LEGISLATIVE HEARING ON H.R. 198, H.R. 1154, H.R. 1855, H.R. 2074, H.R. 2530, AND DRAFT LEGISLATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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LEGISLATIVE HEARING ON H.R. 198, H.R. 1154, H.R. 1855, H.R. 2074, H.R. 2530, AND DRAFT LEGISLATION

MONDAY, JULY 25, 2011

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

The Subcommittee met, pursuant to notice, at 4:10 p.m., in Room 334, Cannon House Office Building, Hon. Anne Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Bilirakis, Roe, Runyan, Michaud, Carnahan, and Donnelly.

OPENING STATEMENT OF CHAIRWOMAN BUERKLE

Ms. BUERKLE. Good afternoon. This hearing will now come to order.

Today we meet to discuss a number of legislative proposals aimed at improving the care provided to our Nation's veterans through the U.S. Department of Veterans Affairs (VA). The seven bills on our agenda today are H.R. 198, the "Veterans Dog Training Therapy Act, H.R. 1154, the "Veterans Equal Treatment for Service Dogs Act," H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitative Services Act of 2011," H.R. 2074, the "Veterans Sexual Assault Prevention Act," H.R. 2530, a bill to provide for increased flexibility in establishing reimbursement rates for nursing home care provided to certain veterans in State homes; draft legislation, the "Veterans Health Care Capital Facilities Improvement Act of 2011," and draft legislation, the "Honey Sue Newby Spina Bifida Attendant Care Act."

This hearing represents an important step in the legislative process; and, as such, I look forward to a frank and productive conversation about the policy implications, merits, and potential unintended consequences of each of the proposals on our agenda today.

One of the bills we will discuss this afternoon is H.R. 2074, the "Veterans Sexual Assault Prevention Act," a bill I introduced in response to a truly alarming report issued last month by the U.S. Government Accountability Office (GAO) on the prevalence of sexual assault and other safety instances in VA facilities. I am pleased to sponsor this legislation with our Chairman, Jeff Miller, and with Ranking Members Bob Filner and Mike Michaud as co-sponsors.

In their report, the GAO found that between January of 2007 and July of 2010, nearly 300 sexual assaults, including 67 alleged

rapes, were reported to the VA police. Troubling and in direct violation of Federal regulations and VA policy, many of these incidents were not properly reported to VA leadership officials or the VA Office of the Inspector General (OIG).

As disturbing, GAO uncovered serious deficiencies in the guidance and oversight provided by VA leadership officials on the reporting, the management, and the tracking of sexual assault and other safety incidents.

GAO also found that the Department failed to accurately assess risk or take effective precautionary measures, with inadequate monitoring of surveillance systems and malfunctioning or failing panic alarms.

As someone who has been a domestic violence legal counselor, I have seen firsthand the pervasive and damaging effects of sexual assault and the effect it can have on the lives of those who experience it. Abusive behavior, like the kind documented by GAO, is unacceptable in any form. But for it to be found in what should be an environment of caring for our honored veterans is simply intolerable and unacceptable.

H.R. 2074 would address the safety vulnerabilities, security problems, and oversight failures identified by GAO and create a fundamentally safer environment for veteran patients and VA employees. Specifically, H.R. 2074 would require VA to develop clear and comprehensive criteria with respect to the reporting of sexual assaults and other safety incidents for both clinical and law enforcement personnel.

It would establish a newly accountable oversight system within the Veterans Health Administration (VHA), to include a centralized and comprehensive policy on the reporting and tracking of sexual assaults covering all alleged or suspected forms of abusive or unsafe acts, as well as the systematic monitoring of reported instances to ensure each case is fully investigated and victims receive the appropriate care.

To correct serious weaknesses observed in the physical security of VA medical facilities and to improve the Department's ability to appropriately assess risk and take the proper preventative steps, H.R. 2074 would mandate the Department to develop risk-assessment tools, create a mandatory safety awareness and preparedness training program for employees, as well as to establish physical security precautions, including appropriate surveillance and panic alarm systems that are operable and regularly tested.

It is critical and very important that we take every available step to protect the personal safety and well-being of the veterans who seek care through our VA system and all of the hardworking employees who strive to provide that care on a daily basis. I am eager to discuss H.R. 2074 this afternoon, and I am here to answer any questions that my colleagues might have regarding this legislation.

Also on our agenda today is a draft Committee proposal, the "Veterans Health Care Capital Facilities Improvement Act of 2011." This draft legislation incorporates the Administration's fiscal year 2012 construction request to authorize major medical facility projects and leases. The draft proposal also modifies the statutory requirements for the Department to provide a prospectus to Congress when seeking authorization for a major medical facility

project to ensure that Congress receives a comprehensive and accurate cost-benefit analysis as the basis for making these critical decisions.

This bill also extends authorities to provide for important programs related to such initiatives as housing assistance for homeless veterans and treatment and rehab for veterans with serious mental illness, both of which are set to expire at the end of this calendar year. Additionally, section 6 of the draft bill seeks to provide an extension of the VA's enhanced use lease authority, which is also set to expire this year.

This authority is an innovative and vitally important approach to supporting goals we all share, such as reducing homelessness among our veteran population and making effective use of vacant or underutilized VA property through public-private partnerships. Unfortunately, the Congressional Budget Office (CBO) has scored this provision with a mandatory spending cost of $700 million. We want to work with the Department and the veterans service organizations (VSOs) to resolve this scoring issue to ensure that the VA has the authority to continue utilizing this extremely important program.

The draft bill also includes legislation that was brought to us by our colleague from Colorado, Scott Tipton, to designate the Telehealth Clinic at Craig, Colorado, as the Major William Edward Adams Department of Veteran Affairs Clinic. Major William Edward Adams is a Medal of Honor recipient, and Scott has provided a statement for the record detailing Major Adams' courageous service to our country.

I want to thank all of the Members who sponsored bills and draft legislation before us today, as well as the witnesses from the veteran service organizations, as well as the VA, for taking time out of their busy schedules to share their expertise with us this afternoon. I look forward to our discussion; and I will now yield to the Ranking Member, Mr. Michaud, for any opening statement he may have.

[The prepared statement of Chairwoman Buerkle appears on p. 35.]

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you very much, Madam Chair. I, too, would like to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, veterans, the VA, and other interested parties to provide their viewpoint and discussion of legislation that is before the Subcommittee this afternoon. We have seven bills, as you heard earlier, before us today, which address a number of important issues to our veterans and provide the staff of the Department of Veterans Affairs with the necessary tools to provide the best care for our veterans.

First, we have two bills to help veterans with post-deployment mental health issues through training service dogs. The remainder of the legislation covers a wide range of topics, such as improved traumatic brain injury (TBI) care, sexual assault prevention, facility construction, and spina bifida.

We will also examine my bill, H.R. 2530, which seeks to increase the flexibility in payments for State veterans homes. It would require State veterans homes and the VA to enter into a contract for the purpose of providing nursing home care to veterans who need such care for service-connected conditions or have a service-connected rating of 70 percent or greater.

We have been dealing with this issue since 2006. It took 2 years for the VA to implement the rules and regulations. Then it has taken a couple of years for us to really get to the point where we are today, that we hopefully will be able to move this legislation forward so we can deal with the reimbursement rate issues for State veterans nursing homes before I get to an age where I might be needing a State veterans nursing home. So, hopefully, we will be able to get this dealt with this Congress.

So, with that, I yield back, Madam Chair.

[The prepared statement of Congressman Michaud appears on p. 36.]

Ms. BUERKLE. Thank you very much.

We will now turn to our first panel here today. It is an honor to be able to recognize such a distinguished group of my colleagues joining us this afternoon to discuss the legislation that they have introduced.

First is Michael Grimm, a fellow New Yorker and a Marine Corps veteran. Thank you for your service, and thank you for being here today. Next to Mr. Grimm is Tim Walz, a 24-year veteran of the National Guard and a lifetime member—a long-time, sorry, not lifetime—long-time Member of this Committee. And Dr. Larry Bucshon, a Hoosier from the State of Indiana.

Welcome to all of you. Thank you for taking the time to be here today.

And, Mr. Grimm, we will start with you and your testimony.

STATEMENTS OF HON. MICHAEL G. GRIMM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK; HON. TIMOTHY J. WALZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA; AND HON. LARRY BUCSHON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

STATEMENT OF HON. MICHAEL G. GRIMM

Mr. GRIMM. Madam Chair, thank you very much. It is always good to see a fellow New Yorker.

Ranking Member Michaud and all the Members of the Committee, thank you so much for allowing me the honor of testifying today on H.R. 198, the "Veterans Dog Training Therapy Act."

As a Marine combat veteran, it is a unique honor for me to address this Committee. Having seen firsthand both the physical and mental wounds of war that the members of our Nation's military are faced with, I have a special appreciation for the important work this Committee does every day.

Today, over two million Iraq and Afghanistan veterans have returned home to the challenge of an unemployment rate hovering near 10 percent, which for disabled veterans is actually closer to 20 percent. And, for many, the long road to recovery from the men-

tal and physical wounds sustained during their service, sadly these numbers continue rising.

Over the last 6 months, I have had the honor to meet with a number of our Nation's heroes who are now faced with the challenges of coping with PTSD and physical disabilities resulting from their service in Iraq and Afghanistan. It was these personal accounts of their recovery, both physical and mental, and the important role therapy and service dogs played that inspired my role in this legislation.

The "Veterans Dog Training Therapy Act" would require the Department of Veterans Affairs to conduct a 5-year pilot program in at least three but not more than five VA medical centers assessing the effectiveness and addressing post-deployment mental health and post-traumatic stress disorder (PTSD) throughout the therapeutic medium of training service dogs for veterans with disabilities. These trained service dogs are then given to physically disabled veterans to help them with their daily activities. Simply put, this program treats veterans suffering from PTSD while at the same time aiding those suffering from physical disabilities.

Since I introduced this legislation, it has gained the bipartisan support of 84 co-sponsors, including Financial Services Committee Chairman Spencer Bachus and Ranking Member Barney Frank, as well as Congressman Pete Sessions and Steve Israel. Clearly, this legislation has brought together a number of unlikely allies in support of our Nation's veterans.

Additionally, with veteran suicide rates at an all-time high and more servicemen and women being diagnosed with PTSD, this bill meets a crucial need for additional treatment methods. I believe that by caring for our Nation's veterans suffering from the hidden wounds of PTSD, while at the same time providing assistance dogs to those with physical disabilities, we create a win-win for everyone, which I believe is a goal we can all be proud of.

Working in conjunction with a number of veteran service organizations, including AMVETS and VetsFirst, I have drafted updated language which I intend to have submitted during Committee markup to ensure this program provides our Nation's veterans with the highest quality of care for both PTSD and physical disabilities while maintaining my commitment to fiscal responsibility.

I understand that in the current economic situation we are faced with especially important decisions, decisions that must ensure that taxpayer dollars are spent wisely, which is why I have identified several possibilities to offset and to make sure that this legislation meets the PAYGO requirements. As we move forward in the legislative process, I look forward to working with this Committee to ensure that any money allocated for this program is offset by reductions in other accounts.

Again, I would like to thank the Committee for holding today's hearing, and I look forward to working with you to ensure that this program is included in your continuing efforts to guarantee that our Nation's heroes have the best possible programs for treating PTSD and providing disability assistance.

I would like to extend a special thank you to the Ranking Member for helping me move this legislation along and, again, to every-

one that works so hard every day on this Committee to ensure our veterans have the very best that we have to offer in Congress.

With that, I yield back. Thank you.

[The prepared statement of Congressman Grimm appears on p. 37.]

Ms. BUERKLE. Thank you, Mr. Grimm.

Mr. Walz.

STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Thank you, Madam Chairwoman and Ranking Member Michaud. It is a privilege to be here in front of you. I know what each of you and Members of this Committee give to the care of our veterans. You are truly the voice of a grateful Nation to provide the care and benefits that our warriors so bravely earned.

And I would also like to note the great landmark legislation that comes out of this Committee. This Committee conducts itself in a manner that is the envy of all of Congress in a bipartisan manner, with the sole focus on caring for our veterans. So, Chairwoman, I congratulate you on keeping that great tradition alive and am very appreciative to be here.

The piece of legislation I am introducing, H.R. 1855, the "Traumatic Brain Injury Rehabilitative Services Improvement Act," was introduced last year along with Chairman Miller and Congressman Bilirakis. I am very appreciative of getting this opportunity to hear on this and hopefully moving it to markup.

As my colleague and another veteran so clearly indicated, an unprecedented number of warriors are returning from our wars, having served proudly. Having witnessed and been many occasions to the polytrauma center in Minneapolis, I have seen the incredible battlefield care that is being given to these severely wounded warriors.

But traumatic brain injuries as they come back are the most complex of these injuries. Each case is unique. The injuries can result in a wide-ranging loss of function. Neurological and cognitive loss, impairments in speech, vision, and memory are not uncommon, as is marked changes in behavior and manifestations such as diminished capacity to self-regulate.

It is very difficult to predict the extent of an individual's ultimate level of recovery, but the evidence is very clear that, to be effective in helping an individual recover from a brain injury and return to life as independent and productive as possible, rehabilitation must be targeted to the specific needs of the individual patient.

This piece of legislation is aimed at closing the gaps in current law that have an effect of denying some veterans with severe TBI from achieving optimum outcomes. I want to be very clear. Our VA facilities and the polytrauma centers are providing the best care anywhere in the world. One of the things this piece of legislation does is it codifies what and should be provided to those veterans. That scope of services is limited, in many cases.

Veterans encounter two problems. First, all too common for families to be advised the VA can no longer provide a particular rehabilitative service because the veteran is no longer making significant progress as it is written now. But ongoing rehabilitation is often needed just to maintain function, and individuals who are de-

nied maintenance therapy can regress and lose cognitive gains they have made through a lot of hard work.

A second problem is veterans encounter getting help with community reintegration, learning to live as independently as possible. VA's rehabilitation focus relies almost exclusively on a medical model. That assistance is critical but doesn't necessarily go far enough for some veterans in providing range of support and services.

In contrast, other models of rehabilitative care meet TBI patients' needs through services such as life-skills coaching, supported employment, and community reintegration. These services are seldom made available to veterans.

H.R. 1855 would correct that. Specifically, it would clarify that the VA not prematurely cut off needed rehabilitative services for an individual with a traumatic brain injury, and that veterans with TBI can get the support they need, whether those are health services or nonmedical assistance, to achieve maximum independence and quality of life.

I understand that the VA expressed some concerns with some of the wording, not because they don't want to achieve this and not because they don't believe it is important, it was simply in some of the language. Those have been addressed with a companion version that is being championed by one of our former colleagues and a Member of this Committee, Senator Boozman and Senator Begich. They have that piece of legislation over there; and it is my hope that if we get the opportunity, we certainly have an amendment in the nature of a substitute, Madam Chairwoman, that would address those very needs, and the VA would be satisfied with that.

I am gratified by the broad support. You understand, Madam Chairwoman, Ranking Member, and all Members of this Committee, the veterans' backs are covered by those people sitting behind me, the veteran service organizations who made this a top priority. I am really pleased with all of the support they put into it.

And I would like to give one quote from the Wounded Warrior Project. Their Executive Director, Steve Nardizzi, described this bill as "powerfully addressing the often agonizing experience of wounded warriors who have been denied important community reintegration supports and who have experienced premature termination of rehabilitation services." As Steve said, "This bill offers new hope to these warriors and their families."

So I look forward to responding to any questions, Madam Chairwoman. Again, I thank you so very much for letting us bring this piece of legislation forward. I will be glad to answer any questions, and I yield back.

[The prepared statement of Congressman Walz appears on p. 37.]

Ms. BUERKLE. Thank you very much.

Mr. Bucshon.

STATEMENT OF HON. LARRY BUCSHON

Mr. BUCSHON. Thank you, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee for the opportunity to come and speak to you today about my draft legislation, the "Honey Sue Newby Spina Bifida Attendant Care Act."

In April of this year, I was contacted by a constituent from New Harmony, Indiana, Mr. Ron Nesler, on behalf of his stepdaughter, Honey Sue Newby. Honey Sue's father was a Vietnam veteran exposed to Agent Orange, and she was born with a complicated neurological disorder rooted in spina bifida, a congenital condition in which the vertebrae do not form properly around the spinal cord. The Veterans Administration has previously determined Honey Sue's condition is a direct result of her father's exposure to Agent Orange in Vietnam and have classified her as a Level III child, making her eligible to receive the same full health coverage as a veteran with 100-percent service-connected disability.

In 2007, Mr. Nesler and his wife reached out to my predecessor, former Representative Brad Ellsworth, regarding two issues they had been experiencing with the VA. The first was an administrative burden requiring a letter from Honey Sue's doctor explaining exactly how the treatment she sought was related to her spina bifida. More often than not, this resulted in the VA denying repayment until additional burdensome administrative procedures took place. For example, Honey Sue needed surgery on her mouth after seizures caused her to grind her teeth to nubs. The VA originally denied payments for the procedure, saying the doctor's letter did not clearly make the case that this result was from her condition.

Secondly, Honey Sue's parents are aging and experiencing health problems. Currently, the only long-term services the VA will pay for is nursing home care for individuals like Honey Sue. As a physician, I know that nursing home care is both extremely expensive and inappropriate for what Honey Sue needs. Individuals with spina bifida have a diverse range of needs. Although no two cases of spina bifida are ever the same, the National Spina Bifida Association confirms the majority of these individuals can live independently if they have the proper habilitative care in order to develop, maintain, or restore their functioning.

Former Representative Ellsworth's bill, H.R. 5729, was written to address both of these issues and on May 20, 2008, was passed by a voice vote in the House of Representatives and was later added to S. 2162, the Veterans Mental Health and Other Care Improvement Act of 2008, and was signed into law by President Bush on October 10, 2008.

Since then, the VA has recognized and alleviated the administrative burdens but has not properly interpreted the "habilitative care". Title 38 of the U.S. Code defines habilitative care as professional, counseling and other guidance services and treatment programs—other than vocational training under section 1804 of this title—as are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person. Under this language, I believe the VA is misinterpreting the law and its intent as it concerns individuals with type III spina bifida who simply need supervisory, or as we put in the draft legislation, home and community-based care.

The purpose of this draft legislation is to clarify title 38 to allow individuals with spina bifida the appropriate and cost-effective care that they deserve. The intended result allows individuals to take advantage of home and community based care for those that do not need constant medical care. The term "home and community based

care" is used in a definition of habilitative care in section 1915 of the Social Security Act, and this legislation is modeled after and aims to create consistency for that definition within VA services.

Again, thank you for consideration of the legislation. It is a pleasure to be here and an honor to be here, and I am happy to answer any of your questions. Thank you.

[The prepared statement of Congressman Bucshon appears on p. 38.]

Ms. BUERKLE. Thank you very much.

I will now yield myself 5 minutes for questions. I will start with Mr. Grimm.

First of all, thank you for introducing this legislation. I think that we all understand, and as time goes on we understand even more, the emotional toll that these wars have on those returning home. This legislation is a good opportunity and a good mechanism for us to look at ways that we can most effectively treat those coming home with PTSD.

One of the questions that was raised by the Veterans of Foreign Wars (VFW) regarding H.R. 198, and I would like you to just respond to this if you could, they said, "We do not believe a VA medical center is the right environment for a pilot program involving dog training. We believe the idea behind this legislation would be better achieved through established private-sector organizations with sufficient oversight by the VA."

Could you comment on that for me, please?

Mr. GRIMM. Certainly. I disagree with the VFW because it is a pilot program. Ultimately, I think that this pilot will be very successful, and it will grow, and then it should be more community based and have much more private-sector interaction.

But for the beginning stage, to take this from where it is now as purely a pilot within 3 to 5 sites, I think that we need the proper oversight, assessment, and valuation that can be better achieved in an environment like the VA setting. I also think it will be cheaper right now to be able to do that and will yield better assessments in valuations because of the controlled environment.

Now, once it is proven successful and we want to expand this program throughout the United States, then I would agree that it should be more community based and have much more interaction with private industry and allow that to grow. And I think then it would actually be cheaper—it will be more cost-effective, I should say, for communities to get more involved. But, right now, in its infancy stages, I think that we need the control of the environment to fully assess and evaluate the efficiency and benefits of the program.

Ms. BUERKLE. Thank you.

And just as a follow-up, with the dog therapy program, have they identified cases of PTSD where it may be more or less successful, which veterans may benefit from this treatment or may not? Have they made any distinction about the cases of PTSD and who might benefit from this program?

Mr. GRIMM. That is an excellent question, Madam Chair. My experience so far has been that, amazingly, the work with these animals, with these dogs, has helped already a very, very wide spectrum of cases.

One in particular comes to mind where a young soldier returned and would not speak with anyone, did not want to speak, was pent up with a tremendous amount of anger, went for counseling, would not speak to the counselor and was leaving. On his way out from counseling, walking out, there was someone walking with a dog, and the dog went up to him, and he pet the dog. It was the only interaction that this veteran really had. He wouldn't speak with anyone else, didn't want to, he shut the world out except for this dog.

And someone there noticed how perceptive the dog was to go over to this soldier and the interaction they had in just a few minutes. And they contacted the veteran again and said, would you come back and be willing to work with some of our dogs? And it just completely changed that veteran's life.

So I think there is no way to say that there is one specific type of veteran that has post-traumatic stress. It really is a very wide spectrum, which is why I think this program is going to have tremendous success.

I yield back.

Ms. BUERKLE. Thank you very much.

Mr. Walz, first of all, let me thank you as well for bringing forth this piece of legislation and making sure that there are no institutional barriers between the veterans and the care they need with TBI. There has been some concern regarding the term "quality of life," that the VA will exceed their statutory mission. Can you speak to that? And I am hopeful that we can, in amendment language, address that issue.

Mr. WALZ. Yes. You are absolutely right. That was the piece of legislation, the qualifying language on quality of life. And again, as I said, not because the VA doesn't want to achieve the highest quality of life. They think it is more subjective instead of an objective measure of what they are doing. That word was struck from the Senate version, and they are agreeable for all the other procedures that went through or all the other barriers that were there coming down. The amendment that we would offer would be that identical language, and the Senate was acceptable to the VA.

Ms. BUERKLE. Thank you very much.

I now yield to the Ranking Member, Mr. Michaud, 5 minutes for questions.

Mr. MICHAUD. Thank you very much, Madam Chair.

I want to thank the three panelists this afternoon for taking the time to put forward legislation that will definitely help our veterans get through life and I really appreciate your willingness to do that and for your service to this country as well. I have no question for the panelists, so I yield back.

Ms. BUERKLE. Thank you, Mr. Michaud.

Mr. RUNYAN. I now yield 5 minutes to the gentleman from New Jersey.

Mr. RUNYAN. Thank you, Madam Chair; and thank all of you for bringing these bills in front of us.

Mr. Grimm, as I am a co-sponsor on the piece of legislation, I agree with much of what you are trying to do.

I just wanted to really say for the record that I actually, probably back in February, had a constituent of mine who is a Marine, much

like yourself, come to my district office with his dog. And to listen to his wife tell the story of how it has changed his life, for him to be able to go out and interact with people. It almost gets to the point where the dog is a conversation piece that gets him back into society. And I have seen the gentleman three or four times since then in many different settings, whether it is out where he is actually heading a similar program trying to do it himself.

But, again, we lack the funding to do it, and I think that is kind of the sticking point here.

But to hear his story and to go actually on a camping trip with my daughters, and he happened to be there at the same one, and to hear his wife come to me at the next event we were at and said he wouldn't have been able to do that a year ago—just kind of place that.

Because we always talk about the positive impact, whether it is veterans or seniors, that animals have on them. I applaud you for getting out in front of this, because I think it is worthwhile. I think, as you said in your statement, though, figuring out how we are going to pay for it is ultimately going to be the decision about how we are going to do this. Because there is a lot of upside to it, so I thank you for that.

And, also, Mr. Walz, thank you for what you are trying to do there. I have experienced and I deal with it myself. When you talk about brain injuries, I don't think we necessarily understand the long-term, life-term commitment that we have to have. And to really say somebody has totally recovered and we are going to stop treatment I don't think is reflective of that commitment. I have seen many of my past colleagues in my past career with brain injuries be 30, 40 years old and have full onset dementia and can't function.

It brings back a gentleman that I played against that was working on Wall Street and had to quit because he couldn't function anymore. So we really do have to not turn him away and simply say we have them to the level they are at and then that's it.

There have been many other instances of that where I have had people come and visit me. We have come so far with things like Down Syndrome where they were just trying to get these kids just to get out of high school. I have had several people come to my office and say, my son wants to go to college, and there is nothing there for them.

We really have to take a long-term approach to this, and I just wanted to thank all of you for bringing this up.

I yield back.

Ms. BUERKLE. Thank you, Mr. Runyan.

I yield 5 minutes to Mr. Donnelly.

Mr. DONNELLY. Thank you, Madam Chair.

I just wanted to thank my fellow colleagues for your efforts on behalf of our veterans and for bringing these bills forward. Thank you very much.

Ms. BUERKLE. Thank you.

I yield 5 minutes to Dr. Roe.

Mr. ROE. Thank you. And also thank you for your service and thank you for being here today.

And, Congressman Grimm, I will be on your legislation or I won't ever be able to go home. I have a wife that has done pet therapy for years, and it is tremendously beneficial for seniors. Certainly don't see any reason it wouldn't be beneficial.

We already know—we had a veteran in our office just this past week that brought his dog. It was a bomb dog in Afghanistan, and now he is with this Marine and it helps him to know when he is going to have seizures; the dog can pick it out. So they are tremendous amounts of help, and so certainly I will support that.

And you are correct about finding the resources. One of the things I think we have is a commitment to our soldiers coming home to understand that we have a lifetime commitment to them, not a 1 week or a 1 year or a 5 year. We have for these men and women who go, as you have and Sergeant Major Walz has, to give your time and your treasure for this country, this country has a lifetime commitment, period, to taking care of that, whatever it may be.

So, having said that, I didn't hear—I read your testimony, Sergeant Major. But if you would help me a little bit here. Would there be any part in this—we have a brain injury—I won't go into why it is there—but there is a brain injury center, a private brain injury center, in our area that takes care of traumatic brain injury from the most severe to mild injury. Is there any way or any—I guess, way that a veteran could be treated on the private side with your Act?

Mr. WALZ. Well, this one addresses, Dr. Roe—and, again, thank you. Thank you for your service and your unwavering commitment to this Committee of getting things done. This addresses the VA's responsibility, but it does deal with that reintegration piece of trying to get them back into the community. And at that point in time, we are certainly very interested to see what happens when these—and many of them, as you know, are rural veterans, where they move from the polytrauma centers that are doing fabulous work, and trying to keep this maintenance of effort to keep them out or, as Mr. Runyan said, to move them on in this rehabilitation is critically important.

So we didn't address it in the specifics at that point, because, again, as Mr. Grimm said, we are looking at cost benefits, and this one the VA shows as no added cost. But it does start to bring to bear those outside resources that can be there to move them back in. So I am certainly interested in looking at that with you and see how we can do that, of making sure all those resources, public and private, are brought to bear to the benefit of those veterans.

Mr. ROE. Certainly in young people who have brain injury we are just learning how much recovery you can experience, and it can be very dramatic. I mean, I have seen—and it may not be for someone who is right there side by side, day by day. But when you are seeing it, as I did, we see a patient in 6 months or 3 months or year intervals, you would notice dramatic changes.

And that was what I learned over time, was it used to be when you had a brain injury that was just the way—you were just stuck with that the rest of your life—that is not true anymore. And all of these innovative ways, whether it is with pet therapy or whether it is with innovative things that we are learning, we should be

doing that. And the VA ought to be at the forefront, since there are so many of our veterans that have had brain injuries. And, again, it's a lifetime commitment.

I can't thank you all enough for bringing these here and taking your time to be here and testify in front of this Committee, and I yield back.

Ms. BUERKLE. Thank you, Dr. Roe.

Unless any of my colleagues has additional questions, again, on behalf of all of us, thank you very much for being here today, for taking the time and the energy to act on behalf of our veterans. And, to all of you, thank you for your service to this country.

Our first panel is excused, and we would ask that our second panel join us at the witness table.

Good afternoon. With us on our second panel are representatives from our veteran service organizations.

We have Mr. Shane Barker, the Senior Legislative Associate for the Veterans of Foreign Wars. Good afternoon.

Ms. Joy Ilem, the Deputy National Legislative Director for the Disabled American Veterans (DAV). Welcome to our hearing.

Dr. Thomas Berger, the Executive Director of the Veterans Health Council for the Vietnam Veterans of America (VVA). Welcome, Dr. Berger.

Mr. Carl Blake, the National Legislative Director for the Paralyzed Veterans of America (PVA). Welcome.

And Christina Roof, the National Acting Legislative Director of AMVETS.

Good afternoon to all of you. Thank you for joining us this afternoon, and, Mr. Barker, we will begin with you.

STATEMENTS OF SHANE BARKER, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL VETERANS SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; THOMAS J. BERGER, PH.D., EXECUTIVE DIRECTOR, VETERANS HEALTH COUNCIL, VIETNAM VETERANS OF AMERICA; CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND CHRISTINA M. ROOF, NATIONAL ACTING LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS)

STATEMENT OF SHANE BARKER

Mr. BARKER. Madam Chairwoman, Ranking Member Michaud, and Members of this Committee, on behalf of the more than two million members of the Veterans of Foreign Wars of the United States and auxiliaries, thank you for the opportunity to present our views on today's legislation.

The VFW does not support H.R. 198, the "Veterans Dog Therapy Training Act." Helping veterans with post-traumatic stress by offering them a therapeutic dog training class is indeed a laudable goal. We believe it would be better achieved through public-private partnership with Congressional oversight.

We also believe that such a benefit should not be anchored to VA medical centers. The nature of this service does not readily align

itself with the provision of medical care to veterans, and we do not want it to complicate the care those medical centers provide.

The VFW does support H.R. 1154, the "Veterans Equal Treatment for Service Dogs Act." The use of medical service dogs among veterans is increasing. They serve a critical role as a VA-recognized prosthetic in helping to promote independence. This legislation opens the doors at VA facilities for veterans to utilize such service dogs, broadening VA policy that currently allows only seeing eye dogs into medical facilities. Service dogs are helping our veterans, and they shouldn't have to leave them at the door when they come to VA for medical care.

The VFW supports H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitative Services Improvement Act of 2011." This legislation ensures better TBI treatment plans by focusing on an injured veteran's independence and quality of life while also stressing improvements to their behavioral and mental health functioning.

We all agree that TBI patients deserve more than mere treatment of the physical wounds of war. It has been made painfully clear that even mild TBI can cause emotional, cognitive, and behavioral complications; and this bill would guarantee treatment for these conditions as well.

We thank the Chairwoman and the Ranking Member for their work on H.R. 2074, the "Veterans Sexual Assault Prevention Act," and we are pleased to see this Committee continuing to move this forward. The VFW will continue to staunchly advocate for a zero tolerance policy, because veterans should never have to visit a VA medical facility with concerns about their personal safety.

