger veterans coming home and trying to do anything we can to save them. A lot of the Vietnam vets are mentoring these folks as they come home.

But it is important also on this other issue, in 1972 Ralph Nader did a study that shows there were a half a million bad paper discharges issued during the Vietnam War, most of them for drugs, alcohol and AWOL. Minor nonsense stuff that cost people the rest of their lives to have an albatross around their neck.

Many of them—veterans who came home from Vietnam and were stuck with another year of service who couldn't deal with life back in barracks. We see that today as well so it is a real problem. This is not a new problem, it is an old problem. And maybe if we were doing research on these and other problems we'd know what to do today and we wouldn't have to wait 35 years to figure it out.

As far as the Toxic Research Exposure Act of 2014, this is an issue we have been looking at for quite a number of years now, especially in the last couple of years. Vietnam Veterans of America have held numerous over 100, almost 150 now of town hall meetings all across the country asking veterans about their exposures to Agent Orange and how they think it affected their families. And unfortunately, the answer is pretty horrifying.

Now, I can't tell you for absolutely sure that every issue and every illness is because of Agent Orange I would never say that. I am not an scientist, wouldn't even think about it. But the reality is the VA has done very little in the way of studying Agent Orange

affects in anybody ever, in the whole history of Vietnam veterans coming home. All the years that we have been dealing with the Agent Orange Act since 1991, there has always been outside research the IOM on how to review, not research done by the VA, or through the VA, or under the auspices of the VA.

So we really must encourage you to get this bill passed and it may need some tweaking. And I can tell you we are not looking to play with the claims part of how claims are done. We are simply saying if we see something going on, and we see these issues coming up, you better start taking a look at whether or not it deserves a claim.

And all we have asked people to do is if they think their child's issues are related to their exposure as a veteran, file a claim, get denied, but at least let's get it in. And we have got the VA putting all of those claims in one place in Denver so we can compile the information coming in and get an idea of what kind of wide range of unfortunate illnesses or issues we are dealing with. So that hopefully will give them some direction on what it is they need to research.

So we encourage you to please pass this bill and if we have to tweak it, we will. But the key to this bill also, it is not just about us, it is not just about the Vietnam veterans. We may be the first and one of the largest groups to have been exposed—actually, we weren't the first, talk to the atomic veterans from World War II, but we are the biggest probably of being exposed out there.

But the Persian Gulf veterans frankly have more of a problem than we do in some ways. It is just that fortunately they didn't send that 2 million people to the Persian Gulf the first time out. Now unfortunately they sent them back to the Persian Gulf for the second time out and we have got a couple million people who have tromped through Iraq, and Afghanistan, and other wonderful places and exposed to who knows what out there.

And I can tell you after talking to some of the troops who have come home and talking about their illnesses already and some of their children's illnesses already we have some real serious concerns about what they have been exposed to. So it is extremely important that this bill go through and we start getting this research done now.

I am 69 years old. I have been waiting for this stuff for a long time. The children of the Vietnam veterans are in their forties. It is the grandchildren that now we are even looking at, who even those are in their twenties. I have friends of mine who are great great grand parents. So it is time, it is just that simple, it is time.

Thank you.

[THE PREPARED STATEMENT OF MR. JOHN ROWAN APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Rowan, for your testimony.

I appreciate the fact that all you gentleman came and testified today, that is really fabulous.

I am going to yield myself 5 minutes for comments and questions.

Let me just say that frankly I brought up this toxic exposure bill after talking to veterans in my District. I go around, have a group and try to meet with veterans in every little town I can at the VFW

or the American Legion and they just brought up this issue of these burn pits, which frankly I hadn't really heard of until they brought it to my attention, in the Persian Gulf war back in the 1990s.

We really need to be more on top of this possible exposure, because like you say, the Agent Orange issue didn't come out until 20 years after Vietnam, if not longer. And, we just need to be on top of these possible exposures in a more timely fashion. That is one of the reasons I brought forward the bill and we are happy to look at tweaks to it to make sure it doesn't affect, the determination of disability. That is the reason we are having this hearing franking is to get input from other people to learn more about how to do things.

The only other comment I wish to make was about the alternative therapies. I just got exposed to an equine therapy in my District. I went out with Ms. Brownley in California and got some exposure to Hope. And, I am not really a horse person, but I went to this equine therapy and I met some veterans there, Vietnam War veterans who were mentoring younger veterans who felt it was a real help to them, because as you know, not the same treatment is good for everyone. There should be a wide variety of options to treat people with PTSD and other combat trauma history. I thought it was really an awakening.

The problem is how to make sure that, there is a good quality of treatment and there is a good effect with all this disparate types of alternative therapies. We have heard from yoga to acupuncture. How are we going to make sure this all makes sense to veterans? I am happy to explore that in this committee, but we need to make some progress. I think Ms. Brownley's bill is a great step forward.

Do any of you have comments on the alternative medical therapies as proposed and the couple of pieces of legislation I have today? Anybody want to weigh in?

Mr. NEIWEEM. Mr. Chairman, I will just jump in. I think looking at complementing alternative medicines would be a step forward, and certainly some pieces of legislation start including survey instruments, you know, looking at veterans and sort of talking to them. I think when you focus on the veteran, you get that feedback, and so instead of asking VA, you are asking veterans. And many veterans can benefit from these types of treatments and it goes hand in hand with the peer support model of veterans tending to be comfortable talking to other veterans.

Mr. ROWAN. Yeah, I would add too, that the only caveat we had about that is it needs to be reviewed scientifically, that we ensure that what they are doing is in fact scientifically correct, and that they can double-check it and triple-check it and make sure it is working.

One of the other things I think you will find a lot of time with the alternatives therapies is they can't be done alone. And that is one of the problems we got. Sometimes people tend to grab on one thing and say, oh, this is wonderful. This is all I have to do and I am going to be cured. Well, not really.

I mean we got into that years ago with alcohol and substance abuse. We would clean people off, dry them out in the VA rehabs and all this stuff and they would come right back again because

nobody never ever dealt with their PTSD, which is why they were getting drug and alcohol problems in the first place. You needed to do both. You had to dry them out at the same time you were treating them for PTSD.

So yes, maybe somebody needs a therapy dog because it calms them down, and it is really cool, and I like dogs. And I can understand that, but at the same time, they still need to go to therapy, they still need to go to a rap group, they still need to talk their problems out. So as a complementary program, I think it would be very interesting, as long as the science works.

Dr. BENISHEK. I definitely agree with that, Mr. Rowan. Thank you.

I will yield the remainder of my time.

Ms. BROWNLEY. I yield to you for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And I guess I just wanted to follow up on that with you, Mr. Rowan, because my understanding is at least with the bill that we were just talking about, 4887, that you had said that you felt hesitant about endorsing it because you felt like more research needed to be done, which is consistent with what you just said.

And I wanted to make it clear that the bill before us today—actually includes the research component of that defined, to really determine its efficacy. And if it is a proven program, then to figure out how to integrate it into the various services, for our veterans. And so, I would love it if you would take another look and overwhelmingly support the bill, I would appreciate it very much.

Mr. ROWAN. Yes, we will. The head of my veterans health council is the guy who is really the expert on all of this stuff. And so he is my PTSD person so he is going to be the one to follow it, I'm sure.

And we will be happy to work with you on that one.

Ms. BROWNLEY. Very good. Very good.

And I know that the chair was speaking of Reigns of Hope that is in my district, equine therapy. But there is a psychotherapist there. And so it is complementary.

And I know that the veterans who are going there for services tried all of the traditional methods and it wasn't until they got out into a rather beautiful setting up in Ojai, if anybody has ever been in Ojai, it is in my district—in a beautiful open setting in an orange grove, around horses and a very calming atmosphere that, finally, veterans were willing to really begin to talk about what some of their issues are.

Mr. ROWAN. Yeah. I think what—you are just making a good point, the issue of being out somewhere where it is nice and calm and peaceful.

Vets—a lot of the vets—the Vietnam vets literally did that, ran into the hills. Couldn't live in the cities. Had to get out. Had to get into the countryside. It was part of the way they coped.

But, again, I think the key is the complementary aspect. You know, it is no question, if they can get calmed down, then they can get treatment. You can talk to them. If they are in an agitated state, somebody is not going to talk to you.

So if the animals will calm them down or other kinds of treatments calm them down and they can get them into a program, get them into a rap group, boy, that is terrific.

Ms. BROWNLEY. Yes. We have some veterans who are traveling 6 hours to actually utilize this therapy because it has been the only thing that has really worked for them.

Mr. NEIWEEM. am I pronouncing your name correctly?

Mr. NEIWEEM. It is pretty close, Ms. Ranking Member. It is "Neiweem."

Ms. BROWNLEY. "Neiweem." I apologize.

So in your testimony you stated that suicide prevention is obviously your number one priority, as is ours. And you talked about the Clay Hunt Bill as being a starting point.

What else should we be doing?

Mr. NEIWEEM. Well, I think there are several provisions in the Clay Hunt Bill, but just one example is the community outreach prevention.

So we are looking at creating these veteran networks and expanding peer-to-peer support, and we reach out there. And you talk to veterans and they are always comfortable talking with other veterans. We hear that again and again.

So it's been sort of a successful approach. In some of the scenarios where, you know, that tragic ending occurs, usually that individual has lost touch with the community and left.

And in, you know, VA's written remarks, they sort of—you know, they talk about the peer support program they have right now. They describe it as, you know, a very robust support program that has at least three specialists at every VA medical center. Three people is very robust? I would disagree with that.

Now, it is good and it is—it is working. I think it is successful in looking at the 973 peer specialists. But why aren't we doubling down on that? Why aren't we looking at that and expanding that to get more veterans out in the community?

You know, we know that VA has had these mental health summits and reached out. But is that enough? So you have one summit and then it is sort of you all get together and then you lose touch. So this bill gets into that.

And we appreciate all the support from all the members, especially Chairman Miller, Mr. Walz and others, pushing this bill. So that is one example. It just is emphasizing peer support. That is just one section of the bill, one example.

And your bill, Congresswoman Brownley, looking at CAM—I mean, we have to look at that. And if we don't look at it and work towards looking at evidence-based things, then we are never going to add it.

And we have to get away from this "VA knows best," you know sort of philosophy, "The VA knows," "The VA." Well, talk to the veterans. Because, for many, it is very therapeutic to horseback-ride, fishing. The list goes on. So——

Ms. BROWNLEY. Thank you, sir.

And I will yield back.

Dr. BENISHEK. Thanks, Ms. Brownley.

Dr. Roe.

Dr. ROE. Thank you, Mr. Chairman.

First of all, thank you all for your service. Mr. Rowan and I are of the same vintage. So thank you for your service in Vietnam.

We have—one of our famous VA medical centers is the Alvin C. York Medical Center, a Medal of Honor winner. And when I was—we were doing the VA bill last—this last summer, before we went on recess and got it signed into law, I discovered, as Tim Walberg did, that a Medal of Honor winner was a category 3. I want them to have the Secretary's name on speed dial.

There are 79 of these men. I had the privilege of being at the Bristol Brothers Speedway in August with three Medal of Honor winners. And they had their convention in Knoxville that weekend. And those men should go to the front of the line. That is one—that is basically one Medal of Honor winner for every other major medical center.

I don't think it is going to create any big hardship for the VA to take care of these men, and—and I think they should be at the front of the line. If they want an appointment at 10 o'clock tomorrow, a Medal of Honor winner ought to have it. It ought to cost them absolutely nothing.

So I would want to expand a little bit on Mr. Walberg's and go full bore on that for a Medal of Honor winner. That is just a shout-out to them. We have had two in my district. These are incredible people and they need to be honored.

And it is shameful that we had them ever as a category 3. They are number 1 in my book forever. As a matter of fact, they ought to have the President's number on speed dial. That is how I feel about the Medal of Honor winners.

Now, number two, on what Mr. Collins was talking about, typically, on a newborn baby, probably 95 percent of the issues that we see—and Dan can help me with this—but probably 95 percent of the issues that we see exacerbate themselves within 6 weeks.

I don't know what the problem is with just having a 6 weeks' checkup included in that bill, like we do for any other pregnant mother. I took care of women for 30 years and delivered their babies and took care of their children.

And I don't know why 2 weeks is put in there. I have never seen a 2-week checkup. My children always got checked by the pediatrician, and they went on and had their 6 weeks' checkup. And I would just expand that to 6 weeks and let's get most of the issues out of the way. That is just a suggestion that I have.

One of the things that—that I agree totally on are on your alternative therapies. Mr. Rowan is correct. We do need to use evidence-based therapy. I think you are right or you will end up wasting a lot of money and time and maybe not do any good. So I think that is extremely important. Ms. Brownley, I agree with you on that.

And we are very much involved in this. My wife is helping set up a pet therapy program for our local VA, and many people want to help. We know those things help. I saw a veteran the other day with his service dog with him at a—at a Memorial—I mean, at a Veterans Day event. And I know this guy. And he is much, much better because of that therapy dog. There is no question about it. And he says he is and he can function now.

But it needs to be studied. It is not for everybody. And I agree with you, Mr. Rowan. It is probably—adjunctive therapy, we should call it, not primary therapy.

The one issue—and, Mr. Adams, I want you to respond to this. And this is a real problem I have had dealing with, because we have veterans, as Mr. Rowan pointed out, that come to my office—my Congressional office who—usually, it is Vietnam—who went AWOL after they got back.

I know—when I was in the 2nd Infantry Division, we couldn't tolerate that behavior, if you had someone that was disruptive like that. And probably there is no doubt—I was a medical officer in the 2nd Infantry Division. I probably did a very poor job of identifying some of these folks with mental illness and—who should have been—had a general discharge, not dishonorable discharge, from the military and they would have been able to do what you do.

But we all know that a soldier that goes AWOL puts his unit at risk. And that is the trouble I have had in dealing with that. How—how do you—I know it was a bad decision. It could have been because of something they had no control of.

As Mr. Rowan said, going forward—it has taken us 40 years to figure this out—I think the DoD needs to be more careful when they discharge someone to—to be clear, instead of just getting it off the books quick and taking care of the problem, because it carries, as you pointed out, Mr. Adams, a lifetime of ramifications. Because that person could very well be brought back into society and have a perfectly productive life if they are treated right. Maybe we just missed it on the way in or out.

So you have got to help me with that a little bit because I don't—that one is tough for the military. It is. Because they can't have disruptive behavior in a platoon or whatever.

So if you would let me have about a minute and let him respond to that.

Dr. BENISHEK. Sure.

Dr. ROE. Thank you.

Mr. ADAMS. Well, thanks for your interest in your question, Dr. Roe.

I agree with you entirely. I agree with you entirely. And, as I said, in the case of Terrence Harvey, he needed probably to be separated from service.

Now, the VA should have done it properly. It should have identified the problem, given him a medical discharge. They didn't do that. And that should be corrected by the Armed Services Committee through the DoD.

It is a different question today if that person who needed to have been separated from service for whatever reason deserves our society's and country's support dealing with the burdens they carry from the service. And the law is already written to separate those two things because they are different.

The commander needs to make decisions today to ensure the effectiveness of his unit today. The VA needs to make decisions over the life of that veteran to ensure that we uphold our responsibilities to that veteran. They are two different things.

If the committee puts the burden on the DoD for deciding who gets sent out of the VA, they are essentially combining those two

things, giving responsibility to the commanders that the commanders don't want. The commanders don't want to be responsible for the lifetime after that veteran actually left service.

By separating those, giving clear separate instructions to the VA, that allows the DoD and the VA to do their separate jobs and allows us to give appropriate response and treatment to veterans on a case-by-case basis.

Dr. ROE. But they would be—they would be given a medical discharge, though. That has to happen at the DoD level.

Mr. ADAMS. So the correct way to proceed, to take the example of Mr. Harvey, was he should have been recognized and diagnosed with PTSD and given a medical discharge. And if that had happened, he would be in the door at the VA.

Dr. ROE. He would be fine. Right.

Mr. ADAMS. He would be fine.

Now, what we can do right now is you can tell him to go back to the DoD and ask them to change their mind.

Dr. ROE. It will never happen.

Mr. ADAMS. Well, yeah. I mean, I can—I do it. It takes 3 years, 87 percent denial rate, depending on service. There is two different agencies, different forms, different procedures. It just doesn't—it is not a solution to at-risk veterans.

The VA can solve it on the spot. That is under the existing law. They just have rules that I think don't reflect the public and certainly not my expectations of who should be in, who should be out.

Dr. ROE. Thank you.

I thank the Chairman for allowing me to have a little extra time. I yield back.

Dr. BENISHEK. Absolutely.

Mr. ROWAN. Mr. Chairman, can I respond to the Doctor's question just quick?

We did this back in the 1970s and 1980s. I did discharge upgrades. We upgraded 70 to 80 percent of the claims we did in New York City at the time.

The reality—and we—and we are suing all of the military people right now about these discharges they gave out for the wrong diagnosis that should have been PTSD.

But I wholeheartedly agree. The VA can bring all these people in tomorrow. They can take them. Unless they had a dishonorable discharge for serious crimes and offenses, they can take them in and treat them. And that is the key part, the treatment.

Dr. BENISHEK. Mr. Bilirakis, 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it again.

And I want to thank the panel for their support and their testimony today, but thank you for the support of the COVER Act. And, again, that is why we are here. If you have any suggestions to improve my particular bill, please don't ever hesitate.

And, again, I am big on these alternative therapies or complementary therapies. I know they work because I speak to the veterans every day. But, of course, we do have to have the science.

I have a couple questions and then—I would appreciate a yes or no. But if you have to elaborate quickly, that is fine, too. But I want—for the entire panel.

I guess we will begin with Mr. Neiweem.

Do you believe the therapies accepted and currently practiced by the VA are yielding the best wellness-based outcomes for veterans affected by the mental health concerns?

Mr. NEIWEEM. Congressman, first of all, we support your bill strongly.

I would say there is essentially sort of two tracks. There is the counseling track, and there is sort of the prescription drug track, in my experience. So those results vary greatly, depending on the individual.

So that is my—my best answer is it varies. So the incorporation of CAM alternatives I think offers new alternatives that we need to look at.

Mr. BILIRAKIS. Thank you.

Mr. Adams.

Mr. ADAMS. With respect, Mr. Congressman, our attention is really focused on those who are excluded entirely from the VA health system.

There are two narrow benefits that are available to people, even if they have what—what we call bad paper, and they are too limited.

One is access to the vet centers, which you may be familiar with. They have the same eligibility requirements, but they just basically don't ask too many questions when people come in.

They only provide talk therapy. We would love it if they also had access to medical treatment as well as complementary treatment. None of those are available to them, and we hope that that—that can be.

Mr. BILIRAKIS. Mr. Morosky.

Mr. MOROSKY. I would say some are more successful than others. More needs to be done.

Mr. BILIRAKIS. Mr. Rowan.

Mr. ROWAN. No.

Mr. BILIRAKIS. Okay. Thank you very much. Appreciate it.

Do you believe the veterans affected by mental health are being over-prescribed with prescription drugs for their ailments? If we can start right here again.

Mr. NEIWEEM. I think, in some cases, that is true. And I think, in the case of many veterans, that is where, you know, sort of VA can be lagging, too, is the time that elapses between appointments, struggling to get, you know, an appointment with a, you know, VA outpatient clinic.

If you have, you know, adverse reaction to certain medications, certainly, you know, you can call. But, again, until we improve sort of the time with which veterans can get in there, you know, I think we are going to still see, you know, issues with prescription medications and others as things can change.

So consistency with—with VA appointments and timeliness with getting veterans in to see care I think is critical.

Mr. BILIRAKIS. Mr. Adams.

Mr. ADAMS. I do work with veterans who feel that they are over-prescribed medication. From my perspective, often I think the problem is they don't understand that they have options, even within medical responses. So veterans will say, "This makes me feel terrible. I am going off my meds."

Mr. BILIRAKIS. Are there options within the VA?

Mr. ADAMS. Within—even within the VA. Even within medical treatment. I mean, there is really a sense of powerlessness among—among some. So some say, "I am going off meds. I just can't take it."

And I say, "You know, you can do that if you want, but you can also go to your doctor and say, 'I feel this way. I don't feel good. This drug you put me on last week does make me feel bad. Do you have something else?'"

And so I think encouraging both the existence of options within and outside the VA, inside and outside the medical—certainly the medical sphere—I think that can go a long way toward giving people control over their health.

Mr. BILIRAKIS. Thank you, sir.

Mr. Morosky.

Mr. MOROSKY. We hear from veterans that feel overmedicated, that feel that they are medicated incorrectly. They are receiving pills that aren't doing anything for them, but certainly are overmedicated. We know of people who have died from overdoses because of overmedication.

So this is one of the reasons why we think CAM therapies are important, because it goes away from the one size fits all and gives people other safer alternatives.

Mr. BILIRAKIS. Yeah. You know a lot of these alternative therapies are available. But the ranking member said, you know, you have to drive 6 hours for the equine therapy. And we have it in our district, too.

But the problem is that, financially, a lot of these nonprofits are having a hard time during these economic times. And we need to reimburse them for these service, if they are effective. And I see that they are effective.

Mr. Rowan.

Mr. ROWAN. I think it is less of a problem than it was in the early days. I can tell you that. All they had was drug therapy originally. I mean, there were no—that is—there was nothing. They just—the guy went over there, they gave you a bunch of pills and you went home and often got yourself in deeper trouble.

The key, I think, is the combination of all of the things. And I think the problem is it is just not enough staff time and not enough veteran centers out there. There is just not enough of anything out there. They need more staff. They need more help. They need to get people in to be treated quickly. That is the other problem.

You can't let somebody languish out there when they have a mental health question going on because often there is other issues. You know—and, you know, the typical thing that usually shows up is substance abuse or alcoholism, spousal abuse, child abuse.

I mean, one of the key things, I think, that works, by the way, is the vet court system because that captures these folks and at least we get in—that forces them to get into a system and to have somebody supervise them—that is the other key question—having the outside agency like the court supervise their process and having a veteran mentor helping them through the process.

Mr. BILIRAKIS. Very good.

Mr. ROWAN. And some of that may be therapy. And some of—all the other kinds of things you are talking are very interesting. We would like to talk about it.

Mr. BILIRAKIS. Thank you very much.

I—well, my time has expired, Mr. Chairman. I yield back.

Dr. BENISHEK. Thank you.

I want to thank you gentleman for appearing before us today. And I really appreciate your input. And stay in touch with us so we can tweak these things that help us all better. Thanks so much.

I would like to welcome the third and final panel to the witness table.

Joining us from the Department of Veterans Affairs is Dr. Rajiv Jain, Assistant Deputy Under Secretary for Health for Patient Care Services.

Dr. Jain is accompanied by Jennifer Gray, Staff Attorney for the VA Office of General Counsel.

Thank you both for joining us today.

STATEMENTS OF RAJIV JAIN, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JENNIFER GRAY, ESQ., STAFF ATTORNEY, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF RAJIV JAIN, M.D.

Dr. JAIN. Thank you, Mr. Chairman. Good afternoon. And Ranking Member Brownley and members of the subcommittee, thank you for the opportunity to address the bills on today's agenda and to discuss the impact of these bills and VHA's healthcare operations. Joining me today is Jennifer Gray with VA's Office of the General Counsel on my left.

I want to first thank the subcommittee for the opportunity to testify concerning the bills we support, starting with H.R. 5475.

VA supports H.R. 5475, which would expand coverage for newborns through their first 14 days of life. We are still analyzing the cost of this bill, but we believe it would provide an expanded benefit to a relatively small number of newborns who need the additional coverage.

VA also fully supports and appreciates H.R. 4720, legislation designed to recognize the service of Medal of Honor recipients and to ensure that they receive cost-free care to maintain their health and well-being. Toward this end, VA believes that, in addition to moving them to priority group 1, we would need to amend the statutory authorities governing copayments.

However, we would like to work with the committee to ensure that the end goal of costly care is attained as it is for other special categories of veterans, such as catastrophically disabled veterans, former prisoners of war, and Purple Heart recipients.

VA also supports the goals of H.R. 4977, which would establish a commission to examine the efficacy of the evidence-based therapy model used for treating mental health illnesses, identify areas to improve wellness-based outcomes, conduct patient-centered sur-

veys, and examine available research on complementary and alternative treatment therapies for mental health issues.

However, as outlined in our testimony, we have concerns about the manner in which the bill would carry out that goal because of the duplicative nature of some of the requirements and the unintended burden it may place upon our veterans. We would like to work with the committee to address these concerns and develop a bill that addresses the needs of these veterans.

Likewise, we believe that H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act, is a very important piece of legislation, but may potentially overlap with programs already underway in VA.

VA appreciates that Congress continues to raise awareness of mental healthcare and suicide prevention, two of our highest priorities. VA would welcome discussions with the committee to examine how best to address these issues and identify and fill gaps that may exist.

We received H.R. 4887, the Expanded Care For Veterans Act, and H.R. 5686, the Physician Ambassadors Helping Veterans Act, just prior to today's hearing. And, therefore, we were not able to provide views at this time. We would be happy to discuss either of these bills today or to meet with the committee to provide technical assistance going forward.

Finally, let me state at the outset that, while we do not support H.R. 5484, we do support the goals behind many of the provisions in this bill. However, we are concerned that key elements are not clearly defined, such as how a newly established advisory board for toxic exposures would review claims and operate in relation to existing statutes, regulations, and processes for claims adjudication.

We also feel that the center established by the bill would duplicate the work being done by other agencies that have been doing this sort of work for many years. We would like to acknowledge that more needs to be done in this area, and we would be happy to work with the VSOs and the committee to address these issues.

In closing, thank you, Mr. Chairman, for the opportunity to testify before you today. My colleague and I would be pleased to respond to your questions.

[THE PREPARED STATEMENT OF DR. JAIN APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Dr. Jain.

I would like to yield myself 5 minutes to discuss this legislation and to ask some questions.

I am curious about this written testimony that placed the Medal of Honor recipients in priority group 1 rather than priority group 3. There was a statement, apparently, in your written testimony that said this would result in no additional benefit for the veteran.

Dr. JAIN. Sir——

Dr. BENISHEK. What does that mean exactly?

Dr. JAIN. Right, sir. Mr. Chairman, I will be happy to clarify.

The issue here—and I will turn to my colleague here on the left in a second—but the issue is that the—the service of medal recipients who are in category 3, if we were to move them in category 1, which we do support, would still not give them the cost-free care

that we are looking for because the statutes that govern that piece are different statutes.

But let me ask Ms. Gray to clarify that.

Ms. GRAY. Right. So we have specific statutes that deal with copayments. For example, 1722A deals with the medication copayments, and that is tied—those who are exempted from paying the copayment, it is tied to either service connection or income or being a prisoner of war.

So in order to make sure that recipients of the Medal of Honor are also exempt, we would have to make changes to 1722A and, likewise, 1710 and 1710B.

Dr. BENISHEK. Is there any other difference, then, between the veterans in priority group 1 and priority group 3? Is there any difference, other than that provision, between the people that——

Dr. JAIN. No, sir, as far as we know. Now, those service of medal recipients that are already service-connected, they would automatically be in priority group 1.

So the difference is whether they are service-connected or not, and that is what ends up being there in group 3. So we definitely support moving them to group 1. So that would be definitely the right thing to do.