The VFW also supports H.R. 2530. This legislation will eliminate the system currently in place to reimburse State homes for nursing home care provided to veterans. It would require the VA to negotiate adequate payment structures with an individual State home prior to entering into agreements for services. This bill has broad stakeholder support, and we strongly believe that it will put many complications with the current system to rest.

The VFW strongly supports the "Honey Sue Newby Spina Bifida Attendant Care Act." Honey Sue Newby is entitled to VA care because she is the child of a Vietnam veteran and is afflicted with spina bifida. Her condition renders her unable to care for herself, and the VA considers her disability on par with the 100-percent service-connected totally disabled veteran, yet her provision of care is substantially lower. This bill provides needed relief by greatly broadening the types of care that she and other similarly affected children can receive and by redefining home care to expand services and offer financial incentives to employ a live-in caregiver. We strongly support passage of this legislation.

Finally, the VFW supports the "Veterans Health Care Facilities Capital Improvement Act of 2011." This legislation will remedy a handful of serious structural concerns at individual VA facilities and expand authorizations to enhance facilities in other high-demand locales.

We support the extension of current enhanced use lease authorities in this bill. However, we are concerned that removing provisions to ensure that they contribute to the mission of VA will diminish services to veterans. Added revenue is already being cited

in some current leases as the main factor contributing to VA's mission, so we believe these provisions are essential to the continued success of enhanced use leases.

This bill would also require VA to detail expected costs to make a facility fully usable for its intended purposes, instead of merely requesting the funds to build the bare bones facility. We believe Congress should know up front how much VA needs to furnish and supply the facilities it intends to build.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions that you or the Committee may have.

[The prepared statement of Mr. Barker appears on p. 41.]

Ms. BUERKLE. Thank you, Mr. Barker, for your testimony.

Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee. Thank you for inviting me to testify on behalf of the Disabled American Veterans at this legislative hearing. We are pleased to present our views on the five numbered bills and two draft measures before the Subcommittee today.

DAV does not have an approved resolution from our membership that supports a pilot program as proposed in H.R. 198, the Veterans Dog Training Therapy Act, so we are unable to take a formal position on this bill. We do, however, recognize that working with service animals could play an important role in promoting maximum independence and improved quality of life for persons with disabilities and that a pilot program such as the one proposed in this measure could be of benefit to certain veterans.

The next bill for consideration, H.R. 1154, the "Veterans Equal Treatment for Service Dogs Act," would prohibit the VA Secretary from restricting the use of service dogs by veterans on any VA property that receives funding from the Secretary. DAV does not have a resolution on this specific topic either. However, we note VHA recently published a national policy directive on admittance of service and guide dogs into VA health care facilities. Unfortunately, in the last several months, we have received a number of complaints from DAV members suggesting actual local policy as enforced by individual facilities or network management may differ markedly from VA's national policy.

We believe the current national policy and local enforcement of it could accomplish the goal of this measure. We suggest the Subcommittee ask the VA what actions have been taken since the directive was issued to ensure current policy is fully implemented and is enforced consistently throughout the system. Based on their response, the Subcommittee may want to choose to provide oversight to ensure VA's standardization of the existing policy or move forward with enactment of this measure, to which DAV would have no objection.

DAV is pleased to support H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitation Services' Improvements Act of 2011." This measure aims to clarify the definition of rehabilitation and to strengthen VA's mandate to sustain gains made in the rehabilita-

tive process in veterans who have incurred serious traumatic brain injuries.

DAV members have approved a national resolution calling for comprehensive treatment and more research to ensure veterans with TBI receive the best care possible. This bill aims to fulfill the goals of maximizing an individual's independence and quality of life and is fully consistent with DAV resolution 215. For these reasons, we urge the Subcommittee to recommend its enactment.

Madam Chairwoman, we appreciate your introduction of H.R. 2074, the "Veterans Sexual Assault Prevention Act." As indicated in our previous testimony to the Subcommittee on this issue, veterans, VA staff, and visitors should be assured of a safe environment at VA health care facilities. This bill firms up VA's requirement to document, track, and control the incidents of sexual assaults that occur on properties and grounds of the VA. We believe the measure reflects GAO's recommendations calling for greater transparency, accountability, related to the reporting of sexual assaults and other incidents affecting the safety of veterans and VA staff.

H.R. 2530 would revise the methodology used to reimburse State veterans homes that provide nursing home care for veterans with service-connected disabilities rated 70 percent or greater or for veterans who need nursing home care due to a service-connected disability. This bill is intended to restore the original intent of section 211 of public-law 109–461, which was enacted in order to authorize VA to place 70 percent service-connected veterans in State homes and to reimburse the homes at rates comparable to those received by contract community nursing homes. DAV commends the bill's sponsors for their continuing efforts to ensure their highest-priority veterans have the option of entering a State home to meet their long-term care needs, and we recommend enactment of H.R. 2530.

DAV has no resolution from our membership on the specific issues addressed in the two remaining draft bills under consideration by the Subcommittee, the "Honey Sue Newby Spina Bifida Attendant Care Act" and the "Veterans Health Care Facilities Capital Improvement Act." However, DAV is supportive of assisted living options as an alternative to institutionalized care, and we appreciate the Subcommittee's continuing support of VA's capital infrastructure needs. Therefore, DAV would offer no objections to enactment of either bill.

Madam Chairwoman and Members, this completes my testimony, and I am happy to answer any questions you may have.

[The prepared statement of Ms. Ilem appears on p. 43.]

Ms. BUERKLE. Thank you very much.

Dr. Berger.

STATEMENT OF THOMAS J. BERGER, PH.D.

Dr. BERGER. Chairwoman Buerkle, Ranking Member Michaud, and distinguished Members of the Subcommittee, Vietnam Veterans of America thanks you for the opportunity to present our views on the pending legislation for veterans and their families.

H.R. 198, the "Veterans Dog Training Therapy Act," although VVA generally supports this legislation, we have a couple of questions. One is, what are the certification standards that will be used

to ensure that the animals can perform the essential service dog skills, which are mentioned specifically in the Act? There are 11 of them.

The second question we have is what quantitative metrics or measurements will be used to measure the impact of the service dogs on the psychosocial mental health and physiological disorders suffered by the participating veterans? Again, those 11 items that are referred to in the bill itself.

H.R. 1154, the "Veterans Treatment of Service Dogs Act," VVA supports this legislation but again asks the question in the larger sense, what constituents certification of one's animal as a service dog? As you are well aware, probably, the VA issued some proposed regulations back in June that call for certification under the terms of a couple national or international organizations. We want to know how those are going to work relative to admission of animals into the VA as service dogs.

H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitation Services Act," we strongly support this legislation. It is very clear that Command Sergeant Major Walz understands the necessity for a broadly integrated and individualized psychosocial mental health and physical treatment plan and service in order to maximize the quality of long-term care for our veterans suffering from TBI.

H.R. 2074, the "Veterans Sexual Assault Prevention Act," VVA strongly supports this legislation as an initial effort to address and correct the failures of the VA from protecting and safeguarding our veterans in VA facilities, as noted in the June, 2011, GAO report.

H.R. 2530, which will provide for increased flexibility in establishing rates for reimbursement of State homes, et cetera, we have already heard the long title of that. This proposed legislation to be introduced by Congressman Michaud would correct problems that had come about as a result of Public Law 109–461; and, as you have heard from my colleagues, this legislation will achieve the goals of the original law from a couple of years ago, which was to provide veterans with service-connected disabilities rated 70 percent or greater with an additional option which may be more convenient, provide better care, and usually costs less to the Federal Government in the same care provided through VA operated nursing homes or contract community homes.

Now, the "Honey Sue Newby Spina Bifida Attendant Care Act" draft legislation, we strongly support this legislation, as it will provide a decades-long-overdue service and services to the child of the Vietnam veteran parent suffering from spina bifida.

I had the opportunity to meet Honey Sue a couple of weeks ago in Indianapolis, and I can tell you that this will be welcome by not only Honey Sue herself, but by her parents.

The "Veterans Health Care Facilities Capital Improvement Act of 2011" draft legislation, although this legislation calls for needed construction modifications at a number of VA medical facilities, VA cannot at the present time support this legislation in its present form as it is unclear as to whether the proposed changes suggested in section 6, Modification of Department of Veterans Affairs Enhanced Use Land Authority, will eliminate any possible breaches of VA fiduciary duty for leasing property to private entities, as has

been alleged to have occurred at the West Los Angeles Medical Center and Community Living Center campus.

Once again, on behalf of VVA National President John Rowan, our national officers board, and membership, I thank you for your leadership in holding this important meeting on these pieces of legislation; and I also thank you for the opportunity to address you today on behalf of America's veterans. Thank you.

[The prepared statement of Dr. Berger appears on p. 47.]

Ms. BUERKLE. Thank you very much, Dr. Berger. Mr. Blake, would you like to proceed?

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairwoman Buerkle, Ranking Member Michaud, Members of the Subcommittee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to be here to testify today on the proposed legislation.

With regards to H.R. 198, while PVA has no specific position on the bill, the "Veterans Dog Training Therapy Act," we believe that it could be beneficial therapy for veterans dealing with post-traumatic stress disorder (PTSD) and other mental health issues.

PVA supports H.R. 1154, the "Veterans Equal Treatment for Service Dogs Act of 2011. While we believe this legislation should be unnecessary based on the provisions of section 504 of the rehab act, the actions of the VA clearly demonstrate the need for this legislation.

PVA fully supports H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitative Services Improvement Act." If enacted, H.R. 1855 would ensure that long-term rehabilitative care becomes a primary component of health care services provided to veterans who have sustained a traumatic brain injury. Because all of the impacts of TBI are still unknown, this legislation to expand services and care, providing for quality of life and not just independence, and emphasizing rehabilitative services is important to the ongoing care of TBI patients. It is imperative that a continuum of care for the long term be provided to veterans suffering from TBI. This bill will address the intricacies associated with TBI and help veterans and their families sustain rehabilitative progress.

PVA fully supports H.R. 2074, a bill that would require a comprehensive policy on reporting and tracking sexual assault incidents and other safety incidents that occur at VA medical facilities. PVA believes policy mandates that specifically outline sexual assaults within the VA should be handled are long overdue. The implementation of policies involving sexual assault will reinforce veterans' confidence in the VA's ability to provide a safe environment for care.

PVA recommends that the proposed legislation require the leadership of each Veterans Integrated Services Network (VISN) to be responsible for the centralized reporting, tracking, and monitoring while also requiring the VISN to provide the tracking reports to VA's Central Office. Additionally, PVA recommends that VA provide clear and concise policy guidance that includes a specific time frame in which frontline VA personnel responsible for the initial processing of assault claims must begin processing those reports.

PVA generally supports H.R. 2530 to allow for increased flexibility in establishing rates for reimbursement for State veterans homes. As we understand it, the VA and the National Association of State Veterans Homes have begun discussions about developing a reimbursement agreement that is satisfactory to both parties. However, this legislation will give the VA the authority to further develop appropriate reimbursement methodology.

PVA supports the draft "Veterans Health Care Capital Facilities Improvement Act." VA's significant inventory of real property and physical infrastructure is truly a remarkable asset in the provision of health care and benefit delivery to veterans. At the same time, these facilities must be properly managed and cared for to ensure that the investment made in the use of these buildings and properties coincides with the benefit derived from their use.

With regard to this bill, I would only offer one bit of caution or perhaps a question. I noted in the legislation that proceeds that are generated through enhanced use lease and other authorities will be now transferred into the major/minor construction accounts which we think is a very good idea, given the backlog of projects that exist and the need for needed funding in those accounts. However, that money is now presumably being transferred away from the medical care collections fund which is where it is currently being sent. And so I think the Subcommittee needs to look at how now putting this money into the major/minor construction accounts may affect medical care collections estimates and overall the effect on the health care accounting of the VA.

With that, Madam Chairwoman, Ranking Member Michaud, I would like to thank you for opportunity to testify, and I would be happy to answer any questions that you have.

[The prepared statement of Mr. Blake appears on p. 48.]

Ms. BUERKLE. Thank you very much, Mr. Blake.

Ms. Roof.

STATEMENT OF CHRISTINA M. ROOF

Ms. ROOF. Madam Chair, Ranking Member Michaud, and distinguished Members of the Committee, on behalf of AMVETS, I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding these very important pieces of legislation today. You have my complete statement for the record, so today I will be specifically speaking to H.R. 198 and H.R. 1154.

AMVETS supports H.R. 198, the "Veterans Dog Training Therapy Act." AMVETS lends our support to the updated language of H.R. 198 that will be submitted in the Committee markup. AMVETS believes the updated language will help ensure that H.R. 198 provides veterans only the highest quality of care.

By way of background, AMVETS has worked with Paws with a Cause and Assistance Dogs International accredited agencies to help provide service dogs to disabled veterans, for over 25 years. Through this partnership, AMVETS has witnessed firsthand the incredible changes that occur in a veteran's life when introducing a dog into their overall treatment plan. These changes are often illustrated through a veteran's ability to maintain a higher quality

of life and greater mental health improvements when compared to veterans undergoing clinical care alone.

H.R. 198 and a dog that will be included in the study have the ability to break down barriers in a veteran's world by shattering public stigmas and increase a veteran's overall well-being by reigniting their purpose through allowing them to help—to continue to serve their—excuse me—to continue to serve their country by assisting their fellow comrades. Again, AMVETS is happy to lend our support to H.R. 198.

AMVETS strongly supports H.R. 1154, the "Veterans Equal Treatment for Service Dogs Act." In 2009, I began to personally play an active role in AMVETS 30-plus years experience in working with disabled veterans and service dogs. I could never imagine that 2½ years later I would be sitting here testifying on a piece of legislation that is in dire need of being signed into law and implemented without any further delay. This piece of legislation I am speaking about is H.R. 1154.

AMVETS believes this cost-free piece of legislation will permanently eliminate an often overlooked and unwarranted hurdle to care disabled veterans are currently experiencing when seeking necessary VA care and services. To date, title 38, part one, subsection 1.218(a)(11) states: "Dogs and other animals, except seeing eye dogs, shall not be brought upon property except by as authorized by the head of each facility or designee." AMVETS finds the aforesaid language in title 38 to be inconsistent and outdated when compared to the sections of title 38 it is to govern.

While numerous parts of title 38 are constantly updated to reflect the health care needs of today's wounded warriors, this section of title 38 has been overlooked and, thus, has failed to be updated since July of 1985. This outdated law resulting in disabled veterans utilizing VA-approved service dogs as a prosthetic device to be denied entrance into Veterans Affairs Medical Centers (VAMCs) and Community-Based Outpatient Clinics (CBOCs) they depend on for their life-sustaining care.

One of these veterans who has personally experienced this barrier to care is AMVETS member Mr. Kevin Stone and his service dog, Mambo, who are in attendance today and we thank him. AMVETS believes disabled veterans such as Mr. Stone using a service dog as a prosthetic device must have the same access rights to VA care and facilities already currently afforded to blind veterans using guide dogs.

During the next panel, VA officials will argue H.R. 1154 is unnecessary due to the directive they have already published. Moreover, VA officials have recently stated H.R. 1154 was unnecessary due to the fact that under existing statutory authority under title 38, section 901, VA to implement national policy followed its VA properties. AMVETS believes that while VA is correct in outlining the authorities granted by section 901, we must respectfully disagree with VA that H.R. 1154 is unneeded or is too narrow given the scope of its intent.

VA's years of inaction in addressing this easily correctable hurdle to care clearly illustrates the strong need of change that is proposed by H.R. 1154, and while AMVETS applauds VA's recent publication of a directive seeking to temporarily address this matter,

we still believe there are numerous loopholes that need to be closed to guarantee all veterans receive the care and services they need regardless of the disability and regardless of the prosthetic device they use.

Through our close work with VA and the 111th Congress, and now the 112th Congress, AMVETS has done everything in our power to remove this hurdle to care for disabled veterans. Now, AMVETS has reached a point where only you, the Members of the 112th Congress, can, once and for all, end this vicious cycle of veterans being denied care through your swift and bipartisan passage of H.R. 1154. AMVETS, VSOs and the veterans communities look to you to please finally close this loophole and hurdle to care for veterans.

Madam Chair and distinguished Members of the Committee, AMVETS again thanks you for inviting us to share with you our views and recommendations on these very important pieces of legislation. This concludes my testimony. I stand ready to answer any questions you may have for me.

[The prepared statement of Ms. Roof appears on p. 52.]

Ms. BUERKLE. Thank you very much, and thank you to all of our witnesses for your testimony here this afternoon.

At this time, I would like unanimous consent from the Committee to allow lifelong Texan, our colleague, Mr. Carter, to join us here this afternoon, to sit at the dais and ask questions of the panel. Without objection, so ordered.

And with that, I would like to yield my 5 minutes to Mr. Carter for his questions.

STATEMENT OF HON. JOHN R. CARTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. CARTER. Thank you, Madam Chairman, and I didn't hear all of the testimony as to where everybody stood on this. I am the sponsor of H.R. 1154, and when I started this whole process, Mambo and his friend came to see me, along with quite a few other of the dogs.

And let's be honest about how you view this. What exactly do these dogs do if they are not seeing eye dogs, which we are all used to since Second World War, what purpose do they serve? And as I listened to the conversation with these folks, I realized the old saying that my wife has written on the wall in the Dutch language, it says that it is not the mountain that you have to climb that gets you, it is the grain of sand in your shoe.

And what these dogs give to these military folks is they help them to cope with something that is a disability for them. In some instances, they have a critical guide component like they do with dogs for the visually impaired. In others, they have a psychological component. You know, it was Harry Truman who said if you want a friend in Washington you better buy a dog.

But the truth is, these dogs are a friend—not only a friend, they are their partner—they are their partner in moving through life, and when they get to the door of the place they are seeking medical help and they leave their partner outside the door, they lose the confidence that partner gives them, and they lose, in some instances, the reaction to sounds that they can't catch, if it is hearing

loss. That dog knows how to deal with them if they are approaching seizure times, and they are likely to have seizures. And of course, if they have limbs, I have watched them use the dog to help them gain their balance as they stand up.

And so from that, to us it may be a grain of sand, but to them it is their partner that is getting them through the day, and to me, it just seemed a real shame because we are already admitting dogs to the facility anyway for people who are blind, and then to say, well, we are not going to allow them for these other people who are relying on them just as desperately to enter this facility, that is why I took up this project. That is why I think it is a worthy project. I think I will ask, Ms. Roof, isn't that the general concept of what this whole AMVETS program is?

Ms. ROOF. Yes, sir. As I said, you are exactly right in everything these dogs give. These dogs are also, such as Mr. Stone, his prosthetic device. As you said, he could not many times stand up, or he would lose balance without that dog, and you had mentioned as well, VA is already paying benefits to many of these veterans for the upkeep of this dog as a prosthetic device. So it is quite unfortunate and sad honestly that they have to leave them at the door.

Mr. CARTER. Well, thank you, and I don't know—she is the only member of the panel I heard. So I better yield to other members of the panel to ask questions about what was said. Thank you.

[The prepared statement of Congressman Carter appears on p. 39.]

Ms. BUERKLE. Thank you very much, and I yield 5 minutes to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you, Madam Chair. This question is for everyone on the panel, starting with Mr. Barker.

We asked for the report and was actually shocked when you look at the number of sexual assaults and rapes. We saw the report and are very supportive of the legislation before us. We also have heard a lot of instances in the last few years as far as within VA facilities themselves.

So my question is, what is the most important change that could be implemented to improve the culture within the VA to make it more accommodating toward female veterans and women in general?

Mr. BARKER. The position of the VFW on this is clear, I think. Our written testimony shows that we feel the lack of a holistic VA-wide training program that is required for all VA employees to go through and be—some kind of verification process that every VA employee has gone through, this training is required.

We have talked a lot about VISN-to-VISN different policies, and the culture is not going to change overnight on this issue. It won't change at all unless there is some sort of direction from the very top that makes very clear that there is no room for this kind of incident to happen at any VA facility. It really needs to come from the very top, and it needs to be fully consistent for all VA employees.

Ms. ILEM. We appreciate the question. Just this past weekend, VA had their national training summit for women veterans. We had over 750 women veterans attend, along with VA's women veteran veterans program managers. I think one thing that we con-

sistently heard in talking with women veterans over the time of the event was that they would like to see these changes, and actually Secretary Shinseki made a call to action to women to submit to him what needs to be fixed, first and foremost, and what can VA do.

This came up in the discussion with women veterans over and over, for example, I don't feel comfortable going a VA facility; someone's leering at me, talking to me; I need to go to my mental health appointment, but I am not comfortable in there—just a variety of anecdotes of just overall unwelcome feelings.

I think some of the things that we need—could do right away would be—first of all, the education piece, making it a top priority in VA to make sure all of the staff and clinicians are educated, and if they see things happening, they have to intervene to make our women veterans feel welcome.

They need to have focus groups they need to listen, the voices of women veterans out there, that women veterans can say this is the particular problem in this facility that I am encountering.

And I think with regard to the legislation that is being proposed, having it done consistently, if someone reports a sexual assault or an incident, it needs to be taken seriously and it needs to be handled appropriately. I mean, reading just briefly some of the testimony from other organizations—actually it was SWAN (Servicewomen's Action Network) I was just reading prior to the hearing. They gave some very prime examples when someone did do the right thing reporting, and yet it was still not taken seriously or these people are still in employment in VA. Thank you.

Dr. BERGER. I would agree with my colleagues, particularly Mr. Barker's comments, but it starts with leadership and I would also go as far as to say that if there are lapses found in the reporting system in any shape or fashion, that the person responsible, meaning the facility director, is reprimanded in some fashion, and that may mean some kind of financial. If that is the only way to get people to pay attention, then we need to do it that way. We need accountability. We need accountability.

I, too, was at the women's conference last weekend, and I think at some point down the line that General Shinseki's asking the women for comments, those need to be turned over, okay, so that we can see how to mesh those in with what we see in front of us today to see if it is really working. So those are some of the things that I could recommend.

Mr. BLAKE. I don't know that there is a whole lot more I could say other than I would like to second both what Ms. Ilem and Mr. Berger said. I would suggest an education and training side is of the utmost importance, particularly as it relates to the VA staff. The thing to understand is that there is a still challenge of overcoming the culture of the patients. I mean, you can't change the way patients are in some cases, but you can certainly affect the way that culture is managed by the VA and its staffing.

And I couldn't agree with Mr. Berger more than the issue about accountability, which goes to my comments about reporting requirements that should be on the various levels within VHA. It can't be just about, well, this incident occurred, and we develop a report, and then that is the end of it. It needs to be followed and

tracked and there has to be ramifications if someone doesn't take appropriate steps because these are serious incidents and they need to be treated as such.

Ms. ROOF. AMVETS concurs with all of my colleagues' statements. You know, this was so upsetting when this came out, and the more I talked to our members, come to find out, I actually spoke to three different female AMVETS members that had experienced a sexual assault. It was reported. However, they felt like they never got closure. So I thank you all for introducing this very, very important piece of legislation. Thank you.

Ms. BUERKLE. I now yield Mr. Roe 5 minutes for questions.

Mr. ROE. Thank you, Madam Chairman, and I want to thank you for introducing this piece of legislation. I think, Dr. Berger, you hit it right on the head, that there should be no tolerance. There should be a change of culture, and it comes from the top. I agree with that 100 percent, that the leadership—when you have no tolerance for that type of behavior, it won't happen. And it is a criminal offense in many cases as well. They can be prosecuted by a criminal court system, and it is a very serious offense, and so I want to thank you for doing this, bringing our attention to it, and bringing the entire country's attention to it, that it won't be tolerated at the VA, and not tolerated anywhere.

The other thing I want to say, Ms. Roof, is if Bill Kilgore were here he would probably say hello from AMVETS, and I want to thank you for bringing that up, the issue about the service dogs. We use service dogs to protect our troops in foreign countries. They are out there on the front lines every day. Service dogs are welcome in this building, in all these buildings, and they wouldn't be welcome at a VA when they are helping a veteran. It is kind of—when you think about it, they have helped our veterans in battle. They are welcome here in the Capitol, in our offices, in this building, and they should be welcome when they are assisting veterans, and so thank you for bringing that up and being supportive.

And also, in my second term here, I really haven't taken the time to thank the veteran service organizations for the great job you do in representing veterans, and you do and you point out things that many times haven't been brought to my attention. So that is all I have. I don't have any questions but just a comment. So thank you for being here.

Ms. BUERKLE. Thank you very much. I now yield the gentleman from Missouri 5 minutes for questions.

Mr. CARNAHAN. Thank you, Madam Chairman and Ranking Member. I want to give a special thanks to each of you representing the veterans service organizations and the work that your organizations do on behalf of our veterans.

I also want to thank the gentleman from Texas, Mr. Carter, for being here on behalf of his bill and pushing that.

I had wanted to ask a specific question about the bill, H.R. 198. Certainly, it provides an assessment for addressing PTSD symptoms through the therapeutic meaning of service dogs for veterans with disabilities, but the current legislation only allows for, or only authorizes a pilot program. My question is—would ask the VA to address the mental health crisis facing our Nation's veterans, would the legislation be more successful if the bill encouraged the

VA to partner with community-based services such as Pets to Vets to better establish a model for a large scale service dog program, would that be a something we should look at as well to be able to scale it up faster?

Ms. ROOF. Sir, the language that—well, thank you for your support first and foremost. The language that will be submitted to the Committee in markup actually does address that. It does address to—to make the bill a little bit more fiscally within our means of what we have to work with right now. They will be partnering with private organizations.

Mr. CARNAHAN. That is great. We heard about that idea as well, and I think using some of those existing programs that are already up and running may help be able to get us up to a scale up that national model faster. Yes, sir.

Dr. BERGER. Mr. Carnahan, our comments really, just want to echo what I said earlier. If you are—I don't disagree with what was just said about public-private partnerships, but that the assessment standards that are used for the impact of the service dogs run across the board, whether it is a VA or public or private facility or training facility that those standards are really important, and that they be the same. And that way, after the end of this 5-year program, okay, we will know just how effective this is in a quantitative fashion, and that is really important if we are talking about expanding it down the line. We need standardized collection of data.

Mr. CARNAHAN. Great. Certainly that is helpful to us here in making decisions going forward as well. Anybody else? If not, thank you all very much, and I yield back.

Ms. BUERKLE. Thank you. Unless any of my colleagues have any other questions, our second panel is finished here today. Again, thank you for your testimony. Thank you for being here and mostly thank you for all you do on behalf of our veterans. We truly appreciate your service and dedication. We will now ask the third panel to join us.

Good afternoon to all of you. Representing the Department is Robert L. Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health. Dr. Jesse is accompanied by James M. Sullivan, Office of Asset Enterprise Management, Office of Management; Jane Clare Joyner, Deputy Assistant General Counsel; and Charlma Quarles, Deputy Assistant General Counsel.

Ms. BUERKLE. Dr. Jesse, please proceed, and thank you for being here this afternoon.

STATEMENT OF ROBERT L. JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS; ACCOMPANIED BY JAMES M. SULLIVAN, DIRECTOR, OFFICE OF ASSET ENTERPRISE MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; JANE CLARE JOYNER, DEPUTY ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CHARLMA QUARLES, DEPUTY ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Well, thank you very much, Chairwoman Buerkle and Ranking Member Michaud and distinguished Members of the Subcommittee. We appreciate the opportunity to be here today to present the Administration's views on several bills that would affect the VA health care system, and as you just said, joining me today are Mr. Sullivan and Ms. Joyner and Ms. Quarles.

Madam Chairman, I would like to begin by focusing on H.R. 2074, the "Veteran Sexual Assault Prevention Act," and just to be very clear, we do agree with the objectives as outlined in the legislation. We take the GAO report very seriously. We are extremely concerned over the safety and security of our veterans, our employees, and visitors, and this is among our highest priorities. We take all allegations seriously. We investigate them thoroughly.

Last month, we told you about our efforts to improve safety and security at our facilities, and now I would like to share with you for a moment just some of our more recent progress.

VA's safety and security work group is developing appropriate proactive interventions to reduce the risk of sexual assaults. We are testing our computerized reporting system for ongoing data tracking and trending and establishing guidance to train both staff and providers. The work group has submitted initial action plans and there will be a final written report by September 30, 2011. Additionally, VA is evaluating universal risks for assessing the chance of violence and designing appropriate intervention actions. An oversight system like the one required by the bill will be in place in VHA later this summer, and we will have clear and consistent guidance on the management and the treatment of sexual assaults by the end of 2011.

While we agree with many of the bill's goals, we do have several concerns. First is the VA is committed to enhancing our safety and security policies, but we do need time to pilot these initiatives, particularly the reporting tools, before we can fully implement them. We believe we can have an operational system by the end of the year, and while we recognize the urgency of the actions, we do not want to rush and settle for what may be a second best solution.

We also have a serious concern with the bill's requirement that VA report alcohol or substance abuse-related acts committed by veterans. VA's an integrated health care network. We treat all of the health care needs of the veterans, including substance use disorders and alcoholism. Reporting and tracking these events may deter veterans from seeking care, and we do not want to create a potential disincentive for the veterans to seek treatment, and we recommend that this provision be deleted. We are happy to meet

with the Committee and you, Madam Chairman, to discuss these issues in more detail.

We also agree with the objectives in many of the other bills under consideration. We are particularly pleased to support the draft capital improvement bill. In addition to authorizing critical construction projects, the bill will also extend VA's enhanced use lease authority, which has benefited veterans and VA in local communities and a critical piece of the Secretary's plan to end homelessness.

We also agree, in large part, with H.R. 1855, the "Veterans TBI Rehabilitative Services Improvements Act." VA's primary aim for veterans with serious or severe injuries has always been and continues to be maximizing their independence, their health, and their quality of life. Out of these concerns, VA has developed robust rehabilitation therapy programs to help veterans learn or relearn skills and develop resources to sustain their rehabilitation programs. Our primary concern with this bill was the term "quality of life," and I was very happy to hear Mr. Walz's comments that we have worked through those issues.

Turning to the issue of service dogs, the Subcommittee is considering a bill to require a pilot program, which veterans with PTSD train service dogs for other disabled veterans, and another bill would mandate VA permit veterans with service dogs to access our facilities. For the reasons outlined in my written statement, we believe both these bills are unnecessary because of efforts the Department is already taking. We are happy to discuss these in more detail.

Finally, I am pleased to report that the VA supports in principle H.R. 2530, which would increase the flexibility in the rates of reimbursement for State homes. VA's been working closely with State veterans home associations, and we believe this legislation has the general support of all parties. We have noted one minor technical amendment which we believe could further enhance our flexibility in working with our partners at the State homes. My written statement will discuss that issue in more detail, but I will provide any assistance you may need on the issue.

This concludes my prepared statement. Thank you for the opportunity to testify and be pleased to respond to any questions you may have.

[The prepared statement of Dr. Jesse appears on p. 56.]