Dr. BENISHEK. All right. I have another question about H.R. 5059 that you are somewhat unsure if we could do anything more for the veteran, because you think you are doing everything.

It doesn't seem to jibe with the fact that we have 22 veterans a day that are still committing suicide, and that number doesn't seem to be changing all that dramatically to me.

So, I mean, if this doesn't do it, then, what would do it, Dr. Jain? I mean, I want to get that number down to zero.

Dr. JAIN. Sir—Mr. Chairman, we fully agree with you. And so the issue is not that we don't support the goals. We definitely support the goals. The only concern that we have is that we have other efforts underway in the VA that are achieving the kind of things that the bill would achieve.

So I will give you some examples, sir. The—for example, the issue of the outside review, we have a contract with the National Academies of Science, which is a purely independent body that is currently in effect, and that is reviewing the mental health and the suicide prevention programs in the VA.

We also have done data-sharing agreements with all the 50 States to understand our understanding of the suicides. And we published a report in February 2013 from that to inform our prevention efforts. We also have a VA/DoD suicide data repository, and we published a report in January of 2014.

But we do support, sir, the—that there should be a one-time targeted evaluation of the suicide prevention program to support the implementation of the 2013 joint VA and DoD clinical practice guidelines for management of risk of suicide. So——

Dr. BENISHEK. What has changed in the last 6 months, then, about suicide prevention practices within the VA that you have learned from the studies that you are already conducting? What have you changed? Have you changed anything in the last 6 months, Dr. Jain?

Dr. JAIN. So—yes, sir. I think—let me clarify. I think that there are—about 3 to 4 months ago, we did a very deep dive into the four or five major causes for suicide, which have to do with depression, sleep disorders, PTSD.

So we worked with our subject matter experts to understand what is the evidence base, and we have updated the—the guidelines for treatment of some of these conditions. And we are now in the process of implementation of those guidelines.

Dr. BENISHEK. Well, I certainly understand that you are giving me a long answer. But I am still very disappointed in the way the VA is taking care of veterans who are suicidal.

I mean, that is basically—the reason that we are sitting here today, Dr. Jain, is that 22 veterans are committing suicide a day and we want to find an answer.

And you tell me that, you are doing your own outside evaluations, but the numbers—aren't going down, Dr. Jain, and that is a problem for me.

Dr. JAIN. I would agree with that, sir. And that is definitely a problem for us. And we are always looking at better ways of doing things. We are looking at whatever the evidence base is, whatever we can do, whether it is complementary and alternative therapies.

And I know that Ms. Brownley's bill is—and we will talk about that in a minute. But we are always looking to see what other improvements we can put in place and how we can make the treatments better.

Mr Benishek. Okay. Well——

Dr. JAIN. So to extent the bill would help us, we are certainly in support of that part.

Dr. BENISHEK. All right. I am out of time.

Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Well, thank you for the segue in terms of talking about my bill. I appreciate that very much.

And in your testimony you said you hadn't really reviewed the bill. So if that is true, you don't have any concerns one way or the other because you haven't reviewed it. Or do you have some concerns regarding the efficacy of CAM therapies—if you will elaborate, please.

Dr. JAIN. Sure. And I would be—certainly be giving you some sort of general views on this and not the official view, as you are saying.

So I think what we are trying to do here, we definitely do support in the sense that the VA has already made a commitment to develop an integrated health coordinating center.

So we—we have this in our strategic plan to be moving towards whole health approaches, to be looking at alternative medicine approaches for pain management, PTSD, depression, you name it. I think there are many conditions that could be benefited by use of alternative therapies.

I think—as the previous panel indicated, I think the concern that we have is that we need to make sure that the evidence base is strong. And so the VA is launching a study with Institute of Medicine, for example, to have them do a review with us to see what

the evidence base is and what their recommendations would be. So that is a brand-new effort.

We are also implementing some new therapies. For example, we have implemented acceptance and commitment therapy for depression. 600 clinicians were trained in that particular therapy. We have chiropractic services. We have health coaching. We have music therapy.

And then we have EMDR, or eye movement desensitization and reprocessing therapy, in some of the locations where we have trained providers. So we are beginning to move in this direction. We are also conducting research to further support that.

We are partnering with the National Institute of Complementary and Alternative Medicine to work with them. Several of our staff on their—are on their advisory committee and working with them to understand what is working and how we can bring that into the VA.

Ms. BROWNLEY. So in your research that you are speaking of and what you are doing to date, how are you interacting with veterans to find out what they want?

Dr. JAIN. That is a very good question, and I—and you bring that up. And, actually, we are just in the process of sending out a survey to veterans—it should be in the next few weeks—that would be asking just that question, to understand what their needs are, how they feel about this thing, and what they would prefer. So that is very much in process now.

Ms. BROWNLEY. Well, it is a little bit of a concern to me to hear that you are going down a path of research and training in some instances and not really understanding what our veterans want in terms of, what their priorities are.

I mean, I would hope that, at the end of the day, their priorities would be our collective priorities. And so it is a little bit of a concern. It seems like it is an afterthought.

Dr. JAIN. Well, let me just say this. I mean, I certainly understand their concern. And we take that to heart, and we will continue to engage with the veterans.

As you were mentioning in your example, some of the CAM therapies are, frankly, coming up as local innovations in some of our medical centers. So we are not holding them back. So I think the equine therapy is a perfect example.

So what happens is, at some of our medical centers, you have clinicians who very much believe in a certain type of alternative therapy and, with the support of the local management, they are going forward with some of these ideas because they do want to solve some of these issues for our veterans.

But now we are taking a more systematic effort, as a system-wide, to understand what the needs are and what is it that we need to do.

Ms. BROWNLEY. Are you familiar with the studies that the NIH and the VA, collaboratively are pursuing relative to alternative therapies in managing pain and other health conditions?

Dr. JAIN. Yes, I am. And, actually, based on some of those studies and some of the work that is already there, there is a commitment that the—the Integrated Health Center has made to pick

two—at least two CAM therapies for chronic pain management by the end of next year.

So this will require—now, you might ask why wait until the end of next year. So let me explain some of the challenges that we do face. There are issues relating to training of the providers. This really is a culture change.

Most of our providers are trained in allopathic Western medicine. To bring in CAM therapies as adjunct therapies to main therapies will require the training of the staff. We are going to need to train our veterans.

We are going to also work with—there are other challenges we are having. We don't even have—many of the States don't have licensing categories. They don't have certification categories. Within our system, we don't have professional groupings.

So, for example, I will also tell you the acupuncturist is another example. So recently we—we do believe that acupuncture is a very—has a lot of the evidence now for pain management. And in order to hire the acupuncturist in the VA, we are now trying to create a professional category for acupuncturists.

And as we are going out to hire those, we are finding out that most of the States have no provisions for acupuncturists in terms of licenses or certifications. So how do we even go out to recruit these folks when those things are not available? So we are at the cutting edge. And so I think we are dependent on some of these other things.

Ms. BROWNLEY. Well, I know I have exceeded my time. But if I could just make one comment before we conclude?

Dr. BENISHEK. Sure.

Ms. BROWNLEY. So, I hear what you are saying. I don't think, at the end of the day, it is a good idea for the VA to decide to take all of these sort of CAM therapies and try to determine their efficacy and then try to bring them all under the VA roof.

As you said, there are——

Dr. JAIN. Right.

Ms. BROWNLEY [continuing]. Various communities and programs that are taking place right now that are working—that we know are working for veterans and that I think we should take a—sort of a systematic approach towards that and begin to, contract with some of these groups who are already proven and successful so that we are providing services to veterans today and not waiting for a year or 2 years to bring, all of these new therapies under the roof of the VA. So I will just offer that as a comment.

Thank you, Mr. Chair.

Dr. Benishek. Ms. Brown.

Ms. BROWN. Thank you.

I guess my question goes back to the 22 veterans per day that is committing suicide. And what is exactly the Department doing to address this? Because I have found that it is not just one thing. I mean, are we working with the stakeholders? When we have a veteran that—let's say a homeless vet, it is not just that he needs a house. He needs comprehensive services.

And I don't necessarily know whether the VA have to provide it. We can partner with some of our stakeholders. And so can you give us an update as to where we are.

Dr. JAIN. Yes. So thank you, Congressman, for that question.

And I couldn't agree with you more. This is a very troubling issue, and we continue to be always looking to see what can we do better.

And so I will just give you some of the examples of the kind of things we are constantly doing. And I realize it is still not enough because it still is a very significant issue.

But—but over the last year or so, for example, we have developed a strong working collaboration with the Department of Defense where we develop the integrated health strategies that look at a combined guideline for suicide management. So this is a brand-new effort where the suicide management and DoD and the VA is now coordinated.

We have this data registry that is joint between VA and DoD where we are able to exchange information with each other to understand what are the factors that are contributing to suicides. We have this partnership with the States where we exchange data with the States and understand what is happening in the States with veterans that we serve and veterans that we do not serve and what are the differences with that and what can we learn.

And some of that data analysis, it is very interesting. And Mr. Rowan was testifying earlier that—that the numbers—when you look at the sheer numbers, the numbers are higher in our middle age to—you know, in the upper 50s, 60s veterans group, even though the younger veterans, the percentage is quite high. But the overall numbers are much higher in that group.

So what we have found is that, within the VA—those veterans who receive care in the VA, those suicide rates are now starting to trend down as opposed to the veterans who do not receive care in the VA.

So some of our programs are starting to have an impact, but it is not enough. And we are open to the idea of continuing to look, from any source, any ideas that we can find to implement those.

Ms. BROWN. The question about alternative medicine and particularly the acupuncture, in Florida, I do know that we certify—there is a couple of schools in my area.

And it seems that it works for pain. I don't know about anything else, but pain—I know it don't work for weight. But I do know it works for pain and it works for some other things.

So, like I said, we have two schools. And I will gladly get you information on it. We have a school in Jacksonville and a school in Orlando.

Dr. JAIN. Now, thank you, Ms. Brown.

And I would agree with you. And that is why we have identified pain as one of the top areas where alternative matters can potentially help our veterans. So that is something that we will be looking at.

Ms. BROWN. Thank you.

I yield back the balance of my time.

Did you have any other comments about any other bills before us? I see that you said one of them, you just received it yesterday. So you didn't have any comments?

Dr. JAIN. So I think the only—well, I did make a comment on Ms. Brownley's bill. I think, in terms of the bill on the Physician Ambassadors Program——

Ms. BROWN. Yes. 5686.

Dr. JAIN. Right. 5686.

I think the only one comment that I wanted to offer is that, even though officially, again, we do not have a formal view, but, generally speaking—and I was a chief of staff in Pittsburgh and, also, in Salem for many years. And so we have provisions in Title 38 now to bring the DoD compensation physicians. And I just found out that we currently have about 4,100 WOC physicians in the VA system.

So I think that part of our concern is that a lot of this is there and we didn't have the details, from what Congressman was saying, in terms of what the challenges are. But—but we are able to—I just wanted to say that we are able to bring WOC physicians now. And so that should not be an issue, unless there is some other concerns.

Ms. BROWN. Thank you.

And I yield back the balance of my time.

Dr. BENISHEK. I am just going to follow up, as long as I have you here, Dr. Jain——

Dr. JAIN. Yes, sir.

Mr. BENISHEK [continuing]. On a couple of things that came up in the other folks' questions.

And that is, apparently, Mr. Culberson was saying that, in talking to the VA that there wasn't a way for the volunteers to—did you hear his testimony?

Dr. JAIN. I did. And I really wanted to clarify with him because I was surprised about that, sir.

Dr. BENISHEK. Well, I think we should look into that a little bit more.

Dr. JAIN. All right.

Dr. BENISHEK. The only other question that has come up several times today—and Ms. Brownley and I were talking about it—and, I have a concern about this alternative therapy, for example, equine therapy, because to scientifically prove that the equine therapy is actually helpful to the veteran, that study may take years.

And I know I have a concern, in view of the fact that I talk to every veteran that has been through it, they are all really positive about it and, yet, the time that it takes to certify this—there is no American society of equine therapists that are going to certify the equine therapy.

Is there a way within the VA to do an individual evaluation of a program, on an individual basis and qualify that program for some sort of reimbursement?

Because the people that I was working with, it is all volunteer or, funded by a nonprofit outside the VA, which is all well and good. Maybe that is the way we are going to have to go until we can get some kind of a certification process.

But is there a process within the VA to do an individual program such as this and provide some reimbursement for the people that are doing that?

Dr. JAIN. So, Congressman, thank you for that question.

I think that the general process that the VA follows to take an innovative idea like the one with equine therapy is to then validate that model with further research internally and then usually externally with Institute of Medicine.

And we—over the years when—when you start talking about expanding the benefits package to include, we would have to then expand the benefit package to include this therapy. Because if you offer it in one part of the country—as you know, sir, we are a national system.

So if we make it available in one part of the country, then we have to make it available to other veterans who may have need for that type of service. So that is always a challenge. So the process we usually follow is very heavily evidence-based.

Dr. BENISHEK. Well, no. I understand the reasoning for that. And, you know, I certainly want evidenced-based therapy. But it is just that we have such a crisis on our hands here.

Dr. JAIN. Right.

Dr. BENISHEK. I am trying to figure out a way to reasonably expand the system without danger to our veterans, but also a way to get more people involved in the care.

Dr. JAIN. So there are—two mechanisms come to mind, sir. I think one would be to—we do have a process where we expand the pilot and then make it broader based, and that usually allows us to gather more information.

We also can conduct research studies that are multicenter that allows using the research Dollars to further investigate the topic. So we do have a couple of mechanisms.

Dr. BENISHEK. All right. Thank you for your time this afternoon. I think we are just about done.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks, and include extraneous material.

Without objection, that is ordered.

I would also like to thank all the witnesses and audience members for joining us this afternoon.

The hearing is now adjourned.

[Whereupon, at 4:40 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. TIM WALBERG (MI–07)

Testimony for Medal of Honor Priority Care Act (H.R.4720)

Chairman Benishek, Ranking Member Brownley and Members of the Subcommittee, I thank you for the opportunity to speak this morning in support of my legislation, H.R.4720, the Medal of Honor Priority Care Act of 2014.

As the Members of this Committee are well aware, the Congressional Medal of Honor is the highest award for valor which can be bestowed upon an individual serving in the United States Armed Forces and is awarded to soldiers who have displayed conspicuous gallantry and intrepidity at the risk of life above and beyond the call of duty. The Medal of Honor is a distinguished award given to a select few. Less than 3,500 has been awarded, and of those, only 79 are living recipients. When one looks at the recent major conflicts in Iraq and Afghanistan, only 16 have been awarded.

My state of Michigan is honored to have two living recipients of this award, Corporal Duane E. Dewey and Private First Class Robert E. Simanek. Both received the decoration for their heroic action in the Korean War, and hearing of their harrowing stories of bravery has reminded me of the sacrifice American soldiers are willing to make to protect their comrades and their country.

Medal of Honor recipients deserve our utmost appreciation, and I believe the small portion of our servicemembers who have gone above and beyond the call of duty and earned the highest honor in our nation's Armed Forces have earned the right to be placed in the top priority group to receive their healthcare benefits.

All veterans deserve access to the healthcare they have earned, but as you all know, the VA uses a priority system to determine eligibility for these healthcare services. Some of the factors that will affect a soldier's priority group ranking are whether the soldier has a service-connected disability, whether they were a former prisoner of war, the time and place of service, as well as income level. Currently, Medal of Honor recipients are in Priority Group 3.

I'd be remiss in not pointing out that the idea to initially look into this legislation came from a veteran who lives in my district and works with the veteran community.

This bill would not affect a large population of veterans, but I believe we have a duty to ensure these heroes have access to the VA when they need it. I'm proud to have the support of 13 of my colleagues from both sides of the aisle, as well as support from the Disabled American Veterans.

I thank the Chair for permitting me to appear before the Subcommittee today.

PREPARED STATEMENT OF THE HON. GUS M. BILIRAKIS (FL–12)

Thank you for holding this very important hearing and for providing me an opportunity to testify on my bill and discuss the importance of exploring complementary alternative treatments for Veterans affected with mental health concerns.

As we all know, the costs of wars and the price for freedom are paid for through the valor of brave men and women. These individuals selflessly put themselves in harm's way so that we may enjoy the freedoms of our democracy. With statistics showing that one in five Veterans who served in Iraq and Afghanistan have been diagnosed with Post-Traumatic Stress, we must responsibly ask ourselves—are we doing enough when it comes to addressing mental health in our Veteran population?

Recent data has shown that every day in this country—an estimated 22 Veterans take their own lives. It is unconscionable that more casualties have occurred with our servicemembers here domestically upon their return from active duty as opposed to overseas while serving their country. Many of these tragic suicides are the result of depression, homelessness and a lack of available resources to assist in their transition into civilian life. My bill, H.R. 4977, the Creating Options for Veterans Expedited Recovery Act (COVER) will help remedy this tragic problem and provide additional therapies to our nation's wounded heroes.

The COVER Act will establish a commission to examine the Department of Veterans Affairs current evidence-based therapy treatment model for treating mental illnesses among veterans. Additionally, it will analyze the potential benefits of incorporating complementary alternative treatments available within our communities.

The duties of the commission designated under the COVER Act include conducting a patient-centered survey within each Veterans Integrated Service Network. The survey will examine several different factors related to the preferences and experiences of Veterans with regard to their interactions with the Department of Veterans Affairs. Instead of presuming to know what is best for Veterans, we should simply ask them and work with them on finding the right solutions that best fits their unique needs.

The scope of the survey will include: the experience of a Veteran when seeking medical assistance with the Department of Veterans' Affairs; the experience of Veterans with non-VA medical facilities and health professionals for treating mental health illnesses; the preferences of a Veteran on available treatments for mental health and which they believe to be most effective; the prevalence of prescribing prescription drugs within the VA as remedies for treating mental health illnesses; and outreach efforts by the VA Secretary on available benefits and treatments.

Additionally, the commission will be tasked with examining the available research on complementary alternative treatments for mental health and identify what benefits could be attained with the inclusion of such treatments for our Veterans seeking care at the VA. Some of these alternative therapies include, among others: accelerated resolution therapy, caring and training service dogs, music therapy, yoga, acupuncture therapy, meditation, and outdoor sports therapy. Finally, the commission will study the potential increase in benefit claims for mental health issues for Veterans returning from Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn. We must ensure that the VA is prepared with the necessary

resources and infrastructure to handle the increase in those utilizing their earned benefits to address the mental and physical ailments incurred from military service.

Once the Commission has successfully completed their duties, a final report will be issued and made available outlining its recommendations and findings based on their analysis of the patient-centered survey, alternative treatments and evidence-based therapies. The Commission will also be responsible for creating a plan to implement those findings in a feasible, timely, and cost effective manner.

I am happy to have the support of the Iraq and Afghanistan Veterans of America, the American Legion, and VetsFirst. With the collaboration of our nation's greatest heroes, Congress, and the VA, we can increase access to quality care for Veterans across the country and help better meet their needs when seeking the care they need.

Thank you for allowing me to testify on behalf of the COVER Act today and I urge all of my colleagues to support this important piece of legislation and show our Veterans with action, and not just promises, that we have them "covered."

PREPARED STATEMENT OF HON. TIM WALZ (MN–01)

In support of H.R. 5059, the Clay Hunt SAV Act.

Chairman Miller, Ranking Member Michaud, thank you for your leadership and dedication to our nation's heroes. I am very grateful for the opportunity to tell you about a very important piece of legislation to help rid our communities of veteran suicide.

H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act, is an example of how we get things right on Capitol Hill. The legislation is named in honor of Iraq and Afghanistan War Veteran and suicide prevention advocate, Clay Hunt. Clay epitomized what it meant to live a life of service, both in and out of uniform. He helped countless veterans overcome their demons but tragically took his own life in March of 2011. The legacy he left behind, however, will live on for generations to come.

The bill you see before you was the result of strong partnerships with our veteran service organizations, strong bipartisanship efforts here in Congress, and relentlessness shown by Clay's parents, to get this thing done. This bill is what you get when you have folks sitting around the table, trusting one another, and working together to get it right for our nation's veterans. I'd like to send a special note of thanks to two Air Force vets for helping get this thing done. Thanks go to Christine Hill from Chairman Miller's staff and Tony DeMarino from Ms. Duckworth's staff for their hard work.

Our premise for this bill was simple: suicide occurs because many vets return to their community and then disconnect from it. So, we wanted to create a bill that would get the communities involved and coordinated. We also knew it would be important to increase the capacity and efficiency of VA care to deal with over a million veterans returning from war.

Specifically, the bill:

1. Establishes a peer support and community outreach pilot program to assist transitioning servicemembers with accessing VA mental healthcare services.
2. Requires the VA to create a one-stop, interactive website to serve as a centralized source of information regarding all mental health services for veterans.
3. Addresses the shortage of mental healthcare professionals by authorizing the VA to conduct a student loan repayment pilot program aimed at recruiting and retaining psychiatrists.
4. Requires the DoD and National Guard to review the staffing requirements for Directors of Psychological Health in each state.
5. Requires a yearly evaluation, conducted by a third party, of all mental healthcare and suicide prevention practices and programs at the DoD and VA to find out what's working and what's not working and make recommendations to improve care.
6. Establishes a strategic relationship between the VA and the National Guard to facilitate a greater continuity of care between the National Guard and the VA.
7. Authorizes a Government Accountability Office (GAO) report on the transition of care for PTSD and TBI between the DoD and the VA.

One veteran lost to suicide is one too many. With many of our warriors returning from war, all too often our heroes return only to face a war of their own at home. While there is no bill that will completely end veteran suicide, this comprehensive, bipartisan measure is a step in the right direction. I'm proud to have worked with Chairman Miller, Rep. Duckworth, a combat veteran herself, IAVA, and the VFW

to introduce this bipartisan, important legislation. And I urge my colleagues to support this measure so that we can pass it quickly into law. Thank you.

PREPARED STATEMENT OF HON. DOUG COLLINS (GA–09)

Chairman Benishek, Ranking Member Brownley, and distinguished members of subcommittee, thank you for the opportunity to testify on H.R. 5475, to amend title 38, United States Code, to improve the care provided by the Secretary of Veterans Affairs to newborn children. I am very appreciative of the Subcommittee's consideration of this legislation.

The motto of the Veterans Administration comes straight from Abraham Lincoln's Second Inaugural. He got the idea straight from scripture. So the challenge for us to "care for him who shall have borne the battle, and for his widow, and his orphan," isn't a new one.

Since September 11, 2001, more than a quarter of a million women have answered the call to serve. They've faced terrorism in the deserts and mountains of Iraq and Afghanistan. So in the 21st century, we must also consider she who shall have borne the battle.

When she returns, what of her children?

The finest military in the world is powered by men and women in their physical prime. The young women who decide to serve this country in the armed forces aren't immune from the same questions that all young women face about whether they pursue a career, a family, or both. Yet they are offered a healthcare system that for so many years has been designed to serve men.

With the increasing number of female veterans, the VA must expand its care and services to meet their needs. Maternity care tops that list of needs, and I've offered one way we can help. In 2010, Congress passed and the President signed the "Caregivers and Veterans Omnibus Health Services Act of 2010" to provide short-term newborn care for women veterans who received their maternity care through the VA. Signed into law on May 5, 2010, this legislation authorized up to seven days of newborn care.

On January 27, 2012, The Department of Veterans Affairs published a regulation officially amending VA's medical benefits package to include up to seven days of medical care for newborns delivered by female Veterans who are receiving VA maternity care benefits. The rule, which became effective Dec. 19, applied retroactively to newborn care provided to eligible women vets on or after May 5, 2011.

Since this seven day authorization was enacted by Congress in 2010, we've learned more about the unique challenges facing female veterans and the changing trends in these veterans seeking maternity and newborn care from the VA. According to a study published in the Women's Health Issues Journal this year, from 2008–2012 the overall delivery rate by female veterans utilizing VA maternity benefits increased by 44 percent and a majority of the women using VA maternity benefits had a service-connected disability.

Unless Congress extends the authorization for length of newborn care coverage provided by the VA, there will be veterans who face difficult financial decisions and complexity in navigating insurance options at the same time that their newborn is fighting for their life. This is why I introduced H.R. 5475. This legislation extends the authorization of care from seven days to 14 days and provides for an annual report on the number of newborn children who received such services during such fiscal year. Improved data on the trends in female veterans utilizing newborn care will help Congress and the VA better meet their needs in the years to come.

I know what it's like to be the parent of a little baby who needed intensive medical care for an extended period the moment she was born. It's my hope that any new mother, who has given selflessly to her country, wouldn't have to worry about Congress standing in her way as she tries to give selflessly to her own child.

Our goal should always be to provide the mother with the pre-natal care she needs to give her newborn the best chance of a healthy delivery with no post-natal complications. There are significant needs and challenges that a female veteran faces when returning home from the battlefield such as homelessness, sexual and physical abuse, and mental health conditions such as Post Traumatic Stress Disorder. And this legislation won't solve all of those great challenges. But my hope is H.R. 5475 will give her a little peace of mind knowing her newborn will get some extra help from the VA and that Congress is committed to her and her family.

In a focus group conducted on Women Veterans' Reproductive Health Preferences and Experiences and published by Women's Health Issues Journal in 2011, one Marine said, "I can essentially say that I gave my reproductive years to the Marine Corps. And those are the years you can serve . . . You know, you do sacrifice and you say, well, "mission first before a family mission," type of thing and the more I think about I think, you know, the VA probably should address that part of womanhood and have that understanding."

There are multitudes of ways that the VA must adapt to better meet the needs of female veterans. By increasing the authorization of care, we can ensure that Congress is not standing in the way of the VA seeking to do just that. Absent the legislative change made by H.R. 5475, the VA cannot provide more than 7 days of care. And I believe that is unacceptable.

In closing, we owe it to our female veterans to expand and improve the healthcare services that the VA can provide them and their children. Female veterans face unique challenges and barriers, including very limited newborn care coverage. While the majority of female veterans who receive maternity care from the VA are able to return home with their newborn within the current seven day time frame, some cannot due to newborn health complications. It is these veterans and their children that need Congress' help today.

Expanding the authorization of care from seven to 14 days will give these female veterans more time to make alternate arrangements and secure private or public insurance for their newborn's continued health needs.

I thank the Chairman and Ranking Member for holding this hearing and I'm happy to discuss this legislation further with any of my colleagues. Thank you.

PREPARED STATEMENT OF HON. JOHN CULBERSON (TX–07)

H.R. 5686—Physician Volunteer Ambassadors Helping Veterans.

I recently had a chance to speak with a top physician from MD Anderson in Houston, who was frustrated that she and her talented colleagues had been rebuffed several times when offering to volunteer their time and expertise at VA hospitals. As Chairman of the Military Construction and Veterans Affairs Appropriations Subcommittee I find it incredibly troubling that at a time when veterans are forced to go outside of the VA healthcare system because of waiting lists and staffing shortages or wait months for an appointment, a physician from one of the best hospitals in America is told by VA that they do not want her free help. Together Dr. Beth Edeiken-Monroe and I decided that Congress should cut through the bureaucracy holding up the volunteer process for qualified physicians at VA facilities.