Ms. BUERKLE. Thank you, Dr. Jesse, and I will yield myself 5 minutes for questions. I am concerned about the legislation, H.R. 2074, and I would like to ask some questions with regard to your comments.

In your testimony, you state that the timeline for the implementation of this policy is not feasible. VA is committed to enacting this policy but needs the time to complete work on reporting tools and processes and to pilot these initiatives before the policy will be fully implemented. You mentioned in your opening comment about testing a computerized reporting system.

The GAO report that came out that identified these problems was issued last month, and it reviewed the prevalence of sexual assault and other safety issues over the last 3 years. So it seems to me, unless the VA was completely unaware of what was going on,

that you would have had time to address these problems and make the changes and corrections, and take care of what has been going on within the VA system. If you could comment on that.

Dr. JESSE. Yeah, sure. So I think where we failed in this matter was that we actually have multiple reporting mechanisms, and we at a national level I guess had not reconciled them. So we had reporting mechanisms that were coming up through the police side and these starting in 2009 I think as you heard before with this stand-up of the integrating—the IOC—the integrated operations center were coming through that side. And then we had administrative reports coming up through VHA's line in the forms of issue briefs. And there was a failure on our part to reconcile the two, to make sure that everything that was coming up through issue briefs was matched up to everything that was coming up on the police report and vice versa.

And in order to do that, it essentially required taking what was largely a paper process, if you will, and putting in something that could be, in an electronic fashion, reconciled, and that is the piece that is in the process of being built now. We think we have a system that is workable, but it is—as always, you have a million use case scenarios that have to run through this and make sure that it is working.

Ms. BUERKLE. Well, I guess I would really caution the VA system, that time is of the essence. We don't have time for pilots and testing when this is going on, and it has gone on for the last 3 years. This needs to be tended to, and it seems to me that if you are talking about duplication and just a failure to reconcile your systems, that doesn't require you to get another system. That just requires reconciliation so that you have complete reporting system.

Dr. JESSE. Yes, ma'am. There actually are large numbers. The system we actually have this operating now, and we just need to make sure that it is working in all the different scenarios that we have.

Ms. BUERKLE. Do you know what the name of the system is that will be handling the reconciliation between the two systems?

Dr. JESSE. Well, right now, I think it is being called the data management and tracking system.

Ms. BUERKLE. Perhaps you could provide for the Committee further information on that tracking system.

Dr. JESSE. Sure, we would be glad to.

Ms. BUERKLE. See how that is implemented.

Dr. JESSE. Absolutely.

[The VA failed to provide information in time for printing:]

Ms. BUERKLE. The other question I wanted to ask you, if whether or not you think this piece of legislation is perhaps duplicative or is just taking care of issues that you are already taking care of in the VA, if you see any parts of this bill that are unnecessary.

Dr. JESSE. Well, in some respects, the legislation very closely, I think, follows the recommendations of the GAO, and we have already—basically, we have concurred with the recommendations of the GAO and have started to put all of these pieces into play.

So I guess you could say that the major objections—I mean, there is no inherent objection to having the legislation. It actually often helps us support what we are doing. The big concern was the time-

line, and we actually think we are going to beat that timeline, but to be held to it may force things to happen in a fashion a little bit quicker than we would like.

And then the other piece there is, I think, a pretty significant concern about the comments surrounding how we would be required to track and report substance abuse issues. There is some pretty—very, I think, delicate patient-related components of that that might through public reporting compromise those patients.

Ms. BUERKLE. Thank you, Dr. Jesse. I now yield 5 minutes to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair. I want to thank you, Dr. Jesse, and those accompanying you today.

I was reading your testimony as it relates to the State veterans homes and it is kind of confusing. Could you explain exactly what technical concerns you have with the bill, because my understanding is that the VA actually worked to draft the bill or——

Dr. JESSE. Yes. And I will confess that I am not a business office person, but I think I can explain this adequately. I think the technical concern was the limiting term of a contract, as opposed to service provider agreements, and that the concern was that it being specific contracts might take some of the flexibility out of making these arrangements, and that by having service provider agreements, it actually broadens it, and that language was vetted through the director of the veterans homes, the national director, and I think, my understanding is that everybody's comfortable with that language.

Mr. MICHAUD. So you are concerned because it gives the VA greater flexibility?

Dr. JESSE. No. Actually we were concerned that by specifically saying contract, it closed the flexibility. By using this additional term, it gives us greater flexibility. You want to——

Ms. JOYNER. The bill that was presented is slightly different than what appeared in the legislative proposal that was given to the Committee on June 7, and basically it is subsection a(2) which talks about negotiating to create rates. The concern was that it references the provider agreements, and for provider agreements, those would be a set rate. They wouldn't be subject to negotiation.

So the concern was in subsection a(2) by referencing the provider agreements, that wouldn't be a viable option if we had to negotiate to do that. So the recommendation we could work with Committee staff to explain it in more detail would be to take out the reference to provider agreements in subsection a(2).

Mr. MICHAUD. We have been dealing with this issue for a number of years, and that is why I am surprised that you still have a technical problem with the legislation. So we are willing to work with the VA because I think the law is very clear in the first place that Congress passed is that VA will pay for full cost of nursing home care. Full cost to me means full cost. Just because the rules and regulations VA adopted, you narrowed the full cost only for these services, and then when you put provisions in there saying that once you receive payment for full cost, these narrow services that VA decided to interpret differently, and the nursing homes could not reimburse, or collect payment from Medicare or Medicaid,

that has caused a huge problem within the nursing home facilities throughout the country.

And so hopefully we will be able to get this fixed before markup later this week so that all parties can agree on. Because I don't think it is that difficult.

Dr. JESSE. I actually think we are in agreement now. So it is—and we are anxious to have this work. We are not trying to create more barriers, but I think we are in agreement, both parties, that the language that you have now, or you will have is acceptable and will do what needs to be done.

Mr. MICHAUD. Thank you. I have no further questions. I yield back.

Ms. BUERKLE. Thank you. I yield Mr. Carter 5 minutes for questions.

Mr. CARTER. Thank you, Madam Chairman.

I have just got a—I have a main interest here about the service dogs and the facilities, but I, as an old trial judge, I can't help, but have a few questions about sexual assault.

First, I have to ask a reference because I am not aware of any previous material. Are these touchings? Are they spoken words? Are they even worse? Do they rise to aggravated sexual assault which is genital contact? Just exactly what are we talking about here?

Dr. JESSE. So if you—and I know this was an interest to the Committee. If you look in the current time period from when the GAO report ended until last week, there is little—141 reports of sexual assault. So of those, six were alleged rape, of which two were substantiated; 78 were inappropriate touching, of which 31 were substantiated; and then the other were, others, and there is a number of things that that could be. It could be public nudity, things along those lines, and this is actually one of the real issues here is what is the definition of sexual assault, and OIG has a different definition than GAO, and one of the Committees that has been working on this is that is to actually come up with the definition that makes sense in our environment and that seems to be moving towards the GAO definition.

Now, it is interesting because that, I think, specifically excludes, if I remember this correctly, sexual discrimination as opposed to the more physical things, but it is—remembering that in our environment, we are often dealing with very sick people. We are often dealing with people who are disoriented, even people who aren't disoriented and come into a hospital and they can, they lose when they are out of touch of their own surroundings or when they are getting different medications, can become disoriented. And they do things and things happen that they wouldn't do normally and the real important part for us is to make sure that, first of all, people are protected.

People aren't armed and that we can understand what these terms really mean. So from the judge's perspective, actually having a definition to work off becomes, I think, a crucial first step forward.

Mr. CARTER. There are plenty of definitions in the law books.

Dr. JESSE. Well, that is the problem, there are plenty of definitions, then you have to be able to work off one of them.

Mr. CARTER. First off, I assume everybody in this room would assume that in the scope of the terrible things that happen to people in the world, sexual assault is right at the top of the list, or pretty close to it, murders may be above it. At least in the courthouse of most of the States that I know about, we consider aggravated sexual assault to be one of the very serious things, and in my particular county, everyone that has been convicted of aggravated sexual assault will be in the penitentiary for at least 60 years. So we take that very seriously and that is a curtailment for people.

Doctors have a duty to report what they assume to have been aggravated sexual assault. Do you report this to the authorities? And I understand there are mitigating circumstances and those delusions or whether people are, you know, taking some kind of medicine or something. That may be an extenuating circumstance, but sexual assault shouldn't be tolerated in any form or fashion by any institution in this country.

Dr. JESSE. No, we agree fully, and we do have requirements which will be reiterated, which we will re-educate everybody on about the requirements for reporting.

Mr. CARTER. Well, not just reporting, but if necessary put them—turn them over to the district attorney.

Dr. JESSE. Oh absolutely.

Mr. CARTER. One or two of those might break a lot of folks of some bad habits.

You said you were concerned about—I am going to ask about my dog bill right quick. The vet dogs you say are handled by regulation and I do appreciate. Let me say that when that issue was raised, we do thank you for handling it by regulation. However, it was along—you don't think that this complicates, in any way, that regulation if we were to make this—actually pass this bill into law? You just take the position it is unnecessary; is that correct?

Dr. JESSE. In terms of access?

Mr. CARTER. Yes.

Dr. JESSE. So we, I think, were not clear about what the VA policy was, which is, I think, what has created the problem. The directive that was put out earlier this year makes that policy very clear, and I don't think the legislation adds anything to that policy. Again, it is incumbent on our part to make sure——

Mr. CARTER. Could at least I make an argument what it adds to the policy is surety?

Dr. JESSE. Excuse me.

Mr. CARTER. What it adds to the policy is surety. You are sure you have this right now because it is a law, whereas before, regulations change by regulators, and they can change with the wind. And so it is much more a right of a soldier—I use soldiers because I have nothing but soldiers in my district just about—but warriors. Warrior has a right to have that dog with them if we pass this and make it law. It is at the whim of the regulators otherwise, and I would argue that at least is a good reason why we should go forward.

Dr. JESSE. Well, as I said, we believe strongly what you believe and we have the regulation in place now.

Mr. CARTER. Thank you. Thank you, Madam Chairwoman.

Ms. BUERKLE. Thank you, Mr. Carter. Mr. Carnahan, I yield 5 minutes for questions.

Mr. CARNAHAN. Thank you, Madam Chair, and thank you, Dr. Jesse, and the panel.

I guess I wanted to follow up on Mr. Carter's questions about the service dog legislation. You said it was not necessary because of steps the VA is taking internally and I want to be sure I understand it. Are those steps you believe have already been taken, or they are in the process?

Dr. JESSE. Oh, yes, sir. There is a directive—well, it is 2011–13, which means it was put out probably in late January or early February, that very clearly articulates that veterans with service dogs have access to all VA facilities.

Mr. CARNAHAN. And it is your belief that based on that, the legislation is not necessary?

Dr. JESSE. Well, except in the context that Mr. Carter said that it puts it into law versus regulation, but as I say, we have the regulation in place already, and we would—it is incumbent on us now to ensure every person and every VA understands that this is the requirement.

Mr. CARNAHAN. I think that is certainly an important step in the process, but I certainly want to go on record again strongly supportive of Mr. Carter's legislation to get that put into law.

Also, switch to another topic. In reviewing the legislation before us today, the draft legislation on the "Veterans Health Care Capital Facilities Improvement Act," some funding in there is especially important to the St. Louis region of the Jefferson Barracks Medical Center. They have, as you know, it is really a win-win there, because the medical center has conveyed 33 acres to the National Cemetery that was running out of space, and so that is going to be a big boost to the National Cemetery there. It has been a big demand from veterans in our region, but also this funding for these new buildings is going to help the medical care at that facility.

So we think that is highly important for veterans in the region. One of the things related to those buildings, and we have had this come up in several discussions with regard to our government buildings, is the extent to which they are going to be designed to be more energy efficient and more green design. We have seen pretty dramatically the effect even though there may be a little bit more up-front cost by building these buildings more efficiently. Normally, the pay-back period is 3 to 5 years on that improved technology in design of the buildings, so we have some really long-term savings involved from operating those buildings. To what extent is that going to be incorporated into these buildings at the VA center there?

Mr. SULLIVAN. Good afternoon. In the 2012 budget, there is $80 million requested for the portion of the project in St. Louis that you refer to, as well as an updated authorization request included in this bill. That phase of the funding is for the site utility work and the energy plant, which will incorporate the latest requirements for greening in terms of renewable energy, as well as the latest standards for building to energy efficiency standards. These standards are included in this project, as well as all VA projects that go forward.

Mr. CARNAHAN. Great. Again, thank you for your work on that and just want to really reiterate what a real win-win that is for the VA Medical Center in St. Louis, and for our National Cemetery. Thank you. I yield back.

Ms. BUERKLE. Thank you. I believe the Ranking Member has one follow-up question so I yield 5 minutes to him.

Mr. MICHAUD. Thank you, Madam Chair. Actually, this is for Judge Carter. As you heard Dr. Jesse mention, when you look at the definition of aggravated sexual assault, if each State might have a different definition, one of the concerns that we have as a Committee is how you train VA employees to deal with it? And with different definitions by different States, and when you have directors moving from one State probably to another State, they might have a different definition. I hope with your expertise, that you might be able to help us how we can deal with this and make it easier as well for the VA system.

Mr. CARTER. Well, it has been a while since I have been in the rewriting of some of the laws, but I can tell you that most of the States now have adopted a sort of uniform definition of aggravated sexual assault and lesser degrees of sexual assault, and the reason I say most of them, some States still use the—some would argue non-legal description called "rape" and "statutory rape," and of course, colloquially we still use those terms, but most States I think, there is plenty of studies that will tell you exactly what they have done to make their changes. But that has been involved now over the last 30 years, and I would venture a guess that you would find that most of the sexual assault definitions that you find in the law are very, very similar, at least, first cousins.

The concepts were all the same, words were slightly different. So you can get a pretty good guidance from any penal code of any State, what overall it is across the country. Maybe with a few exceptions and that is where I would start. I would start getting somebody to just check and see how uniform the penal codes are. I am sure there is somebody that can give you that information very quickly.

Mr. MICHAUD. Thank you very much.

Mr. CARTER. If you can't get it, I can find it. I can get somebody who can get it for you. Just holler at me.

Mr. MICHAUD. Thank you. Thanks again, Madam Chair.

Ms. BUERKLE. Thank you. I yield myself just a couple of minutes. I have a couple of follow-up questions.

First of all, you are going to submit to us the data processing and the system you are going to use in and the timeline and how that will work. Could you also provide to us how the VA has complied with the GAO report, what pieces of their recommendations have you put in place, and what pieces remain outstanding and what progress you have made with regards to their recommendations.

Dr. JESSE. Absolutely.

[The VA subsequently provided the update on the actions taken by VA in response to the eight GAO recommendations, with a letter and enclosures, dated August 5, 2011, from John R. Gingrich, Chief of Staff, U.S. Department of Veterans Affairs, to Randall Williamson, Director, Health Care, U.S. Government Accountability Office, which appears on p. 81.]

Ms. BUERKLE. Okay. Very good. Thank you. I do want to comment on something you said because I think it bears commenting on, and that is, you said that you know the definition of sexual assault may be a problem to reach that conclusion because you have to have a definition that makes sense relative to the environment within the VA, that there are very sick people, very disoriented people.

I would argue that the levels of illness and issues that the patients have within the VA system would raise the bar for the VA system, but sexual assaults are sexual assaults, and that only means that the VA system has to—work harder, be more effective and be much more aware of what is going on within VA facilities. It doesn't change what sexual assault is. It doesn't change the outcomes, but it requires more and it raises the bar for the VA system.

Dr. JESSE. Absolutely. It is a terrible problem, and we are taking this very much to heart. We agree.

Ms. BUERKLE. And with that, and if there are no further questions I move the Members have 5 legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

Once again, Dr. Jesse and to the entire panel our sincere thanks for you coming here today and answering our questions. To all of our audience, thank you for your participation. To the veterans in this room, thank you all for your service to this Nation. We are deeply appreciative of what you have done for our country, and you have preserved and protected our freedoms, so thank you for your service to this Nation.

This hearing is now adjourned.

[Whereupon, at 5:57 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Ann Marie Buerkle, Chairwoman, Subcommittee on Health

Good afternoon. This hearing will come to order.

Today, we meet to discuss a number of legislative proposals aimed at improving the care provided to our Nation's veterans through the Department of Veterans Affairs (VA).

The seven bills on our agenda today are: H.R. 198, the Veterans Dog Training Therapy Act; H.R. 1154, the Veterans Equal Treatment for Service Dogs Act; H.R. 1855, the Veterans Traumatic Brain Injury Rehabilitative Services Act of 2011; H.R. 2074, the Veterans Sexual Assault Prevention Act; H.R. 2530, to provide increased flexibility in establishing reimbursement rates for nursing home care provided to certain veterans in State Homes; draft legislation, the Veterans Health Care Capital Facilities Improvement Act of 2011; and, draft legislation, the Honey Sue Newby Spina Bifida Attendant Care Act.

This hearing represents an important step in the legislative process and, as such, I look forward to a frank and productive conversation about the policy implications, merits, and potential unintended consequences of each of the proposals on our agenda.

One of the bills we will discuss this afternoon is H.R. 2074, the Veterans Sexual Assault Prevention Act, a bill I introduced in response to a truly alarming report issued last month by the Government Accountability Office (GAO) on the prevalence of sexual assault and other safety incidents in VA facilities. I am pleased to sponsor this legislation with our Chairman, Jeff Miller, and with Ranking Members, Bob Filner and Mike Michaud as co-sponsors.

In their report, GAO found that between January 2007 and July 2010 nearly 300 sexual assaults, including 67 alleged rapes, were reported to VA police.

Troublingly, and in direct violation of Federal regulations and VA policy, many of these incidents were not properly reported to VA leadership officials or the VA Office of the Inspector General.

As disturbing, GAO uncovered serious deficiencies in the guidance and oversight provided by VA leadership officials on the reporting, management, and tracking of sexual assault and other safety incidents.

GAO also found that the Department failed to accurately assess risk or take effective precautionary measures, with inadequate monitoring of surveillance systems and malfunctioning or failing panic alarms.

As a domestic violence counselor, I have seen firsthand the pervasive and damaging effects sexual assault can have on the lives of those who experience it.

Abusive behavior like the kind documented by GAO is unacceptable in any form, but for it to be found in what should be an environment of caring for our honored veterans is simply intolerable.

H.R. 2074 would address the safety vulnerabilities, security problems, and oversight failures identified by GAO and create a fundamentally safer environment for veteran patients and VA employees.

Specifically, H.R. 2074 would require VA to develop clear and comprehensive criteria with respect to the reporting of sexual assault and other safety incidents for both clinical and law enforcement personnel.

It would establish a newly accountable oversight system within the Veterans Health Administration (VHA) to include a centralized and comprehensive policy on reporting and tracking sexual assault incidents, covering all alleged or suspected forms of abusive or unsafe acts, as well as the systematic monitoring of reported incidents to ensure each case is fully investigated and victims receive appropriate treatment.

To correct serious weaknesses observed in the physical security of VA medical facilities and improve the Department's ability to appropriately assess risk and take the proper preventative steps, H.R. 2074 would mandate the Department to develop

risk assessment tools, create a mandatory safety awareness and preparedness training program for employees, and establish physical security precautions including appropriate surveillance and panic alarm systems that are operable and regularly tested.

It is critically important that we take every available step to protect the personal safety and well-being of the veterans who seek care through the VA and all of the hardworking employees who strive to provide that care on a daily basis.

I am eager to discuss H.R. 2074 this afternoon and am here to answer any questions my colleagues may have about this legislation.

Also on our agenda today is a draft Committee proposal, the "Veterans Health Care Capital Facilities Improvement Act of 2011." This draft legislation incorporates the Administration's fiscal year 2012 construction request to authorize major medical facility projects and leases. The draft proposal also modifies the statutory requirements for the Department to provide a prospectus to Congress when seeking authorization for a major medical facility project to ensure we receive a comprehensive and accurate cost-benefit analysis as the basis for making these critical decisions.

It also extends authorities to provide for important programs related to such initiatives as housing assistance for homeless veterans and treatment and rehabilitation for veterans with serious mental illness, both of which are set to expire at the end of this calendar year.

Additionally, section six of the draft bill seeks to provide an extension of VA's enhanced use lease authority which is also set to expire this year. This authority is an innovative and vitally important approach to supporting goals we all share, such as reducing homelessness among the veteran population and making effective use of vacant or underutilized VA property, through public-private partnerships. Unfortunately, the Congressional Budget Office has scored this provision with a mandatory spending cost of $700 million. We want to work with the Department and the veterans service organizations to resolve this scoring issue to ensure that VA has the authority to continue utilizing this important program.

The draft bill also includes legislation that was brought to us by our colleague from Colorado, Mr. Scott Tipton, to designate the telehealth clinic in Craig, Colorado as the "Major William Edward Adams Department of Veterans Affairs Clinic." Major William Edward Adams is a Medal of Honor recipient and Scott has provided a statement for the record detailing Major Adam's courageous service to our country.

I want to thank all of the Members who sponsored the bills and draft legislation before us, as well as the witnesses from the veterans services organizations and the Department, for taking time out of their busy schedules to share their expertise with us this afternoon. I look forward to our discussion and will now yield to the Ranking Member, Mr. Michaud for any opening statement he may have.

Prepared Statement of Hon. Michael H. Michaud,
Ranking Democratic Member, Subcommittee on Health

I would like to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, veterans, the VA and other interested parties to provide their views on and to discuss introduced legislation within the Subcommittee's jurisdiction in a clear and orderly process.

We have seven bills before us today which address a number of important issues for our veterans and provide the staff of the Department of Veterans Affairs with the necessary tools to provide the best care for our veterans. First, we have two bills to help veterans with post-deployment mental health issues through training service dogs. The remainder of the legislation covers a wide range of topics, such as improved TBI care, sexual assault prevention, facilities construction, and Spina Bifida.

We will also examine my bill, H.R. 2530, which seeks to increase flexibility in payments for State Veterans Homes. It would require State Veterans Homes and the VA to enter into a contract for the purpose of providing nursing home care to veterans who need such care for a service-connected condition or have a service-connected rating of 70 percent or greater.

I look forward to hearing the views of our witnesses on the bills before us today.

Madam Chair, I yield back.

Prepared Statement of Michael G. Grimm, a Representative in Congress from the State of New York

Chairman Buerkle, Ranking Member Michaud, thank you for allowing me to testify today on H.R. 198, the "Veterans Dog Training Therapy Act." As a Marine Combat Veteran of Operation Desert Storm it is a unique honor for me to address this Committee. Having seen firsthand both the physical and mental wounds of war that the members of our Nation's military are faced with, I have a special appreciation for the important work this Committee does every day.

Today, over 2 million Iraq and Afghanistan Veterans have returned home to the challenge of an unemployment rate hovering near 10 percent, which for disabled veterans is actually closer to 20 percent, and, for many, the long road to recovery from the mental and physical wounds sustained during their service. Sadly, these numbers continue rising every day.

Over the last 6 months I have had the honor to meet with a number of our Nation's veterans who are now faced with the challenges of coping with PTSD and physical disabilities resulting from their service in Iraq and Afghanistan. Their stories are not for the weak of heart and are truly moving. It was these personal accounts of their recovery, both physical and mental, and the important role therapy and service dogs played, that inspired this legislation.

The Veterans Dog Training Therapy Act would require the Department of Veterans Affairs to conduct a 5-year pilot program in at least three but not more than five VA medical centers assessing the effectiveness of addressing post-deployment mental health and PTSD through the therapeutic medium of training service dogs for veterans with disabilities. These trained service dogs are then given to physically disabled veterans to help them with their daily activities. Simply put, this program treats veterans suffering from PTSD while at the same time aiding those suffering from physical disabilities. Since I introduced this legislation it has gained the bipartisan support of 83 cosponsors, including Financial Services Committee Chairman Spencer Bachus and Ranking Member Barney Frank as well as Congressmen Pete Sessions and Steve Israel. Clearly, this legislation has brought together a number of unlikely allies in support of our Nation's veterans.

Additionally, with veteran suicide rates at an all time high and more servicemen and women being diagnosed with PTSD, this bill meets a crucial need for additional treatment methods. I believe that by caring for our Nation's veterans suffering from the hidden wounds of PTSD while at the same time providing assistance dogs to those with physical disabilities we create a win-win for everyone, which I believe is a goal we can all be proud to accomplish.

Working in conjunction with a number of Veteran Service Organizations, including AMVETS and VetsFirst, I have drafted updated language which I intend to have submitted during Committee markup of H.R. 198 to ensure this program provides our nations veterans with the highest quality care for both PTSD and physical disabilities, while maintaining my commitment to fiscal responsibility.

I understand that in the current economic situation we are faced with it is especially important to ensure taxpayer dollars are spent wisely, which is why I have identified several possible offsets, to include shifting funds from the Veterans Affairs General Administrative Account, to make sure this legislation meets pay-go requirements. As we move forward in the legislative process I look forward to working with the Committee to ensure that any money allocated for this program is offset by reductions in other accounts.

Again, I would like to thank the Committee for holding today's hearing and I look forward to working with you to ensure that this program is included in your continuing efforts to guarantee that our Nation's heroes have the best possible programs for treating PTSD and providing disability assistance.

Prepared Statement of Hon. Timothy J. Walz, a Representative in Congress from the State of Minnesota

I want to thank Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee for giving me the opportunity to appear before you today to discuss my bill, H.R. 1855, the Traumatic Brain Injury Rehabilitative Services Improvements Act of 2011.

It is a deep privilege to be a Member of a Committee devoted to serving those who have served our country. We are truly the stewards of a grateful nation that recognizes our obligation to America's servicemen and women.

We are also Members of a Committee with a great history—not only of developing landmark legislation to meet the needs of many generations of veterans, but of

doing this important work on a bipartisan basis. The Committee's rich legacy continues to the present.

Reflecting on the needs of many of those veterans, I introduced legislation late last year, together with Chairman Miller and Congressman Bilirakis, to help some of our most severely injured, those with traumatic brain injury. That legislation was aimed at improving the rehabilitative services that are so important to these young men and women.

Having re-introduced the bill earlier this year, I'm particularly appreciative that the Subcommittee has included it on the agenda.

Unprecedented numbers of warriors are returning home from Iraq and Afghanistan with severe polytraumatic injuries. This is not only due to the nature of the fighting and the kinds of injuries being sustained, but to advances in military medicine and logistics that have saved countless lives that might have been lost in previous wars.

Traumatic brain injuries are among the most complex injuries our personnel have sustained. Each case is unique and injuries can result in wide-ranging loss of function. Neurological and cognitive loss or impairment in speech, vision, and memory, for example, are not uncommon—as is marked behavioral change, with such manifestations as impaired judgment or diminished capacity for self-regulation.

It is difficult to predict the extent of an individual's ultimate level of recovery, but the evidence is clear that to be effective in helping an individual recover from a brain injury and return to a life as independent and productive as possible, rehabilitation must be targeted to the specific needs of the individual patient.

H.R. 1855, the Traumatic Brain Injury Rehabilitative Services Improvements Act of 2011, is aimed at closing gaps in current law that have had the effect of denying some veterans with severe TBI from achieving optimal outcomes.

Many VA facilities have dedicated rehabilitation-medicine staff, but the scope of services actually provided to veterans with a severe TBI can be limited, both in duration and in the range of services authorized. Veterans encounter two distinct problems. *First*, it is all too common for staff to advise families that the VA can no longer provide a particular rehabilitative service because the veteran is no longer making significant progress. But ongoing rehabilitation is often needed to *maintain* function, and individuals who are denied maintenance therapy can regress and lose cognitive and other gains they've made through rehab work.

A second problem veterans encounter is in getting help with community reintegration, and learning to live as independently as possible. VA's rehabilitation focus relies almost exclusively on a medical model; that assistance is critical, but doesn't necessarily go far enough for some veterans in providing the range of supports a young person needs to achieve the fullest possible life in the community.

In contrast, other models of rehabilitative care meet TBI patients' needs through such services as life-skills coaching, supported employment, and community reintegration therapy. These services are seldom made available to veterans. Yet research has shown that with these types of innovative non-medical supports, individuals with severe TBI can flourish in a community setting. Denying wounded warriors such supports compromises their achieving the fullest possible recovery.

H.R. 1855 would close these gaps. Specifically, it would clarify that VA may not prematurely cut off needed rehabilitation services for an individual with traumatic brain injury, and that veterans with TBI can get the supports they need—whether those are health-services or non-medical assistance—to achieve maximum independence and quality of life.

I'm gratified by the broad support the bill has won from major veterans' service organizations. And I'm particularly pleased at the strong endorsement from Wounded Warrior Project, whose Executive Director, Steve Nardizzi, described the bill as "powerfully addressing the often agonizing experience of wounded warriors who have been denied important community-reintegration supports and who have experienced premature termination of rehabilitation services." As Steve said, "This bill offers new hope to these warriors and their families."

I look forward to responding to all of your questions, and with that, I yield back my time.

Prepared Statement of Hon. Larry Bucshon, a Representative in Congress from the State of Indiana

Thank you Chairwoman Buerkle, Ranking Member Michaud, Members of the Subcommittee, for the opportunity to come and speak to you today about my draft legislation, the Honey Sue Newby Spina Bifida Attendant Care Act.

In April of this year, I was contacted by a constituent from New Harmony, Mr. Ron Nesler, on behalf of his stepdaughter, Honey Sue Newby. Honey Sue's father was a Vietnam Veteran exposed to Agent Orange; and she was born with a complicated neurological disorder rooted in Spina Bifida, a congenital condition in which the vertebrae do not form properly around the spinal cord. The Veterans Administration has previously determined Honey Sue's condition is a direct result of her father's exposure to Agent Orange in Vietnam and have classified her as a Level III child, making her eligible to receive the same full health care coverage as a veteran with 100 percent service-connected disability.

In 2007, Mr. Nesler and his wife reached out to my predecessor, former-Representative Brad Ellsworth regarding two issues they had been experiencing with the VA. The first was an administrative burden requiring a letter from Honey Sue's doctor explaining exactly how the treatment she sought was related to her Spina Bifida. More often than not, this resulted in the VA denying repayment until additional burdensome administrative procedures took place. For example, Honey Sue needed surgery on her mouth after seizures caused her to grind her teeth to nubs. The VA originally denied payments for the procedure saying the doctor's letter did not clearly make the case that this result was related to the condition.

Secondly, Honey Sue's parents are aging and experiencing health problems. Currently, the only long term services the VA will pay for is nursing home care for individuals like Honey Sue. Nursing home care is both extremely expensive and inappropriate for what Honey Sue needs. Individuals with Spina Bifida have a diverse range of needs. Although no two cases of Spina Bifida are ever the same, the National Spina Bifida Association confirms the majority of these individuals can live independently if they have the proper habilitative care in order to develop, maintain or restore their functioning.