After looking into it, I found that Congress already told VA to accept volunteers in its facilities—over two decades ago; it just rarely chooses to use this authority. It seems that VA needs more guidance as to when Congress expects it to use this valuable resource—so I crafted legislation that does just that. I spelled out that when volunteers are available and willing to help in facilities that are strained by appointment waiting times or staffing shortages, VA should make every effort to accept their assistance in a prompt manner.

By accepting the help of more volunteer physicians within VA hospitals, we will be able to keep more veterans within the VA healthcare system while alleviating some of the pressure on strained facilities. This would allow VA to continue its management over the quality, consistency, and specificity of more veterans' care. While this bill is not intended to solve long-term staffing problems, it could be a step in helping more veterans gain prompt access to reliable and high quality care within their local VA.

Through the existing privilege granting process these volunteer doctors are covered from medical malpractice liability just as any other physician within the VA or Health and Human Services systems is covered. I also wanted to be sure that VA received a substantial benefit for its effort in granting privileges to these doctors so I included a 40 hour minimum volunteer service hours per year requirement. We have received an outpouring of support from doctors who are excited about this bill and want to volunteer their time with the VA.

I'm thankful for the opportunity to hear about this issue from Dr. Edeiken in Houston. This simple idea could potentially help hundreds of our veterans get quick access to high quality and reliable healthcare.

For generations, veterans have shown untold courage and sacrifice to ensure that our American way of life can continue long into the future. The men and women who have served our country are truly American heroes, and it's not surprising that people around the country want to help the VA serve our veterans. This is a simple, cost effective, community building resource that we should be using to help veterans quickly access the high-quality and reliable healthcare within the VA system that they have earned.

Statement of Iraq & Afghanistan Veterans Of America
before the
House Committee on Veterans' Affairs
Subcommittee on Health
for the hearing on
Pending Legislation

November 19, 2014

Bill #	Bill Name	Sponsor	Position
H.R. 4720	Medal of Honor Priority Care Act	Rep. Walberg	Support
H.R. 4977	Creating Options for Veterans Expedited Recovery Act	Rep. Bilirakis	Support
H.R. 5059	Clay Hunt Suicide Prevention for American Veterans Act	Rep. Walz	Support
H.R. 5475	A bill to improve the care provided by the Secretary of the VA to newborn children.	Rep. Collins	Support
H.R. 5484	Toxic Exposure Research Act	Rep. Benishek	Support
H.R.4887	Expanding Care for Veterans Act	Rep. Brownley	Support

Chairman Benishek, Ranking Member Brownley, and Distinguished Members of the Subcommittee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA), we would like to extend our gratitude for the opportunity to share with you our views and recommendations regarding these important pieces of legislation.

IAVA is the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is critically important but simple – to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of nearly 270,000 members and supporters, we strive to help create a society that honors and supports veterans of all generations.

In partnership with other Veteran Service Organizations (VSO), IAVA has worked tirelessly to see that veterans' needs and concerns are appropriately addressed by the Department of Veterans Affairs (VA) and by Congress. IAVA appreciates the efforts put forth by this Subcommittee to address the issues and challenges facing our nation's

veterans and their families. We stand with you in supporting legislation to continue improving the services offered by VA, empowering veterans to improve their lives after military service, and ensuring that veterans are fully aware of all the benefits available to them as our nation begins transitioning away from more than a decade of war in Iraq and Afghanistan. IAVA is, therefore, able to offer its support to the bills that are the subject of this hearing today because we believe their adoption would better enable the VA to live up to its commitment on behalf of the American people.

H.R. 4720

IAVA supports H.R. 4720, the Medal of Honor Priority Care Act, which would place Medal of Honor recipients in the highest priority group for VA care.

Currently, Medal of Honor recipients are in priority group 3 under the VA's priority group system. While these recipients represent a very small population of veterans, their courage, valor and sacrifice under the most harrowing circumstances should be met with timely VA care.

H.R. 4977

IAVA supports H.R. 4977, the Creating Options for Veterans Expedited Recovery (COVER) Act, which would establish a Commission to examine complementary and alternative treatments for PTSD and evaluate current evidence-based models for treating mental health issues that veterans are experiencing.

Establishing the Commission to review VA's treatment models is an important step forward in increasing access to quality healthcare for veterans who have served in Iraq and Afghanistan over the past decade. Complementary and Alternative therapies can go a long way to aid veterans in their readjustment to civilian life.The results of the surveys that the Commission will conduct will be valuable as VA looks at how it should continue to adapt to meet the needs of veterans.

H.R. 5059

IAVA supports HR 5059, the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, which is comprehensive legislation aimed at expanding and improving care and services provided to veterans and service members with mental health injuries or those risk of suicide.

Combating veteran suicide is IAVA's top priority in 2014. In IAVA's 2014 Member Policy Survey, over 47% of our respondents told us they knew a veteran who served in Iraq or Afghanistan who had attempted suicide, and over 52% knew two or more veterans who had died by suicide. Additionally, data from the VA also indicate that at least 22 veterans die by suicide every day.

Congress must invest in improving suicide prevention programs and mental health services to help reduce the number of suicides among troops and veterans. The Clay

Hunt SAV Act would begin to create a comprehensive approach to mental health care and suicide prevention programs at the VA and DoD. Specifically....

This legislation will also require the DoD to review discharges for individuals that were unjustly separated with a service-connected mental health injury or disorder. Our military has unjustly discharged thousands of individuals with service-connected mental health injuries or disorders. Now these veterans are ineligible for many VA programs. A review of these records will provide access to care and mental health support for veterans that have been unjustly denied services and support.

Veterans and service members should also receive high quality, evidence-based care. In the past few years, hundreds of mental health services and suicide prevention programs have been implemented at the DoD and the VA. However, these programs are not always properly evaluated to find out what's working and what's not working. This legislation would require a yearly review of all suicide prevention programs to make sure programs are effective and producing results.

IAVA recognizes that there is no one solution to combating veteran suicide. However, this comprehensive legislation is a starting point that addresses many areas of care aimed at reversing the alarming trend. We look forward to working with this Subcommittee on strengthening the mental health care services and suicide prevention programs available to veterans and service members.

H.R. 5475

IAVA supports H.R. 5475, which would authorize newborn children born in VA hospitals to stay up to 14 days after birth. Newborn children born to mothers in VA hospitals are currently authorized to remain under VA care for 7 days after birth. However, infant illnesses and complications after birth can often leave newborns needing additional care. Authorizing this 7-day increase in care will provide a greater continuity of care for newborns.

H.R. 5484

IAVA supports H.R. 5484, the Toxic Exposure Research Act, which would establish a national center for research focused on the diagnosis and treatment of health conditions faced by veterans, and descendants of veterans exposed to toxic substances during military service.

This center, at the will of participants, would be able to conduct studies and research on individuals or their descendants whom have been exposed to toxic substances during military service. The legislation additionally directs the Secretary to establish an advisory board to assist the national center on medical issues relating to these toxic exposures.

Studying and understanding the long-term health of our newer veterans who may have been exposed to toxic chemicals while serving in Iraq and Afghanistan is an important

step that will better prepare VA to address their health needs in the future.

H.R. 4887

IAVA supports H.R. 4887, the Expanding Care for Veterans Act, which would expand research and education on the delivery of complementary and alternative treatments for veterans.

The requirements of this legislation would mandate VA develop a plan to expand its scope of research, delivery, and integration of complementary and alternative medicines to veterans. Veterans deserve to have access to a broad variety of treatments to assist in their readjustment to civilian life. Veterans often have individual needs that can require a diverse set of treatment solutions. This legislation would increase the availability of veterans to seek unique treatments.

Mr. Chairman, we at IAVA again appreciate the opportunity to offer our views on these important pieces of legislation, and we look forward to continuing to work with each of you, your staff, and the Committee to improve the lives of veterans and their families.

Thank you for your time and attention.

Biography of Christopher Neiweem
Legislative Associate, Iraq and Afghanistan Veterans of America

As Legislative Associate, Christopher maintains Congressional relationships and supports advocacy programs. Chris spent 6 years in the U.S. Army Reserve as a military police NCO and served a tour of duty in 2003 during Operation Iraqi Freedom detaining Enemy Prisoners of War (EPWs), and performing base security and customs in during the Iraq war. He completed a Bachelors Degree in political science from Northern Illinois University in 2007 and completed a Masters Degree in 2011 from the University of Illinois at Springfield in political affairs.

Statement on Receipt of Grants or Contract Funds

Neither Mr. Neiweem, nor the organization he represents, Iraq and Afghanistan Veterans of America, has received federal grant or contract funds relevant to the subject matter of this testimony during the current or past two fiscal years.

VETS HELPING VETS SINCE 1974

TURNED AWAY AT THE DOOR:

SUICIDE CARE WITHHELD FROM AT-RISK VETERANS DUE TO MISCONDUCT IN SERVICE

HOUSE VETERANS' AFFAIRS COMMITTEE
Health Subcommittee
Legislative Hearing on H.R. 4720, H.R. 4887, H.R. 4977, H.R. 5059, H.R. 5475, H.R. 5484
November 19, 2014

Executive Summary

Suicide is often the culmination of increasingly dangerous and dysfunctional behavior. When servicemembers start experiencing mental health stress on active duty, military commands often misunderstand their behavior change as misconduct and discharge them. The VA has authority to deny access to its services for veterans discharged for misconduct, and it does so in the large majority of cases. This creates a pipeline of suicide risk that starts with in-service mental health trauma and culminates with veterans who are at risk of suicide and denied access to VA support.

The Committee should direct the VA to extend eligibility to two categories of veterans at high risk of suicide, even when there was some misconduct in service: those that have deployed to a combat theater and those with service-connected mental health conditions. The Committee should also direct the VA to provide tentative eligibility for health care and homeless housing services while making its eligibility decision.

I. Introduction

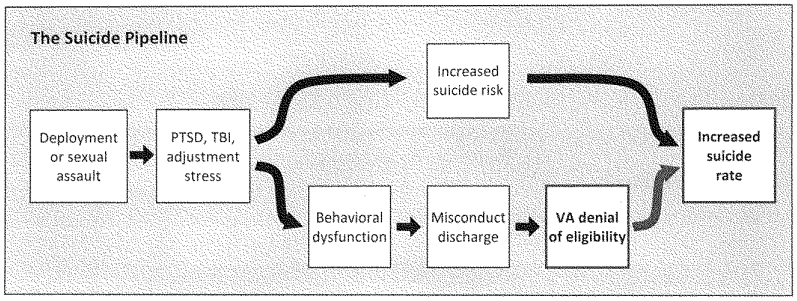
The rate of suicide for veterans outside of VA care is increasing.[1] In 2010, veterans outside of VA care were committing suicide 30% more frequently than those enrolled in VA care.[2] For the most high-risk cohort, men under age 30, the suicide rate for those outside VA care is nearly double the rate for those under VA care.[3] Excluding a servicemember from the VA increases the chance that this servicemember will commit suicide. One way that the VA excludes servicemembers at elevated risk of suicide is by denying "veteran" status to many servicemembers discharged for misconduct.

This testimony describes why servicemembers at risk of suicide are more likely to get misconduct discharges, how the VA denies and delays services to these servicemembers, and how Congress can make a targeted change to VA statute to prevent unnecessary veteran suicide.

II. Servicemembers at risk of suicide are more likely to receive misconduct discharges

Certain mental health conditions are known to increase suicide risk. PTSD in veterans is associated with elevated suicide risk both for those with PTSD diagnoses[4] and those with PTSD symptoms that fall below the threshold for a PTSD diagnosis.[5] Veterans with TBI are 55% more likely to die by suicide.[6] Service members with prior deployments are more likely to attempt suicide, even when compared against other service members with similar mental health profiles.[7,8] Other predictors of suicide risk also involve behavioral dysfunction, such as Major Depressive Disorder, Substance Abuse, and Intermittent Explosive Disorder.[9, 10]

The military Services should be prioritizing these servicemembers for treatment and medical discharge. Often, they do not.



How mental health disabilities acquired in service lead to misconduct discharges

PTSD, TBI, and Major Depression produce behavioral dysfunction through an exaggerated startle response, inability to control reflexive behavior, irritability, or attraction to high-risk behavior.[11] Some of the medicines used to treat the conditions may induce fatigue or lethargy that also interferes with basic functioning. In fact, interference with social and occupational functioning is a primary measure of the severity of these conditions.[12] For servicemembers on active duty, these behavioral disorders may result in infractions of unit discipline. The Army reports that 25% of servicemembers who attempt or commit suicide while on active duty had prior misconduct infractions.[13]

Military Services often do not treat these disciplinary infractions as symptoms of mental health risk. The servicemember may not yet be diagnosed, or the command may not believe that the conduct is due to in-service trauma. Recent press reports provide many examples of servicemembers with early mental health trauma where their behavior in service was managed as a discipline problem rather than a mental health problem.[14] Even if the military service has already acknowledged a disability and is in the process of giving a medical discharge, the military Services may suspend the medical separation process and give an immediate misconduct discharge if any misconduct occurs and the servicemember volunteers to be separated rather than be court-martialed.[15]

In some cases, it is official policy to give misconduct discharges to servicemembers at risk of suicide. According to a 2010 Army report on active-duty suicide, one of its strategies for deterring suicidal behavior is aggressively separating servicemembers who exhibit high-risk behaviors.[16] A 2012 Army study found that the commander of Warrior Transition Units at Ft. Bliss showed a "primary attitude" that was "punitive, like a correctional facility."[17]

The result is that servicemembers with mental health risks are more likely to get misconduct discharges. Marines with PTSD from combat exposure are 11 times as likely to be separated with a misconduct discharge.[18] Service members "at mental health risk" are 32% more likely to be separated from service within a year of deployment than service members not "at mental health risk."[19]

Kash Alvaro

He deployed to Afghanistan and acquired PTSD and TBI so severe that it triggers seizures and heart palpitations. He was given an OTH discharge while waiting for a medical separation. His unit did not provide transportation to his medical appointments, reported that his seizures were faked, and did not approve his request to be assigned to a Warrior Transition Unit. He was discharged after he had isolated himself in his apartment for two weeks. Granted VA care only after media attention.

Source: Colorado Springs Gazette, "Other Than Honorable", *csgazette.biz/soldiers/*

III. The VA denies and delays care to former servicemembers with misconduct discharges

The VA does not recognize all those who served in the armed forces as "veterans." Congress directed the VA to recognize as "veterans" only those servicemembers who were "discharged [] under conditions other than dishonorable."[20] This phrase does not only exclude servicemembers with Dishonorable discharges.[21] Congress chose the term "discharged under conditions other than dishonorable" instead of the term "received a discharge characterization other than a Dishonorable" in order to separate the VA eligibility standard from the military discharge standard. The VA may grant veteran status to a servicemember with a fully "Dishonorable" discharge,[22] and it may deny veteran status to a servicemember with a fully "Honorable" discharge.[23] The Court of Appeals for the Federal Circuit has confirmed this interpretation[24] and the VA applies it.[25] It is the VA, not the DOD, who decides who is a veteran.

VA standards to determine veteran status are inadequate

However, Congress never gave the VA instructions on how to make this decision. Congress did not say what kinds, severity, or frequency of misconduct would lead a servicemember to forfeit his or her recognition as a "veteran." Nor did Congress say the nature or duration of service that would overshadow later misconduct so that overall service would be honorable and thereby preserve the servicemember's "veteran" status. Although examination of the legislative history provides some indication of what Congress meant by the phrase "under conditions other than dishonorable,"[26] the statute itself provides the VA with no instruction. Congress added some eligibility requirements, such as a prohibition on giving benefits to veterans discharged by General Court-martial,[27] however these are additional requirements that do not define what is "other than dishonorable" service is for the purpose of showing "veteran" status.[28]

In the absence of any instruction from Congress, the VA created its own definition.[29] The VA will presume that discharge was under honorable conditions if the military service provided an Honorable or a General discharge.[30] Otherwise, the VA will only grant "veteran" status after evaluating the service record and comparing it against its criteria for "discharge under dishonorable conditions."[31] About 10,000 servicemembers each year receive discharges other than "Honorable" or "General", such that the VA will not recognize them as "veterans" until the VA has decided that their conduct meets its standards for a discharge under honorable conditions.[32] In the Marine Corps, this includes about 10% of all servicemembers that complete Entry Level Status.[33]

The VA will decide that the misconduct resulted in dishonorable conditions of service if it involved any of the following "very broad"[34] categories:

> *"(1) Acceptance of an undesirable discharge to escape trial by general court-martial. (2) Mutiny or spying. (3) An offense involving moral turpitude. This includes, generally, conviction of a felony. (4) Willful and persistent misconduct. This includes a discharge under other than honorable conditions, if it is determined that it was issued because of willful and persistent misconduct. A discharge because of a minor offense will not, however, be considered willful and persistent misconduct if service was otherwise honest, faithful and meritorious. (5) Homosexual acts involving aggravating circumstances or other factors affecting the performance of duty. Examples of homosexual acts involving aggravating circumstances or other factors affecting the performance of duty include child molestation, homosexual prostitution, homosexual acts or conduct accompanied by assault or coercion, and homosexual acts or conduct taking place between service members of disparate rank, grade, or status when a service member has taken advantage of his or her superior rank, grade, or status."*

The VA will excuse this misconduct if the servicemember was "insane" at the time.[35] The VA has proposed to define "insanity" for this purpose in the same way that it is used to define the criminally insane: where there is "such a defect of reason … that he or she did not know or understand the nature or consequence of the act, or that what he or she was doing was wrong."[36]

These standards are notable for what they do not contain:

- First, there is no provision instructing the VA's staff to consider whether misconduct was outweighed by a combat deployment. The regulations do state that "one minor offense" would be overlooked if service was otherwise "meritorious", however the VA has said that a combat deployment is not inherently meritorious because this is merely performing "the job as required."[37]

- Second, there is no provision instructing VA staff to consider whether behavior was mitigated by a difficult deployment. The VA has done so for other eligibility criteria, such as in regulations that instruct its staff that "hardship or suffering incurred during overseas service, or as a result of combat wounds of other service-incurred or aggravated disability, is to be carefully and sympathetically considered in evaluating the person's state of mind."[38] No similar regulation applies to deciding whether in-service misconduct bars recognition as a veteran.

- Third, no regulation considers whether a mental health condition may explain the misconduct, unless the person was fully "insane."[39] The VA has proposed to adopt the same standard for "insanity" as what is used in criminal defense.[40] In

other words, the VA would not excuse even minor in-service misconduct unless the servicemember was so mentally ill that the VA would also excuse homicide.[41] This does not encompass the relatively moderate incapacity to conform to military discipline that might result from early symptoms of mental health trauma or traumatic brain injury.

Denial of Care

These standards permit the VA to deny veteran status to the large majority of servicemembers it evaluates. Overall, the VA has decided that service was dishonorable in 80% of the cases it evaluates.[42] If all former servicemember asked the VA to determine their veteran status, the VA would decide that about 8,000 servicemembers each year should not be recognized as veterans.[43] While some of these servicemembers certainly forfeited their recognition as veterans, we believe that an 80% rejection rate reflects standards that are much too severe. Nor do we believe that the public expects 8,000 servicemembers every year to be denied recognition as veterans.

Servicemembers denied veteran status are eligible for almost no services from the VA. Congress limits almost all the VA's services to veterans or their survivors, spouses and dependents.

There is only one exception authorized by statute. Congress authorizes the VA to provide medical care for service-connected conditions to "certain people administratively discharged under other than honorable conditions."[44] In practice, this means that if a servicemember with an Other Than Honorable discharge applies for Compensation for a disability incurred in service, and if the VA decides that the person does not deserve veteran recognition, then the VA will deny Compensation for that condition but will allow the former servicemember to receive medical care for that condition only.

In practice, this does not happen very often. By the VA's own statistics, it provided health care for service-connected disabilities in only 7% of the cases where it had denied veteran status.[45] We routinely receive VA decisions on Compensation claims where the Regional Office denies veteran status but fails to determine whether the condition is service-connected for purposes of obtaining medical care for that condition.

Terrance Harvey

He deployed with the 82nd Airborne for the first Gulf War. He earned the CIB clearing bunkers and recovered casualties on the "Highway of Death." After his return he started experiencing symptoms of PTSD. He attempted suicide once during service. He felt that he was unable to receive care, and was denied permission to take leave to be cared for by his family. He left anyway, and when he voluntarily returned he was given an OTH discharge. He became estranged from his family, was living on the streets, and attempted suicide twice since separation. The VA still withholds care.

In many cases the VA simply refuses to even consider whether a servicemember should be recognized as a veteran. In our experience, a servicemember with a potentially disqualifying discharge who approaches a health center for care will be turned away. The VA will never even consider whether that person's conduct was honorable. The Seattle Times documented the case of an Army OEF veteran with a Bronze Star Medal and a PTSD diagnosis—a servicemember who should certainly be recognized as a veteran—who was turned away from a VA medical center without care.[46] This is contrary to official policy, according to which VHA eligibility staff are supposed to initiate a request for a Character of Discharge determination, the VBA's process for determining veteran status.[47] Instead, staff concluded "you are not a veteran" and "you are dishonorable" and refused to initiate a character of discharge review. In two cases handled by Swords to Plowshares, VHA staff agreed to initiate an eligibility review only after the involvement of an attorney.

Delay of care

The VA's procedures delay its adjudication of this fundamental question, whether a servicemember deserves recognition as a veteran. Those delays result in extended denial of services even in cases where the servicemember is found to have served honorably.

The VA places Character of Discharge issues in its slowest adjudication lane. The task of determining "veteran" status is considered an "Administrative Adjudication" by the VBA. These issues are handled by "non-rating" teams. In response to the claims backlog, the VBA has shifted staff onto "rating" teams, leaving "non-rating" teams understaffed. Currently, issues in the "non-rating" team are taking twice as long as "rating" issues.[48] Therefore VA compensation claims, as slow as they are, are handled twice as fast as the question of whether a servicemember is even a "veteran." Because a Compensation claim from someone with a misconduct discharge must complete the Character of Discharge issue before the VBA even starts the service connection issue, the total claim takes three times as long as a typical Compensation claim. At the Oakland Regional Office, these claims take on average two and a half years to complete. Eligibility staff at the Palo Alto Health System discourage veterans from asking the health center to request an adjudication because these requests usually take 3 years to complete.[49]

Ted Wilson

He volunteered for the Marines and deployed to Vietnam twice. He earned two purple hearts, was hospitalized for "nervous shock." He attempted suicide while hospitalized after a second mental health crisis. On his second tour he had a breakdown and started a fight with MPs. He was given an OTH discharge. Without psychiatric care, he started illegal drug use, became homeless, and attempted suicide once. The VA still withholds care.

The VA does not provide medical care while it performs an evaluation of service. VA regulations allow for "tentative eligibility" to be provided while eligibility questions are answered,[50] however this regulation specifically excludes tentative eligibility where the issue is Character of Discharge.[51] The VHA has discretion to provide care on a "humanitarian basis" if the servicemember signs a contract agreeing to pay for the services if required;[52] however, the VHA does not routinely offer this while the VA is evaluating character of discharge.[53] For urgent services, such as emergency psychiatric care and emergency homeless services, this delay amounts to a denial of the service sought.

IV. The VA's practices increase the risk of veteran suicide

Exclusion from VA care increases risk of suicide. The VA's successful suicide prevention efforts lowered the rate of suicide among veterans enrolled in VA care.[54] However, the rate of suicide for veterans outside of VA care is increasing. In 2010, the latest data available, veterans outside of VA care were committing suicide 30% more frequently than those enrolled in VA care.[55] For the highest-risk cohort, male veterans under age 30, the suicide rate for those outside VA care is twice the rate of veterans under VHA care.[56] Excluding a servicemember from the VA increases the chance that this servicemember will commit suicide.

The VA knows these people by name. The VA has a list of servicemembers who committed suicide, based on state death reports. Some of them at some time asked the VA to evaluate their service and grant them VA care. The VA rejected them 85% of the time,[57] an even higher rate than the average 80% denial rate. That means the VA turned away at least 448 servicemembers who went on to commit suicide. The actual number is certainly higher, because the VA list does not receive death reports from all states, and it doesn't include people who sought care at VA hospitals and where the staff turned them away without filing an eligibility request.

V. Solutions

Four changes can provide targeted solutions to the problems identified above.

1. **Issue: The VA denies veteran status without requiring consideration of mental health conditions and without consideration of deployment service.**
   Solution: The VA should enact presumptions to give the benefit of the doubt to certain categories of servicemembers most at need of care: those who mental health disabilities acquired in service and those who were deployed to contingency operations.

2. **Issue: The VA does not provide care prior to deciding whether service was "under conditions other than dishonorable."**
   Solution: The VA should be instructed to provide health care to servicemembers pending original determination of veteran status.

3. **Issue: The VHA routinely fails to initiate an evaluation of character of service.**
   Solution: The VHA should automatically start a request for a "Character of Discharge" determination when a servicemember with an OTH or BCD discharge requests health care, as the VBA does for Compensation and Pension claims.

4. **Issue: The VBA places those decision it its slowest decision-making lane.**
   Solution: The VA should assign Character of Discharge reviews into expedited decision teams.

See Exhibit 1 below for legislative language that would address these issues.

VI. Conclusion

Our current wars created tens of thousands of people injured by the conditions of their service. Often, this results in behavioral disorders that may appear as misconduct to their chains of command. There is a pipeline from in-service mental health trauma to behavioral dysfunction to misconduct discharge, and it ends with veterans at risk of suicide denied access to VA support. The VA's administrative processes deny immediate care to these servicemembers, and creates bureaucratic barriers to critical care that can save lives. Certain behaviors may be incompatible with continued military service, but we also recognize that those servicemembers, who once served honorably, deserve and need our support after they separate. Congress gave the VA the duty to extend services to those servicemembers. Their slow bureaucratic process and their refusal to follow their own rules effectively deny care and dignity to those servicemembers. They deserve better.

Exhibit 1: Suggested Legislative text

SEC. __. ELIGIBILITY FOR SERVICEMEMBERS WITH SERVICE IN A CONTINGENCY OPERATION OR WITH MENTAL HEALTH DISABILITIES.

(A) EVALUATION OF CONDITIONS OF DISCHARGE.— Section 5303B is Title 38 of the United States Code is added to read:

"5303B EVALUATION OF CONDITIONS OF DISCHARGE.—

(a) Any former servicemember who served on active duty in a theater of combat operations or an area at a time during which hostilities occurred in that area shall be presumed to have been discharged under conditions other than dishonorable in the absence of clear and convincing evidence to the contrary.

(b) Servicemembers who acquired mental health disabilities during service shall be presumed to have served under conditions other than dishonorable in the absence of clear and convincing evidence to the contrary.

(c) The Secretary may prescribe by regulation additional criteria for evaluating conditions of discharge."

(1) The presumptions in this paragraph do not overcome the prohibitions in Section 5303 of Title 38.

(b) TENTATIVE ELIGIBILITY DETERMINATIONS.—Section 1701 of Title 38 of the United States Code is amended to add the following after paragraph (a)(5):

"(6) The Secretary shall provide tentative eligibility to benefits under Chapter 17 and under Chapter 20 to former service persons not described in paragraphs (1) and (2) who received other than honorable discharges, pending verification of discharge or release under conditions other than dishonorable. No overpayments will be assessed for services provided during this period."