Former Rep. Ellsworth's bill, H.R. 5729, was written to address both of these issues and on May 20, 2008 H.R. 5729 was passed by voice vote in the House of Representatives and was later added to S. 2162, the Veterans Mental Health and Other Care Improvement Act of 2008. This legislation was signed by President Bush on October 10, 2008 (Public Law 110–387).

Since then, the VA has recognized and alleviated the administrative burdens, but has not properly interpreted 'habilitative care'. Title 38 of the U.S. Code defines habilitative care as 'professional, counseling, and guidance services and treatment programs (other than vocational training under section 1804 of this title) as are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person.' Under this language, I believe the VA is misinterpreting the law and its intent as it concerns individuals with type III Spina Bifida who simply need supervisory, or as we put it in the draft legislation—home and community based-care.

The purpose of this draft legislation is to clarify Title 38 to allow individuals with Spina Bifida the appropriate and cost effective care they deserve. The intended result allows individuals to take advantage of home and community based care for those that do not need constant medical care. The term 'Home and community based care' is used in the definition of 'habilitative care' in section 1915 of the Social Security Act and this legislation is modeled after and aims to create consistency for that definition within VA services.

Again, thank you for the consideration of this legislation. I am happy to answer any questions.

Prepared Statement of Hon. John R. Carter, a Representative in Congress from the State of Texas

Thank you Chairwoman Buerkle, Ranking Member Michaud, and distinguished Members of the Subcommittee. I am here today to discuss H.R. 1154, the Veterans Equal Treatment for Service Dogs (VETS Dogs) Bill, which I introduced on March 17, 2011. This bi-partisan bill has gained widespread support, with over 60 Cosponsors to date.

The VETS Dogs Bill is quite simple and does not cost any money; it merely ensures that Veterans with medical service dogs have equal access to all Veterans Affairs (VA) facilities. Currently, only seeing-eye and guide dogs are allowed access. This bill was first brought to my attention by the American Veterans (AMVETS) organization, and is supported by the Veterans of Foreign Wars (VFW), Military Order of the Purple Heart (MOPH), VetsFirst, and Paws with a Cause. Additionally, this bill complies with the Americans with Disabilities Act (ADA) as well as the Rehabilitation Act.

The VETS Dogs Bill recognizes that medical service dogs are used increasingly more for treatment and assistance of medical issues other than blindness. For example, Veterans currently use medical service dogs for support in cases of Traumatic Brain Injuries (TBI), hearing loss, seizures, as well as for mobility assistance. With this increased usage, it is crucial that we help these Veterans and their service dogs gain access to all VA facilities.

The VA issued a directive in March 2011 requiring the Veterans Health Administration (VHA) to allow medical service dogs into its facilities. While this is a very positive step for the VA, this directive does not apply to all VA facilities and expires in 2016. The VETS Dogs Bill will assist the VA in solidifying this directive through including all VA facilities and by making such access permanent law. I applaud the VA for continuing to make great strides to improve care provided to all wounded Veterans. This bill simply closes the gap in access that currently exists.

I would like to recognize Deb Davis from Paws with a Cause, who is here with her dog Krickit today. Deb helped to write this important piece of legislation. Additionally, Kevin Stone and his dog Mambo are also in attendance today. Mambo assists Kevin with mobility, and serves as a great example of how medical service dogs can help wounded Veterans. Kevin believes that Mambo has allowed him to regain his independence and quality of life. However, Kevin has been denied access to VA Medical Centers (VAMC) since Mambo is not a seeing-eye or guide dog. We are failing Kevin and other wounded Veterans if we allow this to keep happening. Madame Chairwoman and Committee Members, thank you for giving me the opportunity to speak today on the Veterans Equal Treatment for Service Dogs (VETS Dogs) Bill.

U.S. Representative John R. Carter was elected in 2010 to his fifth term representing Texas' Thirty-First Congressional District in the U.S. House of Representatives. Since his first election in 2002, Congressman Carter has established himself as a leader in Congress who has the foresight and courage to author and support numerous pieces of legislation that would increase the protection of U.S. citizens and bring justice to those who threaten our freedom and way of life.

Congressman Carter was also unanimously re-elected in 2010 to a third term as House Republican Conference Secretary. In this position, Congressman Carter is the sixth highest-ranking Republican in the House.

He has served on the prestigious House Appropriations Committee since 2004, and currently sits on the Transportation, Homeland Security, and Military Quality of Life and Veterans Affairs Subcommittees. During the 108th Congress, Congressman Carter was a Member of the House Education and the Workforce, Judiciary, and Government Reform Committees.

Carter also continues to serve on the House Republican Steering Committee, an official group of members who are in charge of placing Members on Committees. Carter has been honored to serve on this select panel since being elected to Congress.

Congressman Carter's leadership ability has been recognized by his colleagues and others. During his first term, Congressman Carter was named one of the "Top Five Freshman" in Congress by Capitol Hill's leading newspaper.

For Congressman Carter, leadership goes far beyond the Committee room and onto the House floor, where he has successfully had legislation passed and signed into law under both Presidents Bush and Obama. Bringing to Congress 20 years of judicial experience, Congressman Carter has consistently worked to advance a tough on crime agenda.

In July 2004, President Bush held a signing ceremony for Congressman Carter's Identity Theft bill at the White House. The law lessens the burden of proof making identity theft easier to prove and prosecute and also defines and creates punishment for aggravated identity theft.

Congressman Carter bears the nickname of "Judge" on Capitol Hill and at home for serving over 20 years on the bench. In 1981, Congressman Carter was appointed the Judge of the 277th District Court of Williamson County and was elected District Judge in 1982. Before becoming a Judge, Congressman Carter had a successful private law practice and continued to practice law while serving as the Municipal Judge in Round Rock. He was the first county-wide elected Republican in Williamson County history. As an attorney, Carter represented the Round Rock and Williamson County communities through their first booming phases of growth and continues to support and guide today's growth. Congressman Carter has seen the economy both rise and fall and has a plan to assist the residents in Congressional District 31 to ensure their prosperity.

A true Texan at heart, Congressman Carter was born and raised in Houston and has spent his adult life in Central Texas. Carter attended Texas Tech University where he graduated with a degree in History and then graduated from the University of Texas Law School in 1969. Congressman Carter and his wife, Erika, met in

Holland and have been happily married since June 15, 1968. Since then they have built a home and raised a family of four on Christian beliefs and strong Texas Values.

Prepared Statement of Shane Barker, Senior Legislative Associate, National Legislative Service, Veterans of Foreign Wars of the United States

Madam Chairwoman and members of this committee, on behalf of the 2.1 million members of the Veterans of Foreign Wars of the United States and our Auxiliaries, the VFW would like to thank this Committee for the opportunity to present its views on these bills.

H.R. 198, Veterans Dog Training Therapy Act

The VFW appreciates the intent behind this bill. However, we do not believe a VA medical center is the right environment for a pilot program involving dog-training. We believe the idea behind this legislation—to help veterans with post-traumatic stress disorder by incorporating a therapeutic dog training class as a part of their treatment—would be better achieved through established private sector organizations with sufficient oversight by VA. Partnering with outside entities that have experience and proven success in this area would provide the veteran with the outcomes this bill wants to evaluate. It would also localize the program by moving it from VA medical centers to the communities where many of our veterans live. Overall, we think such changes would achieve greater results with no further cost to VA, and with fewer complications for our veterans.

H.R. 1154, Veterans Equal Treatment for Service Dogs Act

The use of medical service dogs among veterans is increasing, and many of our newest veterans who are returning home from war with mental and physical disabilities have a particular need for their services. We believe that trained dogs play a significant role in helping to provide independence to individuals with a broad range of disabilities.

Currently, VA allows seeing-eye dogs to enter medical facilities without limitations. Senator Harkin's legislation would allow all service dogs into facilities that receive VA funding. The VFW is happy to lend our support to a benefit that is often overlooked and can go a long way towards helping an individual with a disability who may not be able to perform a task independently.

H.R. 1855, the Veterans' Traumatic Brain Injury Rehabilitative Services' Improvements Act of 2011

The VFW supports this legislation to expand and improve the plan for rehabilitation and reintegration of TBI patients. This legislation would require VA to broaden their TBI treatment plans to focus on an injured veteran's independence and quality of life while making improvements to their behavioral and mental health functioning. We know that VA is working to do more than merely stabilize these men and women, but we are fully supportive of adding language to the United States Code that requires VA to pursue treatment options that would improve their functioning.

It expands the scope of rehabilitative service for veterans suffering from brain injury to include behavioral and mental health concerns. As a result of this bill, the phrase "rehabilitative services" replaces the word "treatment" in pertinent areas of the United States Code, thereby conforming it to the prevailing wisdom that TBI patients deserve more than mere treatment of their injuries. This change is critical because these men and women deserve ongoing evaluation and additional intervention where necessary to ensure a full recovery. We believe the changes in this bill would make it easier for veterans struggling with the aftermath of a TBI to receive such coverage. Finally, this bill would also support TBI patients by associating sections of the law related to TBI rehabilitation and community reintegration to a broader definition of the term "rehabilitative services" that comprises a range of services such as professional counseling and guidance services. This bill would help to ensure our response to traumatic brain injuries consists of more than just healing the wounds that we can see. Our veterans deserve every chance to lead productive lives, which is why the VFW believes that VA and U.S. Department of Defense

(DoD) should look into any and all potential rehabilitation and treatment models for veterans who suffer from TBI.

H.R. 2074, Veterans Sexual Assault Prevention Act

We thank Health Subcommittee Chairwoman Buerkle and Chairman Miller for introducing H.R. 2074, the "Veterans Sexual Assault Prevention Act," and we are pleased to see this Committee continuing to work diligently on this critical issue. As we have said before, one incident of assault, of a sexual nature or otherwise, is one too many. The VFW reaffirms, in no uncertain terms, the need for a zero-tolerance policy. Less than that is unacceptable and inexcusable. Veterans should never have to visit a VA medical facility with concerns about their personal safety.

We want the guilty punished, but we also strongly believe that any legislation signed into law should ensure exonerated employees are not adversely affected. VA must be extremely judicious not to allow unsubstantiated allegations to bring about negative consequences for the accused, while at the same time holding the guilty accountable for such heinous actions. The VFW does not want to see dedicated employees leave the VA system for this reason, so any successful cultural change within VA must include protections for innocent employees wrongfully accused.

The most important missing piece is a comprehensive, continuous, and evidence-based training program. All efforts to properly identify sexual assault and to create programs to forward allegations to appropriate officials are in vain if employees are not trained to be vigilant and to identify problem situations. We strongly believe that VA must institute a first-class training program that is mandatory for ***all*** VA employees to attend.

They must also clarify what constitutes sexual assault, because the lack of a clear and consistent VA-wide definition has allegedly led to many events not being reported, or resulted in no action on those events that were reported. GAO also recommended VA police create a system-wide process that would result in cases involving potential felonies to be automatically reported to the VA Office of the Inspector General. Frankly, we are shocked that such a common-sense Standard Operating Procedure does not already exist.

VA leadership has failed in their obligations for too long, and the hidden nature of this unacceptable problem requires Congress to act quickly. We stand ready to assist the Committee in passing this legislation without delay.

H.R. 2530, a bill to amend title 38, United States Code, to provide for increased flexibility in establishing rates for reimbursement for State homes by the Secretary of Veterans Affairs for nursing home care provided to veterans.

The VFW supports this straightforward legislation to eliminate the rigid system currently in place to reimburse State homes for nursing home care provided to veterans. The current reimbursement system pays State homes uniformly across the country, without taking into account costs of living or costs of goods and services from State to State. These costs vary considerably, and the result of the uniform payment schedule results in some States doing well, and other States not being able to provide needed services without some significant negative financial impact.

The services State veterans homes provide are critical, and they are not looking for disproportional profits. They are looking to sustain themselves, and we strongly believe that VA must be a partner in that effort. This legislation would help achieve that by allowing VA to enter into contracts with individual State veterans homes for payment schedules that are crafted in consultation with the State home. This change will make these payments more equitable and sustainable for everyone involved, and this bill has broad stakeholder support. We strongly believe that it will put these complications to rest, and will work to bring about its passage into law.

Draft Legislation, the Honey Sue Newby Spina Bifida Attendant Care Act

The VFW supports this measure to give VA the authority to provide more appropriate care for Honey Sue Newby, and other children of Vietnam veterans suffering from Spina Bifida. The story of Newby is a harrowing tale of VA—for whatever reason—being counterproductive in providing care at every turn. It is also a story of perseverance on the part of this family to find the care that Honey Sue desperately needed. That provision of care was granted by Congress and earned by virtue of Mr. Newby's service. However, the record is clear that they have suffered time and time again due to onerous VA requirements.

This bill will make it easier for family attendants to persevere through VA requirements as they care for a child with Spina Bifida by broadening the types of

care VA can provide, and will allow VA to enter into contracts with providers who offer enhanced and new types of care. It expands outpatient care to include adult day health services. Perhaps most importantly, it expands home care to help offset having a live-in, unrelated personal caregiver in cases where not having one would result in admission to a hospital, a nursing care facility, or an intermediate care facility.

These changes will greatly improve the quality of life for families of veterans exposed to Agent Orange who have children who suffer from Spina Bifida. We strongly support this legislation and look forward to working with you to get it enacted.

Draft Legislation, Veterans Health Care Facilities Capital Improvement Act of 2011

The Veterans Health Care Facilities Capital Improvements Act of 2011 is necessary in building and utilizing VA properties in a way that will provide greater quality and access to care for veterans. The authorization of funds for major construction projects closely reflects the requests by VA, and exceeds, by nearly double, the FY 2012 appropriations request for this line item. However, at this rate of authorization and funding, VA will not have the financial resources available to reach their capital planning goals outlined though VA's Strategic Capital Investment Planning (SCIP). The authorization for medical facility leases fulfills VA's request for establishing eight community-based outpatient clinics. The VFW agrees with this level of authorization.

Section 6 outlines the new authority for VA's enhanced-use lease ((EUL). Most importantly, this bill will extend EUL. Without this extension, which is due to expire December 31, 2011, VA will be limited in their ability to reduce homelessness and effectively use properties that are either vacant or underutilized. The VFW agrees with most of the amendments of EUL authorization including the consideration of EUL business plans beyond those proposed by the Under Secretary of Health, ensuring the leases comply with current scorekeeping rules, ensuring that VA's liability is limited, clarification of payment of State and local taxes, and that funds derived from EUL will be deposited into VA's Major and Minor construction accounts.

The VFW does have concerns with the amendment that removes the criteria that mandates EUL properties must "actively contribute to VA's mission." Removal of this provision could change the focus of VA from providing care for veterans to improving revenue of existing properties. Maintaining and improving care for veterans must always be the single focus of VA. Also, any revenue that is produced through the EUL program that would be shifted to VA's Major and Minor construction accounts through the passage of this bill must be a supplement to, and not a substitute for, appropriating funds for these accounts.

The VFW agrees with Section 7 of this legislation. Currently, VA requests construction funding for the actual cost of construction, but leaves out activation costs. Section 7 would ensure that VA requests the full cost of construction costs.

The VFW holds no opinion on the naming of VA facilities. Therefore, the VFW provides no comment on Section 8 of this legislation.

The VFW supports all of the extensions of the expiring authorities that are found in Section 9 of this legislation.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions that you or the Members of the Committee may have.

Prepared Statement of Joy J. Ilem, Deputy National Legislative Director, Disabled American Veterans

Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee:

Thank you for inviting me to testify on behalf of the Disabled American Veterans (DAV) at this important hearing of the Subcommittee on Health. DAV is an organization of 1.2 million service-disabled veterans. We devote our energies to rebuilding the lives of disabled veterans and their families.

Madam Chairwoman, the DAV appreciates your leadership in enhancing Department of Veterans Affairs (VA) health care programs on which many service-connected disabled veterans must rely. At the Subcommittee's request, the DAV is pleased to present our views on five numbered bills and two draft measures before the Subcommittee today.

H.R. 198—the "Veterans Dog Training Therapy Act"

If enacted, this bill would require the Secretary of Veterans Affairs within 120 days of enactment to conduct a pilot program for certain veterans through the therapeutic medium of service dogs. The pilot program would include the provision of training, exercising, feeding, grooming and quartering of dogs by VA for veterans with post-deployment mental health challenges for use as service animals. The stated purpose of the pilot program would be to determine how effectively it would assist veterans with post-traumatic stress disorder (PTSD) in reducing mental health stigma; improving emotional stability and patience; reintegrating into civilian society; and, making other positive changes that aid veterans' repatriation after combat. The bill would require a VA study to document such efficacy and a series of reports to Congress.

Madam Chairwoman, we do not have an approved resolution from our membership that addresses this specific topic, so we are unable to take a formal position on this bill. We are supportive of VA's current policy on admittance of service animals to VA facilities provided it is carried out uniformly nationwide. Also, DAV is looking forward to the receipt of findings from VA's ongoing research project to determine the efficacy of service dog usage by veterans challenged by mental illness and other mental health conditions related to combat deployments including PTSD. We recognize that trained service animals can play an important role in maintaining functionality and promoting maximum independence and improved quality of life for persons with disabilities—and that pilot programs such as the one proposed could be of benefit to certain veterans.

H.R. 1154—the "Veterans Equal Treatment for Service Dogs Act"

This bill would prohibit the Secretary of Veterans Affairs from restricting the use of service dogs by veterans on any VA property that receives funding from the Secretary.

Madam Chairwoman, similar to our lack of a resolution on the above bill, we do not have a resolution on this topic either. The Veterans Health Administration (VHA) has published a national policy directive on admittance of service and guide animals to VA health care properties and into its facilities on those properties. A number of complaints have arisen from our members strongly suggesting the actual local policies enforced by facility or network management may differ markedly from VA's national policy, and that VA makes a distinction between service, guide and "companion" animals, admitting some and restricting others. We believe the current national policy, VHA Directive 2011–013, is adequate and that local enforcement of it clearly addresses this issue and could accomplish the goal of this measure. Therefore, we recommend the Subcommittee provide oversight to ensure standardization of the policy and extension of the policy for VA regional offices under the Veterans Benefits Administration (VBA). We are unaware that VBA has a published policy on veterans and service/guide dogs.

H.R. 1855—the "Veterans Traumatic Brain Injury Rehabilitative Services' Improvements Act of 2011"

Madam Chairwoman, this measure is similar to a bill introduced by the same sponsor, Mr. Walz of Minnesota, at the end of the 111th Congress. We strongly support this bill. If enacted, it would clarify the definition of "rehabilitation" as that term is understood in title 38, United States Code, to strengthen VA's mandate to sustain gains made in the rehabilitative process in veterans who have incurred traumatic brain injuries. The bill would focus VA on behavioral, mental health, cognitive and functions of daily living, in an effort to assure that veterans achieve and sustain maximal recovery from the trauma and lasting effects of brain injury.

Our members have approved a national resolution calling for better VA treatments and more research to ensure veterans with traumatic brain injury receive the best care possible. This bill aims to fulfill the goals of maximizing an individual's independence and quality of life and is fully in keeping with DAV Resolution 215. We commend its sponsors and urge the Subcommittee to recommend its enactment as a high priority.

H.R. 2074—the "Veterans Sexual Assault Prevention Act"

Madam Chairwoman, we appreciate your introduction of this measure following information that came to light earlier this summer indicating a number of sexual assaults occurring in VA facilities had not been properly reported. I had the privilege of testifying before this Subcommittee on that topic, including providing com-

mentary on the Government Accountability Office (GAO) report presented to the Subcommittee at that same hearing.

As I indicated in my earlier testimony, every veteran should be assured of the highest level of quality care and patient safety while receiving health care in a VA facility. A veteran should never fear for his or her own personal safety while visiting a VA facility. VA was established as a place of care, not a place of fear, for veterans, visitors or staff.

We concur with GAO that when a veteran has a history of sexual assault or violent acts, VA must be vigilant in identifying the risks that such veterans pose to the safety of others at its medical facilities. When a sexual assault involves a VA employee, whether perpetrator or victim, the incident takes on even more meaning, and raises a host of questions that were explored by the GAO, and also discussed during your recent hearing. VA needs to take decisive actions to improve personal safety and promote an environment of care that includes protection from personal assaults, including sexual assaults. To do so will take a commitment from all levels of VA and especially VA's senior leadership. We commend GAO for making this critical report. Hopefully, GAO's findings can serve VA and veterans well in providing a roadmap to promote a new environment of care that encompasses a strong consistent culture of safety, and one that can be closely monitored by this Subcommittee as VA completes the recommended changes.

Madam Chairwoman, your bill firms up VA's requirement to document, track and control—and hopefully, to eliminate—incidence of sexual assaults that occur on properties and grounds of the VA. We believe the bill, if enacted, would be consistent with GAO's findings and would serve veterans and VA well as a means of greater accountability and transparency of VA's actions in combating sexual assaults and related incidents affecting the safety of veterans and VA staff.

H.R. 2530—"To amend title 38, United States Code, to provide for increased flexibility in establishing rates for reimbursement of State homes by the Secretary of Veterans Affairs for nursing home care provided to veterans"

H.R. 2530, introduced by the Subcommittee Ranking Member and the full Committee Chairman, would revise the methodology used to reimburse State veterans homes that provide nursing home care for veterans with service-connected disabilities rated 70 percent or greater or for veterans who need nursing home care due to a service-connected disability. The legislation is intended to amend existing statute and restore the original intent of Section 211 of Public Law 109–461, which was enacted in order to authorize VA to place 70 percent service-connected veterans in State Homes and to reimburse them at rates comparable to those received by contract community nursing homes.

DAV strongly supported establishment of the authority contained in Public Law 109–461 that confirmed a VA responsibility to provide full-cost reimbursement to the States for the care of service-connected veterans in order to expand the long-term care options for these highest priority veterans. However, as we noted in prior testimony before this Subcommittee, Public Law 109–461 was enacted in December 2006, but unfortunately VA only promulgated regulations to carry out its intent in April 2009.

The law established State veterans home reimbursement rates for service-connected veterans using two formulas: a geographically adjusted per diem rate established by the Secretary as a corollary to the rates VA currently pays community nursing homes; or, a rate determined by the administrator of a State veterans home based on the calculated daily cost of care at that home. The law also required the Secretary to reimburse State veterans homes for the care of service-connected veterans at the lesser of these two rates.

However, the final promulgated rule contained an unexpected complication when the Office of Management and Budget (OMB) applied the governing financial and accounting policy expressed in OMB Circular A–87. This circular establishes principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments. Under the rules of this circular, a State Home, in determining its daily cost of care, cannot include in that cost structure the depreciation of buildings that were recipients of VA construction grants. As stated in the circular, "[t]he computation of depreciation or use allowances will exclude: . . . (2) Any portion of the cost of buildings and equipment borne by or donated by the Federal Government irrespective of where title was originally vested or where it presently resides." This restriction on counting depreciation as a part of a home's daily cost of care significantly depresses the payable reimbursement rates. As a result of the State Homes'

excluding these significant amounts, the rates determined by the existing statutory formula will invariably become the OMB Circular A–87-determined rates.

Since publication of these regulations, many State Homes have found that the "full" reimbursement rates governed by VA regulations will net their facilities less than their combined payments (from veterans, their State governments, the Department of Health and Human Services, and from VA under the traditional per diem payment subsidy) received before these regulations were issued. Most of the State Homes that were already providing care for service-connected veterans suffered significant decreases in revenue, and other State Homes that were considering placements of service-connected veterans determined that they could not afford to extend such care at the reimbursement rates being offered under the new regulation. As a result, the current statutory language in section 1745(a)(2) is unworkable for the purpose intended by Congress. The unworkability of these rates has served as a denial of access to nursing home care in State extended care facilities to the highest priority veterans, those who need nursing home care for residuals of chronic illnesses and injuries they incurred in military service to America. As a result, the intention of Congress to expand long-term care options for the most seriously disabled service-connected veterans has not been achieved.

Over the past 2 years, VA and State Homes have been working towards a solution that would meet the original intent of Congress in a manner that would be viable for State Homes. Earlier this year, VA submitted draft health care legislation to Congress that contained a provision designed to remedy this situation. The language VA developed in consultation with State homes would end the current reimbursement methodology and replace it with new language requiring VA to, ". . . enter into a contract (or agreement under section 1720(c)(1) of this title) with each State home for payment by the Secretary for nursing home care provided in the home." This provision is intended to reimburse State homes at rates comparable to those currently paid to contract community nursing homes that provide care. The bill also contained language requiring the development of new payment methodologies that will "adequately reimburse the State home for the care provided by the State home under the contract (or agreement)." VA has stated that the use of contracts would ". . . allow the most flexibility to VA and States to ensure that States are paid adequately and according to the complexity and severity of illness of each Veteran." VA intends to use contract templates to streamline the contract process, which would include standard language for pricing based on prevailing rates in the community.

Madam Chairwoman, DAV is hopeful that this legislation will address the problems in the current statutory language and VA's current regulations, and will finally provide a route to resolve this problem. We have some concerns about whether OMB may continue to assert that Circular A–87 would be a controlling factor in determining the level of reimbursement despite the intention of Congress and VA and suggest the Subcommittee may want to make clear its intention on this point in report language. DAV commends the bill's sponsors for their continuing efforts to ensure that our highest priority veterans may have the option of entering a State home to meet their long-term care needs, and we recommend enactment of H.R. 2530.

Draft Bill—the "Honey Sue Newby Spina Bifida Attendant Care Act"

This bill would establish assisted living and attendant care services for children of certain Vietnam veterans who are challenged by spina bifida. We have not received a resolution from our membership dealing with this specific issue; therefore, we can take no formal position on this bill. However, we are supportive of assisted living options as an alternative to institutionalized care; therefore, DAV would not object to its enactment. Nevertheless, we note that Congress has not further considered establishing an assisted living authority within the VA even though a 2004 study on VA's Congressionally mandated assisted living pilot program showed great promise and high acceptance by veterans as an alternative to institutional long-term care. We hope that in a future hearing we will be able to testify in support of a new VA assisted living program.

Draft Bill—the "Veterans Health Care Facilities Capital Improvement Act of 2011"

This bill would authorize a number of major medical facility construction projects and capital leases, as well as authorize the appropriations that support these projects. It would also modify previous Congressional authorizations of projects for a number of facilities and modify and provide VA more flexibility in the existing enhanced-use lease authority under which VA may dispose of unnecessary properties by leasing them to outside entities for compatible-use purposes.

The bill would authorize proceeds from enhanced-use leases to be deposited to accounts used by VA to fund minor and major capital projects. The bill would alter existing cost-comparison studies required in title 38, United States Code, section 8104, as VA contemplates pursuing medical facility acquisition versus proposing new construction for major medical facility appropriations accounts. The bill would authorize the naming of a telehealth clinic in Craig, Colorado. Finally, the bill would extend a number of existing but expiring authorities of law.

Madam Chairwoman, we have no resolution from our membership covering these various matters, but DAV would offer no objections to enactment of this bill. We appreciate the Subcommittee's continuing support of VA's capital needs to ensure the VA health care system is modernized and meets standards for contemporary health care delivery.

Madam Chairwoman, this completes my testimony. Thank you again for inviting Disabled American Veterans to present this testimony today. I would be pleased to address questions from you or other Members of the Subcommittee.

Prepared Statement of Thomas J. Berger, Ph.D., Executive Director, Veterans Health Council, Vietnam Veterans of America

Chairwoman Buerkle, Ranking Member Michaud, and Distinguished Members of the House Veterans Affairs Subcommittee on Health, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on pending legislation for veterans and their families.

H.R. 198, Veterans Dog Training Therapy Act, Directs the Secretary of Veterans Affairs to carry out a pilot program for assessing the effectiveness of addressing post-deployment mental health and post-traumatic stress disorder symptoms through a therapeutic medium of service dog training and handling for veterans with disabilities. Requires such program to be carried out at Department of Veterans Affairs (VA) medical centers that can provide training areas for such purposes.

Although VVA generally supports this legislation, we have several questions: (1) What certification standards will be used to ensure that the animals can perform essential service dog skills?; and (2) What quantitative metrics/measurements will be used to measure the impact of the service dogs on the psychosocial, mental health and physiological disorders suffered by the participating veterans?

H.R. 1154, Veterans Treatment of Service Dogs Act, Prohibits the Secretary of Veterans Affairs (VA) from prohibiting the use of service dogs in or on any VA facility or property or any facility or property that receives VA funding.

VVA generally supports this legislation, but again asks the question: What constitutes certification of one's animal as a "service dog?"

H.R. 1855, Veterans Traumatic Brain Injury Rehabilitative Services Act of 2011, Includes within a program of individualized rehabilitation and reintegration plans for veterans with traumatic brain injury (TBI): (1) the goal of maximizing the individual's independence and quality of life, and (2) improving such veterans' behavioral and mental health functioning. Requires the inclusion of rehabilitative services in a Department of Veterans Affairs (VA) comprehensive program of long-term care for veterans' TBI that has residential, community, and home-based components utilizing interdisciplinary treatment teams.

VVA strongly supports this legislation, and it is very clear that Command Sergeant Major Walz understands the necessity for broadly integrated and individualized psychosocial, mental health, and physical treatment plans and services in order to maximize the quality of long-term care and quality of life for our veterans suffering from TBI.

H.R. 2074, Veteran Sexual Assault Prevention Act, Directs the Secretary of Veterans Affairs to develop and implement, by October 1, 2011, a centralized and comprehensive policy on reporting and tracking sexual assaults and other safety incidents at each medical facility of the Department of Veterans Affairs (VA), including: (1) risk-assessment tools; (2) mandatory security training; (3) physical security precautions (surveillance camera systems and panic alarm systems); (4) criteria and guidance for employees communicating and reporting incidents to specified supervisory personnel, VA law enforcement officials, and the Office of Inspector General; (4) an oversight system within the Veterans Health Administration; (5) procedures for VA law enforcement officials investigating, tracking, and closing reported incidents; and (6) clinical guidance for treating sexual assaults reported over 72 hours after assault.

Requires the Secretary to: (1) submit an annual report to Congress on such incidents and policy implementation, and (2) prescribe applicable regulations.

VVA strongly supports this legislation as an initial effort to address and correct the failures of the VA for protecting and safeguarding our veterans in VA facilities as noted in the June 2011 GAO report.

H.R. 2530, To amend title 38, United States Code, to provide for increased flexibility in establishing rates for reimbursement of State homes by the Secretary of Veterans Affairs for nursing home care provided to veterans.

VVA strongly supports this legislation as H.R. 2530 would correct problems that arose during the implementation of section 211 of P.L. 109–461 affecting State Veterans Homes. With enactment of that law, Congress intended to change the reimbursement mechanism so that State Veterans Homes could provide nursing home care to veterans with service-connected disabilities rated 70 percent or greater and be reimbursed at rates comparable to those provided to community contract nursing homes that provide such care. However, the manner in which VA implemented the new regulations resulted in an unexpectedly low reimbursement rate that actually had the reverse outcome: State Homes now cannot afford to provide care to these, the most seriously disabled veterans.