[1] "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.
[2] Id.
[3] VHA, "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010." (In 2000 the suicide rate for male veterans under 30 outside of VHA care was 63 per 100,000, almost twice the rate of those who are receiving VA healthcare.)
[4] Jakupcak et al. (2009). "PTSD as a Risk Factor for Suicidal Ideation in Iraq and Afghanistan War Veterans." Journal of Traumatic Stress, 22, 303-306. doi: 10.1002/jts.20423
[5] Jakupcak et al. (2011). "Hopelessness and Suicidal Ideation in Iraq and Afghanistan War Veterans Reporting Subthreshold and Threshold PTSD", Journal of Nervous and Mental Disease, 199, 272-275.
[6] Brenner et al. (2011). "Suicide and traumatic brain injury among individuals seeking Veterans Health Administration services." *The Journal of head trauma rehabilitation* 26.4: 257-264.
[7] Nock, et al. (2014). "Prevalence and Correlates of Suicidal Behavior Among Soldiers: Results From the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)." *JAMA Psychiatry*;71(5):514-522.
[8] Kline et al. (2011). "Suicidal ideation among National Guard troops deployed to Iraq: the association with postdeployment readjustment problems." The Journal of nervous and mental disease. 199(12):914-20.
[9] Nock, et al. (2014). "Prevalence and Correlates of Suicidal Behavior Among Soldiers: Results From the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)." *JAMA Psychiatry;* 71(5): 514-522.
[10] Sareen et al. (2005). "Anxiety disorders associated with suicidal ideation and suicide attempts in the National Comorbidity Survey." Journal of Nervous and Mental Disease. 193, 450-454.
[11] James et al. (2014), "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI", Military Medicine, 179, 4:357; Elbogen et al. (2014). Violent behavior and post-traumatic stress disorder in US Iraq and Afghanistan Veterans. The British Journal of Psychiatry, Advance online publication. doi: 10.1192/bjp.bp.113.134627; Tateno et al., "Clinical Correlates of Aggressive Behavior After Traumatic Brain Injury", The Journal of Neuropsychiatry and Clinical Neurosciences 2003;15:155-160. doi:10.1176/appi.neuropsych.15.2.155.
[12] See "General Ratings Formula for Mental Disorders" 38 CFR 4.150 (2009).
[13] U.S. Army "Health Promotion, Risk Reduction and Suicide Prevention Report." July 28, 2010, page 43
[14] *Austin Statesman*, "'Bad paper' discharges can stymie veterans' health care: Diagnosed with post-traumatic stress disorder before he was kicked out of Marines for failing a drug test without counseling" (October 3, 2010) available at http://www.statesman.com/news/news/state-regional-govt-politics/bad-paper-discharges-can-stymie-veterans-health--1/nRyPr/; *Colorado Springs Gazette* "Other than Honorable" (2013) available at http://cdn.csgazette.biz/soldiers/; *Seattle Times*, "Troubled veterans left without health-care benefits" (August 11, 2013) available at http://seattletimes.com/html/localnews/2018894574_vets12m.html; *National Public Radio*, "Veterans and Other Than Honorable Discharges" (2013) available at http://www.npr.org/series/250013036/veterans-and-other-than-honorable-discharges.
[15] For example, AR 600-235 Ch. 10.
[16] U.S. Army "Health Promotion, Risk Reduction and Suicide Prevention Report." July 28, 2010, passim. and page 70 ("Recommended actions: Enforce separation actions for high risk behavior.")
[17] Quoted in "Other Than Honorable", Colorado Springs Gazette http://cdn.csgazette.biz/soldiers/day2.html.
[18] Highfill-McRoy et al. "Psychiatric diagnoses and punishment for misconduct: the effects of PTSD in combat-deployed Marines", BMC Psychiatry 2010, 10:88.
[19] Milliken CS, Auchterlonie JL, Hoge CW. Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War. *JAMA.* 2007;298(18):2141-2148. doi:10.1001/jama.298.18.2141.
[20] 38 USC 101(2)
[21] 38 USC 101(2)
[22] This arises when the VA finds that a servicemember with a Dishonorable discharge was "insane" at the time of the misconduct that resulted in the discharge. 38 U.S.C. 5303(b), 38 C.F.R. 3.12(b).

[23] This arises where the servicemember received a misconduct discharge that the military service later upgraded to Honorable based on certain discharge review programs initiated in the 1970s, but where the VA nevertheless found that the conduct was dishonorable by its own standards. 38 U.S.C. 5303(e), 38 C.F.R. 3.12 (h).
[24] In *Camarena v. Brown*, 60 F. 3d 843 (Fed.Cir. 1995), a servicemember appealed a decision by the VA that his service ending in a Bad Conduct discharge was "under dishonorable conditions." The servicemember argued that the phrase "under dishonorable conditions" only excluded servicemembers with Dishonorable Discharges. The Court held that the VA's determination of whether a discharge was "other than under dishonorable conditions" is not bound by a military service's decision that the discharge characterization was dishonorable.
[25] 38 C.F.R. § 3.12(a).
[26] See *Beyond T.B.D.: Understanding VA's Evaluation of a Former Servicemember's benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces*, 214 Mil.L.Rev 1 (2012); *Recovering an Institutional Memory: The Origins of the Modern Veterans' Benefits System from 1914 to 1958,* 5 Vet. L. Rev. 1 (2013).
[27] 38 U.S.C. 5303(a).
[28] The prohibitions listed in 38 U.S.C. 5303(a) are not provided as standards for the phrase "conditions other than dishonorable" that defines a "veteran" in 38 U.S.C. 101(2). They are additional requirements that apply even if the VA decides that the discharge was "under conditions other than dishonorable" and that the servicemember is therefore a "veteran." In that case the person would be a "veteran" who is barred from all V.A. benefits. If the VA finds that a person was discharged under dishonorable conditions then they are simply not a "veteran" in the first place.
[29] 38 C.F.R. 3.12(a, b, d).
[30] 38 C.F.R. 3.12(a). That presumption may be overcome if the discharge characterization was provided as a result of one of several discharge review programs that occurred in the 1970s. 38 U.S.C. 5303(e), 38 C.F.R. 3.12 (h).
[31] 38 C.F.R. 3.12(d).
[32] "Active Duty Military Discharges, 2004-2011", Department of Defense Active Duty Transaction Files, available at http://www.dod.mil/pubs/foi/Personnel_and_Personnel_Readiness/Personnel/12-F-0647_Active_Duty_Military_Discharges_2004-2011.xlsx
[33] Id.
[34] *Manuel v Shinseki*, Ct. App. Vet. Cl., No. 10-1858 (Vet. App. 2012) (characterizing the governing regulations as "very broad").
[35] 38 U.S.C. 5303(b), 38 C.F.R. 3.12(b).
[36] Proposed 38 C.F.R. 5.1, 71 FR 16,464, 16,468 (2006).
[37] *Title Redacted by Agency*, 03-09 368, Bd. Vet. App. (June 19, 2009).
[38] 38 C.F.R. 3.12(c)(6)(ii).
[39] 38 C.F.R. 3.12(b).
[40] Proposed 38 C.F.R. 5.1, 71 FR 16,464, 16,468 (2006) (explaining that the standard is the same as the one used to define criminally insanity under the common law).
[41] *Id.* (explaining that the new regulation will adopt for all purposes the definition of insanity previously used to evaluate responsibility for homicide).
[42] The Veterans' Disability Benefits Commission, Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century (2007), page 97.
[43] See text accompanying note 32.
[44] 38 C.F.R. 3.360.
[45] Data provided by VHA Central Office Analyst in a phone interview on Just 27, 2014.
[46] *Seattle Times*, "Troubled veterans left without health-care benefits" (August 11, 2013) available at http://seattletimes.com/html/localnews/2018894574_vets12m.html.
[47] See "Note" in "Eligibility Determination", VHA Handbook 1601A.02, page 5 (Nov. 5, 2009).
[48] *See* "Non-rating activity days pending" in *ASPIRE Benefits Dashboard* at http://www.dod.mil/pubs/foi/recent.html.
[49] Phone conversation with Palo Alto Health Care System eligibility staff, October 27, 2014.
[50] 38 CFR 17.34 (establishing a narrow provision for "tentative eligibility determinations" that do not apply where the character of discharge is in question).

[51] 78 FR 28140, 28141 (explaining that only Honorable and General discharges qualify for the tentative eligibility rule because those are the only cases where eligibility "probably will be established").
[52] 38 CFR 17.102(a)
[53] The VHA eligibility determination manual does not include an instruction to make this available. See "Eligibility Determination", VHA Handbook 1601A.02, page 4-5 (Nov. 5, 2009).
[54] "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.
[55] "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.
[56] VHA, "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010." (In 2000 the suicide rate for male veterans under 30 outside of VHA care was 63 per 100,000, almost twice the rate of those who are receiving VA healthcare.)
[57] Data provided by VHA Central Office Analyst in a telephone interview in June 2014.

STATEMENT OF

ALEKS MOROSKY
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

VETERANS' AFFAIRS SUBCOMMITTEE
ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

H.R. 4720, H.R. 4887, H.R. 4977, H.R. 5059, H.R. 5475, and H.R. 5484

WASHINGTON, D.C. November 19, 2014

Chairman Benishek, Ranking Member Brownley and members of the Subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I want to thank you for the opportunity to present the VFW's stance on legislation pending before this Subcommittee. Your hard work and dedication to improving the quality of veterans' health care positively impacts the lives of all those who have served in our nation's military. The bills we are discussing today are aimed at continuing that progress and we thank the Committee for bringing them forward.

H.R. 4720, Medal of Honor Priority Care Act:

The VFW supports this legislation which would elevate Medal of Honor recipients from VA Priority Group 3 to Priority Group 1. The 79 living Medal of Honor recipients are held in the highest esteem by the veterans and military community. These men have turned the tide of battle against overwhelming enemy forces, and saved the lives of their comrades at great risk to themselves. Accordingly, we believe it is entirely appropriate to grant them Priority Group 1 status as a small but meaningful symbol of our appreciation for their heroic actions.

H.R. 4887, Expanding Care for Veterans Act:

The VFW supports this legislation which would expand VA research, education, and delivery of complementary and alternative medicine (CAM) treatments.

Too often, the VFW hears stories of veterans who have been prescribed high doses of ineffective medications to treat their mental health conditions. Countless veterans have experienced first-

hand the dangerous side of pharmacotherapy. Many of these medications, if incorrectly prescribed, have been proven to render veterans incapable of interacting with their loved ones and even contemplate suicide. With the expanding evidence of the efficacy of non-pharmacotherapy modalities, such as psychotherapy and CAM, VA should ensure it affords veterans the opportunity to access effective mental health treatments that minimize adverse outcomes.

VA has made a concerted effort to change its mental health care providers' dependence on pharmacotherapy to treat mental health conditions and manage pain. In 2011, the Minneapolis VA Medical Center launched its Opioid Safety Initiative. Aimed at changing the prescribing habits of providers, the Opioid Safety Initiative educates providers on the use of opioids, serves as a tool to taper veterans off high-dose opioids, and offers them alternative – non-pharmacotherapy – modalities for pain management. This spring, VA implemented the Opioid Safety Initiative system-wide.

VA has also increased its research of non-pharmacotherapy modalities. Last month, the National Center for Complementary and Alternative Medicine announced a 5-year, $21.7 million, agreement with VA to fund 13 research projects to explore non-drug approaches to managing pain and related health conditions. These studies will evaluate the effectiveness of transcranial direct current stimulation, use of mobile devices that display real-time brain activity, mindfulness meditation, and other non-pharmacologic approaches to treating mental health conditions and chronic pain. Similarly, the VFW believes that more work should be done to ensure veterans have safe and effective ways to treat their mental health conditions.

H.R. 4977, Creating Options for Veterans Expedited Recovery Act (COVER) Act:

The VFW supports this legislation which would establish a commission to examine the efficacy of VA mental health care and identify ways to improve outcomes.

Timely and accessible mental health care is crucial to ensuring veterans have the opportunity to successfully integrate back into civilian life. With more than 1.4 million veterans receiving specialized VA mental health treatment each year, VA must ensure such services are safe and effective. As we mentioned in our testimony of H.R. 4877, VA has made a concerted effort to change the way it treats mental health conditions and chronic pain. However, more can be done to ensure veterans have access to non-pharmacologic treatments that minimize side effects and improve outcomes.

H.R. 5059, Clay Hunt Suicide Prevention for American Veterans (SAV) Act:

The VFW is proud to support the Clay Hunt SAV Act which is aimed at combatting the problem of veterans' suicide. This widely known crisis is one that weighs heavily on our nation, and especially those of us who have served in uniform. When a veteran or service member becomes so hopeless that they decide to take their own life, it is equally as devastating as a life lost in combat. What makes suicide perhaps even more tragic, however, is that it is often preventable. We would like to thank Representative Walz and Chairman Miller for bringing forth this

bipartisan legislation which contains numerous provisions that we believe will make a significant impact in addressing this complicated problem.

Section 2 would require annual third party evaluations of all VA and DOD suicide prevention programs with reports to Congress from each secretary. Numerous programs exist, but it is unclear which are most effective. The VFW believes that these reviews will allow Congress to fully evaluate which programs are working and which are not, in order to replicate those that are and promote best practices in both departments.

Section 3 would alter the way characterizations of discharge are reviewed by DOD for certain veterans who received discharges that were less than honorable and whose application for an upgrade is based on matters relating to PTSD, TBI, or MST. Instead of presuming that discharges were correct and placing the burden of proof solely on the veteran to show that an error or inequity occurred, this section would require Discharge Review Boards (DRBs) to presume administrative irregularity and place the burden of proof on DOD to show that the discharge was just. DRBs would also be required to review medical evidence provided by VA or civilian providers in determining the extent of the veteran's mental health conditions.

Discharges that are less than honorable most often disqualify veterans from the VA health care benefits. Those suffering from service-related mental health injuries are left on their own to deal with these problems, making recovery nearly impossible for many. Unfavorable discharges also cut them off from education benefits and make them undesirable to employers. This often propels them into a cycle of joblessness, substance abuse, homelessness, and even suicide.

The VFW believes that section 3 would create a system that is more just for two main categories of veterans. The first is those who served honorably in combat, but were administratively discharged upon returning home due to relatively small infractions. According to the Army Human Resources Command, discharges for misconduct have been steadily increasing since 2006, with the rate increasing by 25 percent since 2009 alone. The VFW does not believe this is because the character and quality of service members is declining, but suspects it is a reflection of the incredible stress service members have been under after a decade of war. Many have completed multiple combat deployments and suffer from often undiagnosed mental health injuries, sometimes leading to minor misconduct such as missing formations or self-medicating with alcohol and banned substances. The VFW does not want to hinder the military's ability to enforce good order and discipline within the ranks, and does not believe in amnesty for every service member who engages in misconduct. We do, however, believe that those with mental health injuries should be provided an equitable system of due process, and we believe that this section would accomplish that goal.

The second group of veterans that would benefit from section 3 is those who erroneously received administrative discharges for personality disorder (PD) or adjustment disorder (AD), but were actually suffering from PTSD, TBI, or MST. These diagnoses are considered preexisting conditions by the military and, therefore, disqualify the veteran from benefits. Since September 11, 2001, approximately 30,000 veterans have been discharged for PD or AD. Troublingly, a 2008 review by the Government Accountability Office found that rates of service compliance with DOD regulations for diagnosing and discharging service members for those

disorders was as low as 40 percent. The VFW suspects that this is because the administrative discharge process for PD and AD is much more expedient for the military unit than the medical evaluation board process required to discharge a service member for a condition acquired while in service. If this is the case, even in only some instances, it is wrong. The review process established by section 3 provides the proper framework to ensure that such potential injustices would be corrected.

Section 4 would require VA to establish a website with the name and contact information for all department mental health services located in each VISN. The VFW supports this section.

Section 5 directs each state's National Guard Joint Force Headquarters (JFHQ) to establish formal strategic partnerships with the VISNs, VA Medical Centers, and local VA OEF/OIF/OND offices in their areas. Recently, VA and the National Guard Bureau have made promising steps towards improving communication and collaboration, such as a duty to warn initiative that will establish the criteria for mandatory reporting by VA to JFHQ regarding veterans who are at high-risk of committing suicide. However, communication between VA and the National Guard Bureau has been historically poor. The VFW believes the provisions of this section are still needed to ensure that the two agencies maintain strong and lasting communication in order to provide seamless care to Guardsmen with psychological wounds.

Section 6 establishes a pilot program to repay the educational loans on mental health professionals that agree to an obligated period of service at VA. Under the program, eligible providers would be able to receive up $60,000 in loan repayments per year, a significant increase from the current VA physician loan repayment program. The VFW believes that this will provide VA with an important tool to recruit and retain high quality mental health providers. The national shortage of mental health professionals is well documented. Without an adequate number of doctors, wait times for VA care will remain too high. Care delayed is care denied, and VA must remain competitive in attracting mental health professionals for employment.

Section 7 alters the GI Bill Yellow Ribbon Program by allowing VA to contribute up to 64 percent of the cost of an advanced degree for veterans pursuing advanced degrees in mental health and who intend to seek employment as VA mental health care providers. The VFW strongly supports efforts to train veterans to serve as mental health care providers, but we believe that efforts to do so should be focused on incentivizing the veteran, rather than the institution. As written, this section would provide more money to institutions already participating in the Yellow Ribbon Program, but would not necessarily create a perceivable incentive for veterans to enter the mental health field. As an alternative, we would suggest providing additional grants or tuition assistance directly to veterans who are pursuing mental health degrees with the intention of seeking VA employment.

Section 8 directs the National Guard Bureau to conduct a zero-based review of the staffing requirements for states/territories for the National Guard Psychological Health Program. Since introduction of this legislation, the VFW has learned from the most recent report by the Recovering Warrior Task Force that the Army National Guard conducted the review of staffing needs and the Psychological Health Program is now completely staffed. We would ask that Congress continue to conduct oversight to ensure that this remains the case.

Section 9 would establish a pilot community outreach program staffed by peer support specialists. Peer support is a proven model of success within VA facilities, and the VFW believes that allowing peer support specialists out in the community to help connect their fellow veterans with the services they need is the next step. This program could be immensely valuable in preventing suicide by allowing peer support specialists to connect with veterans who may never have sought help on their own.

H.R. 5475, a bill to improve the care provided by the Secretary of VA to newborn children:

The VFW supports this legislation which would expand VA's authority to provide health care to a newborn child, whose delivery is furnished by VA, from 6 to 14 days post-birth.

According to the Centers for Disease Control and Prevention, newborn screenings are vital to diagnosing and preventing certain health conditions that can affect a child's livelihood and long-term health. We understand the importance of high-quality newborn health care and its long-term impact on the lives of veterans and their family. VA should do what is needed to ensure newborn children, whose delivery was furnished by VA, receive the proper post natal health care they deserve.

H.R. 5484, Toxic Exposure Research Act of 2014:

This legislation would establish an advisory board to assist VA in determining the association between adverse health conditions and exposure to toxic substances. It would also establish a national center for research to study the health effects of toxic exposures on the descendants of individuals who were exposed to such substances during their military service. The VFW supports this legislation and would like to offer suggestions to strengthen it, which we hope the subcommittee would consider, should it be advanced to markup.

The VFW does not support section 4 which would authorize the Advisory Board to determine whether a veteran, who submits a claim, has a health condition that would qualify such veteran for VA health care or compensation benefits. VA already has an established process for adjudicating all disability claims. Creating a new process for the unique purpose of deciding toxic exposures claims would add further confusion to the disability evaluation system. A new parallel system would disrupt the progress VA is making towards breaking the claims backlog by forcing them to reallocate resources, and would obscure the existing process by proving veterans with potentially conflicting or misleading information. The VFW supports addressing flaws in the current system, but strongly believes that VA should continue to make individual determinations of VA benefits. We suggest the Advisory Board's claims process be limited to whether its research has found that a health condition is associated with exposure to toxic substances. Such a process should serve to inform veterans of the Advisory Board's findings, not determine a veteran's eligibility for VA benefits.

Veterans who were exposed to toxins during their military service deserve to know if their chronic health conditions were caused by such exposure. For far too long, veterans, such as those who flew and maintained contaminated C-123 aircrafts after the Vietnam War, have struggled to obtain VA benefits for chronic health conditions that are directly related their

military service. This legislation would ensure VA devotes the proper time and resources to make objective and evidence-based determinations regarding the health conditions that are associated with toxic exposures.

The VFW also recognizes the need for more research on the health effects of toxic exposures on the descendants of individuals who were exposed to such substances during their military service. In its report *Veterans and Agent Orange: 2012 Update,* the Institute of Medicine (IOM) stated that "the amount of research providing reliable information on the consequences of paternal exposure is extremely sparse not only for [Agent Orange] but also for the full array of environmental agents that may pose threats to the health of future generations." With the existing body of research on this topic, VA has established the Spina Bifida Program, to provide health care and benefits to the children of certain Vietnam veterans, who were born with spina bifida – an extremely debilitating neural tube birth defect. VA also provides health care and benefits to children of women Vietnam veterans born with certain birth defects.

However, exposure to toxic substances is not limited to Vietnam veterans. We believe VA has the responsibility to research whether the descendants of other veterans who have been exposed to toxic substances, such as the approximately 650,000 veterans and family members who now qualify for VA health care benefits as a result of their exposure to contaminated water in Camp Lejeune, are at risk of developing adverse health conditions.

Mr. Chairman, this concludes my testimony and I look forward to any questions you and the members of this subcommittee may have.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, VFW has not received any federal grants in Fiscal Year 2013, nor has it received any federal grants in the two previous Fiscal Years.

Testimony of

Vietnam Veterans of America

Presented by

Richard Weidman
Executive Director for Policy and Government Affairs

Before the

House Veterans Affairs Committee
Subcommittee on Health

REGARDING

H.R. 4720, the Medal of Honor Priority Care Act; H.R. 4977, the COVER (Creating Options for Veterans Expedited Recovery Act); H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act; H.R. 5475, to improve the care provided by the Secretary of Veterans Affairs to newborn children, H.R. 5484 'the Toxic Exposure Research Act and H.R. 4887 Expanding Care for Veterans Act

November 19, 2014

Vietnam Veterans of America

House Veterans Affairs Committee
Subcommittee Health
November 19, 2014

Good afternoon, Mr. Chairman and other distinguished members of the subcommittee Vietnam Veterans of America (VVA) is pleased to have the opportunity to appear here today to share our views concerning pending legislation before this subcommittee

H.R. 4720, the Medal of Honor Priority Care Act - introduced by Congressman Tim Walberg (MI-7), when enacted into law would Increases, from third to first, the priority for enrollment in the Department of Veterans Affairs (VA) health care system given to Medal of Honor recipients, regardless of the date on which the medal is awarded.

Vietnam Veterans of America (VVA) strongly favors passage of H.R. 4720. While this potentially affects only the 79 currently living Medal of Honor (MOH), this is a step to recognize these extraordinary Americans.

H.R. 4977, the COVER (Creating Options for Veterans Expedited Recovery Act) – introduced by Congressman Gus Bilirakis (FL-12), when enacted into law would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community. Vietnam Veterans of America (VVA) believes that many Complementary and Alternative Medicines (i.e., CAM) treatments are being actively promoted as effective cures for PTSD without adequate, rigorous research data to support their claims. In the words of the preeminent PTSD researcher, Dr. Charles W. Hoge, Col., U.S. Army (Ret.), "Obviously it's a lot easier to just claim that a treatment is effective without doing the research, which is why there's a glut of snake oil salesmen in this business now." Currently, effective treatments for PTSD already exist and are well-detailed in the Institute of Medicine (IOM) DoD/VA Evidence-based Clinical Guidelines for PTSD. Thus H.R. 4977's focus on examining the effectiveness of CAM such as music therapy, equine therapy, pet therapy (e.g., dogs), yoga, acupuncture, meditation, outdoor experiential therapy (e.g., sports), hyperbaric oxygen therapy, accelerated resolution therapy (i.e., ART) and other treatment modalities such as dietary and/or herbal supplements, highlights the need for high-quality research of all new PTSD treatments, especially as new treatments seem to be springing up daily and are touted as the latest "silver bullet" for PTSD (and m-TBI) in returning

combat veterans. Some of these treatments have been widely advertised through media news stories and many veterans are wondering why the VA (or DoD) has not adopted them system-wide.

Therefore, Vietnam Veterans of America (VVA) supports the intent of Congressman Bilirakis' bill, H.R. 4977. That is, **VVA supports the creation of a ten-member commission to review the scientific research evidence base for all such CAM treatments**, and not simply rely on ill-founded marketing claims as the reason for VA (and DoD) adopting a CAM. Although VVA supports the intent of H.R. 4977, VVA suggests one addition to the Commission's Membership Appointment criteria (Section 3) – appointees must not have a proprietary interest (financial or otherwise) in any of the CAM treatments that are reviewed under its jurisdiction.

H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act - introduced by Congressman Timothy J. Walz (MN-1) when enacted into law would direct the Secretary of Defense and the Secretary of Veterans Affairs to provide for the conduct of annual evaluations of mental health care and suicide prevention programs of the Department of Defense and the Department of Veterans Affairs, to review the terms or characterization of the discharge or separation of certain individuals from the Armed Forces, to require a pilot program on loan repayment for psychiatrists who agree to serve in the Veterans Health Administration of the Department of Veterans Affairs, and for other purposes. Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on Representative Walz's "Clay Hunt Suicide Prevention for American Veterans Act" (or the Clay Hunt SAV Act), which focuses on suicide and PTSD amongst our military and veterans.

VVA has long believed the research demonstrates a link between PTSD and suicide, and in fact, studies suggest that suicide risk is higher in persons with PTSD. For example, research has found that trauma survivors with PTSD have a significantly higher risk of suicide than trauma survivors diagnosed with other psychiatric illness or with no mental pathology (1). There is also strong evidence that among veterans who experienced combat trauma, the highest relative suicide risk is observed in those who were wounded multiple times and/or hospitalized for a wound (2). This suggests that the intensity of the combat trauma, and the number of times it occurred, may indeed

influence suicide risk in veterans, although this study assessed only combat trauma, not a diagnosis of PTSD, as a factor in the suicidal behavior.

So let's cut to the chase: it is very challenging to determine an exact number of suicides. Some troops who return from deployment become stronger from having survived their experiences. Too many others are wracked by memories of what they have experienced. This translates into extreme issues and risk-taking behaviors when they return home, which is why veteran suicides have attracted so much attention in the media. Many times, suicides are not reported, and it can be very difficult to determine whether or not a particular individual's death was intentional. For a suicide to be recognized, examiners must be able to say that the deceased meant to die. Other factors that contribute to the difficulty are differences among states as to who is mandated to report a death, as well as changes over time in the coding of mortality data (1).

Some studies that point to PTSD as the cause of suicide suggest that high levels of intrusive memories can predict the relative risk of suicide (3). Anger and impulsivity have also been shown to predict suicide risk in those with PTSD (3). Further, some cognitive styles of coping such as using suppression to deal with stress may be additionally predictive of suicide risk in individuals with PTSD (4).

Other research looking specifically at combat-related PTSD suggests that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt, especially amongst Vietnam veterans (5). Many veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war, and these thoughts can often overpower the emotional coping capacities of veterans.

Mindful of this information, VVA was nonetheless surprised with the VA's report of February 1, 2013 on veterans who die by suicide. The report paints a shocking portrait of what's happening among our older vets, most of whom served during the Vietnam era (see chart below).

Percentage of suicides by age and veteran status among males

Age group	Non-veteran	Veteran
29 and younger	24.4%	5.8%
30-39	20.0	8.9
40-49	23.5	15.0
50-59	16.9	20.0
60-69	7.4	16.8
70-79	4.2	19.0
80 and older	3.6	14.5

Clearly, over seventy percent of veterans who commit suicide are age 50 or older.

Among the report's other findings:

• The average age of veterans who die of suicide is just short of 60; for nonveterans, it's 43.

• Female veterans who commit suicide generally do so at younger ages than males. Two-thirds of women who killed themselves were under 50 years of age; one-third were under 40 and 13 percent were under 30. For men, the comparable figures were 30 percent, 15 percent and 6 percent.

• About 15 percent of veterans who attempt suicide, but don't succeed, try again within 12 months.

VVA asks **why?** VVA strongly believes that until VA mental health services develops a nationwide strategy to address the problem of suicides among our older veterans – particularly Vietnam-era veterans -- it immediately adopt and utilize the appropriate suicide risk and prevention factors for veterans found in the "National Strategy for Suicide Prevention 2012: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention" that's available on-line at the web sites for both the Surgeon General's Office and SAMHSA.

In addition, VVA believes that **H.R. 5059 can be strengthened by adding provisions that specifically address the findings and recommendations found in the Institute of Medicine (IOM) 2014 report entitled "Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment",** which was released to the public on June 14, 2014. This report looks at the effectiveness of the growing number of PTSD programs and services, as well as focuses on the opportunities and challenges that VA and DoD face in developing, implementing, and evaluating such services and programs within the context of achieving a high-performing system to care for service members and veterans suffering from PTSD.

The **IOM findings** include –

VA and DoD are not consistently providing the level of quality that would characterize a high-performing PTSD treatment system.

Most service members and veterans with PTSD are NOT receiving evidence-based treatments due to barriers to care that could be overcome.

Neither VA nor DoD utilizes measurement-based care, a hallmark of a high-performing system of care.

Neither VA nor DoD have a strategic plan for dealing with the surge of PTSD, assuring that management at all levels give the issue adequate priority.

Although VA and DoD have increased the use of contract providers, the triage is not always done by clinicians, and there is no requirement that community mental health professionals be familiar with military culture or trained in evidence-based care for PTSD, and there is no adequate mechanism for monitoring the quality of care.

The VA research budget does not reflect the growth in PTSD or its priority to the Department.

The **IOM** report also includes the following **recommendations** –

VA and DoD should develop an integrated, coordinated and comprehensive PTSD management strategy that plans for the growing burden of PTSD for service members' veterans and their families, including women veterans and minority group members.

VA and DoD leaders, who are accountable for the delivery of high-quality health care for their populations, should communicate a clear mandate through their chain of command that PTSD management, using evidence-based best practices, has high priority.

VA and DoD should develop, coordinate and implement a measurement-based PTSD management system that documents patients' progress over the course of treatment and long-term follow-up with standardized and validated instruments.

VA and DoD should have available an adequate workforce of mental health providers – through both direct care and purchased care – and ancillary staff to meet the growing need for PTSD Services. VA and DoD should develop and implement clear training standards, referral procedures and patient monitoring and reporting requirements for ALL their mental health provides. And resources need to be available to facilitate access to mental health programs and services. **NOTE:** VVA suggests consideration of the "Grow Our Own" program currently being piloted at the Federal Health Care Center in North Chicago, IL as a model for recruitment and training of VA health care staff in all medical disciplines, including mental health.

Both VA and DoD should use evidence-based treatments as the treatment of choice for PTSD, and these treatments should be delivered with fidelity to their established protocols. As innovative programs and services are developed and piloted, they should include an evaluation process to establish the evidence base on their efficacy and effectiveness.

VA and DoD should establish a central database or other directory for programs and services that are available to service members and veterans suffering with PTSD.

VA and DoD should increase engagement of family members in the PTSD management process for service members and veterans.

PTSD research priorities in both VA and DoD should reflect the current and future needs of service members, veterans and their families. Both departments should continue to develop and implement a comprehensive plan to promote a collaborative, prospective PTSD research agenda.

All of this brings us full circle to what VVA has been saying for years – **if both DoD and VA were to use the PTSD assessment protocols and guidelines as first recommended by the Institute of Medicine back in 2006** (http://iom.edu/Reports/2006/Posttraumatic-Stress-Disorder-Diagnosis-and-Assessment.aspx), **our troops and veterans would receive the accurate mental health diagnoses needed to assess their suicide risk status**.

VVA thanks Congressman Walz for his efforts to assist our service members and troops suffering with PTSD to obtain high-quality treatment and care. However, a lack of standards, reporting, and evaluation significantly compromises VA and DoD efforts. Use of the IOM's recommendations can offer more detailed guidance for improving processes and infrastructure that will allow VA and DoD to respond more strategically and effectively to the growing PTSD and suicide burden among our service members and veterans.

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H.R. 5475, to improve the care provided by the Secretary of Veterans - introduced by Congressman Doug Collins (GA-09), when enacted into law would improve the care provided by the Secretary of Veterans Affairs to newborn children.

Mr. Chairman our women veterans proudly serves this nation bravely and deserve the best care not only for themselves but their families and VVA supports the bill as it would expand and improve all post-delivery care services, including routine care services, that a newborn child requires up to 14 days of care after birth.

H.R. 5484 the Toxic Exposure Research Act - introduced by Congressman Dan Benishek, (MI-01) with Congressman Mike Honda (CA-17), when enacted into law would establish a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during services in the Armed Forces and also establishes an advisory board on exposure to toxic substances, and for other purposes.

Vietnam Veterans of America (VVA) applauds the leadership of Congressman Dan Benishek, (MI-1) in working with his colleague Congressman Mike Honda (D-CA) to introduce the bi-partisan bill H.R.5484 the Toxic Exposure Research Act of 2014, (formerly H.R. 4816), the Toxic Exposure Research and Military Family Support Act of 2014. Among the invisible wounds of war are those brought home by troops that may not manifest for a decades. Most tragically, they may pass these harmful wounds to the progeny of our nation's warriors. Our children and grandchildren should not have these burdens visited on them.

This bipartisan legislation would establish within the Department of Veterans Affairs a national center for the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during service in the Armed Forces. This is a multi-generational bill, as well as providing for a common vehicle for evaluating potential toxic exposures that may result in toxic wounds in all such events, from Camp Lejeune to Fort McClellan to Agent Orange in multiple locations to Gulf War veterans.

Toxins, such as Agent Orange, have been shown to cause birth defects in the children of military personnel who came into contact with them, either during the Vietnam War, in the storage and transportation of those toxins, or by riding in aircraft that had been previously used to transport the toxins. For Gulf War veterans, the exposure was to chemical weapons that were in an Iraqi ammo dump that was blown up by U.S. Forces at the end of the Gulf War, to oil fires, and possibly to tainted vaccines and medicines.

This is a simple and straightforward proposal that will begin to address the needs of the progeny of every generation of veterans, and the conditions that are so heartbreaking to so many families. (Please see "Faces of Agent Orange" at https://www.facebook.com/pages/Faces-of-Agent-Orange/187669911280144)

H.R. 4887, the Expanding Care for Veterans Act – introduced by Congresswoman Julia Brownley (CA-26), when enacted into law would direct the Secretary of Veterans Affairs (VA) to develop a plan to expand the scope of the VA's research and education on, and delivery and integration of, complementary and alternative medicine services.

Vietnam Veterans of America (VVA) believes that many Complementary and Alternative Medicines (i.e., CAM) treatments are being actively promoted as effective cures for PTSD and other chronic conditions without adequate, rigorous research data to support their claims. Therefore VVA cannot support H.R. 4887 without a review of the scientific research evidence base for all such CAM treatments as has been proposed in H.R. 4977, the COVER (Creating Options for Veterans Expedited Recovery Act) introduced by Congressman Gus Bilirakis (FL-12). See below.

VVA commends the spirit and concern of the sponsors of this bill. However, anything that is claimed to be effective can and should be subject to clinical

trials as soon as possible. VVA has been saying this to promoters of one or another of these alternative treatments for at least a decade, yet they never seem to muster enough confidence in their promoted modality of treatment to set up clinical investigation.

For these reasons, VVA cannot support these provisions in either bill.

Thank you for this opportunity to present our views here today. I will be happy to answer any questions.

VIETNAM VETERANS OF AMERICA
Funding Statement
November 19, 2014

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
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RICK F. WEIDMAN

Richard F. "Rick" Weidman serves as Executive Director for Policy & Government Affairs on the National Staff of Vietnam Veterans of America (VVA). As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam War, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, and from 1998 to the present, serving variously as Membership Services Director, Agency Liaison, Director of Government Relations, and now Executive Director for Policy & Government Affairs. He left VVA to serve in the Administration of Governor Mario M. Cuomo (NY) as statewide director of veterans' employment & training (State Veterans Programs Administrator) for the New York State Department of Labor from 1987 to 1995.

Rick has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans (NCHV), and served at various times on the VA Readjustment Advisory Committee, as a consumer liaison on the Secretary's Advisory Committee on Serious Mental Illness at VA, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities - Subcommittee on Disabled Veterans, Advisory Committee on veterans' entrepreneurship at the Small Business Administration, and numerous other advocacy posts in veteran affairs. He is currently Chairman of the Veterans Entrepreneurship Task Force (VET-Force), which is the consortium of most of the major veterans' service organizations and military service organizations regarding expanding opportunities for veterans, particularly disabled veterans to create, own, and successfully operate their own small business.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veterans affairs. He attended Colgate University (B.A., 1967), and did graduate study at the University of Vermont.

He is married and has four children.

STATEMENT OF
RAJIV JAIN, MD
ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS

November 14, 2014

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 from VA's Office of General Counsel is Staff Attorney Jennifer Gray.

H.R. 4720 Medal of Honor Priority Care Act

This bill would place Medal of Honor recipients in VA's health care system in enrollment priority group (PG) 1 under the Veteran health care enrollment tiers established by the Congress. VA supports efforts to ensure responsive and appropriate health care for Medal of Honor recipients. However, we believe some clarifications on the intent of the bill may be helpful. Enrollment PGs were established to manage the enrollment of Veterans. Placing enrolled Medal of Honor recipients in PG 1, solely based on their Medal of Honor status, would not provide any additional benefits to that population. If the intent of this legislation is to ensure Medal of Honor recipients do not incur VA copayments, VA would be glad to provide technical assistance to accomplish that purpose, as explained below.

VA copayments are not directly related to PG status. The authoritative statutes governing copayments can be found at 38 U.S.C. § 1710 (inpatient/outpatient care), § 1710B (long-term care) and § 1722A (prescription drugs). The Medal of Honor recipients have been recognized as extraordinarily courageous Veterans who served their country without regard for their own safety or well-being. VA would support legislation designed to recognize their service and ensure that they can receive cost-free care to maintain their health and well-being.

Most Medal of Honor recipients have service-connected disabilities and are already enrolled as PG 1 Veterans who are not subject to copayments based on their service-connected disabilities. For the remaining limited numbers who are in PG 2 or 3, amending the statutory authorities governing copayments, rather than moving them to PG 1, will allow them to be copayment exempt, affording them the same benefits as other special categories of Veterans such as catastrophically disabled Veterans, former prisoners of war, and Purple Heart recipients.

A change to make Medal of Honor recipients copayment exempt would require some system changes to the Veterans Health Information Systems and Technology Architecture (VistA) and the enrollment system, but they would be relatively minor. Since these system changes would be combined with other funded projects, the cost would be insignificant. The Medal of Honor recipient population is extremely small and exempting them from copayments would not have any significant impact on our medical care collection fund.

H.R. 4977 Creating Options for Veterans Expedited Recovery Act ("COVER Act")

The bill would establish a commission to examine the efficacy of the evidence-based therapy model used by the Secretary of Veterans Affairs (Secretary) for treating mental health illnesses and identify areas to improve wellness-based outcomes, conduct patient-centered surveys, and examine available research on complementary and alternative treatment therapies for mental health issues.

More specifically, section 2 would establish a Veterans Expedited Recovery Commission (the "Commission") that would be charged with:

- Examining the efficacy of VA's evidence-based therapy model in the treatment of mental health illnesses and identifying areas to improve wellness-based outcomes;
- Conducting a detailed patient-centered survey within each of the Veterans Integrated Service Networks (VISN) of Veterans seeking mental health services;
- Conducting research on the benefits of complementary alternative treatment therapies for mental health issues, as specified by the bill; and
- Studying the potential increase in VA's approval of disability claims for mental health conditions of Veterans who served in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

Section 3 would set forth the manner of appointing members. In general, it would require the Commission to be composed of 10 members, each of whom has recognized

standing and distinction within the medical community; a background in treating mental health; and experience working with the military and Veteran population. The President of the United States would be required to designate the chairman from among the members. Members would serve for the life of the Commission, and any vacancy would be required to be filled in the same manner as the original appointment. The measure would require these appointments to be made not later than 90 days after enactment.

Section 4 would require the Commission to hold its first meeting not later than 30 days after a majority of members are appointed and regular meetings thereafter. To perform its duties, this measure would, among other things, authorize the Commission to take testimony and receive evidence; secure needed information directly from any Federal Department or Agency; and consult and contract with private and public sector entities. It would also authorize a Federal Department or Agency, upon request, to detail personnel (on a reimbursable basis) to assist the Commission but require the Administrator of General Services to provide (on a reimbursable basis) administrative support services requested and required by the Commission.

Section 5 would establish detailed interim, periodic, and final congressional reporting requirements.

Section 6 would provide for the Commission's termination 30 days after the submission of its final report.

While VA supports the intent of H.R. 4977 to examine the efficacy of VA treatment of mental disorders, we do not support the manner in which this bill would carry out that goal for the reasons discussed below. In addition, VA's current programs and reviews, as explained below have substantial overlap with many elements of the work the Commission would do. Finally, the charge of the Commission to examine the efficacy of "VA's evidence-based therapy model" in the treatment of mental health illnesses we believe may be based on a flawed premise, as no single evidence-based therapy model exists by which to treat all mental health issues in Veterans who use VA health care.

Treatment is guided, in part, by the *PTSD Practice Guideline (Guideline)* that was jointly developed by VA and the Department of Defense (DoD) in 2010. The bill's charge to examine the efficacy of VA treatments would partially duplicate the *Guideline* as well as a report issued by the Institute of Medicine, entitled "Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment," issued in June of 2014. Creating such a Commission would also duplicate the efforts of the Institute of Medicine committee that is currently evaluating VA's mental health services. See "Evaluation of the Department of Veterans Affairs Mental Health Services." http://www.iom.edu/activities/Veterans/vamentalhealthservices.aspx

As to the mandated patient-centered survey to be conducted by the Commission, such a charge would be unnecessarily burdensome to Veterans because some of the required information is already available in research programs and program evaluation studies. Other mandated information will be collected as part of VA data collection

initiatives currently in development. Data collection should be refined so as to not burden Veterans by collecting information that is already available within VA or soon will be.

VA research into the benefits of complementary and alternative medicine (CAM) is also already underway. VA is establishing the Integrative Health Coordinating Center (IHCC) within the Office of Patient-Centered Care and Cultural Transformation. Integrative Health reflects the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of *all* appropriate therapeutic approaches, health care professionals, and disciplines to achieve optimal health and healing. Integrative Health is inclusive of CAM. The IHCC is charged to work with VA Mental Health Services, the Office of Research and Development, and other Veterans Health Administration (VHA) program offices to examine the evidence and potential benefits of incorporating complementary and alternative treatments. VA is actively partnering with the National Institutes of Health's National Center for Complementary and Alternative Medicine to study complementary and integrative health approaches. Thus, VA is already engaged in robust efforts on CAM.

The bill's requirement that the Committee conduct research on the benefits of CAM techniques is partially duplicative of the activity of the PTSD Practice Guideline Committee, which is currently preparing to update the *Guideline*. VA continues to review the emerging literature in other ways too, such as its Evidence Synthesis

Program, which issued a review of the evidence on Complementary and Alternative Medicine for PTSD. (See *Efficacy of Complementary and Alternative Medicine Therapies for Posttraumatic Stress Disorder: Evidence-based Synthesis Program.* Investigators: Jennifer L Strauss, PhD, Remy Coeytaux, MD, PhD, Jennifer McDuffie, PhD, Avishek Nagi, MS, and John W Williams, Jr, MD, MHSc. Evidence-based Synthesis Program (ESP) Center, Durham Veterans Affairs Healthcare System. Washington (DC): Department of Veterans Affairs; 2011 Aug.)

Should a Commission be established, there are additional details of H.R. 4977 that we see as problematic. Specifically, the bill requires that members of the Commission include individuals who are of recognized standing and distinction within the medical, integrative medicine, and CAM community with a background in evaluating the efficacy of conventional and CAM mental health treatments (versus those with a background in treating mental health issues). These are relevant qualities, but evaluating the efficacy of any treatment is a research endeavor. As such, scientific experts are needed both to evaluate potential merit of studies in peer review and to conduct safe rigorous trials that will enhance the state of understanding. We would recommend that expertise on the Commission be expanded to include those charged with survey development, population sampling for representativeness, and data collection/analysis, to effectively meet the stated charge.

As to the bill's requirement for VA to study the potential increase in VA's approval of disability claims for mental health conditions of Veterans who served in Operation

Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn, VA could not support the measure without clarification on the purpose of the requirement. We are unclear on what the authors of the bill are suggesting and whether it would cause a potential *increase* in disability claims. VA's aim throughout all its medical care and research is the fullest possible recovery of the Veterans' health, which would have the effect of reducing disability claims.

With respect to the mandated plan by the Secretary, we believe the suggested timeframe is not reasonable given the requirements of the legislation.

VA estimates the costs associated with enactment of H.R. 4977 to be $718,019 over Fiscal Years (FYs) 2015-2016, the total period covered by the legislation. This estimate does not include, however, contract-related costs required for the Commission to discharge its duties. Clarification of certain terms in the legislation and development of a scope of work are needed before contract-related costs and other costs associated with section 2(b)(4) can be estimated and included in our cost projections.

In addition to these views, we note that the Department of Justice (DOJ) has advised of legal concerns about provisions in this bill.

H.R. 5059 Clay Hunt Suicide Prevention for American Veterans Act

Mental health care and suicide prevention are among VA's highest priorities, and we appreciate that the Congress continues to raise awareness of these important issues.

VA agrees with many of the goals of the bill, and as expressed below, existing efforts of the Department are aligned with those goals. VA would welcome discussion with the Committee to examine how some provisions could be adjusted to complement VA's ongoing multi-faceted efforts.

Turning to the specifics of the bill, Section 2 of H.R. 5059 would require VA and DoD to each have an independent third party conduct annual evaluations of the mental health care and suicide prevention programs that are carried out by the respective Departments.

VA supports the intent of this provision to further suicide prevention but has recommendations to improve its effectiveness to combat Veteran suicide, including addressing issues where there is duplication of robust activity that is ongoing at VA.

VA does not believe that requiring an additional ongoing evaluation effort is necessary for its mental health and suicide prevention programs, as they are regularly reviewed by external accrediting bodies including the Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF) as well as many internal review processes. In addition, VA already has robust evaluation efforts focused on mental health care and suicide prevention. For example, in prior years the Congress mandated programs such as the North East Program Evaluation Center (NEPEC), Serious Mental Illness Treatment, Resource and Evaluation Center (SMITREC), and the Program Evaluation Resource Center (PERC). These internal resources allow for timely reports

from subject matter experts in evaluation who are familiar with the complexities of using and analyzing VA's administrative data. Additionally, VA complies with current the Congressionally-mandated reporting requirements, which include posting of information online, pursuant to PL 112-239 (FY 2013 NDAA), section 726. Section 726 requirements overlap with some of the areas mentioned in section 2 of the proposed bill to report on the annual evaluation of VA mental health programs to the Congress and the public. Section 726 calls for the establishment of a contract with the National Academy of Sciences (NAS) to conduct an assessment and provide an analysis and recommendations on the state of VA mental health services. VA has actually already embarked on such a project with NAS that is closely aligned with this requirement. For suicide prevention, VA has been increasing our understanding of suicide among Veterans by developing data sharing agreements with all 50 U.S. states and several U.S. territories. The initial VA Suicide Data Report issued in February 2013 was the first effort to analyze these more complete and timely data points and provide a more comprehensive understanding of Veteran suicide to inform VA's suicide prevention efforts. The February 2013 report contained data and analysis from 21 states.

In an effort to understand the picture of Veteran suicide more completely, VA has advanced development of a VA/DoD Suicide Data Repository (SDR). The January 2014 update to the VA Suicide Data Report is the first analysis using the SDR information. This update also incorporates more recent data from the National Death Index and provides information about suicide rates, which the initial VA Suicide Data Report issued in February 2013, did not.

VA does support, with some modification, the bill's requirement for review of the Department's suicide prevention programs, and looks forward to discussion of this important element of the bill. A Joint VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide was released in 2013. VA recommends that a one-time evaluation of the suicide prevention program be conducted to support implementation of these guidelines. VA believes it can benefit from a one-time, targeted evaluation of this effort.

Section 3 would require DoD to review the characterization of the terms of discharge from the Armed Forces of individuals with mental health disorders that may have affected their terms of discharge. VA defers to DoD on this section.

VA supports the intent of section 4. This section would require VA to: (1) provide Veterans information regarding all of the mental health care services available in the VISN where the Veteran is seeking such services, including the name and contact of each social work office, mental health clinic, and a list of appropriate staff; (2) update the information every 90 days; and (3) include information about the website in outreach efforts.

This requirement generally aligns with the goals and efforts currently underway for ensuring that Veterans can easily locate information about VA mental health services on the Internet. Each VISN and facility maintains their own website. National policy could be reviewed and updated to meet the requirements of this section, ensuring that

appropriate information on mental health services is available and updated on those websites. VA recommends conducting an assessment of available tools for locating information about mental health services, including seeking input from Veterans in order to determine the most useful framework through which VA can provide such information. This requirement should also be considered in the context of the Secretary's goal of creating one phone number and one website for all VA services. VA would welcome discussion with the Committee on how the goals of this section can be furthered.

VA supports the intent of section 5 but notes that the measure would be in some respects redundant of current efforts. Also, we recommend technical edits to improve its value to Veterans. Section 5(a) would require the establishment of formal strategic relationships between VA, DoD, the Reserve Components at the state level, and the local VISN, medical facilities, and other local VA offices, particularly with respect to facilitating mental health referrals, timely mental health services, communication concerning Servicemembers who are "at risk" for behavioral health reasons, and the transfer of documentation for line of duty and fitness of duty determinations.

VA has been working with the National Guard Director of Psychological Health at a national level to develop and establish a Memorandum of Understanding that would address referral issues at a national level. Additionally, VHA's Outreach Collaboration Office Liaison National Guard Reserve has established a formal systematic communication mechanism for the purpose of disseminating information between DoD

and VA with the goal of ensuring that the National Guard and Reserve population receives information on VA health care, benefits, and services. Consistent dialogue with leadership within the Reserve Service will continue to improve and ensure that pertinent information is shared with the Reserve community. Finally, VHA encourages VA Medical Centers to include National Guard and Reserve personnel from their state in their local VA mental health summit. With regard to sharing of information regarding "at risk" Servicemembers, fitness for duty, and line of duty determinations, there are mechanisms already in place for sharing of medical information with appropriate DoD personnel that include sharing of mental health information. Thus, VA strongly encourages (and engages in) collaboration and coordination with National Guard and Reserves to best meet the needs of Reserve Component members, establishing formal agreements at the state and local level. The bill as drafted, therefore, could create redundant efforts.

Section 5(b) sets forth a requirement for a Government Accountability Office (GAO) report on transition of care for posttraumatic stress disorder or traumatic brain injury, particularly focused on psychotropic medications. VA does not oppose this provision. Section 6 would establish a pilot program for the repayment of educational loans for mental health professionals. VA supports the aims of section 6, but we believe the recent enactment of significant changes to VA's education-debt repayment programs (in section 302 of Public Law 113-146 and section 408 of Public Law 113-175) make some parts of section 6 obsolete. We would welcome discussion of this provision with the Committee in light of these developments.

Section 7 would add a new subsection (f) to 38 U.S.C. § 3317; directing VA to carry out a program that would increase the amount VA may contribute under the "Yellow Ribbon G.I. Education Enhancement Program" (Yellow Ribbon Program) for Veterans pursuing an advanced degree in mental health. Currently, the Yellow Ribbon Program is available to Veterans, spouses of Veterans using transferred entitlement, and all children using transferred entitlement, who are receiving Post-9/11 GI Bill benefits at the 100 percent level and attending school at a private institution of higher learning (IHL) or as an out-of-state student at a public institution of higher learning.

The program provides payment for up to half of the tuition and fee charges that are not covered by the Post-9/11 GI Bill, if the institution enters into an agreement with VA to pay or waive an equal amount of the charges that exceed Post-9/11 GI Bill coverage.

Under proposed new subsection (f), VA would provide payment for 66 percent of the tuition and fee charges that are not covered under the Post-9/11 GI Bill. The IHL concerned would provide 34 percent of any of the remaining costs for tuition and fees. The Veteran would need to be eligible for the Yellow Ribbon Program, hold a bachelor's degree, and be pursuing an advanced degree with the intention of seeking employment as a mental health professional with VA. However, VA could not require the Veteran to enter into any binding agreement with respect to such intention.

Pursuant to proposed 38 U.S.C. 3317(f)(5), the Secretary would be authorized (in accordance with 38 U.S.C. 7406) to establish residencies and internships at VA medical

facilities for Veterans participating in the program. If VA employs a Veteran as a mental health professional following such participation, VA would, to the maximum extent practicable, ensure the Veteran is employed in a rural area or an area that VA determines is in greatest need of mental health professionals. In addition, the Veteran would have to be employed in a position that directly relates to the treatment of Veterans rather than a research position.

For purposes of proposed subsection 3317(f), an advanced degree in mental health would be defined as a master's, doctoral, or other graduate or professional degree that ensures the Veteran could be employed as a psychiatrist, psychologist, mental health nurse, nurse assistant, physician assistant, pharmacist, social worker, licensed professional mental health counselor, licensed marriage and family therapist, addiction therapist, occupational therapist, recreational therapist, vocational rehabilitation therapist, health science specialist, health technician, or any other position the Secretary determines appropriate.

Section 7 of the bill would also amend current section 3319 of title 38 to prohibit the use of transferred entitlement under the new program. If enacted, the amendments made by section 7 would apply to a quarter, semester, or term that begins on or after July 1, 2015.

VA supports legislation that would provide training and employment opportunities for Veterans; however, the Department has some concerns with this section of the bill. VA

is not certain a change in the way VA and IHLs share contributions for specific degrees and programs would be beneficial. Under its current structure, the Yellow Ribbon Program is a remarkably successful program with nearly 2,000 participating institutions. During FY 2013, 51,619 students were beneficiaries of the program.