The proposed legislation introduced by Congressman Michaud would correct this problem by changing the statutory authority so that VA could enter into contracts or agreements with State Homes that would reimburse the homes for providing care to veterans rated 70 percent or greater, and be adequately reimbursed based on a new methodology to be developed by the VA in consultation with the State Homes. The language of H.R. 2530 is virtually identical to that which VA has proposed in draft legislation submitted to Congress earlier this year, and is the result of months of negotiations between VA and the National Association of State Veterans Homes. This legislation will achieve the goals of the original law, which was to provide veterans with service-connected disabilities rate 70 percent or greater with an additional option, which may be more convenient, provide better care and usually costs less to the Federal Government than the same care provided through VA-operated nursing homes or contract community homes.

Honey Sue Newby Spina Bifida Attendant Care Act draft legislation: To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide assisted living services to certain children of Vietnam veterans who are suffering from spina bifida.

VVA strongly supports this legislation as it will provide decades-long over-due services to the Vietnam veteran parents of now middle-aged children suffering from spina bifida.

Veterans Health Care Facilities Capital Improvement Act of 2011 draft legislation:. To authorize certain Department of Veterans Affairs major medical facility projects and leases, to extend certain expiring provisions of law, and to modify certain authorities of the Secretary of Veterans Affairs, and for other purposes.

Although this legislation calls for needed construction modifications at a number of VA medical facilities, VVA cannot support this legislation in its present form as it is unclear as to whether the proposed changes suggested in Section 6. "Modification of Department of Veterans Affairs Enhanced-Use Land Authority" will eliminate any possible breaches of VA fiduciary duty for leasing property to private entities, as has been alleged to have occurred at the West Los Angeles Medical Center and Community Living Center campus.

Once again, on behalf of VVA National President John Rowan and our National Officers and Board, I thank you for your leadership in holding this important hearing on this legislation that is literally of vital interest to so many veterans, and should be of keen interest to all who care about our Nation's veterans. I also thank you for the opportunity to speak to this issue on behalf of America's veterans.

Prepared Statement of Carl Blake, National Legislative Service, Paralyzed Veterans of America

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views today on the proposed legislation. Our statement will examine H.R. 198, the "Veterans Dog Training Therapy Act;" H.R. 1154, the "Veterans Equal Treatment for Service Dogs Act;" H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitative Services Act of 2011;" H.R. 2074, the "Veterans Sexual Assault Prevention Act;" H.R. 2530; the draft "Veterans Health Care Capital

Facilities Improvement Act of 2011;" and, the draft "Honey Sue Newby Spina Bifida Attendant Care Act."

H.R. 198, the "Veterans Dog Training Therapy Act"

While PVA has no specific position on this proposed legislation, we believe that it could be beneficial therapy for veterans dealing with Post-Traumatic Stress Disorder (PTSD) and other mental health issues. A model program for this service was created in 2008 at the Palo Alto VA Medical Center in conjunction with the Assistance Dog Program. This program, maintained by the Recreational Therapy Service at the Palo Alto VAMC, is designed to create a therapeutic environment for veterans with post-deployment mental health issues and symptoms of PTSD to address their mental health needs. Veterans participating in this program train service dogs for later placement with veterans with hearing and physical disabilities. As we understand it, a similar, privately-funded, pilot program is currently under way at Walter Reed Army Medical Center (WRAMC) where service dogs have been used in therapeutic settings since 2006.

In these programs, training service dogs for fellow veterans is believed to be helping to address symptoms associated with post-deployment mental health issues and PTSD in a number of ways. Specifically, veterans participating in the programs demonstrated improved emotional regulation, sleep patterns, and sense of personal safety. They also experienced reduced levels of anxiety and social isolation. Further, veterans' participation in these programs has enabled them to actively instill or reestablish a sense of purpose and meaning while providing an opportunity to help fellow veterans reintegrate back into the community. Given the apparent benefit to veterans who have participated in similar programs as the one proposed by H.R. 198, we see no reason to oppose this legislation.

H.R. 1154, the "Veterans Equal Treatment for Service Dogs Act"

PVA supports H.R. 1154, the "Veterans Equal Treatment for Service Dogs Act of 2011."

While we believe this legislation should be unnecessary based on the provisions of Section 504 of the Rehab Act, the actions of the VA clearly demonstrate the need for this legislation. If the VA is unwilling to make the regulatory change to accomplish the intent of H.R. 1154, then we hope Congress will move quickly to enact this important legislation.

H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitative Services Act of 2011"

PVA fully supports H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitative Services Improvement Act of 2011." If enacted, H.R. 1855 would ensure that long-term rehabilitative care becomes a primary component of health care services provided to veterans who have sustained a Traumatic Brain Injury (TBI). Specifically, this legislation would change the current definition of "rehabilitative services" to include maintaining veterans' physical and mental progress and improvement, as well as maximizing their "quality of life and independence."

As we have testified on previous occasions, TBI is one of the most common and complex injuries facing veterans returning from the current wars in Afghanistan and Iraq. Today, we still do not fully understand the impact or gravity of TBI. In April 2008, the RAND Corporation Center for Military Health Policy Research completed a comprehensive study titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* RAND found that the effects of TBI were poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it. RAND found 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. In recent testimony, PVA has raised continuing concerns about servicemembers who do not have the immediate outward signs of TBI getting appropriate care. The military has implemented procedures to temporarily withdraw individuals from combat operations following an improvised explosive device (IED) attack for an assessment of possible TBI, creating a significant military impact, but believing it necessary for soldier health even if it reduced combat forces.

On July 12, 2006, the VA Office of the Inspector General (OIG) issued *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation.* The report found that better coordination of care between DoD and VA health-care services was needed to enable

veterans to make a smooth transition. While VA and DoD have done extensive improvements of coordination since that report, the OIG Office of Health Care Inspections conducted follow-on interviews to determine changes since the initial interviews conducted in 2006. The OIG concluded that 3 years after completion of initial inpatient rehabilitation, many veterans with TBI continue to have significant disabilities and, although case management has improved, it is not uniformly provided to these patients.

Because all the impacts of TBI are still unknown, this legislation to expand services and care, providing for quality of life and not just independence, and emphasizing rehabilitative services, is important to the ongoing care of TBI patients. It is imperative that a continuum of care for the long term be provided to veterans suffering from TBI. This bill will address the intricacies associated with TBI and help veterans and their families sustain rehabilitative progress.

H.R. 2074, the "Veterans Sexual Assault Prevention Act"

PVA fully supports H.R. 2074, a bill that would require a comprehensive policy on reporting and tracking sexual assault incidents and other safety incidents that occur at VA medical facilities. PVA believes policy mandates that specifically outline how sexual assaults within the VA should be handled are long overdue. The implementation of policies involving sexual assault will reinforce veterans' confidence in the VA's ability to provide a safe environment for care.

H.R. 2074 will require VA to develop and implement a centralized and comprehensive policy on the reporting and tracking of sexual assaults and safety incidents that occur at each medical facility. While the proposed legislation provides clear examples and definitions of the types of assaults and incidents that are to be reported, further detail and interpretation is needed for the term "centralized."

Although daily management of VA medical facilities is under the supervision of Veteran Integrated Service Networks (VISNs), PVA recommends that the proposed legislation require the leadership of each VISN to be responsible for the centralized reporting, tracking, and monitoring system, while also requiring the VISNs to provide the tracking reports to VA's Veterans Health Administration (VHA) central office. Such information sharing will enhance accountability and case management, and make data readily available when monitoring incidents or conducting assessments of the newly implemented system. Additionally, PVA recommends that VA provide clear and concise policy guidance that includes a specific time frame in which front-line VA personnel responsible for the initial processing of assault claims must begin processing the report.

PVA also believes that a major component of preventing and appropriately handling sexual assaults and other incidents is ensuring that all occurrences of such events are reported by not only VA personnel, but veterans and other visitors as well. VA medical facilities must provide safe and secure environments for veterans and their families seeking care and services. Therefore, PVA recommends that the proposed legislation include language that requires VA medical facilities to post clear and precise guidance on ways in which individuals visiting VA facilities can safely report sexual assaults and safety incidents.

H.R. 2530

PVA generally supports H.R. 2530 to allow for increased flexibility in establishing rates for reimbursement for State veterans' homes, but believes greater understanding of the problem is needed. The State Veterans Home Program is examined in great detail in *The Independent Budget* for FY 2012. Those comments are reflected here in our statement for H.R. 2530. The VA State Veterans Home Program currently encompasses 137 nursing homes in 50 States and Puerto Rico, with more than 28,000 nursing home and domiciliary beds for veterans and their dependents. State veterans homes provide the bulk of institutional long-term care to the Nation's veterans. The GAO has reported that State homes provide 52 percent of VA's overall patient workload in nursing homes, while consuming just 12 percent of VA's long-term care budget. VA's authorized average daily census (ADC) for State veterans' homes was 19,208 for FY 2008 and was projected to be approximately 19,700 for FY 2010.

VA holds State homes to the same standards applied to the nursing home care units it operates. State homes are inspected annually by teams of VA examiners, and VA's Office of Inspector General (OIG) also audits and inspects them when determined necessary. State homes that are authorized to receive Medicaid and Medicare payments also are subject to unannounced inspections by the CMS and announced and unannounced inspections by the OIG of the Department of Health and Human Services. VA pays a small per diem for each veteran residing in a State

home, currently at a rate of $77.53 per day. This is less than one-third of the average cost of that veteran's care. The remaining two-thirds is made up of a mix of funding, including State support, Medicaid, Medicare, and other public and private sources. In contrast, VA pays Community Nursing Homes over $200 per day with the cost of care in VA Community Living Centers (VACLC) at almost $800 per day.

Service-connected veterans should be the top priority for admission to State veterans' homes, but traditionally they have not considered State homes an option for nursing home services because of lack of VA financial support. To remedy this disincentive, Congress provided authority for full VA payment. Unfortunately, veterans with severe disabilities may be put at a disadvantage in gaining access to State veterans' homes. As part of P.L. 109–461, the "Veterans Benefits, Health Care, and Information Technology Act of 2006," Congress approved payment of different per diem amounts by VA to State veterans' homes which provide nursing home care to veterans with service-connected disabilities, a program dubbed "the 70 Percent Program." VA issued regulations for this program in April 2009 and granted a higher per diem rate for veterans with service-connected disabilities. Unfortunately, PVA is hearing reports that these rates have resulted in lower payments to many State veterans' homes and in some cases are less than the actual cost of care.

PVA believes VA made a good faith effort in establishing the original rates, but may not have taken into consideration the significantly greater cost of care for those with severe disabilities, in particular those service-connected veterans with 70 percent or greater rating. As a result, we are concerned that many severely disabled veterans who would choose to use the State veterans' homes will be denied access simply because the veterans' home cannot afford the cost of their care. This will cause a significant impact on our veterans most in need at a time when VA is continuing to reduce their capacity to provide long-term care facilities.

PVA has been informed by representatives of the National Association of State Veterans Homes (NASVH) that VA seems resistant to modifications of the per diem rate or alternatives that may provide greater reimbursement rates. There is a sense that the VA believes the lower rate is appropriate because VA shoulders a great financial burden when it helps cover the cost of construction, rehabilitation, and repair of State veterans' homes, providing up to 65 percent of the cost, with the State providing at least 35 percent. If true, PVA believes this argument is invalid.

In FY 2011 the construction grant program was funded at only $85 million, the same amount Congress had provided in multiple previous fiscal years. Based on a current backlog of nearly $1 billion in grant proposals, and with thousands of veterans on waiting lists for State beds, *The Independent Budget* for FY 2012 recommends no less than $200 million for this program. Unfortunately, Congress seems poised once again to only provide $85 million for the State homes grant program. The VA is using this grant program as an incentive to build more capacity to avoid the greater cost of building it themselves. PVA firmly believes that construction costs should not be mixed with health care costs. The per diem rate should be independent of any *quid pro quo* VA may believe exists with the State veterans' homes due to construction funding. State veterans homes can provide high quality care at a rate cheaper than VA and should be rewarded for doing so, not punished.

Draft "Veterans Health Care Capital Facilities Improvement Act of 2011"

VA's significant inventory of real property and physical infrastructure is a truly remarkable asset in the provision of health care and benefits delivery to veterans. At the same time, these facilities must be properly managed and cared for to ensure that the investment made in the use of these buildings and properties coincides with the benefits derived from their use.

In the same manner, as the VA begins with the manipulation, sale or leasing of its infrastructure, great care must be taken to ensure that the value and equity in VA's physical property is not squandered. That equity does not belong to the VA or the Federal Government; it belongs to the veterans of the Nation for their future good. With any rearrangement of VA facilities great care should be taken to make certain present as well as future needs of veterans are fully accounted for.

With that caveat, we believe the legislation before the Subcommittee does provide the VA with improved flexibility in leasing unused or underused properties. VA enhanced use lease authority is almost unique among other Federal departments and agencies. Unfortunately, however, the process has been called cumbersome and time consuming, discouraging VA Administrators from wanting to expend the effort to use this route in dealing with a property. Such a lengthy process also greatly discourages potential private sector entities from considering VA properties as a potential investment asset. PVA is pleased to see that the legislation retains the Capital Assets Fund to serve as the repository for the proceeds from the sale or lease of

VA properties and then act as the conduit for the reinvestment of those proceeds for the improvement of other VA facilities. We also find it interesting that the Committee calls for these proceeds to be reinvested into Major and Minor Construction, rather than the Medical Care Collections Fund.

However, we have two areas of caution as the Committee moves forward. First, VA, with proper Congressional oversight, must ensure that it receives fair market value and appropriate leases for these properties. This is particularly important in light of the current real estate market climate. Second, Congress must ensure that proceeds reinvested into Major and Minor Construction are not looked upon by the Office of Management and Budget, as well as the Budget and Appropriations Committees, as an alternative to, and not over and above regular funding for needed specific construction appropriations. Ultimately, we do not want to see VA major and minor construction funding or non recurring maintenance budget line items offset by Capital Asset Fund disbursements.

PVA is particularly pleased that the Subcommittee has chosen to reauthorize a number of programs targeted at assisting homeless veterans. However, we would encourage the Subcommittee to include reauthorization of the Homeless Veterans Reintegration Program (38 U.S.C. § 2021) managed by the Department of Labor. The HVRP is a valuable program focusing on employment of homeless veterans. This program has achieved wonderful success since its inception approximately 25 years ago. The HVRP provides help for those veterans with significant problems including substance-use disorder, severe PTSD, serious social problems, legal issues and HIV. The specialized services needed for these veterans and provided by HVRP are often their only hope.

Draft "Honey Sue Newby Spina Bifida Attendant Care Act"

This legislation would amend Title 38 U.S.C., to provide additional benefits for children with spina bifida of veterans exposed to herbicides while serving in the Armed Forces during in Vietnam. PVA supports this legislation as it would simply improve upon the benefits that already exist for this beneficiary population.

Madame Chairwoman and Members of the Subcommittee, once again PVA would like to thank you for the opportunity to offer our views on the legislative matters pending before the Subcommittee. We look forward to working with you to ensure that meaningful reforms that best benefit veterans are made to the health care services provided by the VA.

This concludes our official statement. I would be happy to answer any questions that you may have.

Prepared Statement of Christina M. Roof,
National Acting Legislative Director, AMVETS

Chairwoman Buerkle, Ranking Member Michaud and distinguished Members of the Subcommittee, on behalf of AMVETS, I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations at today's hearing regarding: H.R. 198, the *"Veterans Dog Training Therapy Act,"* H.R. 1154, the *"Veterans Equal Treatment for Service Dogs Act,"* H.R. 1855, the *"Veterans Traumatic Brain Injury Rehabilitative Services Act of 2011,"* H.R. 2074, the *"Veterans Sexual Assault Prevention Act,"* H.R. 2530, *to amend Title 38, United States Code, to provide increased flexibility in establishing rates for reimbursement of State Homes by the Secretary of Veterans Affairs for nursing home care provided to veterans,"* draft legislation, the *"Veterans Health Care Capital Facilities Improvement Act of 2011,"* and draft legislation, the *"Honey Sue Newby Spina Bifida Attendant Care Act."*

AMVETS feels privileged in having been a leader, since 1944, in helping to preserve the freedoms secured by America's Armed Forces. Today our organization prides itself on the continuation of this tradition, as well as our undaunted dedication to ensuring that every past and present member of the Armed Forces receives all of their due entitlements. These individuals, who have devoted their entire lives to upholding our values and freedoms, deserve nothing less.

Given the fact, this testimony will be addressing multiple pieces of legislation; we shall be addressing each piece of legislation separately, as to make AMVETS testimony clear and concise on the individual subject matters of the bills.

AMVETS supports H.R. 198, the "Veterans Dog Training Therapy Act." AMVETS lends our support to the updated language of H.R. 198 that will be submitted in Committee markup. AMVETS believes the updated language will help ensure that

H.R. 198 provides veterans the highest quality care, while maintaining our commitment to fiscal responsibility.

By way of background, AMVETS has worked with Assistance Dogs International (ADI) accredited Assistance Dog agency, Paws With A Cause for over 30 years, in an effort to help provide disabled veterans Service Dogs. Through this partnership, AMVETS has seen what an immeasurable asset to a veteran's overall wellbeing these service dogs have proven to be to both the trainers and recipients. AMVETS has personally witnessed the incredible changes that occur when introducing a dog into a veterans overall treatment plan. This is often illustrated through speedier improvements to a veteran's physical wellbeing, great improvements to the veteran's mental health and a sustainable overall higher quality of life, when compared to the pace of improvements shown in veterans undergoing normal clinical care.

Veterans who are able to take on an active role in the training of a Service Dog have displayed great improvements to their overall wellbeing and recovery. H.R. 198 is an opportunity for a veteran to once again feel that they have purpose and will be able to play an active role in assisting his/her comrades, just as he/she did while serving in the military. H.R. 198 will also offer a structured program that has clear and concise rules, goals and measurable end results.

Furthermore, AMVETS believes H.R. 198 will prove to be beneficial to the veteran trainers, the veteran Service Dog recipient and to the Department of Veterans Affairs. AMVETS also believes H.R. 198 will aide VA in the development of stronger policies and procedures regarding Service Dogs within the VA health care system, as well as being fiscally responsible through the collaborating of VA facilities with private sector industry experts, ADI agencies for this study. The VA and ADI partnership will ensure the quality of the training process and uniform training standards for the program, provide both a therapeutic, yet professional setting for all parties involved in the study, ensure the safety of both the veterans and the dogs and provide industry expertise and job training skill sets to veterans chosen to participate. AMVETS also applauds Congressman Grimm for going the extra step by finding multiple choices for offset funding.

AMVETS strongly supports H.R. 1154, the "the Veterans Equal Treatment for Service Dogs Act." AMVETS believes this cost free piece of legislation will permanently eliminate an often overlooked and unwarranted hurdle to care disabled veterans are currently experiencing when seeking their necessary VA health care services. To date, 38 CFR, Part 1, § 1.218(a)(11) states:

> "***Dogs and other animals. Dogs and other animals, except seeing-eye dogs, shall not be brought upon property except as authorized by the head of the facility or designee".***

AMVETS finds the aforesaid language of 38 CFR, Part 1, § 1.218(a)(11), to be inconsistent and outdated when compared to the sections of Title 38 it is to govern. While numerous parts of Title 38, specifically Section 1714, are constantly updated to reflect the health care needs of today's wounded warriors, 38 CFR, Part 1, § 1.218(a)(11) has been overlooked and has thus failed to be updated since July of 1985. This outdated regulation is, to date, resulting in disabled veterans utilizing VA approved Service Dogs as a prosthetic device to be denied entrance into the VAMCs and CBOCs they depend on for life sustaining care. Given the current authorities outlined by this subsection, there continues to be wide spread inconsistencies in the policies governing access to VAMCs and CBOCs. These inconsistencies are resulting in disabled veterans who may have never experienced any sort of access problems at their previous VAMC are now met with the serious issue of not being allowed to enter a VA facility with their prosthetic device.

For example, Army veteran, Sue Downes lost both of her legs when her convoy hit multiple IEDs in 2007 in Iraq. Today, after years of rehabilitation, Ms. Downes utilizes several VA-provided prosthetic devices and her Service Dog, which is considered a prosthetic device by VA, and thus is provided benefits for its upkeep. These include her two prosthetic legs and her Service Dog, Lila. Ms. Downes depends on her prosthetic legs for mobility and her Service Dog for balance and further mobility assistance. Lila, Ms. Downes' Service Dog, provides her with not only mobility and balance, but just as important, independence. Recently, while visiting with lawmakers in our Nation's capital, Ms. Downes stated:

> *"I do not understand why VA will provide for the upkeep of both prosthetic devices, my legs and my Service Dog, yet I am only allowed to bring one of the two into VA facilities? I truly do not understand what the reasoning behind this rule is; especially since my legs, on their own, are not enough for me to safely get around. Lila was trained to and now provides me assistance that no cane*

or walker could ever provide. Lila has given me back my independence as a self sufficient mother of two and active member of my community."

AMVETS believes disabled veterans, such as Ms. Downes, using Service Dogs must have the same access rights to VA care and facilities as currently afforded to blind veterans using Guide Dogs. AMVETS also believes VA should never refuse care to a veteran based on their disability or the prosthetic device they use to assist them. Moreover, AMVETS believes H.R. 1154 will permanently eliminate the aforesaid through updating the policies outlined by 38 CFR, Part 1, Section 1.218, as well as more accurately reflecting the policies outlined in 38 CFR, Section 1714.

Recently, VA officials stated that H.R. 1154 was unnecessary due to the fact that under existing statutory authority in 38 U.S.C. 901, VA can implement national policy for all VA properties. While AMVETS somewhat agrees with this statement, the fact remains that VA has been unwilling to exercise this authority. In March of 2011, VA did somewhat exercise this authority through the publication of VHA Directive 2011–013. However, AMVETS still believes the actual regulation must be changed, since directives expire and are much harder to track and to enforce compliance. As such, numerous VAMCs have incomplete, inconsistent or non-existent access policies for Service Dogs. This creates a frustrating and stressful experience for a veteran Service Dog user who must receive their routine care at one VAMC, yet must go to a different VAMC for surgery or specialty care. The individual VAMC access policies, if they exist, between the two facilities will most likely be different, thereby creating an unnecessary and avoidable hurdle to care these disabled veterans must now address.

For example, take Army veteran Kevin Stone. Mr. Stone suffered a severe spinal cord injury while on active duty. Living in the foothills of the Smokey Mountains, Mr. Stone uses Mountain Home VAMC for his routine health care. Yet, the closest VA Spinal Cord Injury Care Center for Mr. Stone is Charlie Norwood VAMC in August, Georgia. Unfortunately, in mid 2009, Mr. stone was caught off guard when he was denied access to the facility for his annual SCI care. Mr. Stone was informed that only blind veterans were allowed to bring their dogs into VA hospitals and that he would have to make other arrangements if he wished to receive his SCI care. Finally after nearly 6 months of delayed care, a Member of Congress had to get involved, just so Mr. Stone could receive his life sustaining SCI care. Mr. Stone's situation was stressful for all of the parties involved and did not have to escalate to such levels. Mr. Stone's situation immediately brought forth concerns and questions for AMVETS on how many other disabled veterans utilizing the assistance of a Service Dog have been denied access to a VAMC or CBOC for care. As we are all aware, the simple fact remains that not every disabled veteran using a Service Dog has access to a Member of Congress for help in their case. This is only one of the many, many examples of the challenges today's disabled veterans utilizing Service Dogs, experience when seeking care with the VA system.

While AMVETS applauds VA's recent efforts in addressing this issue through the publication of a temporary directive, we still strongly believe there are loopholes that still need to be addressed and corrected in order to guarantee veterans receive the care and services they need, regardless of their disability. As we are all aware, directives expire and this issue needs a permanent fix, right now. AMVETS has worked very closely with VA over the past few years to assist in the development and implementation of policies and procedures regarding Service Dogs. AMVETS strong support of H.R. 1154 is in no way intended to be a criticism of VA or their actions in addressing this issue. AMVETS strongly believes H.R. 1154 only stands to help, not hinder, VA in the efforts through the codification of the new policy outlined in their directive addressing Guide and Service Dogs on VA properties. With this in mind, H.R. 1154 will not only strengthen VA's new efforts, but will also provide a permanent correction through closing all possible loopholes and by implementing a stronger, non-discriminatory, uniformed access policy.

AMVETS supports H.R. 1855, the "Veterans Traumatic Brain Injury Rehabilitative Services Act of 2011". While AMVETS is aware that Traumatic Brain Injuries (TBI) are physical injuries, we are also aware of the psychological and cognitive impact TBI can have on a veteran. The irrefutable medical data showing the correlating symptoms of TBI and several psychological disorders clearly illustrates the need for a more "holistic" approach in the treatment and care of veterans who have sustained a Traumatic Brain Injury. This being said, AMVETS strongly supports the language set forth by H.R. 1855, as we believe it will set standards of care in which all aspects of a veterans TBI will be addressed. We too often see veterans being treated for one injury at a time. AMVETS believes VA needs to address and treat the veteran and their injuries as a whole, in order to achieve the best physical and psychological outcomes of care. AMVETS applauds Congressmen Walz and Bili-

rakis for their initiative, through the introduction of H.R. 1855, in changing the way VA cares for TBI and its' related symptoms. AMVETS again lends our support to H.R. 1855.

AMVETS strongly supports H.R. 2074, the "Veterans Sexual Assault Prevention Act." AMVETS was, and still is, outraged by the Government Accountability Office's (GAO) report of findings regarding sexual assault in VA facilities, released in early June 2011. AMVETS finds it even more disturbing that hundreds of sexual assaults were not reported to VA leadership officials or the VA Office of the Inspector General, which is in direct violation of VA policy and Federal regulations. AMVETS finds it to be reprehensible that any veteran receiving care in a VA facility would be subject and/or at risk of being sexually assaulted or harassed. Moreover, AMVETS finds it inexcusable that VA leadership, at all levels, has allowed such occurrences to continue to happen without taking strong actions to protect the same veterans they have vowed to protect and care for. While AMVETS also understands that top VA leadership was not made aware of nearly 300 cases of sexual assault by VISN level leadership, AMVETS still finds it inexcusable that stronger procedures and safeguards were not already in place to address these types of matters before they escalated to current levels. In 2011, VA has the ability to provide electronic limbs, state of the art surgical procedures and world-class care to the veterans they serve. With that being said, AMVETS must respectfully ask why VA cannot provide even the most basic of safety measures in these same facilities? AMVETS concurs with the Chairwomen's statement that *"Never should a warrior in need take the brave step of getting help and be met with anything less than safe, supportive, and high quality care in an atmosphere of hope, health, and healing."* Furthermore, AMVETS also concurs with Chairman Miller's statement that *"In the past week, some have dismissed these allegations, comparing the size of the VA system and the number of allegations, to the private sector. Let me be very clear on this point—there is no comparison. Just one assault of this nature, one sexual predator, or one veteran's rights being violated within the VA is one too many and is absolutely unacceptable."* AMVETS applauds Congresswoman Buerkle and Chairman Miller for their swift actions in an effort to correct these gross and intolerable errors and urges all Members of Congress to follow their lead through the swift passage of H.R. 2074.

AMVETS supports H.R. 2530, to amend Title 38 to provide increased flexibility in establishing rates for reimbursement of State homes by the Secretary of the Department of Veterans Affairs for nursing home care provided to veterans. At a time in our Nation's history when we simultaneously have a large influx in aging veterans requiring home care and disabled veterans returning with substantial injuries also requiring home care, it is time to revisit the policies and procedures associated with our State Veterans Homes (SVH). In December 2006, P.L. 109–461, the "Veterans Benefits, Health Care, and Information Technology Act of 2006", authorized the VA to pay higher per-diem payments for care in SVHs to certain veterans with service-connected disabilities. This long-awaited regulation was issued in April 2009, with a retroactive effective date of March 2007. However, it took the VA 2 years to issue the rules and regulations to implement P.L. 109–461 and yet the rates are still not up to par. Currently, per-diem payments do not cover the full cost of providing services to veterans residing in SVHs, which has resulted in many SVHs to lose millions of dollars and even worse, due to these losses the inability to admit and care for more severely disabled veterans in their facilities. This has become a huge problem for the Medicare/Medicaid certified SVHs operating in 31 States, because current statutory language notes that the "per-diem rates paid by VA constitute payment in full." Thus, SVHs are prohibited from billing Medicare and Medicaid for services they provide to disabled veterans, yet are not reimbursed for by VA. These services include, but are not limited to, X–Rays, labs, PET scans, dialysis and many other critical and medically necessary medical procedures and tests. In reality the current "actual per-diem payments" provided by VA to SVHs have increased, but the total reimbursement is much lower than what SVHs received prior to the enactment of P.L. 109–461, as a result of their inability to bill Medicare and Medicaid. This is an issue that has been overlooked for too long and has resulted in too many veterans not being able to receive the care they need. AMVETS strongly supports H.R. 2530 and urges its swift passage.

AMVETS also supports draft legislation, the "Veterans Health Care Facilities Capital Improvement Act of 2011". AMVETS finds this piece of legislation to be of the utmost importance. While the bill addresses several different matters, AMVETS biggest concern is regarding VA's enhanced lease program. As we are all aware, Secretary Shinseki has laid out a plan who's ultimate goal is to end homelessness among veterans within 5 years. There has been no opposition to this goal from any Member of Congress or the VSO community. It is a fair assumption to believe we

all want to end homelessness among our veteran population as soon as possible. However, AMVETS believes a critical piece of the Secretary's plan is in danger of being eliminated. More specifically, VA's enhanced lease program.

VA's enhanced lease program is responsible for, and comprised of facilities used for, over 95 percent of VA's homeless and at risk veteran and family housing units. If this program were to be allowed to expire, thousands of veterans and their families will find themselves with nowhere to go, except back to the streets. AMVETS believes that if we are to realize the goal of ending homelessness among the population of men and women who have so selflessly served our great nation, we must pass this piece of legislation to ensure the continuance of the enhanced lease program. Again, AMVETS supports the "Veterans Health Care Facilities Capital Improvement Act of 2011" of legislation and urges its quick passage.

Finally, AMVETS supports draft legislation, the "Honey Sue Newby Spina Bifida Attendant Care Act", to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide assisted living services to certain children of Vietnam veterans who are suffering from Spina bifida.

Chairwoman Buerkle and distinguished Members of the Subcommittee, AMVETS would again like to thank you for inviting us to share with you our opinions and recommendations on these very important pieces of legislation. This concludes my testimony and I stand ready to answer any questions you may have for me.