In order to implement section 7, VA would have to identify Post-9/11 GI Bill Veterans who are currently pursuing an advanced degree in mental health, determine their eligibility for the new program, and verify that each Veteran intends to seek employment with VA. This would create a significant administrative burden as the Long Term Solution (LTS), the system used to process Post-9/11 GI Bill payments, does not have the capability to issue varying Yellow Ribbon payments based on the type of program being pursued. Subject to the availability of funding, VA would need one year from the date of enactment to make programming changes to the LTS to support implementation of this section. In addition to LTS changes, the amendments made by section 7 would also require changes to the Comparison Tool, VA Online Certification of Enrollment (VA ONCE) and Web Enabled Approval Management (WEAMS) computer systems. Otherwise, manual processes would be required, which would result in a decrease in timeliness and accuracy for processing GI Bill claims.

Further, the amendments made by section 7 would authorize VA to establish residencies and internships at VA medical facilities for Veterans participating in the program. VHA has already established training programs in mental health disciplines in many locations. These programs lead to a degree, licensure, certification, or

registration. The process to develop training programs requires relationships with accredited educational sponsors and suitable infrastructure for the training program, including space, qualified faculty preceptors, information technology (IT) equipment, staff support, and a sufficient number of patients to satisfy the needs of the educational program. Therefore, establishing residencies and internships must occur in settings with appropriate infrastructure and collaborative educational partnerships.

Benefit costs associated with this section are estimated to be $1.7 million in FY 2016, $9.6 million over 5 years, and $22.1 million over 10 years. Although no direct administrative or personnel costs to VA are associated with this bill, the Veterans Benefits Administration is working with VA's Office of Information and Technology to determine the IT cost estimates required to effectively implement section 7 for system changes to the LTS, Comparison Tool, VA ONCE, and WEAMS.

Section 8 would require DoD to submit to the Congress a "zero-based review", conducted in coordination with the Chief of the National Guard Bureau, of the staffing requirements for individual State National Guard Commands with respect to Directors of Psychological Health.

VA defers views on this section to DoD. There would be no costs to VA associated with this section.

Section 9 of H.R. 5059 would require VA to establish a pilot program focused on assisting Veterans transitioning from active duty. The pilot program would be established in at least 5 VISNs and would establish a community-oriented peer support network and a community outreach team for each medical center in those VISNs.

VA fully supports the intent of this section but views it as duplicative and redundant with work that is already being done in every VISN throughout the country. With regard to peer support, VHA has a very robust peer support program that includes outreach and community integration as a major focus. There are at least 3 peer specialists for every VA medical center and 2 for each "very large" Community Based Outpatient Clinic (CBOC) and a total of 973 peer specialists nationwide. As required by Public Law 110-387, VA has established training guidelines and has instituted a training program that results in certification of peer specialists. VA has a very active national network that includes a peer specialist and a mental health professional from each VISN. These individuals provide linkages to the peer support network throughout the country and mentorship to peer specialists in each VISN. VA's peer support teams interact a great deal with community Veterans' organizations and mental health organizations via the mental health summits that occur at each medical center as well as other activities.

In 2013, VA implemented a national requirement for each medical facility to host a mental health community summit annually. During the summits each facility invites community providers in their area to begin new partnerships or strengthen existing partnerships based on Veteran and family needs in their geographic location. In 2014,

each facility selected a community mental health point of contact to provide ready access to information about VA eligibility and available clinical services, ensure warm handoffs at critical points of transition between systems of care, and provide an ongoing liaison between VA and community partners. VA created an online map containing the name and contact information for all facility POCs by state.
http://www.mentalhealth.va.gov/communityPOC.asp

Costs associated with the provisions of H.R. 5059 cannot be provided at this time.

H.R. 5484 Toxic Exposure Research Act of 2014

In general, H.R. 5484 would require the Secretary to establish a National Center (Center) charged with researching the diagnosis and treatment of health conditions of descendants of individuals who were exposed to toxic substances while serving in the Armed Forces. It would also establish an Advisory Board (the "Board") to identify these health conditions and evaluate disability claims from Veterans and Armed Forces members based on such service-related exposure and make recommendations on such claims to VA and DoD.

Section 2 would define several terms for purposes of the bill, including the term "toxic substance," which would "have the meaning given that term by the Secretary of Veterans Affairs and [would] include all substances that have been proven by peer reviewed scientific research or a preponderance of opinion in the medical community to

lead to disabilities related to the exposure of an individual to those substances while serving as a member of the Armed Forces."

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

Section 3 would also permit the Secretary of Defense or the head of a Federal Agency to make available to VA, as appropriate, records held by DoD, an Armed Force, or that Federal Agency, as appropriate, that might assist the Secretary in making the determinations required above. The measure would require the Center to reimburse the reasonable costs of travel and lodging of any individual participating in a study at the Center, plus those of any parent, guardian, spouse, or sibling who accompanies the

individual. Lastly, this provision would direct the Center to submit a report to the Congress, at least annually, that summarizes, for the preceding year, all completed research efforts and identifies those that are still on-going.

Section 4 would, in general, require the Secretary to establish, not later than 180 days after the Act's enactment, the Board, which would, among other things, be charged with advising the Center and overseeing and assessing its work; determining which health conditions result from exposure to toxic substances; and evaluating cases of exposure of current and former service members to toxic substances related to their service in the Armed Forces. The measure would also establish specific requirements related to composition of the Board, selection of members, terms of service, and duties. It would further direct the Board to determine which health conditions in descendants of individuals exposed to toxic substances while serving in the Armed Forces resulted from such exposure, for purposes of determining the descendants' eligibility for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) health care benefits. The Board would also be required to study and evaluate claims by current and former members of the Armed Forces of service-related exposure to toxic substances.

Section 5 would authorize the Secretary of Defense to declassify documents related to any known incident in which no fewer than 100 members of the Armed Forces were exposed to a toxic substance that resulted in a least one case of a disability that a member of the medical profession has determined to be associated with that toxic

substance. It would limit such declassification to information needed to determine whether an individual was exposed to the toxic substance, the potential severity of the exposure, and any potential health conditions that may have resulted from the exposure. Declassification would not be required, however, if the Secretary of Defense "determines that declassification of those documents would materially and immediately threaten the security of the United States."

Section 6 would require the Secretary of Veterans Affairs and the Secretaries of Health and Human Services and Defense to jointly conduct a national outreach and education campaign directed toward members of the Armed Forces, Veterans, and their family members.

VA does not support H.R. 5484. Of primary concern, the bill is vague insofar as it fails to clearly define how the Board's review of "claims" would operate in relation to existing statutes and regulations governing VA's processing and adjudication of claims for benefits administered by VA. Under the provisions of the bill, the Board would study and evaluate "claims" of service-related exposures to toxic substances submitted by current and former members of the Armed Forces or certain other persons. It is unclear whether the "claims" referenced in this bill are claims for disability benefits administered by VA under title 38 of the United States Code or some other type of claim.

To the extent the bill would require the Board to decide disability compensation and pension claims for benefits administered by VA, it would raise a number of significant

procedural and practical concerns. First, the bill would conflict with the provisions of 38 U.S.C. §§ 511 and 512 requiring the Secretary or authorized officers or employees of VA to decide all claims for benefits. Further, it is unclear whether VA offices would be required to refer all benefit claims based on toxic exposure to the Board; whether the Board would be required to provide the notice, claims assistance, and other procedural protections VA is required by statute to provide to claimants; and whether decisions of the Board would be treated as decisions of a VA agency of original jurisdiction for purposes of appeal and other procedural rights. The scope of section 4(c)(3)(B) of the bill would permit claims to be submitted by any of seven specified individuals or entities. Under current law, however, VA generally recognizes only claims submitted by Veterans and eligible dependents and survivors or their authorized representatives.

To the extent the bill contemplates that the Board would consider claims for benefits authorized under title 38 based on in-service exposure to a toxic substance, its implementation would be impractical and may adversely affect claim processing. Currently, VA regional offices receive thousands of claims related to in-service exposures. Exposure claims must be researched and adjudicated based on the facts and circumstances of each case and decided on the individual merits of each case. The small Board likely would be unable to process this volume of cases within the 180-day deadline section 4(c)(3)(C) would impose for consideration and action on claims. If the Board determines that further consideration of the claim is needed, section 4(c)(3)(C)(ii) of the bill would require the Board to refer the claim to the Center

established under section 3 of the bill. VA is concerned that the procedures under this bill may result in lengthy periods during which a disability claim is awaiting adjudication.

We note that section 4(c)(3)(D)(iii) would require a report from the Board to the Secretary to include "[i]nformation on cost and attributable exposure, as defined in regulations prescribed pursuant to this Act." However, the meaning of the phrase "attributable exposure" is unclear. Although this provision would authorize rules to define this term, the meaning of the term within the context of the bill is so unclear as to provide no basis for proper regulatory interpretation.

In addition, section 2 of the bill would define toxic substances as "all substances that have been proven by peer reviewed scientific research or a preponderance of opinion in the medical community to lead to disabilities related to the exposure of an individual to those substances while serving as a member of the Armed Forces." This definition does not conform to accepted approaches to evaluating the body of scientific evidence as a whole to determine toxic health effects of substances. Peer reviewed journals and medical opinions vary greatly in quality and can, at times, have questionable validity or reliability; this shortcoming is not recognized by the definition in the bill. There are also issues related to the use of the term "disability." Medical professionals provide assessments of functional limitation; whereas, determinations of disability are administrative determinations.

Second, other Federal Departments and Agencies are better poised to support research on multi-generational health effects of toxic exposures. Large populations are needed

to appropriately study rare multi-generational effects. Focusing solely on military exposures – which can often be similar to many civilian exposures – would likely result in inconclusive research. In contrast, VA's approach is to monitor Veterans' health, conduct surveillance studies, and remain abreast of findings from well-conducted studies in other populations. New Veteran-centric studies are conducted when findings by the clinical care, surveillance, or clinical/scientific community have indicated the need for such studies—and when they are likely to yield new insights.

Third, the Center that would be established by H.R. 5484 would duplicate work done by the National Institute of Environmental Health Sciences, the Agency for Toxic Substances and Disease Registry, VHA (the War Related Illness and Injury Study Center, the Office of Research and Development, and the Office of Public Health), as well as other governmental and non-governmental scientific organizations. These existing organizations have for many years conducted research on the impact of environmental exposures on human health. Finally, the diagnosis and treatment of health effects from exposure to toxic agents generally does not differ whether the exposure occurred while performing in a military occupation or a civilian occupation. It is not clear whether the focus of the Center would be to determine additional unknown health outcomes from exposure or translate known health outcomes of exposure – typically best determined by research in non-military populations – to the Veteran population.

As section 5 of the bill requires actions by DoD, VA would defer to that agency for its position on this section. In addition, we note that DOJ has advised of legal concerns about provisions in this bill.

VA cannot estimate the cost of section 4 of this bill for two primary reasons. First, it is unclear how the Board's consideration of "claims" under this bill would interact with and affect VA's claims-adjudication activities. Second, the costs to VA resulting from this bill would depend largely upon the nature of the Board's recommendations concerning benefits for disabilities related to in-service exposure to toxic substances. As to the bill's other measures, VA estimates the costs associated with their enactment to be $7.7 million for FY 2015; $98.5 million over a five-year period; and $227 million over a 10-year period. In the absence of additional funds being made available and appropriated for this specific purpose, implementation of these other measures would require the diversion of significant resources from programs providing direct benefits and services to Veterans.

H.R. 5475, to amend title 38, United States Code, to improve the care provided by the Secretary of Veterans Affairs to newborn children

VA supports legislation to provide expanded coverage for the newborn through the first 14 days of life, subject to finalization of VA's cost analysis for the bill. VA currently offers maternity and newborn benefits as a part of its medical benefits package. These benefits cover recommended post-delivery inpatient and outpatient care for newborns

through the first seven days of life. This care is typically provided by non-VA care through private health care providers and institutions that are reimbursed by VA.

Additionally, it is the standard of care for further evaluations to be conducted during the first two weeks of life to check infant weight; feeding; and newborn screening results. Pending these results, there may be a need for additional testing and follow-up. There are also important psychosocial needs that may need to be addressed, including monitoring stability of the home environment or providing clinical and other support if the newborn requires monitoring for neonatal abstinence syndrome (e.g. withdrawal for maternal drug use during pregnancy).

The expanded coverage for the newborn through the first 14 days of life would include coverage of inpatient and outpatient needs that may fall in the 7-14 day window.

VA is still in the process of evaluating costs for H.R. 5475.

Mr. Chairman, we appreciate the opportunity to present our views on these bills and will be glad to answer any questions.

FOR THE RECORD

PREPARED STATEMENT CONGRESSWOMAN TAMMY DUCKWORTH (IL–08)

In support of H.R. 5059, Clay Hunt Suicide Prevention for American Veterans Act

Chairman Miller, Ranking Member Michaud, thank you for your leadership and dedicated service to our nation's Veterans. I appreciate this opportunity to offer testimony in support of H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act, which I was proud to help introduce with Chairman Jeff Miller and Representative Tim Walz.

The bill, named after 28-year-old Marine Veteran Clay Hunt, who tragically took his own life in March 2011, will provide accountability for the mental healthcare and suicide prevention programs that serve our nation's service men and women and Veterans.

After four years of distinguished service in the Marine Corps, including earning a Purple Heart for injuries sustained in Iraq, Clay Hunt had significant problems accessing the mental healthcare he knew he needed. After Clay's service he sought medical care from the VA and filed for disability related to Post Traumatic Stress. Clay's mom testified before this Committee that while working through this process Clay met multiple challenges, including inability to schedule timely appointments for care, his files being lost by the VA, and once he was finally able to secure an appointment, only receiving prescription medication rather than comprehensive care. Clay's appeal for his disability claim was approved 18 months after the request was filed and five weeks after his death.

Navigating VA healthcare and benefits systems can be daunting for anyone, let alone those who have urgent mental health needs. Clay's story highlights the barriers to care Veterans face, but unfortunately it is not unique. It is a heartbreaking reality that twenty-two Veterans take their own lives each day. Adding to this tragedy is the fact that five of these twenty-two Veterans have been in the care of VA prior to taking their own lives. These are all casualties of war. As a nation, we are failing these brave men and women.

Currently, there are over 2 million Post 9/11 Veterans across the country, and this number will only increase as our military force structure continues to draw down. As the nature of war changes, the injuries our warriors sustain also change. Increasingly, theirs are invisible wounds, which do not have simple treatment and do not always manifest immediately.

Just as these Veterans remained faithful to our country on the battlefield, it is our turn as their Representatives to remain faithful to them and it is our responsibility as a nation to, in the words of Abraham Lincoln, "care for him who shall have borne the battle, and for his widow, and his orphan."

This responsibility includes ensuring that when our service men and women make the brave decision to seek help, they get the quality assistance and treatment they deserve in a timely manner.

I was proud to work with Chairman Miller and Representative Tim Walz on H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act in an effort to reduce the barriers that prevent our Veterans from receiving quality healthcare.

This legislation will task an independent, third party to annually review both the Department of Defense and VA mental healthcare and suicide prevention programs to find out what's working and what's not. It will also make recommendations on how to improve care. The bill also requires VA to create a one-stop, interactive website to serve as a centralized source of information for all mental health services for Veterans. This bill not only seeks to review and modify current VA practices, but also provides the tools to help meet increasing demands and focus on future care through provisions that address the shortage of mental healthcare professionals. Finally, through a pilot program established by this bill, Veterans will receive reintegration assistance directly from the communities in which they live, fostering a smoother and more inclusive transition to life after the uniform.

Post 9/11 Veterans step out of their combat boots and into their work shoes searching for meaningful employment, access to healthcare, and engagement in their communities. As a nation, we have a commitment to ensure that they receive the care that they need when they need it.

Thank you again for the opportunity to offer my testimony. I urge all of the Members of this Committee to support this legislation so that we can begin to turn the tide against suicide.

STATEMENT FOR THE RECORD OF
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
PENDING LEGISLATION

NOVEMBER 19, 2014

Chairman Benishek, Ranking Member Brownley and distinguished Members of the Subcommittee, on behalf of Commander Helm and the 2.4 million members of The American Legion, I thank you and your colleagues for the work you do in support of our service members and veterans as well as their families. The hard work of this Subcommittee creates significant legislation that makes a positive impact on our military and veterans' community.

H.R. 4720: The Medal of Honor Priority Care Act

To amend title 38, United States Code, to increase the priority for enrollment of Medal of Honor recipients in the health care system of the Department of Veterans Affairs.

The Medal of Honor is the highest award for valor in action against an enemy force which can be bestowed upon an individual serving in the Armed Services of the United States.

From the Civil War forward, this decoration has been bestowed upon those service members who performed acts of such uncommon valor that the highest distinction was deemed merited.

Medal of Honor recipients are currently assigned into Department of Veterans Affairs (VA) priority group 3. If this bill is enacted into law, Medal of Honor recipients would be assigned to priority group 1, which is the highest priority group a veteran can be assigned.

In 2009, when legislation at the time (H.R. 1197) was being considered to assign priority status for hospital care and medical services for Medal of Honor recipients, Joseph Wilson, The American Legion's former Deputy Director for Health Care of the Veterans Affairs and Rehabilitation Commission, stated the utmost regard The American Legion has for the recipients of the Medal of Honor and noted that not only should they get a priority status (they were ultimately assigned Priority status 3) but that The American Legion would support legislation to place Medal of Honor recipients in Priority Group 1 for VA health care[1].

The American Legion supports this legislation.

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1 http://archives.democrats.veterans.house.gov/hearings/Testimony.aspx?TID=59634&Newsid=423&Name=%20Joseph%20L.%20Wilson

H.R. 4887: The Expanding Care for Veterans Act

To expand the research and education on and delivery of complementary and alternative medicine to veterans, and for other purposes.

Complementary and alternative medicine (CAM) includes a range of therapies not considered standard to Western (US) medicine. Many treatments considered to be CAM in the US are considered conventional approaches in other parts of the world. CAM is an umbrella term that describes a wide range of modalities: acupuncture/acupressure, deep breathing, healing touch, hypnosis, meditation, yoga, hyperbaric oxygen therapy and more.

This legislation would expand the research and education on and delivery of complementary and alternative medicine to veterans.

In October 2010, The American Legion formed a Post Traumatic Stress Disorder/Traumatic Brain Injury Ad Hoc Committee to "investigate the existing science and procedures, as well as alternative methods, for treating TBI and PTSD currently being employed by the Department of Defense or the Department of Veterans Affairs."

In September 2013, The American Legion released a report entitled "The War Within,"[2] which included findings and recommendations based on comprehensive research by The American Legion's PTSD/TBI Ad Hoc Committee. Key findings from the report include: VA and DOD have no well-defined approach to the treatment of TBI; providers are merely treating the symptoms, DOD and VA research studies are lacking for new non-pharmacological treatments such as virtual reality therapy, hyperbaric oxygen treatment, and other complementary and alternative medicine therapies. The report recommended that Congress increase DOD and VA budgets to improve the research, screening, diagnosis, and treatment of TBI and PTSD, as well as accelerate their research efforts to properly diagnose and develop evidence-based treatments for TBI and PTSD.

In February 2014, The American Legion conducted a TBI and PTSD veteran survey to evaluate the efficacy of their TBI and PTSD care and to see if veterans suffering from these signature wounds are being offered complementary and alternative treatments and if they are, whether they are benefiting from such treatments. Of the 3,116 veterans who completed the survey, fifty-nine percent reported either no improvements or feeling worse after undergoing treatments for their TBI and PTSD symptoms[3]. Thirty percent terminated their treatments prior to completing them[4]. The reasons were as follows: patients were unwilling or unable to comply with the treatments, patients were unmotivated to participate in their treatment, and patients expressed distress associated with recounting trauma which initially resulted in worsening symptoms which eventually led to premature termination.

In June 2014, The American Legion, along with Military.com, sponsored a TBI and PTSD symposium titled, "Advancing the care and treatments for veterans with TBI and PTSD." The

[2] http://www.legion.org/sites/legion.org/files/legion/publications/war-within.pdf
[3] http://www.legion.org/veteranshealthcare/222891/legion-survey-ptsdtbi-care-not-working
[4] Ibid

symposium was held to determine how Congress, DOD, and VA are integrating CAM treatments and therapies into the existing health care models for veterans with TBI and PTSD.

The American Legion supports the passage of this legislation and urges Congress to provide oversight and funding for innovative Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) research currently used in the private sector, such as Hyperbaric Oxygen Therapy and Virtual Reality Exposure Therapy and other non-pharmacological treatments.

The American Legion supports this legislation.

H.R. 4977: The COVER Act

To establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community.

Approximately one in five veterans that served in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) are returning home with Post Traumatic Stress Disorder (PTSD), mental health illnesses, physical injuries and roughly 22 veterans are committing suicide per day.

In response, the COVER Act would establish a commission to explore the possibility of incorporating complementary and alternative medicine (CAM) treatment models into Department of Veterans' Affairs (VA) medical facilities nationwide. This piece of legislation would increase the viable options of alternative treatments that are offered to veterans for the purpose of treating their mental health conditions and physical disabilities.

This legislation would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community.

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[5] http://www.legion.org/sites/legion.org/files/legion/publications/war-within.pdf

as accelerate their research efforts to properly diagnose and develop evidence-based treatments for TBI and PTSD.

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In June 2014, The American Legion, along with Military.com, sponsored a TBI and PTSD symposium titled, "Advancing the care and treatments for veterans with TBI and PTSD." The symposium was held to determine how Congress, DOD, and VA are integrating CAM treatments and therapies into the existing health care models for veterans with TBI and PTSD.

With veteran suicide rates at unacceptably high levels, American veterans need innovative approaches to address these signature wounds of the War on Terror, as well as for veterans of all eras who struggle with these disorders. H.R. 4977 would increase the viable options of CAM offered to veterans for the purpose of treating their mental health conditions and physical disabilities. The American Legion urges Congress to act to provide oversight and funding to DOD and VA for innovative TBI and PTSD research[8]

The American Legion supports this legislation.

H.R. 5059: The Clay Hunt SAV Act

To direct the Secretary of Defense and the Secretary of Veterans Affairs to provide for the conduct of annual evaluations of mental health care and suicide prevention programs of the Department of Defense and the Department of Veterans Affairs, to review the terms or characterization of the discharge or separation of certain individuals from the Armed Forces, to require a pilot program on loan repayment for psychiatrists who agree to serve in the Veterans Health Administration of the Department of Veterans Affairs, and for other purposes.

Members of the United States Armed Forces are often called upon to perform their duties in stressful and life-threatening situations which can result in the development of mental health issues, and suicide rates for US veterans are among the highest with an estimated 18-22 veterans committing suicide every day[9].

[6] http://www.legion.org/veteranshealthcare/222891/legion-survey-ptsdtbi-care-not-working
[7] Ibid
[8] Resolution No. 292: August 2014
[9] http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf

This legislation would require the VA and DOD to arrange for an independent third party evaluation of VA and DOD mental health care and suicide prevention programs. It would also require VA and DOD to enter into certain strategic relationships to facilitate:

- Mental health referrals of members of the reserve components who have a service-connected disability and are being discharged or released from the Armed Forces,
- Timely behavioral health services for such members,
- Communication when such members are at risk for behavioral health reasons, and
- Transfer of documentation for line-of-duty and fitness-for-duty determinations.

In September 2013, The American Legion launched a new Suicide Prevention Web Center[10] on its national website to provide veterans and their families with life-saving resources and programs during their time of transition and need. The American Legion online Suicide Prevention Web Center built on several suicide-prevention initiatives launched in recent years by DOD and VA includes specific suicide-prevention data, statistics, programs and resources organized for veterans, families and the community.

The American Legion urges Congress to pass the Suicide Prevention for American Veterans Act or similar acts that will expand and improve the care provided to veterans and service members who have mental health issues or are at risk for suicide[11].

The American Legion supports this legislation.

H.R. 5475:

To amend title 38, United States Code, to improve the care provided by the Secretary of Veterans Affairs to newborn children.

Currently, VA covers newborns care for the first seven days after birth in a non-department facility for eligible women veterans who are receiving VA maternity care[12].

Newborn care includes routine post-delivery care and all other medically necessary services that are in accord with generally accepted standards of medical practice. VA does not provide child delivery care in VA health care facilities, but rather refers women veterans outside the VA to obtain this care at a non-VA health care facilities at VA's expense. Under current law, if a woman veteran encounters problems during the delivery which poses a health problem for the newborn, and the newborn requires continued care beyond the first seven days after birth, the cost of such care is the responsibility of the veteran and not VA. If this bill is enacted into law, it would extend the time frame VA would be responsible for payment of a newborn care from seven days to fourteen days.

In 2011, The American Legion conducted a Women Veterans Survey with 3,012 women veterans in order to better understand their healthcare needs through VA. The survey found while

[10] http://www.legion.org/suicideprevention
[11] Resolution No. 196: August 2014
[12] http://www.womenshealth.va.gov/WOMENSHEALTH/docs/FAQ_041912_FINAL.pdf

there were improvements in the delivery of VA healthcare to women veterans, challenges with service quality in the following areas remained: tangibles, reliability, responsiveness, competence, courtesy, communication, credibility, security, access and understanding.

In 2012-2013, the System Worth Saving Task Force report[13] focused on women veterans' health care. The objectives of the report were to understand what perceptions and barriers prevent women veterans with enrolling in VA, determine what quality-of-care challenges women veterans face with their VA health care, and provide recommendations and steps VA can take to improve these access barriers and quality-of-care challenges. While maternity and newborn care is primarily purchased outside VA, the Task Force found that several medical centers had challenges with finding hospitals in the area that would accept fee-basis for maternity care services because VA is required to use the Medicare reimbursement rate. At other medical centers, fee-basis expenditures on women veterans' gender-specific services were not available. The American Legion recommended that the Business Officer Manager should be required to track women veterans' gender-specific fee-basis expenditures.

The American Legion is committed to working with VA in order to ensure that the needs of the current and future women veteran populations are met and the VA should provide full comprehensive health services for women veterans department wide[14].

The American Legion supports this legislation.

H.R. 5484: Toxic Exposure Research Act of 2014

To establish in the Department of Veterans Affairs a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during service in the Armed Forces, to establish an advisory board on exposure to toxic substances, and for other purposes.

The effects of the often dangerous environments in which service members operate is a top concern, as thousands of veterans exposed to various toxins are often left behind when it comes to vital treatment and benefits. The American Legion remains committed to ensuring that all veterans who served in areas of exposure receive recognition and treatment for conditions linked to environmental exposures.

This legislation requires the Department of Veterans Affairs (VA) to establish a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during service in the Armed Forces, as well as an advisory board on exposure to toxic substances.

The American Legion has long been at the forefront of advocacy for veterans exposed to environmental hazards such as Agent Orange, Gulf War-related hazards, ionizing radiation and the various chemicals and agents used during Project Shipboard Hazard and Defense (SHAD).

[13] http://www.legion.org/sites/legion.org/files/legion/publications/2013-SWS-Report-WEB.pdf
[14] Resolution No. 45: August 2014

The American Legion continues to urge study of all environmental hazards and their effects on servicemembers and veterans.