Prepared Statement of Robert L. Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Chairwoman Buerkle, Ranking Member Michaud, and distinguished Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on H.R. 198, the Veterans Dog Training Therapy Act; H.R. 1154, the Veterans Equal Treatment for Service Dogs Act (VETS Dogs Act); H.R. 1855, the Veterans' Traumatic Brain Injury Rehabilitative Services' Improvements Act of 2011; H.R. 2074, the Veterans Sexual Assault Prevention Act; and H.R. 2530, a bill to increase flexibility in establishing rates for reimbursement of State Homes. Joining me today are Jim Sullivan, Director of the Office of Asset Enterprise Management; Jane Clare Joyner, Deputy Assistant General Counsel; and Charlma Quarles, Deputy Assistant General Counsel. We have not had sufficient time to develop official views and estimates regarding the draft Honey Sue Newby Spina Bifida Attendant Care Act or section 9 of the draft Veterans Health Care Facilities Capital Improvement Act of 2011. We will forward the views and estimated costs on these items to you as soon as they are available.

H.R. 198 "Veterans Dog Training Therapy Act"

H.R. 198 would require the Secretary, within 120 days of enactment, to carry out a pilot program to assess the effectiveness of addressing post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms of Veterans through a therapeutic medium of training service dogs for other Veterans with disabilities. The bill would require the Secretary to conduct the pilot program at a minimum of three but not more than five Department of Veterans Affairs (VA) medical centers for a 5 year period. Veterans diagnosed with PTSD or other post-deployment mental health conditions would be eligible to volunteer to participate. The bill requires that the VA medical centers selected as program sites have available the following resources: a dedicated space suitable for grooming and training dogs indoors, classroom and office space, storage capacity, other areas for periodic use of training dogs with wheelchairs and for other exercises, outdoor exercise and toileting space for dogs, and the provision of weekly field trips to train dogs in other environments. The pilot program must be administered under the direction of a certified recreational therapist, and the Secretary would be required to establish a Director of Service Dog Training with specific experience such as experience in teaching others to train service dogs in a vocational setting, to oversee the training of service dogs at selected VA medical facilities. Each pilot site would also be required to have certified service dog training instructors.

The bill also includes provisions concerning the service dogs themselves. The bill requires VA to ensure that each service dog in training is purpose-bred for this work with an adequate temperament and health clearance. Dogs in animal shelters or foster homes are not to be overlooked as candidates, but only as determined appro-

priate by VA. The Secretary must also ensure that each service dog in training is taught all essential commands required of service dogs, that the service dog in training lives at the pilot program site or at a volunteer foster home while receiving training, that the pilot programs include both lecture of service dog training methodologies and practical hands-on training and grooming of service dogs, and that the programs are designed to maximize the therapeutic benefit of the Veterans participating in the program and to produce well-trained service dogs for Veterans with disabilities. The Secretary would be required to give hiring preference for service dog training instructor positions to Veterans who have successfully graduated from PTSD or other residential treatment programs and who have received adequate certification in service dog training.

VA would be required to collect data on the pilot program and determine its effectiveness for the Veteran participants. Specifically, under this bill, VA must consider whether the pilot program effectively reduces the stigma associated with PTSD or other post-deployment mental health conditions, improves emotional regulation or patience, instills or re-establishes a sense of purpose among participants, provides an opportunity to help fellow Veterans, facilitates community reintegration, exposes service dogs to new environments in order to help Veterans reduce social isolation and withdrawal, builds relationship skills, relaxes the hyper-vigilant survival state, improves sleep patterns, and enables Veterans to decrease the use of pain medication. VA would be required to submit an annual report to Congress following the end of the first year of the pilot program and each year thereafter to inform Congress about the details of the program and its effectiveness in specific areas.

VA recognizes the therapeutic value to Veterans diagnosed with PTSD of training service dogs for persons with disabilities; however, VA cannot support H.R. 198.

VA has used Animal Assisted Therapy, or Animal Facilitated Therapy, for many years as part of VA's comprehensive approach to health care. VA is currently utilizing therapy dogs as a component of treatment in a number of facilities and settings, including VA's Community Living Centers, palliative care units, and most recently in recovery treatment programs. In July 2008, a Service Dog Training Program was established as a therapy component at the Palo Alto Veterans Healthcare System (Menlo Park Division), in collaboration with Bergin University. Patients who have been diagnosed with PTSD and assigned to the Men and Women's Trauma Recovery Program have the option to participate in the training of service dogs as one of their activities in their comprehensive recovery program. This training focuses on basic obedience (e.g., commands such as "sit," "stay," and "heel") and public access skills (sensitizing dogs to different environments) to prepare the dogs to become service dogs for persons with mobility impairments. Initial patient self-reports and informal observations by staff have been positive, and VA staff members have indicated that the training of dogs, in combination with established recovery therapies, is showing promise.

H.R. 198 imposes specific requirements that focus on the training of service dogs. The bill is very prescriptive as to the requirements of the proposed pilot program (e.g., staffing guidelines), and it would require evaluation of a large and very detailed list of factors, many of which cannot be measured with any degree of specificity or reliability. We are available to work with the Committee to design a workable program and an appropriate mechanism to evaluate whether training service dogs is a clinically appropriate form of treatment.

VA estimates the total cost for this bill would be $2 million in the first year of the program and $10 million over 5 years.

H.R. 1154 "Veterans Equal Treatment for Service Dogs Act (VETS Dogs Act)"

H.R. 1154 would prohibit the Secretary from excluding service dogs from any VA facilities or property or any facilities or property that receive funding from VA.

VA acknowledges that trained service dogs can have a significant role in maintaining functionality and promoting maximum independence of Veterans with disabilities. VA recognizes the need for persons with disabilities to be accompanied by their trained service dogs on VA properties consistent with the same terms and conditions, and subject to the same regulations as generally govern the admission of members of the public to the property. However, H.R. 1154 is unnecessary.

Under existing statutory authority in 38 U.S.C. § 901, VA can implement national policy for all VA properties, and in fact did so for VHA facilities and property on March 10, 2011 (VHA Directive 2011–013), directing that both Veterans and members of the public with disabilities who require the assistance of a trained guide dog or trained service dog be authorized to enter VHA facilities and property accompanied by their trained guide dog or trained service dog consistent with the same

terms and conditions, and subject to the same regulations that govern the admission of members of the public to the property. We would be glad to provide a copy of the Directive for the record. This Directive requires each Veterans Integrated Service Network (VISN) Director to ensure all VHA facilities have a written policy on access for guide and service dogs meeting the requirements of the national policy by June 30, 2011, and VA is reviewing these policies to ensure their compliance with national standards. In addition, VA intends to initiate rulemaking that will establish criteria for service dog access to all VA facilities and property in a manner consistent with the same terms and conditions, and subject to the same regulations, as generally govern the admission of members of the public to the property while maintaining a safe environment for patients, employees, visitors, and service dogs.

H.R. 1154 would prohibit the Secretary from excluding service dogs from any facility or on any property that receives funding from the Secretary. Such a prohibition is unnecessary because it duplicates other statutes discussed below.

Any non-VA facilities and properties with which H.R. 1154 is concerned that are also owned or controlled by the Federal Government must under current law at 40 U.S.C. § 3103, admit on the same terms and conditions, and subject to the same regulations, as generally govern the admission of the public to the property, specially trained and educated guide dogs or other service animals accompanying individuals with disabilities. Other non-VA properties not otherwise owned or controlled by the Federal Government, including but not limited to professional offices of health care providers, hospitals, and other service establishments, will almost certainly meet the definition of a place of public accommodation or public entity under the Americans with Disabilities Act of 1990 as prescribed in regulations at 28 CFR §§ 35.104 and 36.104, and therefore be required to modify their policies, practices, or procedures to permit the use of a service animal by an individual with a disability in accordance with 28 CFR §§ 35.136 and 36.302. We would note that VA facilities are not subject to the Americans with Disabilities Act of 1990, but are subject to the Rehabilitation Act. The Rehabilitation Act does not specifically address the issue of service dogs in buildings or on property owned or controlled by the Federal Government, but does prohibit discrimination against individuals with disabilities, including those who use service animals, in Federally-funded or -conducted programs and activities. In addition, as explained above, there are other existing authorities that address the issue of bringing guide dogs and other service animals onto VA property.

VA estimates that there would be no costs associated with implementing this bill.

H.R. 1855 "Veterans' Traumatic Brain Injury Rehabilitative Services' Improvements Act of 2011"

In 2008, Congress established several programs targeted at the comprehensive rehabilitation of Veterans and members of the Armed Services receiving VA care and services for Traumatic Brain Injuries (TBI). In general, H.R. 1855 seeks to improve those programs (established by 38 U.S.C. §§ 1710C–E) by requiring rehabilitative services, as defined by the bill and discussed below, to be an integral component of those ongoing programs. With one exception, we have no objection to H.R. 1855.

Currently, the provisions of 38 U.S.C. § 1710C set forth the requirements for an individualized rehabilitation and reintegration plan that must be developed for each Veteran or member of the Armed Forces receiving VA inpatient or outpatient rehabilitative hospital care or medical services for a TBI. VA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan,* implements section 1710C.

Section 2(a) of H.R. 1855 would amend some of the mandated requirements in section 1710C. Specifically, it would clarify that the goal of each individualized plan is to maximize the individual's independence and quality of life. It would also require, as part of a plan's stated rehabilitative objectives, the sustaining of improvements made in the areas of physical, cognitive, and vocational functioning. Section 2(a) of the bill would further require that each such plan include rehabilitation objectives for improving and sustaining improvements in the individual's behavioral functioning as well as mental health.

These amendments would not alter VA's policy or operations in any significant way, as VA's primary aim for Veterans with serious or severe injuries has always been, and continues to be, maximizing their independence, health, and quality of life. It is out of these concerns that VA has developed robust rehabilitation therapy programs to help them learn or re-learn skills and develop resources for sustaining gains made in their rehabilitation.

Section 2(a) of the bill would require the individual plans to include access, as warranted, to all appropriate rehabilitative *services* of the TBI continuum of care.

The law now requires these plans to provide access, as warranted, to rehabilitative *components* of the TBI continuum of care (which includes, as appropriate, access to long-term care services).

Current law also requires that each individualized plan include a description of the specific "rehabilitation treatments and other services" needed to achieve the patient's rehabilitation and reintegration goals. Section 2(a) of the bill would replace all references to "treatments" in the affected provision with "services." This would ostensibly broaden the scope of rehabilitative benefits available to these patients beyond what is deemed to be treatment *per se*.

It would also add to each plan the specific objective of improving (and sustaining improvements in) the patient's behavioral functioning. That addition, together with the existing rehabilitation objective to improve a patient's cognitive functioning, would effectively encompass all relevant mental health issues related to TBI. For that reason, we believe the bill's other amendment to separately include a rehabilitation objective for improving "mental health" would create confusion or redundancy. We thus recommend that language be deleted.

Most notably, Section 2(a) of H.R. 1855 would establish a new definition of the term "rehabilitative services," for purposes of all of VA's specially targeted, statutory programs for TBI patients (i.e., 38 U.S.C. §§ 1710C–E). Such services would include not only those that fall under the current statutory definition found in 38 U.S.C. § 1701 but also "services (which may be of ongoing duration) to sustain, and prevent loss of, functional gains that have been achieved." In addition, they would include "any other services or supports that may contribute to maximizing an individual's independence and quality of life." This last definition is overly broad and could be read to include services or items well beyond the field of health care. It is also unworkable. What maximizes an individual's "quality of life" is highly subjective and, as such, the term defies consistent interpretation and application. We believe enactment of that last provision of the proposed new definition would conflict with and exceed our primary statutory mission, which is to provide medical and hospital care. It should therefore be deleted, leaving only the first two prongs of the definition.

Next, as briefly alluded to above, the individualized rehabilitation and reintegration plans required by section 1710C must include access, where appropriate, to long-term care services. The eligibility and other requirements of VA's mandated comprehensive program of long-term care for the rehabilitation of post-acute TBI are found in 38 U.S.C. § 1710D. Section 2(b) of H.R. 1855 would require the Secretary to include rehabilitative services (as that term would be defined by Section 2(a) of the bill) in the comprehensive program. It would also eliminate the word "treatment" in the description of the interdisciplinary teams to be used in carrying out that program. We have no objection to this proposed revision.

Lastly, Congress authorized VA, under specified circumstances, to furnish hospital care and medical services required by an individualized rehabilitation and reintegration plan through a cooperative agreement. (A cooperative agreement may be entered only with an appropriate public or private entity that has established long-term neurobehavioral rehabilitation and recovery programs.) This authority is found at 38 U.S.C. § 1710E. Section 2(c) of H.R. 1855 would add "rehabilitative services" (again as defined by Section 2(a) of the bill) to the types of services that may be provided under those agreements. We have no objection to this proposed revision.

Finally, we note as a technical matter that there is a typographical error in the spelling of "ophthalmologist" in Section 1710C(c)(2)(S) of title 38, U.S.C. Additionally, current law permits inclusion of "educational therapists" among the TBI experts responsible for conducting comprehensive assessments of these patients. (These assessments are then used to design the individualized plans discussed above.) However, this categorization of professionals is no longer used in the field of medical rehabilitation.

We do not otherwise object to H.R. 1855. No new costs would be associated with its enactment.

H.R. 2074 "Veterans Sexual Assault Prevention Act"

H.R. 2074 would amend title 38, United States Code, by adding a new section 1709 known as the "Veterans Sexual Assault Prevention Act." Section 1709 would require VA to "develop and implement a centralized and comprehensive policy on the reporting and tracking of sexual assault incidents and other safety incidents that occur" at VA medical facilities including incidents of sexual assault, criminal and purposeful unsafe acts, alcohol or substance abuse related acts, and acts involving abuse of a patient. VA would need to develop and implement this policy by October 1, 2011. In addition, Section 1709(d) would require VA to submit an annual report to Congress discussing implementation and effectiveness of the policy.

VA considers the safety and security of our Veterans, employees and visitors to be among our highest priorities. We take all allegations seriously and investigate them thoroughly.

In response to a recent Government Accountability Office (GAO) report (GAO–11–530) entitled "VA Health Care: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents," VA has convened an interdisciplinary Safety/Security Workgroup including representatives from VHA and VA corporate offices, including the Office of Operations, Security and Preparedness (OSP) and the Office of General Counsel. VA has charged the Safety/Security Workgroup to define steps necessary to ensure VA is taking every action required to respond effectively to reports of sexual victimization of Veterans, employees, and visitors. The Workgroup is developing appropriate proactive interventions to reduce the risk of these events, testing a computerized reporting system for ongoing data tracking and trending, and is currently establishing guidance for training of staff and providers. Initial action plans from the Workgroup have been submitted, with a final written report to be completed by September 30, 2011. The Workgroup's Chairs provide weekly updates to VA's Under Secretary for Health, ensuring that leadership is aware of the progress being made and can intervene to continue our efforts to improve facility safety.

We believe H.R. 2074 is unnecessary because our current efforts are fulfilling much of what it would require. In addition to the Workgroup, VA is already undertaking other efforts to enhance the safety and security of our facilities. For example, VA is evaluating its risk assessment tools and is developing enterprise-wide assessments that consider issues beyond the Veteran's legal history and medical record. VA is taking steps to consider universal risk for violence and design appropriate intervention actions. These are important steps to improve evaluations of patient risk. Mandatory training on security issues is also in development, and VA plans to provide educational materials for patients and visitors as well so they can help contribute to a safer VA environment for everyone. VA's Integrated Operations Center (IOC), established in 2009, provides oversight of VA facilities 24 hours a day, 7 days a week and is responsible for collecting any reports of serious incidents, including alleged criminal behavior at VA facilities. VHA is already developing an oversight system like that described in the bill. It will be in place later this summer, and will have clear and consistent guidance on the management and treatment of sexual assaults by the end of 2011.

While we agree with many of the aims of H.R. 2074, and are proceeding with similar initiatives, we do have several concerns with the bill as written. First, the timeline for the implementation of this policy is not feasible. VA is committed to enacting this policy, but needs time to complete work on reporting tools and processes and to pilot these initiatives before the policy will be fully implemented so that we can achieve the shared goal of increased safety. Second, VA is concerned that the term "other safety incidents" is overly broad. While the bill requires VA to define the term "safety incident" and provides the Secretary the authority to prescribe regulations to implement the legislation, "other safety incidents" could be read broadly to include any safety incident, including workplace issues (such as a slip and fall situation) and occupational safety concerns. VA believes the intent of this provision is to focus on the security of patients, employees and visitors, and we will define this term accordingly. We are happy to work with the Committee to refine this language in the legislation.

VA also has serious concerns with the requirement that VA report "alcohol or substance abuse related acts" committed by Veterans. VA is an integrated health care system that treats all of the health care needs of Veterans, including substance use disorders and alcoholism. With our focus on universal precautions, we will assess all potential risks, not just those associated with substance use disorders. Alcohol and drug misuse are associated with a host of medical, social, mental health, and employment problems. Fortunately, these problems are treatable and with treatment, the lives of our patients and their loved ones can be enriched. VA does not want to create a disincentive for Veterans to seek treatment for these conditions and recommends that this provision be deleted from the bill.

Since VA is already making significant improvements in our tracking and reporting system that meet or exceed the requirements of the legislation, we estimate that this bill would result in no additional costs. We appreciated the opportunity to discuss this issue and hear your recommendations on June 13. We are happy to meet with the Committee to discuss this issue in more detail.

H.R. 2530 Increased Flexibility in Rates of Reimbursement for State Homes

H.R. 2530 would require State homes and VA to contract, or enter into a provider agreement under 38 U.S.C. § 1720(c)(1)(A), for the purpose of providing nursing

home care in these homes to Veterans who need it for a service-connected condition or have a service-connected rating of 70 percent or greater. This payment methodology would replace the current per diem grant payments for these Veterans which were implemented in 2009. VA supports this provision in principle as subsection (a)(1) is consistent with section 104 of VA's draft bill "Veterans Health Care Act of 2011," which was transmitted to Congress on June 7, 2011.

We do have technical concerns with how the bill would treat provider agreements, as distinguished from arrangements with State Veterans Homes on a contract basis. The requirement in subsection (a)(2) that payments under each provider agreement be based on a methodology developed by VA in consultation with the State home would prevent VA from using provider agreements with State homes. The authority for using provider agreements in 38 U.S.C. § 1720(c)(1)(A) essentially authorizes VA to enter into agreements like the Centers for Medicare and Medicaid Services (CMS) does under the Medicare program without entering into contracts. There are no procedures for negotiating rates of payments under the Medicare program. This facilitates entering into these agreements. If H.R. 2530 were enacted and negotiations are required under this authority, VA would only be able to contract. We are happy to work with the Committee to refine this language in the legislation.

VA estimates that there would be no additional costs associated with H.R. 2530.

H.R. _____ "Veterans Health Care Facilities Capital Improvement Act of 2011"

H.R. _____, the "Veterans Health Care Facilities Capital Improvement Act of 2011", would authorize certain Department of Veterans Affairs major medical facility projects and leases, extend certain expiring provisions of law, and modify certain other authorities. Specifically, this bill would provide authorization for major medical facility construction projects and major medical facility leases, all of which are consistent with projects and leases requested in Department of Veterans Affairs' draft construction authorization bill.

Section 2 would authorize construction of a project for seismic corrections for Building 100 in Seattle, Washington, in an amount not to exceed $51,800,000. Also authorized is a project for construction of seismic corrections and renovation of various buildings, the initial phase of which is Building 209 for housing facilities for homeless Veterans in West Los Angeles, California, in an amount not to exceed $35,500,000.

Section 3 would modify the authorization of five major medical facility construction projects. The authorization of the Veterans Affairs Medical Center in Fayetteville, Arkansas, would be modified to include a parking garage. The total amount for this project is $90,600,000. The previous extension of authorization for the project at the Veterans Affairs Medical Center in Orlando, Florida is modified to include a Simulation, Learning, Education and Research Network Center. The amount of the previously authorized project for the project at the Veterans Affairs Medical Center in Palo Alto, California, is increased to $716,600,000. The amount of the previously authorized project at the Veterans Affairs Medical Center in San Juan, Puerto Rico, is increased to $277,000,000. The amount of the previously authorized project at the Veterans Affairs Medical Center in St. Louis, Missouri, is increased to $346,300,000.

Section 4 would authorize the Secretary to carry out eight major medical facility leases, all of which were included in VA's draft construction bill. Specifically, Section 4 would authorize the Secretary to carry out major medical facility leases for a community-based outpatient clinic in Columbus, Georgia, in an amount not to exceed $5,335,000; an outpatient clinic in Fort Wayne, Indiana, in an amount not to exceed $2,845,000; an outpatient clinic in Mobile, Alabama, in an amount not to exceed $6,565,000; an outpatient clinic in Rochester, New York, in an amount not to exceed $9,232,000; a community-based Outpatient Clinic in Salem, Oregon, in an amount not to exceed $2,549,000; an outpatient clinic in San Jose, California, in an amount not to exceed $9,546,000; an outpatient clinic in South Bend, Indiana, in an amount not to exceed $6,731,000; and, a community-based outpatient clinic in Springfield, Missouri, in an amount not to exceed $6,489,000.

Section 5 would authorize appropriations for the projects and leases listed in Sections 2, 3 and 4, subject to certain limitations. With the exception of Section 5(b), this section is consistent with the Department of Veterans Affairs draft construction authorization bill. Section 5(b) indicates that $850,070,000 is authorized to be appropriated for certain major medical facility projects that were previously authorized. However, we believe the correct amount to be authorized for Section 5(b) is $914,507,000.

Section 6 would make certain amendments to VA's enhanced-use lease (EUL) authority, including granting a much-needed 10-year extension to the current legislation, before it expires at the end of this calendar year. Section 6 of the draft bill would also allow the Secretary to consider proposed EUL business plans by other organizations within the Department, as opposed to just VA's Veterans Health Administration. Third, the draft bill would incorporate certain business parameters to ensure EUL compliance with the latest capital scoring rules and guidelines. Fourth, it would allow the Department to deposit and use future EUL proceeds as part of the agency's major and minor construction accounts. And fifth, the draft bill would add clarifying language to emphasize that the Federal Government's underlying real property ownership, and leaseback of any lands through EULs are exempt from State and local taxes, fees, and assessments. I would like to thank the Subcommittee for addressing VA's EUL authority extension in the Veterans Health Care Facilities Capital Improvement Act of 2011.

The EUL authority was enacted in August 1991, and is codified in sections 8161 through 8169 of title 38 of the U.S. Code. In 2001, the authority was renewed for an additional 10 years through the end of 2011. The Department's authority to enter into additional EUL agreements will expire on December 31, 2011. Without a reinstatement of the EUL authority, VA will no longer have the mechanism in place to acquire third-party investment for new facilities, space, services or revenue to serve Veterans.

The EUL authority allows VA to outlease land and improvements under the department's jurisdiction or control, to public or private sector entities for up to 75 years. In return, VA receives negotiated monetary and/or in-kind consideration. The outleased property is developed, used, and maintained for agreed-upon uses that directly or indirectly support VA's mission.

EULs have provided a variety of benefits such as enhanced services to Veterans, operations and maintenance cost savings, private investment, new long-term revenue for VA, job creation, and additional tax revenues for local, State and Federal sectors. In some instances, EULs have helped VA meet its environmental goals by creating on-site renewable energy facilities enabling VA to reduce its greenhouse gas emissions.

Since the original EUL legislation passed in August 1991, more than 60 projects have been awarded—18 of these for housing providing 1,066 housing units benefiting Veterans. From FY 2006 to 2010, EULs have generated approximately $266 in total consideration.

In terms of Veterans housing, EUL provides multiple benefits: helping to reduce homelessness among our Veterans while leveraging underutilized assets, reducing the inventory of underutilized real estate, and transferring the operation and maintenance costs to the developers—while maintaining VA control of the underlying assets.

Currently, VA has 19 EUL projects underway to provide nearly 2,200 units of housing for homeless Veterans and their families; and approximately 600 units of assisted living and senior housing, which will be curtailed if VA's EUL authority is not extended.

Additionally, if VA's EUL authority is not extended, it will halt another 34 housing projects under VA's Building Utilization Review and Reuse (BURR) Initiative, which involves approximately 1,700 units of housing for homeless Veterans, and 900 units of senior, non-senior independent living, and assisted living housing for Veterans.

Congressional approval of VA's EUL authority extension is critical for VA to continue the successful efforts to facilitate the provision of homeless housing for Veterans and their families through public/private ventures. EUL is a valuable tool used by the Secretary in VA's multi-faceted approach to eliminate Veteran homelessness. If the EUL authority is not extended, a total of 5,500 housing units for homeless Veterans and Veterans at-risk-for homelessness will be affected.

Section 7 of the Act would modify the requirements relating to Congressional approval of certain medical facility acquisitions. Specifically, the Secretary would be required to submit additional information in the prospectus for each major construction facility. We do not object to these modifications.

Section 8 would designate the Department of Veterans Affairs telehealth clinic in Craig, Colorado as the "Major William Edward Adams Department of Veterans Affairs." The Department has no objection to this proposal and defers to Congress in the naming of Federal property.

Section 9 would extend certain expiring authorities. Subsection (a) of section 9 would amend 38 U.S.C. § 1703 to extend the recovery audit program for fee basis and other medical service contracts until September 30, 2020. This authority is currently set to expire on September 30, 2013.

Subsection (b) would amend 38 U.S.C. § 2031 to extend until December 31, 2018, VA's authority to provide certain services to seriously mentally ill Veterans. Title 38 U.S.C. § 2031(a) authorizes VA to provide to seriously mentally ill Veterans, including homeless Veterans, (1) outreach services, (2) care, treatment, rehabilitation, and other services, and (3) therapeutic transitional housing assistance. This authority is currently set to expire on December 31, 2011.

Subsection (c) would amend 38 U.S.C. § 2033 to extend until December 31, 2018, VA's authority to expand and improve benefits to homeless Veterans. Title 38 U.S.C. § 2033 authorizes VA, subject to appropriations, to operate a program to expand and improve the provision of benefits and services to homeless Veterans. The program includes establishing sites under VA jurisdiction to be centers for the provision of comprehensive services to homeless Veterans in at least each of the 20 largest metropolitan statistical areas. This authority is currently set to expire on December 31, 2011.

Subsection (d) would amend 38 U.S.C. § 2041(c) to extend, through December 31, 2018, the Secretary's authority to enter into agreements with homeless providers for the purpose of selling, leasing, or donating homes acquired through the guaranteed loan program. This authority is currently set to expire on December 31, 2011.

Subsection (e) would amend 38 U.S.C. § 2066 to extend Congressional authority to continue the Advisory Committee for Homeless Veterans until December 31, 2018. This authority is currently set to expire on December 30, 2011.

Subsection (f) would amend 38 U.S.C. § 8118(a)(5) to extend until December 31, 2018, the Secretary of VA's authority to transfer real properties under his jurisdiction and control, to other Federal agencies, State agencies, public or private entities, or Indian tribes. This authority is currently set to expire on December 31, 2011.

While VA requested extensions of sections 2031, 2033, 2041 and 2066 of title 38, U.S.C. in our draft bills the "Veterans Health Care Act of 2011" and "Veterans Benefit Programs Improvement Act of 2011," which were transmitted to Congress on June 7 and May 19, 2011, the draft "Veterans Health Care Facilities Capital Improvement Act of 2011" would extend these authorities for a considerably longer period of time. VA requires additional time to evaluate these provisions and we will provide views and costs on this section for the record.

This concludes my prepared statement. Thank you for the opportunity to testify before the Subcommittee. I would be pleased to respond to any questions you or Members of the Subcommittee may have.

Prepared Statement of Fred S. Sganga, President, National Association of State Veterans Homes

I. Overview

The National Association of State Veterans Homes ("NASVH") appreciates the opportunity to submit this statement on H.R. 2530, sponsored by Mr. Michaud and Chairman Miller. The bill will provide for increased flexibility in establishing rates of reimbursement for State Veterans Homes by the Secretary of Veterans Affairs for nursing home care provided to service-connected disabled veterans. The text of H.R. 2530 is identical to legislative language approved by the Senate Committee on Veterans' Affairs on June 29, 2011, as section 109 of S. 914.

H.R. 2530 is intended to remedy the consequences of the implementation of section 211(a) of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Pub. L. No. 109–461) (the "2006 Act"). Section 211(a) of the 2006 Act established new payment mechanisms by the VA for the long-term care of service-connected disabled veterans at State Veterans Homes (the "70 Percent Program"). NASVH believes that the 70 Percent Program must be remedied promptly by legislation. Continuation of the 70 Percent Program in its current form will not only inhibit the long-term care of service-connected disabled veterans, but will also threaten the financial viability of many of the Nation's State Veterans Homes.

NASVH's membership consists of the administrators and staff of State-operated Veterans Homes throughout the United States and in the Commonwealth of Puerto Rico. NASVH members currently operate 142 Veterans Homes in all 50 States and Puerto Rico. Our nursing homes provide over 29,000 nursing home and domiciliary beds for veterans and their spouses, and for the gold-star parents of veterans. Our nursing homes assist the VA by providing long-term care services for approximately 53 percent of the VA's long-term care workload at the very reasonable cost of only about 12 percent of the VA's long-term care budget. On average, the daily cost of

care of a veteran at a State Veterans Home is less than 50 percent of the cost of care at a VA long-term care facility.

Particularly in these times of tight Federal budgets and deficit reduction imperatives, the national State Veterans Home system is an economical alternative to other VA long-term care programs. In fact, a report by the VA's Office of Inspector General stated:

A growing portion of the aging and infirm veteran population requires domiciliary and nursing home care. The SVH [State Veterans Home] option has become increasingly necessary in the era of VAMC [VA Medical Center] downsizing and the increasing need to discharge long-term care patients to community based facilities. VA's contribution to SVH per diem rates, which does not exceed 50 percent of the cost to treat patients, is significantly less than the cost of care in VA and community facilities.

II. Inadequacies of the Current 70 Percent Program

Implementation of the 70 Percent Program has created very serious unintended consequences for State Veterans Homes throughout the country. The 70 Percent Program authorized payment of different per diem amounts by the VA to State Veterans Homes which provide nursing home care to veterans with service-connected disabilities. Although the 2006 Act creating the 70 Percent Program became effective on March 31, 2007, the VA did not issue regulations to implement the 70 Percent Program until April 29, 2009, and problems arose immediately with its implementation. Since that time, NASVH has met repeatedly with VA officials in an attempt to modify the 70 Percent Program administratively to solve these problems, but both NASVH and the VA now agree that some of the problems with the 70 Percent Program can only be solved fully by a modification of the law.

The problems with the 70 Percent Program are as follows. Although VA regulations implementing the 70 Percent Program state that the Program provides a "*higher* per diem rate" for veterans with service-connected disabilities, the regulations actually result in significantly *lower* total amounts being paid to many State Veterans Homes providing "skilled nursing care" to veterans with service-connected disabilities. In fact, the 70 Percent Program, in its current form, substantially underpays State Veterans Homes for "skilled nursing care," and pays State Veterans Homes only about 1/2 to 2/3 of what Medicare previously paid to State Veterans Homes for the same care of the same veterans, and only about 1/3 to 1/2 of what the VA currently pays itself for the same care of the same veterans with service-connected disabilities.