The American Legion has also called on the Department of Defense to immediately cease burning dangerous chemicals in open burn pits, exposing servicemembers to deadly and debilitating toxins.

The American Legion believes in treating the veteran first, funding the necessary research, and ensuring that servicemembers are not exposed to chemical hazards again[15]. This legislation would help address the need to better understand the toxins that many of veterans have been exposed to, and enhance the understanding that the effect of exposure may have on veterans' descendants.

The American Legion supports this legislation.

[15] Resolution No. 125: August 2014

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A M V E T S

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STATEMENT FOR THE RECORD

OF

DIANE M. ZUMATTO
AMVETS NATIONAL LEGISLATIVE DIRECTOR

FOR THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS,

SUBCOMMITTEE

ON

HEALTH

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS
SECOND SESSION

CONCERNING:

HR 4720; HR 4887; HR 4977; HR 5059; HR 5475 & HR 5484

19 NOVEMBER 2014

Distinguished members of the Subcommittee on Health, it is my pleasure, on behalf of AMVETS, to offer this 'Statement for the Record' concerning the following pending legislation: HR 4720; HR 4887; HR 4977; HR 5059; HR 5475; & HR 5484.

I would like to begin today's statement with the following introductory remarks prior to turning to each specific piece of legislation: As the United States absorbs the aftereffects of more than a decade of continuous war and in the face of the planned draw-down of military personnel, the physical and mental health of our military and veterans will continue to be priority issues for AMVETS, the veteran's community and hopefully congress. Thanks to improvements in battlefield medicine, swift triage, aeromedical evacuations and trauma surgery, more combat-wounded than ever before are surviving horrific wounds and will be needing long-term rehabilitation, life-long specialized medical care, sophisticated prosthetics, etc. Your committee has a responsibility to ensure that the VA and our nation live up to the health care obligations imposed by the sacrifices of our veterans.

It is encouraging to acknowledge at this time that, despite the extraordinary sacrifices being asked of our men and women in uniform, the best and the brightest continue to step forward to answer the call of our nation in its time of need. I know that each of you is aware of, and appreciates, the numerous issues of importance facing our military members, veterans and retirees, therefore this testimony will be, following these introductory remarks limited to specific health care legislation.

I would also like to delineate first several general issues that AMVETS would like the committee to monitor and enforce as it goes about its work, followed by specific recommendations related to the VA.

General Recommendations:

- ensure that the VA provides a continuity of health care for all individuals who were wounded or injured in the line of duty including those who were exposed to toxic chemicals;
- ensure that all eligible veterans not only have adequate access, but timely and appropriate treatment, for all of their physical and mental healthcare needs;
- continue to press the VA to work collaboratively with the DoD in creating and implementing a completely operational and fully integrated electronic medical records system;
- continue the strictest oversight to ensure the safety, physical and mental health and confidentiality of victims of military sexual trauma;
- ensure that the VA continues to provide competent, compassionate, high quality health care to all eligible veterans; and

- ensure that the VA continues to receive sufficient, timely and predictable funding for VA health care.

Specific Recommendations:

- Ensure that both advanced appropriations and discretionary funding for VA keeps pace with medical care inflation and healthcare demand as recommended in the IB so that all veterans healthcare needs can be adequately met;
- Maximize the use of non-physician medical personnel as a way to mitigate physician shortages and reduce patient wait times especially while utilization of the VA system continues to rise;
- Ensure that VA makes more realistic third-party medical care collection estimates so that Congress doesn't end up under-appropriating funds based on false expectations which in turn negatively impact veteran care. Additionally, VA needs to redouble its efforts to increase its medical care collections efforts, because taken together, the cumulative effects of overestimating and under-collecting only degrade the care available to our veterans. Furthermore, VA needs to establish both first- and third-party copayment accuracy performance measures which would help minimize wasted collection efforts and veteran dissatisfaction;
- VA needs to incorporate civilian healthcare management best practices and include a pathway to VA hospital/clinic management for civilians as part of their succession plan requirements, so that VA will be able to attract the best and the brightest healthcare managers in the industry;
- VA could immediately increase its doctor/patient (d/p) ratio to a more realistic and productive levels in order to cut wait times for veterans needing treatment and/or referrals. While the current VA (d/p) ratio is only 1:1200, the (d/p) ratio for non-VA physicians is close to 1:4200. Instituting this one change would drastically improve our veterans access to needed healthcare;
- VA needs to improve its patient management system so that veterans have more appointment setting options available to them, which could reduce staffing errors and requirements. VA should also consider utilizing a hybrid system whereby half the day might consist of scheduled appointment and the other half would be for walk in or same-day appointment. The elimination of the need for non-specialty appointments would allow veterans quicker access to their primary care providers;
- The current VA healthcare system appears to be top-heavy with administrative staff and short-handed when it comes to patient-focused clinical staff. This imbalance can only lead to noticeable veteran wait times;

- The VA needs to thoroughly review its entire organizational structure in order to take advantage of system efficiencies and to maximize both human and financial resources, while also minimizing waste and redundancies;
- VA needs to collaborate with HHS (Health & Human Services) so that it can utilize/share the benefits of the UDS (Uniform Data System). The UDS is a core set of information appropriate for reviewing and evaluating the operation and performance of individual health centers. The ability to track, through the UDS system, a wide variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues would be invaluable in improving the overall VA healthcare system;
- Rather than have veterans go unseen or untreated due to limited appointment or physician availability, veterans should be allowed to utilized the currently existing system of FQHCs (Federally Qualified Health Centers). FQHCs include all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and they qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs are required to: serve an underserved area or population; offer a sliding fee scale; provide comprehensive services; have an ongoing quality assurance program; and to have a governing board of directors. Allowing veterans to seek care, even on a temporary basis, until the VA appointment backlog is eliminated, would provide our veterans with immediate care and would relieve some of the pressure on the VA system;
- VA must immediately improve its recruitment, hiring and retention policies to ensure the timely delivery of high quality healthcare to our veterans. VA currently utilizes a cumbersome and overly-lengthy hiring process which reduces its ability to deliver critical services. VA need to consider adopting a more expedient hiring/approval process which could include some form of provisional employment;
- VA needs to have, and utilize, the option to terminate non-performing employees at all levels of the organization so that only dedicated, accurate, motivated employees will remain in service to our veterans; and
- Finally, VA needs to reform their incentive programs so that only high-performing employees receive appropriate bonuses for their excellence in serving our veterans.

Pending Health Care Legislation

HR 4720: Medal of Honor Priority Care Act – AMVETS supports this legislation which increases, from third to first, the priority for enrollment in the VA health care system for MOH recipients, regardless of the date on which the medal was awarded.

HR 4887: Expanding Care for Veterans Act - AMVETS fully supports the development and use of alternative treatment modalities as a valuable option in treating/managing chronic pain or other conditions which may not adequately respond to more traditional clinical therapies.

If enacted, this legislation would:

a) direct the Secretary of Veterans Affairs (VA) to develop a plan to expand the scope of the VA's research and education on, and delivery and integration of, complementary and alternative medicine services;
b) require the Secretary to carry out, through the VA's Office of Patient Centered Care and Cultural Transformation, a three-year program to:
    1) assess the feasibility and advisability of integrating the delivery of complementary and alternative medicine services selected by the Secretary with other VA health care services for veterans, and
    2) identify and resolve barriers to providing such services and integrating them with other VA health services;
c) require such program to be conducted, at not fewer than 15 VA medical centers, by integrating the provision of complementary and alternative medicine services with other VA health care services provided to veterans who have a mental health condition, experience chronic pain, or have a chronic condition. Requires veterans' participation to be voluntary;
d) direct the Secretary to contract with a qualified independent entity for comprehensive studies of the barriers encountered by veterans in receiving, and by administrators and clinicians in providing, complementary and alternative medicine services through the VA. Provides for the conduct of such studies through surveys of veterans and VA administrators and clinicians;
e) require the Secretary to carry out a three-year program awarding grants to public or private nonprofit entities to assess the feasibility and advisability of using wellness programs to complement the provision of mental health care to veterans and family members who are eligible for readjustment counseling from the VA.

HR 4977: Creating Options for Veterans Expedited Recovery (COVER) Act – AMVETS supports this legislation which would establish the Veterans Expedited Recovery Commission which would:

a) examine the efficacy of the evidence-based therapy model used by the Secretary of Veterans Affairs for treating mental health illnesses of veterans and identify areas to improve wellness-based outcomes;

b) conduct a patient-centered survey within each of the Veterans Integrated Service Networks to examine the experience of veterans with the Department of Veterans Affairs (VA) when seeking medical assistance for mental health issues through the VA health care system, their experience with non-VA facilities and health professionals for such issues, their preferences regarding available treatments for such issues and which methods they believe to be most effective, their experience with complementary alternative treatment therapies, the prevalence of prescribing prescription medication among veterans seeking treatment through the VA health care system to address mental health issues, and the Secretary's outreach efforts regarding the availability of benefits and treatments for such issues;
c) examine available research on complementary alternative treatment therapies for mental health issues (including music, yoga, and meditation therapy) and identify what benefits could be made with the inclusion of such treatments for veterans; and
d) study the potential increase in the approval by the Secretary of claims for compensation relating to mental health issues for veterans who served Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

The bill also directs the Secretary, upon a report by the Commission, to submit: (1) an action plan for implementing recommendations and a time frame for implementing complementary alternative treatments, or (2) a justification for not doing so and an alternative solution to improve the efficacy of the therapy model.

HR 5059: Clay Hunt Suicide Prevention for American Veterans Act or the Clay Hunt SAV Act – AMVETS enthusiastically supports this comprehensive legislation which seeks to minimize, if not eliminate, the tragic instances of veteran suicide. The problem of veteran suicide has continued, unabated, for far too long now and, at this point in time, there appears to be no end in sight to this senseless and horrific loss life. AMVETS supports this legislation and will continue to support future legislation that seeks a remedy to this national disgrace until there is no longer a need. While we acknowledge that this legislation, in and of itself, may not totally eradicate the problem of veteran suicide, we believe it would certainly make a difference because it would:

a) require the Secretary of Veterans Affairs (VA) and the Secretary of Defense (DOD), at least annually, to each arrange for an independent third party evaluation of, respectively, the VA and DOD mental health care and suicide prevention programs;
b) require a board reviewing the discharge or dismissal of a former member of the Armed Forces whose application for relief is based at least in part on post-traumatic stress disorder or traumatic brain injury related to military operations or sexual trauma, to:
    1) review the medical evidence from the VA or a civilian health provider that is presented by the former member;

2) review the case, with a presumption of administrative irregularity, and place the burden on the VA or DOD to prove, by a preponderance of the evidence, that no error or injustice occurred;

c) direct the VA Secretary to publish an Internet website that serves as a centralized source to provide veterans with regularly updated information regarding all of the VA's mental health care services;

d) require the VA Secretary and the DOD Secretary to enter into certain strategic relationships to facilitate:
   1) the mental health referrals of members of the reserve components who have a service-connected disability and are being discharged or released from the Armed Forces,
   2) timely behavioral health services for such members,
   3) communication when such members are at risk for behavioral health reasons, and
   4) the transfer of documentation for line-of-duty and fitness-for-duty determinations;

e) require the VA Secretary to carry out a pilot program to repay the education loans relating to psychiatric medicine that are incurred by individuals who:
   1) are eligible to practice psychiatric medicine in the Veterans Health Administration (VHA) or are enrolled in the final year of a residency program leading to a specialty qualification in psychiatric medicine, and
   2) demonstrate a commitment to a long-term career as a psychiatrist in the VHA;

f) direct the VA Secretary to carry out a program, as part of the Yellow Ribbon G.I. Education Enhancement Program, under which the VA Secretary and an institution of higher education (IHE) agree to cover the full cost of charges not covered by post-9/11 educational assistance that are incurred by veterans who:
   1) are pursuing an advanced degree in mental health at the IHE, and
   2) intend to seek employment as a mental health professional in the VA. Allows the VA Secretary to cover up to 64% of those charges, if the school covers the remainder;

g) require the DOD Secretary to submit to Congress a zero-based review of the staffing requirements for individual State National Guard Commands with respect to Directors of Psychological Health;

h) direct the VA Secretary to establish a pilot program at not less than five Veterans Integrated Service Networks (VISNs) to assist veterans transitioning from active duty and to improve the access of veterans to mental health services. Requires the pilot program at each VISN to include:
   1) a community oriented veteran peer support network, and
   2) a community outreach team for each medical center in such VISN.

HR 5475: a bill to amend title 30, US Code, to improve the care provided by the secretary of Veteran Affairs to newborn children – AMVETS supports this legislation

which would allow the Secretary of Veterans Affairs (VA) to provide the newborn child of a woman veteran who is receiving VA maternity care with post-delivery care services for 14 days after the child's birth if the veteran delivered the child in a VA facility or another facility with which the VA has a contract for such services. (Currently, such care may not be provided for more than 7 days.)

HR 5484: Toxic Exposure Research Act of 2014 – AMVETS, as the lead organization in the recently established, Toxic Wounds Task Force, wholeheartedly supports this important legislation and encourages swift passage of this much needed bill. Additionally, at the AMVETS 69th annual convention this summer, our members approved two separate resolutions in support of legislation which addresses the critical issue of military toxic exposure. This legislation is an excellent next step in acknowledging the physical effects, and healing the wounds, suffered by our service members knowingly, and unknowingly, exposed to toxic chemicals. This legislation would provide the following important provisions:

a) establish a National Center for the Research on the Diagnosis and Treatment of Health Conditions of the Descendants of Individuals Exposed to Toxic Substances During Service in the Armed Forces;
b) requires the national research center to employ at least one licensed clinical social worker to coordinate the access of individuals to appropriate federal, state, and local social and health care programs and to handle case management;
c) establish an Advisory Board for the National Center responsible for advising the National Center, determining health conditions that result from toxic exposure and to study and evaluate cases of exposure;
d) authorize the Secretary of Defense to declassify documents related to incidents in which at least 100 members of the Armed Forces were exposed to a toxic substance that resulted in at least one case of a disability caused by exposure, except when declassification would threaten national security; and
e) create a National Outreach Campaign on Potential Long-Term Health Effects of Exposure to Toxic Substances by Members of the Armed Forces and their Descendants.

In closing, I'd like to add a personal note regarding this bill: both my sister and I were stationed at Ft. McClellan, AL which is considered one of the most toxic sites in the U.S. My sister and I are/have suffered the negative effects of our exposure. Unfortunately, not only have we paid an extremely high price for serving our country, but even my children have unusual health issues due to my exposure.

Thank you for your time and continued efforts to address the special health care needs of our military and veterans. This concludes my statement.

CNS Response

Submission for the Record
House Committee on Veterans Affairs, Subcommittee on Health

Thomas T. Tierney, George C. Carpenter IV

In July, we asked that the Committee take note of the growing role of predictive analytics in reducing harm from mental health medications chosen by trial and error. Our news today is very positive, and it is our belief that HR 5059 may accelerate adoption of such innovations.

Suicide Prevention — the best place to start is to avoid the wrong medications

In mental health, the elephant in the room is that standard treatments don't work very well, and evidence for them has deteriorated substantially since the medications were first approved. Since each medication used to treat mental disorders carries an FDA "black-box warning" for suicidality, reducing trial and error treatment is a military imperative.

Predictive analytics — in the form of PEER Interactive — have significantly reduced trial and error in multiple clinical trials. Results of the Walter Reed PEER Trial became clear in the first 10% of trial enrollment, as shared with Congress in April. Statistically significant results have been reported for physicians who followed PEER recommendations vs. physicians who did not follow PEER, including:

- 75% greater improvement in Suicidality scores
- 144% greater improvement in Depression scores
- 139% greater improvement in Post-Traumatic Stress Disorder (PTSD) scores
- 43% more patients remained in treatment, with more than 50% improvement in treatment efficiency

As every PEER trial has demonstrated, **doctors with more information achieve better outcomes.** From a budget standpoint, we can no longer afford trial and error prescribing of medications as our dominant treatment, with costs that are 4 times higher than effective first-line treatment. And the human costs of trial and error therapy, for veterans and their families, are intolerable.

Preventable medical error — the problem

In July, the parents of Clay Hunt and Daniel Somers gave us stories that were hard to hear: they spoke of treatment delays, trial and error pharmacotherapy, and inexplicable differences in treatment between facilities. Still, VHA faces challenges in improving access, because:

- VHA cannot hire clinicians fast enough - only 681 residents enter the specialty each year
- Clinicians in private practice cannot fill the gap - only 13% have capacity (per RAND)
- Current treatments are not effective enough to prevent dropouts

Comment on HR 5059

- We ask the Subcommittee to be cognizant of the severe supply limitations in Psychiatry, which impacts hiring and retention of mental health professionals.
- We recommend that VHA prioritize research on physician extending technologies, like PEER, which can multiply the reach of VHA's current pool of Psychiatrists.

The Military response to preventable error

In September 2014, Defense Secretary Hagel committed to "system-wide improvements in quality and safety", with a mandate to reduce preventable error across the board and to achieve results that are not just average, or above average, but the best in class. The review was prompted by internal reports and a New York Times series finding widespread evidence of preventable error.

By the end of the year, each military hospital must have metrics in place to track quality improvement. Army Surgeon General Patricia Horoho articulated some of the principles behind this system-wide commitment to reducing preventable error:

- Take corrective action immediately — at the point of care
- Ensure transparency and accountability
- Use outcome data to improve the quality of treatments

The Army Surgeon General's leadership is welcome, and we believe the hard lessons of its adoption path can be useful for the VHA in the course of its transformation under Sec. McDonald.

Comment on HR 5059

- Performance Metrics and Annual Independent Review are critically important components of 5059 — the only way to drive out fear of reporting and address root causes.
- Standards of evidence - VHA must set clear and transparent standards for evidence of superiority, so new innovations can be rapidly tested and adopted.
- Need to improve on VHA's ability to rapidly execute public-private partnerships.

Emerging Technology Improves the Odds

Physicians in the 1990s made a surprising discovery: if they could match known medication outcomes to a standard test of electrophysiology, they could target medications directly to patients who would be more likely to respond to a particular agent. Even better, they could avoid the wrong medications. Just like most other specialties, where doctors use tests like x-rays, blood tests, or bone scans to guide their choice of treatment. The database, which now exceeds 37,000 clinical endpoints for 10,000 unique patients, is called PEER (Psychiatric EEG Evaluation Registry).

PEER is an outcome registry and recommendation engine based on machine-learning, so outcomes in this trial can make future generations of the PEER Report more predictive and useful to physicians. This same approach was pioneered by pediatric oncologists beginning in the 1970s, when cancer registries allowed physicians to better match treatments to patient phenotypes, driving cure rates for childhood cancers approaching 90% today.

The Walter Reed PEER Trial

The Walter Reed PEER Trial is designed to follow up to 1,600 soldiers under a public-private partnership with Walter Reed National Military Medical Center. First interim results focused on 150 evaluable subjects who were treated for up to six months at Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, two of the nation's largest psychiatric treatment centers for active military members.

The findings have been peer-reviewed for publication in Neuropsychiatric Disease and Treatment, the journal of the International Neuropsychiatric Association. Each of the interim trial results above were statistically significant, and were consistent with multiple prior studies of PEER technology. Accordingly, the FY15 Defense Appropriations Bill calls for expansion of this approach:

> **Prescription Effectiveness of Psychotropic Medications...**
> *The Committee understands that this research is currently taking place at Walter Reed NMMC and Ft Belvoir Community Hospital and encourages its expansion to additional sites as preliminary findings have shown promising early results.*

Cumulative evidence

While the evidence base for antidepressants has worsened in recent years, the evidence base for quantitative EEG biomarkers has grown: there are now 98 controlled trials of EEG-medication response prediction, representing 6,025 subjects. Most were independent studies of

similar technologies or sub-components of PEER, with 6 controlled studies sponsored by CNS Response.

Conclusion

Improving medication performance for our veterans is a problem that neuroscience can answer, that can improve lives today. We support passage of HR 5059, to help the VHA accelerate adoption of the best evidenced-based psychiatric care that our country has to offer.

CNS Response Disclosure of Federal Grants

Grantor:	Dept. of the Army
Subagency:	USAMRAA United States Army Medical Research Acquisition Activity
Grant/contract amount:	$1,782,211.00 (pending)
Paid to date:	$54,000.00
Performance Period:	07/01/2013 to 09/30/2015
Indirect cost limitations or CAP limitations:	
Grant number:	1217707
Grant/contract award notice provided as part of proposal:	Yes
Cooperative Research and Development Agreement(CRADA) with Walter Reed National Military Medical Center (WRNMMC)	378604-12
ClinicalTrials.gov identifier:	NCT01794559

Thomas T. Tierney

Thomas T. Tierney is Chairman of CNS Response and a Vietnam Veteran. He holds a BS (Business) and MS (Logistics Management) with distinction and holds graduate credentials in National Security Management from the Industrial College of the Armed Forces and Air War College. After completing a combat tour in Vietnam, he was assigned as a Pentagon Research Associate at the world-famous RAND Corporation in Santa Monica, California. In 1971 he joined Vitatech Nutritional Sciences, Inc. establishing it as a thought-leader in health-empowered nutritional formula innovation and production processes. In addition to operating one of the most respected FDA licensed manufacturing facilities in the industry, he has held positions as chairman of the board of the University of California, Irvine Foundation, and is a legacy trustee covering over 28 years service. Mr. Tierney also participates as a member of the UC Irvine Health Affairs Strategic Advisory Board and leadership initiatives to enhance programs in Veterans Affairs, the brain aging, stem cell applications in human health, longevity and disease prevention strategies, translational science and diabetes. He is a member of Orange County Advisory Boards for Homeland Security and Sheriff's Department.

BACKGROUND

PRESIDENT & CEO
CNS Response Inc. (CNSO:OB)

CHAIRMAN & CEO
WorkWell Systems Inc.

CHAIRMAN & CEO
CORE Inc. (Nasdaq:CORE)

VICE PRESIDENT, OPERATIONS
Baxter International Inc.

AWARDS

Innovation in Healthcare Award, ASL, 2004

Ernst & Young Entrepreneur of the Year Finalist, DC, 1998

PUBLICATIONS

Journal of Managed Care Medicine, Vol 9, No. 1, 2006

The Shape of Things: The Rising Impact of Obesity
LRP Publications, 2006

BOARDS

Remedy Interactive Inc., Sausalito, CA

WEBSITE

www.cnsresponse.com

2013

George C. Carpenter IV
CEO, CNS Response Inc.

A results-oriented biomedical executive with a passion for leading high growth and turnaround companies, George's focus is bringing new technology and business processes to underserved markets.

As CEO of CNS Response, Inc., (CNSO:OB) George is leading the commercialization of the company's patented PEER INTERACTIVE® technology for psychotropic medication management. CNS Response is the first biomarker solution for providers, in behavioral medicine.

Prior to CNS Response Inc., George ran WorkWell Systems, a national physical medicine firm managing occupational health testing programs for Fortune 500 employers. From 1990 to 2001, George served as Chairman and CEO of CORE, Inc., (Nasdaq: CORE) after leading the management buyout of this division of Baxter Healthcare. CORE was a pioneer in workforce health care management and analytics, establishing a record for clinical

software innovation and talent development that, in the words of one Wall Street analyst, "created an industry". CORE was acquired in 2001 by Assurant Inc.

Prior to founding CORE George was a Vice President of Operations with Baxter Healthcare served as a Director of Business Development and as strategic planner for Baxter's alternate site businesses. His career began at Inland Steel in manufacturing process control and Sales.

George serves on a variety of biomedical advisory and fiduciary boards, and is a frequent speaker and writer on healthcare technology and financing issues.

He earned his MBA in Finance from the University of Chicago and a BA with Distinction in International Policy & Law from Dartmouth College. George and his family live in Laguna Niguel, CA.

CBS MarketWatch

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STATEMENT OF
JOY J. ILEM
DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR
SUBMITTED FOR THE RECORD TO THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
HOUSE OF REPRESENTATIVES
November 19, 2014

Chairman Benishek, Ranking Member Brownley and Members of the Subcommittee:

DAV (Disabled American Veterans), an organization of 1.2 million wartime veterans who were wounded, injured or made ill due to their military service, appreciates this opportunity to offer testimony for the record on legislative measures that are of particular interest to the Committee, DAV and our membership.

H.R. 4720, the Medal of Honor Priority Care Act

Prior to enactment of Public Law 111-163, Medal of Honor awardees were not expressly covered in any priority group for the purposes of enrolling and receiving health care from the Department of Veterans Affairs (VA). Section 512 of this law positioned Medal of Honor recipients in priority group three along with former prisoners of war and Purple Heart awardees. At the time of enactment of Public Law 111-163, 96 of 3,492 total recipients were alive. Today, 79 remain, according to the Congressional Medal of Honor Society.

H.R. 4720 would elevate, from third to first, the priority given to Medal of Honor awardees for enrollment in the VA health care system. The Medal of Honor is the highest military award for valor issued to an individual in military action against an enemy of the United States. This bill would uphold our nation's commitment to these select few heroes by conveying to them a higher enrollment priority status for access to an array of VA hospital and medical care services.

While the DAV has no national resolution received from our membership that endorses this particular legislation, we would offer no objection to its enactment, and we appreciate the effort being made on behalf of these extraordinary patriots.

H.R. 4887 – the Expanding Care for Veterans Act

This bill, similar to a bill introduced earlier in this Congress by the Chairman of the Senate Committee on Veterans Affairs, S. 1950, would rrequire the VA Secretary to carry out, through the VA's Office of Patient Centered Care and Cultural Transformation, a three-year

program to: (1) assess the feasibility and advisability of integrating the delivery of complementary and alternative medicine services selected by the Secretary with other VA health care services for veterans, and (2) identify and resolve barriers to providing such services and integrating them with other VA health services.

The bill would require this program to be established at not fewer than 15 VA medical centers, by integrating the provision of complementary and alternative medicine services with other VA health care services provided to veterans who are challenged by mental health conditions, experience chronic pain, or exhibit certain chronic conditions. The program would be conducted on a voluntary basis.

The bill would directs the Secretary to contract with a qualified independent entity for comprehensive studies of the barriers encountered by veterans in receiving, and by administrators and clinicians in providing, complementary and alternative medicine services through the VA. It would provide for the conduct of such studies through surveys of veterans, VA administrators, and VA clinicians.

The bill would also require the Secretary to carry out a three-year program of awarding grants to public or private nonprofit entities by the VA Readjustment Counseling Service (RCS) to assess the feasibility and advisability of using wellness programs to complement the provision of mental health care to veterans and family members who are eligible to receive readjustment counseling from the VA's Vet Centers.

At our most recent national convention, DAV members adopted National Resolution 028, calling on Congress and VA to guarantee veterans' access to a full continuum of care, including mental health, and alternative and complementary care. While we are concerned about the untested concept of RCS's granting funds to enable some veterans to gain access to outside wellness programs as a complement to psychological counseling in Vet Centers, we strongly support the basic purposes of the bill in advancing complementary and alternative medicine in the VA.