"Skilled nursing care" is relatively common nursing care that involves significant amounts of rehabilitative services such as physical therapy, occupational therapy, speech therapy, expensive pharmaceuticals, and specialty medical services that often are not easily accessible at a nearby VA Medical Center by a State Veterans Home. As implemented, the 70 Percent Program does not provide to many State Veterans Homes their total cost of "skilled nursing care" for service-connected disabled veterans, despite Congressional intent. This is a problem largely for those 34 States that have Medicare-certified State Veterans Homes and that provide a substantial amount of skilled nursing care to veterans with service-connected disabilities. The number of States that have Medicare-certified State Veterans Homes that provide "skilled nursing care" is steadily increasing.

The 70 Percent Program's inadequate reimbursement levels have caused many State Veterans Homes that provide a substantial amount of skilled nursing care to veterans simply not to admit veterans to their State Veterans Homes under the 70 Percent Program, to limit the numbers of such admissions, or to admit veterans under the 70 Percent Program without restriction and expose themselves to substantial financial losses. This is exactly the opposite result sought by Congress when it passed the 2006 Act. In short, although the current 70 Percent Program is workable for some State Veterans Homes which provide largely non-skilled nursing care to veterans with service-connected disabilities, it causes substantial problems for an increasing majority of States in the Nation which provide substantial amounts of skilled nursing care to such veterans in State Veterans Homes. As such, the 70 Percent Program is not achieving its central intended purposes, and it must be corrected.

In addition, because of a quirk in the existing 70 Percent Program law, almost no State Veterans Home in the Nation actually is paid the "higher" prevailing per diem rate established by the VA for the 70 Percent Program. This is so because a combination of 38 U.S.C. §1745 and the VA regulations implementing §1745 require that State Veterans Homes be paid only "*the lesser of*" the per diem rate established by the VA for the 70 Percent Program or a rate determined under OMB

Form A–87. The OMB Form A–87 rate is almost always significantly less than the prevailing per diem rate published by the VA for the 70 Percent Program, and this has caused an additional financial hardship for State Veterans Homes.

Lastly, the most regrettable unintended consequence of the 70 Percent Program is that, for service-connected disabled veterans, it unnecessarily replaced a program (under 38 U.S.C. § 1741) that had worked well for decades for the States that have Medicare-certified State Veterans Homes with a program (under 38 U.S.C. § 1745) that has a multitude of regulatory and financial problems.

III. The Remedy Proposed by H.R. 2530

NASVH has been working with the VA since the 70 Percent Program regulations were implemented in 2009 to resolve these difficulties. Although reluctant to overhaul the program initially, the VA now has recognized the need for substantial changes. The VA transferred administrative responsibility for the financial aspects of the 70 Percent Program from the VA Office of Geriatrics and Extended Care to the VA Chief Business Office. NASVH has met several times with senior officials at the Chief Business Office and we are confident that they are sincerely trying to solve the problems of the 70 Percent program.

Most recently, the VA and its Chief Business Office have proposed to amend the current 70 Percent Program statutory language under 38 U.S.C. § 1745 to authorize the VA to enter into direct contracts with State Veterans Homes under 38 U.S.C. § 1720 that could adequately and accurately reimburse State Veterans Homes for providing long-term care to 70 Percent Program veterans. This is, in essence, the remedy proposed by H.R. 2530. However, this solution will work effectively only if it is implemented fairly by the VA, taking into account the following considerations.

First, as stated above, NASVH is working with the VA Chief Business Office to develop adequate and accurate reimbursement measures for the long-term care of 70 Percent Program veterans. The most equitable approach appears to be to establish that payments by the VA for *basic* long-term care under section 1720 contracts be comparable to the existing "higher" prevailing per diem rate established by 38 U.S.C. § 1745. This is a mechanism that will work effectively to reimburse State Veterans Homes for the basic nursing care of service-connected disabled veterans.

Second, any payment program implemented by the VA should require that payments by the VA for "outlier" specialty medical services and drugs provided to veterans by State Veterans Homes under a section 1720 contract be made at rates and under eligibility criteria comparable to those used by Medicare. Rather than leave the determination of the reimbursement levels for such services provided to service-connected disabled veterans to the whims or annual changes in VA policy or personnel, Medicare payment levels and eligibility criteria can serve as constant and fair guidance for any VA program to reimburse State Veterans Homes for "outlier" specialty medical services and drugs under section 1720 contracts for the long-term care of service-connected disabled veterans.

Third, we emphasize that a contract is a two-sided instrument. Both sides must agree for a contract to exist. The ability of a State Veterans Home to enter into a contract with the VA for the long-term care of a service-connected disabled veteran means necessarily that a State Veterans Home also has the option *not* to enter into such a contract, if the State Veterans Home believes that the reimbursement terms offered by the VA for the care of such a veteran are not adequate. In short, the VA will succeed in having State Veterans Homes provide significant amounts of nursing home care to service-connected disable veterans only if the VA pays State Veterans Homes adequately for such care.

Lastly, it is important for the Subcommittee to realize that the enactment of the above provisions should not cost the Federal Government anything additional and should, in fact, save the Federal Government substantial amounts of money. This is so because of the simple fact that enactment of the Bill's proposals described above will encourage more service-connected disabled veterans to receive long-term care at State Veterans Homes rather than at VA long-term care facilities, and State Veterans Homes cost far less on a per veteran per day basis than VA long-term care facilities.

The cost differences are dramatic. The average cost per veteran per day at a VA long-term care facility is $944.25 (VA, Volume II, Medical Programs and Information Technology Programs, Congressional Submission, FY 2012 Funding and FY 2013 Advance Appropriations Request, page 1H–19). Assuming enactment of the proposals described above, the average cost per veteran per day at a State Veterans Home, including basic care, drugs, and outlier specialty costs is not likely to exceed $450.00 per day. Accordingly, every service-connected disabled veteran that receives long-term care at a State Veterans Home rather than at a VA long-term care facility

will save the Federal Government over $494 per day, or $180,310 per veteran per year.

Nationally, there are 24,422 State Veterans Home nursing facility beds that could be occupied by 70 Percent Program veterans. On the average, 13 percent of these beds, or almost 3,175 beds, are unoccupied. Approximately 2,000 additional State Veterans Home nursing facility beds that could be occupied by 70 Percent Program veterans are under construction. Accordingly, if State Veterans Homes were to fill only their currently vacant beds with 70 Percent Program veterans, the Federal Government would save approximately $5.7 billion over 10 years. If only half of the vacant State Veterans Home long-term care beds were filled by 70 Percent Program veterans instead of such veterans receiving long-term care services at VA long-term care facilities, the Federal Government would save $2.8 billion over 10 years.

Currently, however, many State Veterans Homes, especially those providing "skilled nursing care," are discouraging the admission of service-connected disabled veterans to their facilities because the payment structure under the current 70 Percent Program is so inadequate. The solution to this is to pay State Veterans Homes adequately and accurately to care for service-connected disabled veterans. State Veterans Homes cost far less on a per veteran per day basis than VA long-term care facilities. The VA should fully utilize a less-costly resource (State Veterans Homes) before using a more-costly resource (VA long-term care facilities). It is simply good business, and good veterans health care policy, for the Chief Business Office of the VA to seek to reimburse State Veterans Homes adequately for the long-term care of service-connected disabled veterans.

NASVH thanks the Subcommittee for its continuing efforts to solve this important problem, and we encourage the Members of the Subcommittee to favorably report H.R. 2530. We look forward to continuing to work with the VA and Congress to resolve these issues promptly so that we can better serve our Nation's veterans.

Prepared Statement of Rick A. Yount, Director, Paws for Purple Hearts

Madam Chairwoman and Members of the Subcommittee, as the Founder and Director of the Paws for Purple Hearts program, I would like to thank you for the opportunity to submit a statement for the record in support of H.R. 198, the Veterans Dog Training Therapy Act and H.R. 1154, the Veterans Equal Treatment for Service Dogs Act. I am pleased that the Subcommittee is recognizing the important roles that dogs are playing in helping to heal the physical and psychological wounds of our Nation's Veterans.

H.R. 198

Attached to this statement is an overview of the Paws for Purple Hearts (PPH) program that inspired the introduction of H.R. 198, the Veterans Dog Training Therapy Act. The program's pilot was originally implemented at the Palo Alto VA Trauma Recovery Program at Menlo Park commencing in July 2008. It has since expanded to DoD medical facilities, including Walter Reed Army Medical Center and the National Intrepid Center of Excellence for Psychological Health and Traumatic Brain Injury. The provisions of H.R. 198 are based on the PPH program developed at VA Menlo Park.

I created the PPH program based on my experience as a licensed social worker and certified service dog instructor. The program was designed to provide meaningful therapeutic activities based on the continued mission of caring for the needs of a fellow Veteran. The training was developed to address all three symptom clusters associated with post-traumatic stress disorder (PTSD). Since beginning this therapeutic intervention model 3 years ago at VA Menlo Park, I have witnessed amazing responses to this program from both active duty Servicemembers involved in the current conflicts, as well as Vietnam Veterans who have participated in the training of service dogs for their fellow Veterans. Many accredited assistance dog organizations involve prisoners and at-risk teens in the training of dogs to serve people with disabilities. When it comes to training dogs for Veterans, no one takes that task more seriously than those who served by their sides in conflict. Veterans who have experienced psychological wounds never stray from the core value of caring for their fellow Veterans. This warrior ethos serves as a powerful motivational tool to inspire Veterans with psychological injuries, including PTSD, to voluntarily participate in the training of service dogs for their comrades. After teaching hundreds of college students and at-risk teens to train service dogs, I have found no one more dedicated

to the cause than the Warriors and Veterans I have worked with in the PPH program.

Training a service dog for a fellow Veteran provides a valuable opportunity for the Veteran trainer to reintegrate into civilian life. As part of the training, the Veterans have the responsibility to teach the dogs that the world is a safe place. Through that process, they must convince themselves of the same. The Veteran trainers are taught to praise and treat the dogs when they hear a car backfire or other startling events. Rather than turning inward to ruminate on their past trauma, they must get outside of their own heads to focus on the dogs and their mission to help another Veteran. Additionally, the dogs act as social lubricants and offer opportunities to Veterans, who often isolate themselves from society, to experience positive interactions with members of the community. The training requires the emotionally numb Veterans to use demonstrative positive emotion in order to successfully teach their dogs. Veterans participating in the program have reported that using positive emotions to praise the dogs has significantly improved their family dynamics as their children respond to this positive parenting strategy.

PPH offers a symbiotic opportunity to address the needs of two cohorts of Veterans in one program. It is safe, available, cost-effective, and has earned the respect of VA and DoD health care providers. In addition to the recognized mental health benefits of the training, the quality of the service dogs that result from that training was documented recently by the History Channel's "Modern Marvels" program dedicated to dogs. Venuto, the PPH dog that was featured in the program, enhanced the mental health of 20+ Veterans with PTSD as they participated in his training. Venuto was then successfully partnered with a Veteran who is paraplegic as a result of a Spinal Cord Injury (SCI).

To substantially benefit over 20 Veterans with one dog allows the VA to provide outreach to a greater number of Veterans without the logistical challenges of providing a dog to each Veteran. Also, the Veteran trainers gain valuable dog handling and care skills should they receive a service dog in the future. As described in the attachment, the presence of the service dogs in training at VA and DoD medical facilities also benefits other patients and health care providers.

The positive clinical observations of the VA Menlo Park service dog training program were formally presented during workshops at the VA National Mental Health Conference and the International Society for Traumatic Stress Studies Conference in 2009. I was joined by a Menlo Park VA Staff Psychologist and a Recreational Therapist in making those presentations. The workshops inspired significant interest from other VA Medical Centers in replicating the program at their sites.

There is a great opportunity for collaboration between the VA and the DoD with regard to the training, provision, and research associated with service dogs. The Army Surgeon General held an Animal-Assisted Intervention Symposium in December of 2009. The Army Family Act Plan of 2010 identified "providing service dogs to Wounded Warriors" as the #2 priority out of 82 issues. The leadership at the National Intrepid Center of Excellence (NICoE) for Psychological Health and Traumatic Brain Injury under the Defense Centers of Excellence has embraced service dog training as an intervention worthy of research. The VA could simplify the task of collecting specified outcomes by partnering with the NICoE to avoid duplication of effort and waste of resources.

The VA has questioned whether there is a substantial need for service dogs by Veterans. This issue was addressed in a 2007 study published in the Psychosocial Process Journal that indicated 42 percent of randomly selected Veterans with SCI desired information concerning service dogs. The study determined that "Among veterans with SCI there is a substantial interest in service dogs. Health care providers have a responsibility for educating individuals with SCI about the potential benefits and drawbacks of service dogs and for facilitating the process of obtaining information from service dog training organizations." The study concluded that, "The VA could help support these organizations financially or establish training centers of its own to increase the availability of trained dogs in order to accomplish what Public Law 107–135 intended."

The Department of Veterans Affairs is not currently providing any funding for the service dog training therapy pilot program at VA Menlo Park, even though VA officials have recognized the therapeutic value of the program. Private donors provided the seed funding to demonstrate the efficacy of this intervention for the symptoms of PTSD. Although the Secretary currently has the authority to establish a VA funded Veterans service dog training pilot program, the Department has resisted taking any financial responsibility for this promising intervention. Consequently, enactment of H.R. 198 is necessary to sustain the VA Menlo Park pilot program and to expand this model to other VA treatment facilities.

H.R. 1154

I support the provisions of H.R. 1154, the Veterans Equal Treatment for Service Dogs Act, because Veterans should be afforded the same rights at VA facilities as other Americans are provided under the Americans with Disabilities Act. Language needs to be included in the bill to ensure that service dogs in training under the guidance of certified instructors associated with Veterans Dog Training Therapy programs receive the same status as fully trained service dogs for purposes of access to VA facilities.

Paws for Purple Hearts (PPH)

PROGRAM LOCATIONS

Palo Alto VA Health Care System
Trauma Recovery Program
Menlo Park, CA 94025

Walter Reed Army Medical Center
Warrior Transition Brigade
Washington, DC 20307

National Intrepid Center of Excellence
National Naval Medical Center
Bethesda, MD 20889

INTRODUCTION

Paws for Purple Hearts (PPH) is a dual-purpose program created to meet the needs of Servicemembers and Veterans with physical and/or psychological injuries. The approach uses the process of service-dog training to remediate Post-Traumatic Stress symptoms in Servicemembers and Veterans. The trained dogs are then placed with fellow Veterans who have mobility-limiting injuries.

Founded on the time-honored tradition of Veterans-helping-Veterans, PPH enables Servicemembers and Veterans to actively provide support for their fellow injured Servicemembers and regain a tangible sense of purpose. PPH is currently being implemented at Department of Defense (DoD) and Veterans Administration (VA) sites. Two hundred active duty and Veterans with PTSD have participated in the program since it was first offered in 2008. Five service-dogs trained by PPH instructors have been placed with Veterans. Two Servicemembers have become accredited service dog-trainers and are pursuing careers in this field.

The curriculum of the service-dog training program is specifically designed to remediate the core-symptoms of post-traumatic stress, such as re-experiencing, avoidance, and hyperarousal. Clinical experience to date has been encouraging with respect to traumatic stress symptom and harm reduction, a decrease in the need for pain and sleep medicine and improved communication skills and sense of well-being.

PROGRAM OVERVIEW AND HISTORY

Paws for Purple Hearts (PPH) is an innovative therapeutic service-dog-training program that teaches Veterans and active duty military personnel with post-traumatic stress disorder (PTSD) the skill of training service-dogs for Veterans with war-related injuries. The use of psychiatric service-dogs with patients who have psychiatric disorders is well described (Barker & Dawson, 1998; Mason & Hagan, 1999). Studies have shown that under stressful conditions, the presence of a dog is effective at reducing stress responses in healthy adults, adults with hypertension, and in children with attachment disorders (Allen, 1991 and 1999; Kortschal, 2010). PPH is a voluntary program and is used as an adjunct to a wide range of PTSD treatments including Cognitive Behavioral Therapy (CBT), Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) and/or medications.

PPH was created by social worker and professional dog trainer Rick Yount, in 2006. It was inspired by the success of a therapeutic service-dog training program he started in Morgantown, West Virginia to help at-risk teens develop social skills while providing them with a rewarding career path. Yount's *Golden Rule Assistance Dog Program* (GRAD) was offered to public school drop-outs through Morgantown's Alternative Learning Center. Several GRAD-trained assistance dogs were placed with disabled veterans. In July 2008, Yount's Paws for Purple Hearts program was implemented at the Palo Alto VA's Men's Trauma Recovery Program in Menlo Park, California. One hundred and thirty Servicemembers have participated in that program. Based on the program's success, Yount was asked to establish PPH at Walter Reed's Army Warrior Transition Brigade (WTB). Forty-five Soldiers have partici-

pated in the formal Internship Program or the Patient Service-dog Training Program since February, 2009. In October of 2010, PPH was invited to be part of the PTSD and Traumatic Brain Injury research and treatment mission at the new National Intrepid Center of Excellence (NICoE), in Bethesda, MD.

MILITARY NEED FOR SERVICE DOGS AND COST EFFECTIVENESS

A 2009 study published in *The American Journal of Public Health* found that close to 40 percent of Iraq and Afghanistan Veterans treated at American health centers during the previous 6 years were diagnosed with PTSD, depression, or other mental health issues. The study also found that a lack of social support—being separated, divorced, widowed, etc., may pose a serious risk for new post-deployment mental health problems and underscores the need for social support services for returning Veterans who are unmarried and/or without social support. (Seal, et al., 2009). Sixty percent of PTSD patients still meet the criteria for PTSD after being treated with empirically supported interventions (Monson, 2006; Schnurr, 2007). Therefore, it is imperative to explore adjunctive treatments for PTSD that may improve outcomes.

There is also substantial interest in service-dogs among Veterans with Spinal Cord Injury. A survey in 2007 showed that 30 percent of Veterans with Spinal Cord Injury reported at least some interest in obtaining a service-dog and 42 percent desired information concerning service-dogs (Brashear, 2007). This urgent need of Veterans for well-trained service-dogs has been recognized by Congress with passage of several laws authorizing the Department of Veterans Affairs to provide service-dogs to disabled Veterans.

The 2010 Army Family Action Plan named "provide service-dogs for Wounded Warriors" as the #2 priority out of 82 issues. Involving Veterans and Servicemembers in the training of service-dogs for fellow Veterans creates a symbiotic opportunity to serve two needs with one program.

The PPH Program supplies high-quality purpose-bred service dogs. Certified PPH dog-trainers or selected "puppy-parents" take responsibility for the welfare and behavior of the dogs at all times when the dogs are on military or VA property. This allows active-duty Servicemembers and Veterans with PTSD who cannot or do not own dogs, to have the opportunity to experience the high quality connection with a dog that provides the powerful relief of PTSD symptoms. It also circumvents the logistical difficulties of owning and keeping dogs on base and in medical centers. The program is also highly cost-effective, providing dog-assisted therapeutic relief to a large number of PTSD patients with a limited number of service dogs. For instance, in the course of the 30–60 day PPH program offered at the Palo Alto VA Hospital, as many as 20 patients with PTSD may participate in the training of single service dog. All participants come away from the program with the valuable knowledge and skills that will allow them to connect with dogs they may own in the future in the most rewarding and therapeutic way.

WORKING DOGS/WORKING TRAINERS

Paws for Purple Hearts engages Servicemembers in the active duty of creating valuable service dogs for other disabled Servicemembers. PPH's training philosophy is based on a strong bond and positive methods of shaping behaviors. Mastering the skills and patience required to train a service dog helps the PPH trainers to regain control of their emotions, focus their attention, and improve their social competence and overall sense of wellbeing. Two participants in the Palo Alto VA program have gone on to pursue accreditation as professional dog trainers and we anticipate that many more will be inspired to become professionally involved in creating the thousands of service dogs that will be needed by our wounded warriors.

DOGS HEALING THE WORKPLACE

The impact of the PPH Program on Veterans and Servicemembers has been observed to reach well beyond its participants. Nearly 500 Servicemembers have benefited indirectly from the presence of the PPH program in PTSD residential treatment. These are Vets who share rooms with the dogs and their trainers, those who interact with the dogs as "uncles," and those who encounter dogs that are present in their various treatment groups. A conservative estimate of 650 WTs have also been indirectly impacted by the presence of this program on the campus of Walter Reed. The presence of the program on VA and military installations brings these PPH participants and their dogs into friendly contact with dozens of other Servicemembers every day and provides not only a stress reducing interaction, but also the

opportunity for the PPH participants to share their positive experiences with fellow Veterans and Servicemembers.

DOGS HEALING THE HOME

The methodology used in training service dogs to assist individuals with mobility impairments has striking similarities to the best practices of effective parenting. The goal of creating a respectful and responsible service dog requires the employment of sound behavioral shaping techniques based on positive and humane methods. Using the service dog training to draw attention to these parallels provides a means to teach critical parenting tools in a non-threatening manner.

HOW THE PROGRAM WORKS

PTSD symptoms fall into three broad categories: Re-experiencing, avoidance/numbing and increased arousal. The interventions in the PPH program are targeted to remediate each category of these symptoms as follows:

1. Re-experiencing: Procedures used in training PPH service-dogs require the trainer to focus on the dog's "here and now" point of view to recognize the "teachable moments" when instruction will be most effectively processed and retained. The presence of the dog during a stressful situation or encounter changes the context of the arousal event and anchors the trainer in the present, reminding the Servicemembers or Veterans that they are no longer in dangerous circumstances. If the patient/trainee does experience a trigger for symptoms, the presence of the dog can lower anxiety levels.
2. Avoidance and Numbing: Training a service-dog requires that it be carefully exposed to a wide range of experiences in the community. This creates a need for servicemembers with PTSD to challenge their impulses to isolate and avoid those same environments that the dogs must learn to tolerate. Dogs are natural social lubricants and so it is nearly impossible for the trainer to isolate from other people during this part of the training. Interactions with others in the company of the dogs, has been reported to be less threatening since the focus of the interaction is on the dog and the training.

   In order to shape the behavior of a service-dog, the trainer must also connect successfully with the dog. PTSD patient-trainers must overcome their emotional and affective numbness in order to heighten their tone of voice, bodily movements, and capacity for patience in order deliver their commands with positive, assertive clarity of intention and confidence. In doing this, trainers soon discover they can earn their dog's attention and best guide them to the correct response. The dog's success must then be rewarded with emotionally-based praise. The PPH training technique allows the trainers to experience rewarding positive emotional stimulation and social feedback. The basic daily needs of a service-dog involve structured activities that also bring the trainer and dog into the kind of close nurturing contact that further creates a behavioral and psychological antidote to social avoidance.
3. Arousal: PPH service-dogs are bred to be responsive to human emotions and needs. Their sensitivity to and reflection of their trainer's emotional state provides immediate and accurate measures of the trainer's projected emotion. This also challenges the trainer to overcome his or her tendency for startle reactions in order to relay a sense of security and positive feedback when their young dogs are faced with environmental challenges such a loud sirens and approach by strangers.

   PPH service-dogs are also bred to be affectionate and have a low-arousal temperament that puts their trainers "at ease." With these dogs at their sides, PPH trainers perceive greater safety and social competence and are able to shift out of their hyper-vigilant, defensive mode into a relaxed state that makes them ready and able to connect with others.

CLINICAL OBSERVATIONS AND PARTICIPANT TESTIMONIALS

Over the last 3 years, anecdotal reports from the PPH program director and PTSD treatment team members indicate that PPH participants exhibit the following improvements.

- Increase in patience, impulse control, emotional regulation
- Improved ability to display affect, decrease in emotional numbness
- Improved sleep

- Decreased depression, increase in positive sense of purpose
- Decrease in startle responses
- Decrease in pain medications
- Increased sense of belongingness/acceptance
- Increase in assertiveness skills
- Improved parenting skills and family dynamics
- Less war stories and more in the moment thinking
- Lowered stress levels, increased sense of calm

The following are observations made by Rick Yount after operating PPH for 2 years at the Palo Alto VA and at Walter Reed (Case 1), testimonies from Servicemembers who participated in the program (Case 2–5), and testimony from a disabled Veteran who has received a PPH trained mobility-assistance dog (Case 6). All persons involved in these accounts gave consent for their story to be included here.

Case 1: A Marine hit by multiple separate IED explosions during his multiple tours in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), the war in Afghanistan, had been in the PTSD treatment program for several weeks but was not participating in treatment despite a myriad of behavioral and pharmacological interventions. He sat in the corner with his sunglasses on, occasionally twitching his head from side to side in a tic-like manner. His peers were hesitant to interact with him due to his body language and lack of motivation to respond to their attempts to connect with him. His interest in the dogs prompted him to participate in the PPH program. Within two days of working in the PPH program, he began to smile and bond with the dog. His involvement led to his first positive interactions with staff and fellow Veterans. Instead of leaving the PTSD program without successfully completing it, he was able to finish the entire program and process his trauma through the support of his dog, peers and treatment team.

Case 2: This testimony was given by a PPH participant with PTSD who served in Iraq as a National Guard Reservist was struggling with family issues:

My family has noticed a difference in the way I interact with them as a result of working with my service-dog in training. I am patient with my children when they are around, I haven't yelled at them in several months and they aren't afraid of me when I'm around. I think that is a direct result of working with my dog. I have also benefited from the association with my service-dog in training as we spend time on bonding every day. I feel loved by him and I feel comforted when he is around. It's been nearly 4 years since I have felt comforted. When the dog is with me people that I pass come up and talk to me and I have social interaction that I wouldn't have had without the dog. I'm grateful the VA started this program and I got to be part of it. I wish more veterans got the opportunity I've been given to work with these amazing animals. Please consider this program on a larger scale so more veterans can benefit from training or receiving a service-dog.

Case 3: A young soldier, recently returned from Iraq, arrived in the PTSD program. He had recently attempted to take his own life. His struggle with hopelessness continued to inhibit his affect and stifle his ability to engage in treatment. One of the dogs interacted with him while he was waiting for the next group to begin. He smiled as he pat the dog on his head. He began training the next day, taking the training tasks very seriously. His psychiatrist told the Director of the Service-dog Program that the dog had accomplished what the doctor had been unable to do in 6 months. After his discharge from the program, the soldier was partnered with a service-dog to continue helping with his PTSD symptoms.

Case 4: A Marine who had served as a "Devil Dog" (term used to refer to a Marine) for 19 years was treated for PTSD in 2005. He returned for treatment in 2006 when he was unable to control his anger. He asked to join the newly instituted PPH program. He voluntarily provided this account of his experience with PPH:

I would have never imagined by working with these dogs my life would change forever. After over a year with severe sleep, depression and anger issues I found myself able to sleep for longer periods of time during the night and found myself calm during times where I would have exploded in anger. After analyzing this major change in my behavior the doctors quickly discovered that the common denominator was a service-dog trainee named Verde.

Please understand that my story is not a rare one. I have seen remarkable changes in not only myself but in the other residents that have participated in the training of these animals. For years doctors have thrown medication at my issues with minimal results but Verde has caused my life that would have been surely shortened by my issues to be full again. I know that I will always suffer with PTSD issues but having my new friend by my side like a fellow Marine will ensure that my quality of life will improve.

Case 5: Army Veteran returned from Iraq showing many of the signs of PTSD. Over the next 4 years, his depression deepened, he lost his job and was divorced. He tried many different medications and finally was enrolled in the PTSD program. He volunteered this testimony about PPH:

While in the program I learned a lot about PTSD and gained many tools to help me cope with the disorder, but there was one part of the program that stood apart; Paws for Purple Hearts. Soon after signing up to train the dogs I found myself sleeping better and was in a surprisingly good mood, before I knew it I was not hiding in my room anymore. I started laughing again and I began to feel good. I felt good about myself and what I was doing; helping to train this dog for a fellow veteran. Going out and not isolating was a huge leap forward for me. When you are with one of these dogs everyone wants to stop you and talk to you. This is not the most comfortable thing for someone with PTSD. After a while I was having conversation with complete strangers. They come with such a positive attitude that it reinforces that not all people in the world are bad and it begins to rebuild trust, which is one of the many things that one with PTSD struggles with. Another struggle is self restraint and patience and working with a dog will test your patience. If at any time I feel uneasy or start to have a little anxiety all I have to do is reach down and pet my dog or maybe even bend down and give him a hug, and it seems that everything is going to be just fine.

As my time for being part of this program came near an end, I discovered I wanted and needed to continue being part of this program. So I enrolled in The Bergin University of Canine Studies, to further expand my education in the service-dog field. In May of 2010 I completed the AS program. The PPH program has not only helped me in learning to cope with PTSD, but it has also helped me find what it is that I want to do in life. I know without this I could easily slip back into a lot of the old patterns that I had. My hope is to share with other Veterans the wonder of working with these dogs and help them get the same help I got through this program.

Case 6: The following is a personal account of how a PPH bred and Veteran-trained service dog has affected the life of the Veteran with PTSD who also uses a wheelchair as a result of his spinal cord injury. He suffered a spinal cord injury while serving in the Army during the Vietnam era. He received his service-dog in December 2009. His dog helps by pulling his wheelchair, retrieving dropped objects, bracing for transfers and opening doors. The impact that his dog has had on his PTSD symptoms are expressed in his reflections.

Since being paired with my dog I have realized many benefits. Some nights I couldn't turn my brain off. I would be on hyper vigilance unable to sleep at all. I was given Trazadone (PRN). I hated the way I would feel the next day from Trazadone. Since receiving my dog, my sleep has improved 100 percent and I no longer use it. Over the years I've been prescribed many meds for pain (300 mg. TDI) Gabapentin for burning pain nerve, Morphine, and Oxycontin. I now take no pain meds and have learned to live with my constant pain which flairs with activity or weather. I have also taken several prescription drugs to treat depression including Prozac and Welbutron. I feel no need to take depression medication anymore either.

The Veteran also reported significant improvement in his emotional control, positive social interaction and parenting skills and family dynamics.

THE NEED FOR EMPIRICAL STUDY OF THE PPH INTERVENTION

The PPH research team, in collaboration with senior research officials at the NICoE, has designed the first research protocol to examine, systematically, PTSD symptom reduction as well as the physiologic and behavioral changes that occur during interactions between Veterans suffering from PTSD and dogs in the PPH service-dog-training program that is ongoing at Walter Reed Army Medical Center's Warrior Transition Brigade and at the Palo Alto Veterans Administration Health care System Men's Trauma Recovery Program.

Based on the scientific literature and clinical observations of the program to date, we hypothesize that we will be able to scientifically verify that PTSD symptoms will be reduced, psychosocial functioning will increase and markers of stress as well as inflammation will be reduced by the human-dog interaction in the PPH training program. This is exactly the sort of "evidence-based research" into the mind/body therapeutic effects of human-animal interaction that has been lacking and causing a resistance to the placement of service-dogs with Servicemembers and Veterans despite Congressional approval of legislation supporting this effort and the growing demand from Wounded Warriors. We hope that the PPH study will advance not only our scientific understanding of the healing powers of animals in our lives, but pro-

vide the science that the DoD and VA need to approve animal-assisted therapy programs and the placement of service dogs with Servicemembers and Veterans with psychiatric and physical disabilities.