H.R. 4977 – The Creating Options for Veterans Expedited Recovery ("COVER") Act

This bill would establish a commission to examine the evidence-based therapy treatment models used by VA for treating mental illnesses in veterans, and would be required to study the potential benefits of incorporating complementary and alternative treatments available in community facilities in treating such veterans.

At our most recent national convention, DAV members adopted National Resolution 028, calling on Congress and VA to guarantee veterans' access to a full continuum of care, including mental health, and alternative and complementary care. Our delegates also approved resolutions urging enhanced psychological counseling for family members of service-connected veterans with mental health challenges (No. 166); improved resources in VA mental health programs (No. 193); mental health scholarships for future VA mental health practitioners (No. 205); effective mental health treatment of veterans who are survivors of military sexual trauma (No. 125); and, better addressing the mental health aspects of VA's pain management programs (No. 145). While none of these resolutions contemplate and do not call for a special commission in this

regard, we believe the purposes of the bill to be consistent with DAV's interest and advocacy in VA's expansion of alternative and complementary treatment techniques for both physical and mental health challenges in veterans, and in aiding them in managing their pain levels. Therefore, similar to our support for H.R. 4887, DAV strongly supports this bill and recommends its enactment.

We note for the Subcommittee's interest that this bill would establish four purposes of this commission, including examining the efficacy of current approaches to care and identifying ways to improve it; conducting a wide survey of patients seeking information on defined areas of their experience with VA health care; examining available research on complementary and alternative treatment methods; and, studying the potential increase in mental health disability compensation paid by VA to veterans of the wars in Iraq and Afghanistan. While DAV certainly supports the first three purposes in advancing complementary and alternative medicine in VA, the fourth purpose is non-germane to the overall thrust of the bill. We would strongly recommend this language be deleted by the Committee on further consideration of this legislation. A commission focused on complementary and alternative medicine in VA health care would not ordinarily be expected to divert its attention to a non-germane, Veterans Benefits Administration topic. We recommend the sponsor introduce new legislation and that it be considered by your Disability Assistance and Memorial Affairs Subcommittee rather than the Health Subcommittee.

We would be pleased to work with the Committee and the sponsor of this measure to ensure the intended purposes of the bill would be met in advancing complementary and alternative medicine in VA.

H.R. 5475, to amend title 38, United States Code, to improve the care provided by the Secretary of Veterans Affairs to newborn children

This bill would extend from seven days to 14 the number of days of post-partum health care VA could authorize for the newborn child of an enrolled veteran under VA obstetric care. The bill would also require an annual report to Congress on the number of children who received such care under VA authorization.

DAV members adopted National Resolution No. 197, at our most recent national convention, calling on VA to improve health care services—including gender-specific services—for women veterans, and in particular for women veterans of childbearing age. Therefore, DAV supports the purposes of this bill and urges its enactment.

We note the bill would require VA to make its annual report by October 31st, each year. We recommend the bill be amended to lengthen the amount of time VA would be granted to make its report to ensure Congress receives an accurate count of activities under the authority. VA closes its workload accounts after September 30th, but experiences a number of challenges in annual data roll-up, which often delays external reporting. A more reasonable reporting date would be December 31st, in our view. We ask the Committee to consider making that change.

H.R. 5484, the Toxic Exposure Research Act of 2014

This measure would require the VA Secretary to select one VA medical center to serve as a National Center for research on the diagnosis and treatment of health conditions of descendants of individuals exposed to toxic substances while serving in the armed forces.

Under the bill, VA would be required to establish an advisory board to advise the center; determine which descendants of military members exposed to toxic substances would be eligible for health care coverage under VA's Civilian Health and Medical Program of Veterans Affairs (CHAMPVA); and, determine a link between exposure and health conditions in these descendants for the purposes of adjudicating claims for VA disability compensation and health care benefits.

The Secretary of Defense would be authorized to declassify documents related to any known incident in which not less than one hundred members of the military were exposed to a toxic substance that resulted in at least one case of disability.

The VA, Department of Defense (DOD), and Health and Human Services Secretaries would be required to jointly conduct a national outreach and education campaign on toxic exposure incidents, resulting health conditions, and the potential long-term effects of such exposures.

In our most recent National Convention, DAV delegates passed resolutions regarding toxic exposure during military service. These resolutions recognize the importance of sufficient funding for research on toxic and environmental exposures and possible health outcomes; the employment of Congressionally mandated studies by the National Academy of Science (NIH) to review and evaluate scientific literature and prior research to determine whether links exist between exposure and certain physical conditions for the purposes of VA benefits and services; and, to conduct research to improve the care and benefits for veterans exposed to military and environmental hazards while serving.

The VA research mission is to advance biomedical research and development in areas that most directly address the diseases and conditions that affect veterans. Unfortunately, funding from Congress for VA research has not been sufficient to enable the program to meet its mission to understand many underlying health, injury and disorder mechanisms to create evidence-based decisions on those conditions presumed to be caused by exposures in military service as well as the diagnosis, treatment, and rehabilitation methods for veterans. Unfortunately, many sound research proposals cannot be awarded due to insufficient funding. VA research funds are awarded to the highest peer-reviewed proposals, and those with the most merit to ultimately improve veterans' health.

DAV agrees with the thrust of this legislation because it corresponds with the NAS Institute of Medicine's recommendation for VA to further investigate possible health effects in offspring following paternal exposure. However, DAV is unable to support this particular measure, which would circumvent rather than improve the current statutory process for establishing the basis for presumptive disability determinations by VA, and could even erode its

credibility. As an example, this measure would put in place a new advisory board whose duties could well conflict with the findings of the IOM in future reports. In addition, this measure would insert the advisory board into a complex VA claims adjudication process with little discussion or consideration of its impact on that function. We believe this bill should not be advanced but further addressed and considered by your Disability Assistance and Memorial Affairs Subcommittee.

H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act (the Clay Hunt SAV Act)

The Clay Hunt SAV Act would require the Departments of Veterans Affairs (VA) and DOD to conduct annual evaluations of mental health services and suicide prevention programs, to review character of discharge or separation for certain service members; and, establish a pilot program on loan repayment for psychiatrists who agree to serve in each agency.

Specifically, Section 2 of this bill would require the VA and DOD to submit to an independent third party evaluation of each Department's mental health care and suicide prevention programs on an annual basis to determine best practices and cost effectiveness of those programs. An annual report would be required for the Committees on Armed Services and Veterans Affairs.

Section 3 would require a military review board for veterans with mental health disorders that affect the character of their proposed discharges from the armed forces. As circumscribed by the bill, an individual's application for relief must be based at least in part on post-traumatic stress disorder (PTSD), traumatic brain injury (TBI) related to military service, or military sexual trauma. The board would be tasked to review medical evidence presented by the veteran with a presumption of administrative irregularity, and place the burden on VA or DOD to prove that no error or injustice occurred in such case.

Section 4 would instruct the VA Secretary to publish a website that is regularly updated and serves as a centralized source of information for veterans regarding all of VA's mental health care services including the names and contact information for all appropriate offices and staff.

Section 5 would require the VA and DOD Secretaries, in consultation with the Chief of the National Guard Bureau, to enter into formal strategic relationships to facilitate:

- mental health referrals of reserve component members who have service-connected disabilities and are being discharged from active duty,
- timely behavioral health services for such members, and
- Communication between the departments when such members are at risk for behavioral health reasons, and the transfer of documentation for line-of-duty and fitness-for-duty determinations.

Section 5 also would require the Government Accountability Office (GAO) to assess and report on the transition of care of individuals with PTSD or TBI to include the programs, policies, and regulations that affect the transition of care, particularly with respect to those who

have been prescribed or are taking antidepressants, stimulants, antipsychotics, mood stabilizers, anxiolytics, depressants, or hallucinogens. The report would also be required to analyze the extent to which the pharmaceutical treatment plan of an individual changes once he or she is treated at VA, and the factors determining such changes. The report would further examine the extent to which the Secretaries of Defense and Veterans Affairs work together to identify and apply best pharmaceutical treatment practices to include a description of the off-formulary waiver process of the VA Secretary and the extent to which the process is applied efficiently at the treatment level, and the benefits and challenges of combining the formularies across DOD and VA.

Section 6 would require the VA Secretary to initiate a three-year pilot program to repay the education loans relating to psychiatric education that are incurred by those who demonstrate a commitment to a long-term career as in psychiatry in VA, who are eligible to practice psychiatric medicine in the VA, or who are enrolled in the final year of a residency program leading to a specialty qualification in psychiatric medicine. The Secretary would select at least ten individuals to participate annually in the pilot program, and determine an appropriate length of obligated service to the Department. The bill requires a report two years following the establishment of this pilot program requiring detailed information on the number of individuals who participated, their locations, and an assessment of the quality of work performed.

As a new part of the "Yellow Ribbon G.I. Education Enhancement Program," Section 7 of the bill would require the VA Secretary to carry out a program in partnership with an institution of higher education (IHE) and agree to cover the full cost not covered by the post-9/11 G. I. Bill incurred by veterans who are pursuing advanced degrees in the mental health field at the IHE and intend to seek employment as mental health professionals in VA.

Section 8 would require the DOD Secretary to submit to Congress a zero-based review of the staffing requirements for individual State National Guard commands with respect to Directors of Psychological Health.

Section 9 would require the VA Secretary to establish a new pilot program in at least five Veterans Integrated Service Networks (VISNs) to assist transitioning veterans and to improve the access of veterans to mental health services. The pilot program at each VISN would include a community-oriented veteran peer support network, and a community outreach team for each medical center in such VISN. A report would be due not later than 18 months after the date the pilot was established, containing detailed information about the program, including participation data and recommendations on implementing peer support networks throughout the Department.

The overall intent of H.R. 5059 reflects three of DAV's key National Resolutions. The first is Resolution No. 193, which, in part, concludes that the DOD and VA share a unique obligation to meet the mental health care needs of veterans who are suffering from readjustment difficulties as a result of wartime service, and that program improvements and enhanced resources are necessary to ensure suicide prevention is a key priority for the Departments. DAV Resolution No. 202 calls on Congress to adequately fund VA Vet Centers which are an integral part of VA's mental health system in treating post-deployment mental health challenges through non-medical and peer psychological counseling. In part, the resolution notes how Vet Centers

lead all VA mental health programs in conducting veteran-to-veteran peer counseling services. The peer-to peer program has been expanded in VA and is proving to be extremely beneficial in coaching veterans into care, and keeping them engaged in recovery-oriented treatment. Finally, DAV Resolution No. 205 calls on Congress and VA to establish scholarships for future VA mental health practitioners. For these reasons DAV is pleased to support this important measure which seeks to make program improvements related to suicide prevention and would improve access to appropriate mental health services for service members and veterans who need such services.

This concludes my testimony, Mr. Chairman. DAV would be pleased to respond for the record to any questions from you or the Subcommittee Members concerning our views on these bills.

STATEMENT FOR THE RECORD

OF

PARALYZED VETERANS OF AMERICA

PROVIDED TO THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

CONCERNING PENDING LEGISLATION

NOVEMBER 19, 2014

Chairman Miller, Ranking Member Michaud, and members of the Committee, 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 Committee. 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 dysfunction. PVA members are the highest percentage of users among the veteran population,

and 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. 4720, "Medal of Honor Priority Care Act"

PVA supports H.R. 4720, to amend title 38 of the United States Code to move Medal of Honor recipients from priority group three to group one for enrollment in the Department of Veterans Affairs (VA) health care system. Currently, under Section 1705(a)(3), Medal of Honor awardees are listed in priority group three. As our most revered and decorated veterans, awarded for valor in action against an enemy of the United States, they deserve nothing less than to be granted rapid access to hospital care and the highest possible quality medical services.

H.R. 4887, the "Expanding Care for Veterans Act"

PVA supports the "Expanding Care for Veterans Act" to further the research and delivery of complementary and alternative medicine to veterans. This legislation would direct the Veterans Administration (VA) to research the effectiveness of integrating alternative medicine into the health care services currently offered to veterans. VA would then educate and train current medical staff on the new practices at VA medical centers. Consultations would be held with key stakeholders and medical experts in order to identify the best practices to offer. Studies would be conducted to determine the greatest barriers to integration and coordination of care. The last provision of H.R. 4887 would establish a program on the use of wellness programs as complementary approach to mental health care for veterans and their families eligible under section 1712A(a)(1)(C) of title 38, United States Code. VA Secretary would award grants to

private or public nonprofit entities to assess the feasibility of using such a program. PVA fully supports the use of complementary and alternative medicine and believes such care options will give veterans with catastrophic injuries and disabilities additional options for pain management and rehabilitative therapies.

H.R. 4977, "Creating Options for Veterans Expedited Recovery Act"

PVA generally supports H.R. 4977, "Creating Options for Veterans Expedited Recovery Act". This legislation would establish a commission to examine VA's current mental health therapy model and the potential benefits of incorporating complementary alternative therapies. The bill aims to fill in the needs gaps for those who are not effectively served by traditional, evidence-based treatment plans. PVA believes that effective medical care, traditional or alternative, ought to be readily available to a veteran in need. Therapies for the commission to evaluate range from outdoor sports therapy, to accelerated resolution therapy, to service dog therapy. These options fall outside the VA's typical services. It is PVA's position that all VA mental health care should meet the specific, individual need of the veteran seeking medical services on a consistent basis. Complementary and alternative medicine give veterans with mental illness, as well as catastrophic disabilities, additional treatment options. This commission could offer an opportunity to identify additional "best practices" across medical disciplines.

H.R. 5059, "Clay Hunt Suicide Prevention for American Veterans Act"

PVA supports H.R. 5059, the "Clay Hunt Suicide Prevention for American Veterans Act". If enacted, this legislation would increase access to and quality of mental health services while amplifying the staffing capacity to meet demand. Given the serious shortage of military mental

health professionals, the proposed student loan pilot program could help to garner quality and dedicated staff within the Veterans Administration (VA). As most of today's graduates enter the workforce with educational debt, this program could attract the highest caliber of new graduates to provide quality care to veterans, and remain competitive with private sector employers in the health care industry. Additionally, this legislation would mandate VA and the Department of Defense (DOD) coordinate the transfer of care from each agency in such a way that maintains the integrity and continuity of the treatment being received. H.R. 5059 would require a yearly evaluation, conducted by a third party, of the DOD and VA and their suicide prevention practices and programs. With an estimated 22 veteran suicides committed each day, this legislation is a step toward addressing the systemic issues that impede the delivery of timely, quality mental health care from the VA and DOD.

H.R. 5475, "The Newborn Care Improvement Act"

PVA supports H.R. 5475, a bill to amend Section 1786 of title 38, United States Code, to authorize hospital stays of up to 14 days for newborns under VA care. The current provision allows for a maximum stay of seven days. As the average hospital stay for a healthy newborn is two days, H.R. 5475 would provide enormous relief for families facing complications immediately after birth or severe infant illness.

H.R. 5484, "the Toxic Exposure Research Act of 2014"

While PVA understands the intent of this legislation, we have serious concerns about H.R. 5484, "Toxic Exposure Research Act of 2014". First, the bill would require the Veterans Administration (VA) Secretary to select one VA medical center to serve as the National Center

for research on the treatment of health conditions of descendants of individuals exposed to toxic substances while serving in the Armed Forces. We appreciate that this bill recognizes the importance of understanding the long-lasting effects of toxic exposure. However, we are unconvinced that this responsibility rests with VA. The research and treatment of toxic exposure could be better carried out by a public health agency with a broader health care focus, such as the Department of Health and Human Services or National Institute of Health, with the direct support of the Department of Defense.

We have further concerns about the establishment of an Advisory Board for the National Center to determine links to health conditions for the purpose of adjudicating a claim for VA compensation and healthcare benefits. The proposed involvement of the Advisory Board in the adjudication processes could cause serious conflict with an already complicated claims process for veterans and their families. These complications would only be exacerbated should the Advisory Board's findings differ with the VA. This bill does not address the resolution of such an unwelcome scenario.

PVA would once again like to thank the Committee 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, service members, and their families. We would be happy to answer any questions that you may have for the record.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2013

National Council on Disability — Contract for Services — $35,000.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $262,787.

SUBMISSION FOR THE RECORD OF WOUNDED WARRIOR PROJECT
LEGISLATIVE HEARING ON H.R. 4720; H.R. 4977; H.R. 5059; H.R. 5475 AND H.R. 5484

NOVEMBER 19, 2014

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project® to provide our view on pending veterans' legislation. Founded on the principle of warriors helping warriors, Wounded Warrior Project prides itself on providing 20 service programs that advance that principle. Driven by our mission to honor and empower wounded warriors and our vision to foster the most successful, well-adjusted generation of veterans in our nation's history, we welcome this opportunity to illustrate our support for H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act (SAV Act).

The SAV Act seeks to combat the scourge of mental health injuries—the "invisible wounds" of war—that face this generation of injured veterans. Chief among the injuries targeted by this bill are Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). We applaud the Committee's engagement on these important issues.

Since 2010, WWP has been using the information gathered from our annual Wounded Warrior Project Alumni Surveys to refine existing programs, develop new initiatives, and better serve injured service men and women. This year, 21,120 respondents identified several mental health-related challenges affecting injured warriors today. In fact, mental health conditions were among the most frequently reported health problems of wounded veterans, with 75% having experienced PTSD, 67% reported depression, and 64% reported experiencing anxiety. Forty-three percent of Alumni reported experiencing a TBI.[1]

Military experiences affect injured warriors in profoundly adverse ways. Nearly two-thirds reported having had a military experience that was so frightening, horrible, or upsetting that they had not been able to escape from the memories or effects. More than 49% reported having trouble concentrating; more than 49% had little interest or pleasure in doing things; and 76% said they had sleep problems. Overall, the survey results indicate that, for many, the effects of mental and emotional health problems are even more serious than the effects of physical problems.

Without question, the VA has made earnest efforts to identify and treat mental health issues by instituting system-wide mental health screening, increasing levels of mental health staffing, conducting training on clinical techniques and, increasing focus on integrating primary care and mental health treatment. Nevertheless, a comprehensive study of 50,000 Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF) veterans diagnosed with PTSD found that fewer than 10% completed the recommended course of treatment, while one in five did not have a single follow-up visit.[2] These data call into question government's strategy for engaging and sustaining veterans in treatment for combat-stress and related mental health conditions.

For those with mental health conditions other than PTSD, they are even less likely to receive effective care.[3] Without access or adequate care, one apparent consequence of so few warriors getting sufficient treatment is a disturbing rise in the number of suicides among veterans. Recent data have only begun to describe the issue.[4] There is an urgent need for intervention that improves engagement and retention in treatment and there is an ongoing issue of identifying and tracking the scope of the problems.[5] While access to care is the first step in preventing suicide, identifying the factors that lead warriors to drop out of therapy is a critical factor in reversing this troubling trend.

H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act, would improve mental health care and services, and suicide prevention programs at the VA and Department of Defense (DoD) in several ways. Among its many strong provisions, the bill would:

- Amend the requirements for reviewing the discharge characterizations of individuals diagnosed with PTSD or a TBI;
- Authorize the VA to conduct a student loan repayment pilot program aimed at recruiting and retaining psychiatrists; and
- Establish a peer support and community outreach pilot program to assist transitioning service members with accessing VA mental health care services.

The importance of these three provisions to injured service men and women merits further discussion.

SEC. 3. REVIEW OF CHARACTERIZATION OR TERMS OF DISCHARGE FROM THE ARMED FORCES OF INDIVIDUALS WITH MENTAL HEALTH DISORDERS ALLEGED TO AFFECT TERMS OF DISCHARGE: Would amend the requirements for reviewing the discharge characterizations of individuals diagnosed with PTSD or a TBI.

With only estimates that thousands of OEF/OIF veterans may have been administratively discharged inappropriately (i.e. given "bad paper") due to conduct related to previously undiagnosed PTSD or mental health issues, the scale of the "bad paper" problem in our country has not been well defined, while each passing year compounds the problems for those affected.[6] For too many, separation from service based on questionable diagnoses (e.g. personality disorder or adjustment disorder), for substance abuse, or conduct that may have been related to service-incurred conditions can result in loss of earned benefits and being denied gainful employment after their service.[7] These individuals are also at high risk of unemployment, incarceration, substance abuse, and homelessness, and without access to needed resources, their prospects can be especially grim.[8]

The Department of Defense has tightened some rules regarding these types of discharges, but little has been done to provide retrospective remedial action. Moreover, with reports that increases in "bad paper" discharges have mirrored upticks in the overall numbers of wounded, there is a real concern that many injured warriors are falling through the cracks and in need of a correction to their discharge status.[9]

For veterans who file claims for service-connection for PTSD based on military sexual trauma (MST), in particular, the challenges both of providing or identifying evidence to support the claim and of meeting the inherently subjective requirement that that evidence be deemed "credible," can be monumental. The VA's regulation invites consideration of corroborative evidence of behavioral changes in service, but "markers" of such changes cannot only be very subtle, but may be nonexistent. Moreover, it has been observed that many adjudicators handling these cases look for obvious, blatant, concrete evidence that is more likely to be in the claims file, rather than subtle, nuanced evidence.[10] Section 3 of the SAV Act would provide critical relief for these victims of MST to begin to receive the treatment that they need and deserve.

We ask that the Subcommittee support and sustain this provision.

SEC. 6. PILOT PROGRAM FOR REPAYMENT OF EDUCATIONAL LOANS FOR CERTAIN PSYCHIATRISTS OF VETERANS HEALTH ADMINISTRATION: Would authorize the VA to conduct a student loan repayment pilot program aimed at recruiting and retaining psychiatrists

While there is real concern regarding a future shortage of physicians, the country is already experiencing shortages in the behavioral health workforce, and has for some time. To add, the shortage is not evenly distributed, or new. In 2007, a study indicated that 55% of U.S. counties—all rural—have no practicing psychiatrists, psychologists or social workers.[11] Another study found that 77% of U.S. counties had a severe shortage of mental health workers, both prescribers and non-prescribers.[12] The current behavioral health workforce shortage in rural America does not differ markedly from that described more than a decade ago by a presidential commission on mental health, which found that rural areas suffer from chronic shortages of mental health professionals and need improved access to mental health services.[13]

Behavioral health care providers have a critical role to play in treating the invisible wounds of OEF/OIF including PTSD, TBI, pain, and substance abuse, and dependence. Troubling shortages in the mental health workforce, particularly among psychiatrists and particularly in rural areas, pose high risk of those needing services experiencing great disparities in access and quality of mental health.[14] With a large proportion of Post-9/11 wounded veterans living in rural areas, evidence suggesting a growing urban-rural divide in access to both tertiary medical care and behavioral health care is cause for concern. Moreover, the mental health workforce is aging, with the median age of psychiatrists 55.7; nearly half are 65 or older.[15] While there has been growth in the number of both psychologists and social workers for many years, the number of psychiatrists has been stable and has not kept up with population growth.[16] We see no evidence that a meaningful increase in the number of psychiatrists or in their geographic distribution will occur without incentives or policies such as this.

We ask that the Subcommittee support and sustain this provision.

SEC. 9. PILOT PROGRAM ON COMMUNITY OUTREACH: Would establish a peer support and community outreach pilot program to assist transitioning service members with accessing VA mental health care services

Social support has proven to be extremely significant in improving outcomes for those with PTSD, highlighting the importance of developing effective family interventions.[17] While PTSD is strongly associated with relationship distress and instability, many veterans would prefer family-based interventions and treatments that target interpersonal issues, but few are able to access such resources.[18] Although stigma and organizational barriers to care are often cited as explanations for why only a small proportion of service members with psychological problems seek professional help, negative perceptions about the utility of mental health care may be even stronger deterrents.[19]

To reach these warriors, we conclude that there is merit in a strategy of expanding the reach of treatment, to include greater engagement, increased family-based interventions, understanding the reasons for negative perceptions of mental health care, and "meeting veterans where they are."[20] Peer support is also an area that could improve to increase engagement in mental health care. Underscoring the benefit of warriors reaching out to other warriors, our 2014 survey found that 59% identified talking with another OEF/OIF veteran as a top resource for coping with stress.[21]

Current law requires VA medical facilities to employ and train warriors to conduct outreach to engage peers in behavioral health care.[22] Early reports from our Alumni point to the success of this initiative and suggest value in expanding the program to reach more veterans. In addition, with many disabled veterans responding well to engagement with peers, group therapy can be an important tool, whether in combination with individual psychotherapy or as a supportive treatment in itself.

We offer our Peer Support program as an example to consider. In April 2013, the Wounded Warrior Project's Peer Support Program began to engage our Alumni through Peer Facilitated Support Groups (PFSG), to test the concept of warrior-guided peer support groups. The success of four pilot PFSGs, marked by the overwhelmingly positive feedback from our Alumni, led to the approval, in October 2013, to continue the pilot and expand it to 16 PFSGs.

The feedback from our Alumni speaks volumes of how peer support and community outreach can positively affect veterans. Below is a sample of the feedback our Alumni have provided:

A mentor wrote staff about his experience mentoring others saying,

> *"During the time I have been a mentor, I have gained invaluable knowledge about myself, my mentees and life in general [...] The mentorship program has truly been awesome! On both spectrums, as it relates to dealing with individuals coping with multiple issues of PTSD, TBI, chronic pain and various*

other issues. Being able to reach out and just talk to someone and vent is such a rewarding experience alone. It is inner peace and healing for the giver as well as the receiver. Thank you for allowing me to heal and help others in the process."

A mentee wrote to WWP staff about his mentor saying,

> *"I couldn't be more grateful and like I told [my mentor], I'm finally feeling like I belong to something. The only other place I felt like I belonged in my whole life was the military. I feel like I can actually trust the other [alumni] members, you and [my mentor] have shown me that. Not sure why, but I do feel pride in being part of the Wounded Warrior Project, which is something I haven't felt in years."*

At the recent Peer Facilitated Support Group training, an Alumnus said that by becoming a peer facilitator, it showed the progress he had made in getting better, and demonstrated to him how much he wants to help other warriors. He was thankful for having access to the Peer Support program saying, "No one can relate to a [veteran] like another [veteran]."

While visiting the Orlando peer facilitated support group, a WWP Peer Support staff member was able to speak with several Alumni about how they were doing and how WWP was helping them out. One Alumnus stated, "I was very lonely and felt out of place until I found this group." He went on to say that with the help of his peer mentor, he has gotten a job, become more social, attended several events and is attending peer mentor training in the near future to give back.

Lastly, a mentee who expressed suicidal ideations provided feedback to the Peer Support staff saying,

> *"Yesterday and the night before last I wanted to kill myself so bad like a marathon runner wants to drink water. I could feel it, see it, taste it! But I need you to know that [WWP staff member] and [my mentee] are in my circle for the right season of my life...I'm not a bum and I hate feeling like a burden to others. I hate asking for help because I feel like it means that I'm not capable of taking care of my kids...It's scary and it's embarrassing and it's never something I wanted to happen, but THANK YOU!!! ...I'm going to VA mental health today...."*

We ask that the Subcommittee support and sustain this provision.

We believe these provisions in the Clay Hunt SAV Act would serve injured service men and women well as they battle their invisible wounds now and in the future, and that they add significant value to the other provisions H.R. 5059. We encourage the Subcommittee's support for this bill.

Thank you for your consideration of Wounded Warrior Project's views on these issues.

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