* * * Footnote references are available upon request

Prepared Statement of David E. Sharpe, Founder, Pets2Vets

INTRODUCTION

Madame Chairwoman and Members of the Subcommittee, I would like to thank the Subcommittee for the opportunity to submit my written testimony. I applaud the ongoing efforts by Congress to address issues facing active duty servicemen and women, veterans and emergency first responders such as PTSD, TBI and other mental health issues.

MY STORY AND THE FOUNDING OF P2V

My name is David E. Sharpe. I am 32 years old and served in the U.S. Air Force Security Forces for 6 years (1999—2005) where I endured several incidents that, I thought, didn't affect my personal relationships with my family, friends, and colleagues. A short time after my first deployment to Saudi Arabia during November 2001 in support of Operation Enduring Freedom, I encountered a one-one confrontation with a Taliban sympathizer pointing his weapon in my face during Entry Control Point Checks. A second incident occurred in 2004 while I was on patrol in the country of Pakistan and noticed two suicide bombers directly outside the base perimeter (razor wire) with a ladder (used to cross the razor wire) and a belt of explosives strapped to one of the men's chest while pointing at the chow hall area. One could only believe that these two men were planning to fulfill a successful suicide bombing attack against U.S. military personnel.

Upon my return from my first deployment in March 2002, I began to act violently towards my family, friends and myself—all symptoms of my being diagnosed 8 years later by the VA with having PTSD and depression. I found myself waking up in the middle of the night with cold sweats, random crying, having outbursts while blaming and questioning myself how I had handled the life-threatening situations I had found myself in. However, my life would get much worse before it would improve.

I finally hit bottom on the bedroom floor of my apartment. I sat, legs folded, ready to finish the fight with the demons that had followed me back from the war zone: the sudden rages; the punched walls; the profanities tossed at anyone who tried to help me. There was nothing in my room other than dirty Air Force uniforms, some empty bottles of alcohol and a crushing despair. I took a deep breath. I shut my eyes and closed my lips a little tighter around the cool steel of my .45. And then something licked my ear. I looked around and locked gazes with a pair of brown eyes. Cheyenne, my sheltered dog, cocked her head to one side—it was just one of those looks that an animal gives you. It was a look like: What are you doing? Who's going to take care of me? Who else is going to let me sleep in your bed? For a long minute, I stared into the puzzled face of my 6-month-old pit bull mix. And then slowly, reluctantly, I backed the barrel of my .45 out of my mouth. There is no doubt about it; I owe Cheyenne my life.

Immediately, I felt so relieved, like a 10,000-pound weight had been lifted off my chest. Soon after, my family and friends noticed a significant change in my behavior—a reduced number of outbursts, better attitude, no more suicide attempts—all because of this little pit bull mix puppy. Cheyenne's heroics were in her unconditional love and devotion to me—the devotion and love that most pet owners can attest to. It's interesting that a torn-eared puppy from a shabby animal rescue saved me. Not my father (a retired 32-year U.S. Army RANGER) or my grandfather (a PT Boat Commander in the South Pacific during World War II) or a friend. It was Cheyenne who was the force that pulled me back into society. I couldn't talk to anybody—not my father, not the counselors—but I can talk to my sheltered dog, and she never judges me. Eight years later, my father stated, "He's [me] a different person now. All that stuff was taking over his life. That dog [Cheyenne] just listened to him for hours." [1] But all that time I had suffered in silence.

For the first time in January 2010 (with the help of a friend), I walked into the Washington, D.C. VA Hospital to seek additional help in my life. The process to de-

[1] Dogs' devotion helps heal vets' inner wounds; The Washington Post; June 23, 2011; Steve Hendrix.

termine my having PTSD and depression was very frustrating; however, it was worth the time. I will admit that there was some fear of speaking to a human for the first time about my military service and I was somewhat apprehensive. But, Cheyenne helped me become an extrovert, and telling another person or persons proved to not be so difficult as I thought it would be.

One year later, on January 11, 2011, I married Jenny Fritcher, an Air Force staff sergeant stationed at Ramstein Air Base in Germany. My wife will be discharged from active duty and join me in Arlington, Virginia in August 2011. More importantly, we're expecting our first child in January 2012—I credit all of this to my sheltered dog, Cheyenne. Through the unconditional love of my sheltered dog and my training her to perform basic manners (e.g. sit, stay, nudge my hand when I get hyper vigilant) I became resilient and am now a productive member of society, working as a Program Analyst in the Intelligence Community.

Because of Cheyenne and my belief that other veterans could benefit from animals like her, I set out on a mission in October 2009 with only $2,500 in my savings account to create the nonprofit organization, Pets 2 Vets, or **P2V (www.P2V.org). P2V** pairs active duty military, veterans and emergency first responders dealing with the stress of their service with shelter animals as part of their healing process. This innovative and enterprising organization proves that an outside-of-the-box concept can help others like me in a very short time and is somewhat grounded in science. A July 2011 study published in the *Journal of Personality and Social Psychology* revealed that pet owners had greater self-esteem, greater levels of exercise and physical fitness, and they tended to be less lonely than nonowners.[2] These are exactly the qualities needed by veterans with mental health disorders, and my goal is for **P2V** to aid them in their recovery while at the same time saving our Nation's shelter animals.

Today, **P2V** has aided dozens of our Nation's heroes while finding loving homes for shelter animals in just under its first 2 years of operation. The organization currently serves veterans by using volunteers who are trained by a VA licensed clinical psychologist. The volunteers pick up the veterans from their homes (rural areas included) and transport them to P2V-partner shelters to adopt or visit animals of their choice—the VA doesn't have to provide the facility, and veterans are removed from the monotony of a hospital environment. P2V also provides transportation for veterans by its volunteers in rural areas to visit or adopt shelter animals. P2V pays for or its partner shelters waive adoption fees, supplies a gift card for necessary pet equipment (leash, collar, feeding-water bowls and crate), and pays for the veteran's first 2 years of pet insurance (Banfield Pet Hospital Wellness Plans; located at 770 locations nationwide), and basic manners training. Finally, veterans are provided multiple options in the selection of a companion animal (dog or cat). In conjunction with the appropriate health care services, the entire P2V process allows veterans to feel a sense of self worth and accomplishment that helps lead them on the road to becoming a productive member of society. For example, Marine sergeant Jimmy Childers, recipient of a shelter dog named Tidus stated, "Tidus isn't going to be fetching my [prosthetic] leg for me or anything. He's here to bring joy into my life, and he does that every day."[3]

PROPOSED LEGISLATION

H.R. 198, Veterans Dog Therapy Training Act, introduced by Reps. Grimm (R–NY), Michaud (D–ME), King (R–NY) and Lance (R–NJ) provides the assessment of addressing post-deployment mental health and PTSD symptoms through a therapeutic medium of training service dogs for veterans with disabilities. P2V supports the concept of such legislation but is concerned that the bill is too narrowly drafted to benefit a large number of veterans.

Currently, the legislation only allows for a pilot program to assess the effectiveness of the training of service animals on the mental health of veterans suffering from post-traumatic stress disorder or other post deployment mental health conditions. However, as we have learned over the years, the VA needs all available resources—a toolbox of sorts—to address the mental health crisis facing our Nation's veterans. Therefore, P2V recommends the Committee broaden the scope of the bill to encourage the VA to partner other community-based service/companion animal programs already in existence and review their effectiveness on the well-being of

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[2] Journal of Personality and Social Psychology; Friends With Benefits: On the Positive Consequences of Pet Ownership; July 4, 2011; Allen R. McConnell, Christina M. Brown, Tonya M. Shoda, Laura E. Stayton, and Colleen E. Martin.

[3] Dogs' devotion helps heal vets' inner wounds; The Washington Post; June 23, 2011; Steve Hendrix.

veterans in need. P2V as well as many other organizations can provide successful and inexpensive models that can augment traditional services as well as serve as alternatives to conventional care.

In conclusion, while many veterans do require the assistance of a highly trained service animal and could benefit from training such animals, most veterans with whom I have spoken simply are looking for the companionship of an animal to feel acknowledged and accepted.

My sheltered dog is the sole reason why I am here today. Furthermore, my dog has allowed me to grow close relationships with my family and friends with the help of the Department of Veterans' Affairs, and I believe that other veterans can benefit from the same type of companionship. I appreciate your time and the opportunity to share my personal experiences with having PTSD, educating you about P2V and making recommendations on H.R. 198.

[The attachments are being retained in the Committee files.]

Prepared Statement of Greg Jacob, Policy Director, Servicewomen's Action Network

Madam Chairwoman and Distinguished Members:

Servicewomen's Action Network (SWAN) is a national organization that supports, defends, and empowers today's servicewomen and women veterans of all eras. SWAN's vision is to transform military culture by securing equal opportunity and the freedom to serve in uniform without threat of harassment, discrimination, intimidation or assault. SWAN also seeks to reform veterans' services on a national scale to guarantee equal access to quality health care, benefits and resources for women veterans and their families.

SWAN fully supports H.R. 2074, a bill to require a comprehensive policy on reporting and tracking sexual assault incidents and other safety incidents that occur at Department of Veterans Affairs (VA) medical facilities.

SWAN has unique insight into the issue of sexual assault at the VA. Our National Peer Support Helpline receives numerous calls from veterans seeking help to remedy a negative experience at the VA. Some of these veterans, both men and women, tell us they were sexually harassed or sexually assaulted at VA facilities, reported it, and saw absolutely nothing done by the VA in response.

- One client told us that while receiving an EKG, a male technician inappropriately touched her breasts during the procedure and repeatedly commented on her appearance. Afterward she did not know how to report the incident, left the hospital and has not returned to the VA since.
- Another veteran was raped by her VA psychiatrist who was a retired Air Force officer. She reported this to the VA administration who told her they could do nothing based on her word alone. She then reported him to the authorities. Although he was not prosecuted, as a result of this veteran's courage the psychiatrist had his treatment license suspended for 5 years.
- Another caller who is employed by the VA as a police officer has apprehended a VA technician twice for sexually assaulting patients and turned him over to the VA administration both times. Yet this technician has not been charged with any crime, is still employed at the same VA and still regularly works with women patients. The officer is completely frustrated with a system that allows rapists to roam the hospitals free to prey on vulnerable patients.

H.R. 2074 would help to reform this system by requiring the VA develop a comprehensive program for reporting and handling sexual assault complaints, a first step in what SWAN hopes will become a rigorous system that keeps everyone who uses the VA safe and secure. An institution that provides for the health care needs of veterans ought to have an effective reporting system in place, particularly given the rampant levels of sexual assault and sexual harassment within the active duty military. The Department of Defense estimates that in 2010 alone, there were over 19,000 sexual assaults in the military,[1] or 52 sexual assaults per day. It is negligent and dangerous to think that somehow those tens of thousands of survivors and perpetrators simply go away after being discharged. The numbers of sexual trauma survivors, both male and female, utilizing the VA is substantial. VA reports that in FY 2010 68,379 patients had at least one outpatient visit to a VHA facility that

[1] Department of Defense, DMDC. 2011. "2010 Workplace and Gender Relations Survey of Active Duty Members." Available: http://www.sapr.mil/media/pdf/research/DMDC_2010_WGRA_Overview_Report_of_Sexual_Assault.pdf.

was for the treatment of a condition(s) related to Military Sexual Trauma. 61 percent (or 41,475) of those patients were women; 39 percent (or 26,904) were men.[2]

VA serves tens of thousands of high-risk veterans every year, and as an institution it must accept responsibility for the care and safety of all its patients from the time they walk onto the grounds of a VA facility until they walk off. The VA must not only do so by providing top notch medical treatment, but also superior administrative support as well. That means every VA run facility must develop a well publicized process in place to handle sexual harassment and sexual assault complaints, must have policies that enforce rules and discipline offenders, must train every member of their staff annually on sexual harassment and sexual assault response, must maintain a security presence that is attentive and effective, and must invest in an infrastructure that allows for a completely safe visit. Safety and care for VA patients should not start or stop at the front door.

The stakes are high. With the number of veterans eligible for care rising year after year and with the rape, sexual assault and sexual harassment crisis continuing unabated in the military, it is essential that the VA protect patients from sexual predators. If the VA fails to do this, veterans desperately in need of care will avoid seeking it out which will result in untold suffering, chronic mental illness, substance abuse, homelessness and in some cases suicide or death. Our Nation's veterans deserve better, and H.R. 2074 will help to ensure that.

Respectfully Submitted.

Tipton, Hon. Scott R., a Representative in Congress from the State of Colorado, letter

U.S. House of Representatives
Washington, DC.
July 22, 2011

Dear House Committee on Veterans' Affairs Subcommittee on Health:

I am honored to submit this statement in support of Section 8 of the Veterans Health Care Facilities Capital Improvements Act of 2011. This section will now replace and mirrors legislation that I introduced in the form of H.R. 1658. Section 8 of this legislation seeks to rename the Department of Veterans Affairs telehealth clinic in Craig, Colorado, after Major William Edward Adams.

It is only fitting and proper that we pay tribute to a heroic American who was awarded our Nation's highest honor for his conspicuous gallantry in the Kontum Province in the Central Highlands of Vietnam. Major William Edward Adams is an inspiration to every citizen of our great nation, and a reminder to all Americans that some will sacrifice everything to preserve our way of life.

Maj. Adams was born in Casper, Wyoming, and raised in Craig, Colorado. He went to high school in Missouri at the Wentworth Military Academy. He graduated from Colorado State University, where he also met his future wife Sandra Adams. Upon graduation he joined the United States Army. Major Adams was deployed to Vietnam in 1970.

On May 25th, 1971, Maj. Adams willingly volunteered for a helicopter rescue mission that would undoubtedly endanger his lightly armored aircraft and his life. The mission was to fly into a remote fire base that was under heavy attack to pick up three critically wounded soldiers. Maj. Adams was fully aware of the advantageous position of the enemy's formidable anti-aircraft guns; as well as the clear skies that would provide no cover from the imminent barrage. While directing and coordinating fire support from other attack helicopters, Major Adams landed his aircraft and picked up the three wounded soldiers. As he began his return flight, Maj. Adams' helicopter was bombarded with enemy rocket and gunfire. He calmly regained control of the aircraft, and prepared to make an emergency landing, but the helicopter exploded before Maj. Adams could touch down. For these actions, Major William Edward Adams posthumously received the Medal of Honor.

It gives me great pride to know that I have fellow countrymen who are capable of such selfless feats of bravery. Thus, renaming the VA telehealth clinic in Craig,

[2] Department of Veterans Affairs, Office of Mental Health Services, Military Sexual Trauma Support Team. (2011). Summary of Military Sexual Trauma-related Outpatient Care Report, FY 2010. Washington, DC: Department of Veterans Affairs, Office of Mental Health Services.

Colorado, after Major Adams honor is an appropriate honor and is also supported by the community.

Sincerely,

Scott Tipton
Member of Congress

Prepared Statement of Heather L. Ansley, Esq., MSW, Director of Veterans Policy, VetsFirst, a Program of United Spinal Association.

Chairwoman Buerkle, Ranking Member Michaud, and other distinguished Members of the Subcommittee, thank you for the opportunity to submit written testimony regarding VetsFirst's views on the Veterans Dog Training Therapy Act (H.R. 198) and the Veterans Equal Treatment for Service Dogs Act (H.R. 1154).

VetsFirst represents the culmination of 60 years of service to veterans and their families. United Spinal Association, through its veterans service program, VetsFirst, maintains a nationwide network of veterans service officers who provide representation for veterans, their dependents and survivors in their pursuit of Department of Veterans Affairs (VA) benefits and health care before the VA and in the Federal courts. Today, United Spinal Association is not only a VA-recognized national veterans service organization, but is also a leader in advocacy for all people with disabilities.

Service animals provide multi-faceted assistance to people with disabilities. Specifically, service animals promote community integration. In addition to performing specific tasks such as pulling a wheel chair or opening a door, these same service animals can also help to break down barriers between people with disabilities and society. In addition to increased social interaction, many people with disabilities also report experiencing a greater sense of independence.

For many years, Congress has recognized the benefits that service animals provide for veterans with disabilities. Specifically, Congress has authorized VA to provide guide dogs for veterans with visual impairments. In 2002, Congress expanded the authority to include service dogs for veterans with hearing and mobility impairments. Most recently, Congress further expanded VA's authority to include service dogs for veterans who have mental health concerns.

VetsFirst is pleased to lend our support to legislation that we believe will further promote and facilitate the use of service animals by veterans with disabilities.

The Veterans Dog Training Therapy Act (H.R. 198)

VetsFirst strongly supports the Veterans Dog Training Therapy Act (H.R. 198) and the substitute amendment that will be submitted at Committee markup. The proposed amendment to this legislation would ensure that accredited service dog agencies and trainers will provide appropriate training and consultation with VA to provide opportunities for veterans with mental health concerns to train service dogs for fellow veterans with disabilities.

We support efforts to ensure that properly trained service animals are available to veterans who can benefit from their assistance. The Veterans Dog Training Therapy Act provides a unique opportunity to benefit not only veterans seeking the assistance of a service dog but also provides veterans with post-deployment mental health concerns or post-traumatic stress disorder the opportunity to benefit from training these dogs. The dual nature of this approach will assist a wide range of veterans.

VetsFirst also believes that requiring VA to work in conjunction with accredited service dog agencies and trainers will benefit all participating veterans. Specifically, veterans assisting with training will be required to follow a structured process to ensure that the service dog is appropriately trained. As a result, veterans receiving these service dogs will be assured that the dogs are properly trained and able to assist them. Furthermore, the skills learned by the veteran trainers could be helpful in allowing them to successfully pursue a career in the service animal field.

Consequently, VetsFirst urges passage of the Veterans Dog Training Therapy Act. We understand that Congressman Grimm has identified possible offset funding for this important legislation.

The Veterans Equal Treatment for Service Dogs Act (H.R. 1154)

VetsFirst, strongly supports the Veterans Equal Treatment for Service (VETS) Dogs Act (H.R. 1154). This legislation would ensure that all veterans with disabilities who use service dogs are able to access VA facilities.

VA regulation, 38 CFR §1.218(a)(11), which applies to "all property under the charge and control of VA," states that, "Dogs and other animals, except seeing-eye dogs, shall not be brought upon property except as authorized by the head of the facility or designee." Exempting guide dogs but not service dogs from VA property leads to unequal protection for veterans and people with disabilities. In addition, allowing the use of service dogs to vary by VA facility has resulted in veterans encountering different access policies based on the discretion of the individual facility directors.

The VETS Dogs Act, which has wide bipartisan support, specifically states that the VA Secretary may not prohibit the use of service dogs in VA facilities or on VA property. .

Immediately prior to the introduction of this legislation, the Veterans Health Administration (VHA) issued VHA Directive 2011–013 titled, "Guide Dogs and Service Dogs on VHA Property." If properly implemented and maintained, the directive could address past access difficulties. Although VetsFirst acknowledges the actions of VA in issuing the directive, we believe that the VETS Dogs Act must be passed to ensure that veterans with disabilities who use service dogs have the assurance of equal access to VA facilities.

Thus, we urge swift passage of the VETS Dogs Act to specifically mandate access to VA services and facilities for all veterans with disabilities who use service dogs.

Thank you for the opportunity to submit written testimony concerning VetsFirst's views on H.R. 198 and H.R. 1154. VetsFirst believes that the ability to use service animals is a critical option for many people with disabilities. Together, H.R. 198 and H.R. 1154 provide the legislative authority to ensure that veterans are able to more fully benefit from service dogs.

We appreciate your leadership on behalf of our Nation's veterans with disabilities. VetsFirst stands ready to work in partnership to ensure that all veterans are able to reintegrate in to their communities and remain valued, contributing members of society.

Prepared Statement of Wounded Warrior Project

Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee:

Wounded Warrior Project (WWP) welcomes the Subcommittee's consideration of H.R. 1855 and is pleased to offer our views on this important bipartisan legislation.

WWP works to help ensure that this generation of wounded warriors thrives—physically, psychologically and economically. Our policy objectives are targeted to filling gaps in programs or policies—and eliminating barriers—that impede warriors from thriving. Importantly, those objectives reflect the experiences and concerns of wounded warriors and family members whom we serve daily across the country.

H.R. 1855 addresses some of the deepest concerns we have heard from warriors' families, and we are very pleased to be able to enthusiastically support this measure. Its enactment would realize a key goal of our policy agenda. Most important, it would materially change lives.

Traumatic Brain Injury Rehabilitation

Impressive military logistics and advances in military medicine have saved the lives of many combatants injured in Iraq and Afghanistan who would likely not have survived in previous conflicts. As a result, servicemembers are returning home in unprecedented numbers with severe polytraumatic injuries. Among the most complex are severe traumatic brain injuries. Each case of traumatic brain injury is unique. Depending on the injury site and other factors, individuals may experience a wide range of problems—from profound neurological and cognitive deficits manifested in difficulty with speaking, vision, eating, or incontinence to marked behavioral symptoms. While individuals who have experienced a mild or moderate TBI may experience symptoms that are only temporary and eventually dissipate, others may experience symptoms such as headaches and difficulty concentrating for years to come.

Those with severe TBI may face such profound cognitive and neurological impairment that they require a lifetime of caretaking. As clinicians themselves recognize,

it is difficult to predict a person's ultimate level of recovery.[1] But to be effective in helping an individual recover from a brain injury and return to a life as independent and productive as possible, rehabilitation must be targeted to the specific needs of the individual patient. In VA parlance, rehabilitation must be "veteran-centered."

While many VA facilities have dedicated rehabilitation-medicine staff, the scope of services actually provided to veterans with a severe TBI can be limited, both in duration and in the range of services VA will provide or authorize. It is all too common for families—reliant on VA to help a loved one recover after sustaining a severe traumatic brain injury—to be told that VA can no longer provide a particular service because the veteran is no longer making significant progress. Yet ongoing rehabilitation is often needed to maintain function,[2] and veterans with traumatic brain injury who are denied maintenance therapy can easily regress and lose cognitive, physical and other gains made during earlier rehabilitation.

Some do make a good recovery after suffering a severe TBI. But many have considerable difficulty with community integration even after undergoing rehabilitative care, and may need further services and supports.[3] Medical literature has documented the need to use rehabilitative therapy long after acute care ends to maintain function and quality of life.[4,5,6] While improvement may plateau at a certain point in the recovery process, it is essential that progress is maintained through continued therapy and support. The literature is clear in demonstrating the fluctuation that severe TBI patients may experience over the course of a lifetime. One study found that even 10 to 20 years after injury individuals were still suffering from feelings of hostility, depression, anxiety, and further deficiencies in psychomotor reaction and processing speed.[7] While some are able to maintain functional improvements gained during acute rehabilitative therapy, others continue to experience losses in independence, employability, and cognitive function with increasing intervals of time.[8] Given such variation in individual progress, rehabilitation plans must be dynamic, innovative, and long term—involving patient-centered planning and provision of a range of individualized services.[9]

For this generation of young veterans, reintegration into their communities and pursuing life goals such as meaningful employment, marriage, and independent living may be as important as their medical recovery. Yet studies have found that as many as 45 percent of individuals with a severe traumatic brain injury are poorly reintegrated into their community, and social isolation is reported as one of the most persistent issues experienced by such patients.[10] Yet research has demonstrated that individuals with severe TBI who have individualized plans and services to foster independent living skills and social interaction are able to participate meaningfully in community settings.[11] While improving and maintaining physical and cognitive function is paramount to social functioning, many aspects of community reintegration cannot be achieved solely through medical services. Other nonmedical models of rehabilitative care—including life-skills coaching, supported employment, and community-reintegration therapy—have provided critical support for community integration. But while such supports can afford TBI patients opportunities for gaining greater independence and improved quality of life, VA medical facilities too often deny requests to provide these "non-medical" supports for TBI patients. While such services could often be provided under existing law through other

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[1] Sharon M. Benedict, PhD, "Polytrauma Rehabilitation Family Education Manual," Department of Veterans Affairs Polytrauma Rehabilitation Center, McGuire VA Medical Center, Richmond, Virginia; http://saa.dva.state.wi.us/Docs/TBI/Family__Ed__Manual112007.pdf (accessed April 27, 2010).

[2] Ibid.

[3] Nathan D. Cope, M.D., and William E. Reynolds, DDS, MPH; "Systems of Care," in *Textbook of Traumatic Brain Injury* (4th ed.), American Psychiatric Publishing (2005), 533–568.

[4] Hoofien D, Gilboa A, Vakils E, et al. "Traumatic brain injury (TBI) 10–20 years later: a comprehensive outcome study of psychiatric symptomatology, cognitive abilities and psychosocial functioning." *Brain Injury* 15.3(2001):189–209.

[5] Sander A, Roebuck T, Struchen M, et al. "Long-term maintenance of gains obtained in postacute rehabilitation by persons with traumatic brain injury." *Journal of Head Trauma Rehabilitation* 16.4(2001): 356–373.

[6] Sloan S, Winkler D, Callaway L. "Community Integration Following Severe Traumatic Brain Injury: Outcomes and Best Practice." *Brain Impairment* 5.1(May 2004): 12—29.

[7] Hoofien, et al. 201.

[8] Sander, et al. 370.

[9] Sloan, et al. 22.

[10] Sloan, et al. 12.

[11] Nathan D. Cope, M.D., and William E. Reynolds, DDS, MPH; "Systems of Care," 533–568.

VA programs,[12] it is troubling that institutional barriers stand in the way of meeting veterans' needs under a "one-VA" approach. Instead, rigid adherence to a medical model and foreclosing social supports is, unfortunately, a formula for denying veterans with severe traumatic brain injury the promise of full recovery. This barrier must be eliminated.

H.R. 1855

H.R. 1855 would amend current law to clarify the scope of VA's responsibilities in providing rehabilitative care to veterans with traumatic brain injury. While current law (codified in sections 1710C and 1710D of title 38, U.S. Code) directs VA to provide comprehensive care in accord with individualized rehabilitation plans to veterans with traumatic brain injury, in some instances warriors with severe traumatic brain injury are not receiving services they need, and in other instances, VA has cut off rehabilitative services prematurely.

Ambiguities in current law appear to contribute to such problems. For example, while the above-cited provisions of law do not define the term "rehabilitation," the phrase "rehabilitative services" is defined for VA health-care purposes (in section 1701(8) of title 38) to mean "such professional, counseling, and guidance services and treatment programs as are necessary to restore, to the maximum extent possible, the physical, mental, and psychological functioning of an ill or disabled person." That provision could be read to limit services to *restoring* function, but not to *maintaining* gains that have been made. (Yet limiting TBI rehabilitative care in that manner risks setting back progress that has been made.) As defined, the term "rehabilitative services" is also limited to services to restore "physical, mental and psychological functioning." In our view, rehabilitation from a traumatic brain injury should be broader, to include also cognitive and vocational functioning, and, given the research cited above, should not necessarily be limited to services furnished by health professionals.

In essence, H.R. 1855 would provide that in planning for and providing rehabilitative services to veterans with traumatic brain injuries, VA must ensure that those services——

1. are directed not simply to "improving functioning" but to sustaining improvement and preventing loss of functional gains that have been achieved (and, as such, that rehabilitation may be continued indefinitely); and
2. are not to be limited to services provided by health professionals but include any other services or supports that contribute to maximizing the veteran's independence and quality of life.

WWP strongly supports this legislation. It would eliminate barriers too many have experienced, and would offer the promise of making good on the profound obligation we owe those who struggle with complex life-changing brain injuries.

We urge the Committee to adopt this important legislation, and would welcome the opportunity to work with you to ensure its enactment.

[12] See VA's program of independent living services (administered by the Veterans Benefits Administration) under 38 U.S.C. sec. 3120, and VA's authority under 38 U.S.C. sec. 1718(d)(2) to furnish supported employment services as part of the rehabilitative services provided under the compensated work therapy program (administered by the Veterans Health Administration).

MATERIAL SUBMITTED FOR THE RECORD

U.S. Department of Veterans Affairs
Washington, DC.
August 5, 2011

Mr. Randall Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

In accordance with the Office of Management and Budget Circular A–50, the Department of Veterans Affairs (VA) is providing an update on the actions taken by VA in response to the eight recommendations contained in the June 7, 2011, U.S. Government Accountability Office (GAO) final report, ***VA Health Care: Action Needed to Prevent Sexual Assaults and other Safety Incidents*** (GAO–11–530).

In commenting on GAO's draft report, VA concurred with GAO's recommendations to the Department. The enclosure provides details about progress VA has made in implementing GAO's recommendations since responding to the draft report.

Sincerely,

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) 60 Day Update to
Government Accountability Office (GAO) Final Report
VA HEALTH CARE: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents
(GAO–11–530)

To improve VA's monitoring of allegations of sexual assault, we recommend that the Secretary of the Department of Veterans Affairs direct the Under Secretary for Health to take the following four actions:

Recommendation 1: Ensure that a consistent definition of sexual assault is used for reporting purposes by all medical facilities throughout the system to ensure that consistent information on these incidents is reported from medical facilities through VISNs to VHA Central Office Leadership.

VA Update to Final Report: Concur. An interdisciplinary work group was formed and charged with developing a definition of sexual assault. The work group adopted the following definition of sexual assault:

> "Any type of sexual contact or attempted sexual contact that occurs without the explicit consent of the recipient of the unwanted sexual activity. Assaults may involve psychological coercion, physical force, or victims who cannot consent due to mental illness or other factors. Falling under this definition of sexual assault are sexual activities such as forced sexual intercourse, sodomy, oral penetration, or penetration using an object, molestation, fondling, and attempted rape. Victims of sexual assault can be male or female. This does not include cases involving only indecent exposure, exhibitionism, or sexual harassment."

VA's Assistant Secretary for the Office of Operations, Security and Preparedness (OSP) communicated this definition, as well as other policy and processes, to Under Secretaries, Assistant Secretaries, and other key officials in a June 16, 2011, memorandum, "Clarification of Policy of Sexual Assault Reporting" (Attachment A). The Deputy Under Secretary for Health for Operations and Management (DUSHOM) subsequently issued a July 7, 2011, memorandum, "Actions Needed to Improve Reporting of Allegations of Sexual Assaults" (Attachment B), to VISN Directors regarding the definition, as well as the new policies and processes. This memorandum required VHA field facilities to take specific actions in regard to reporting sexual assaults including:

- Specifying a definition for what is to be reported as an allegation of or an actual sexual assault;

- Outlining requirements for reporting all allegations of sexual assault on VA property (or off-property in the execution of official VA duties) in accordance with VA Directive 0321, Serious Incident Reports;
- Requiring facilities to submit:
  - an initial issue brief that includes specific information to the Office of the DUSHOM within 24 hours of reporting the incident, and a follow-up issue brief to provide details about any investigation, results of the investigation, actions taken by the facility, and any process or policy improvements made to mitigate future events;
- Communicating with the Office of Inspector General (OIG).

Recommendation 2: Clarify expectations about what information related to sexual incidents should be reported to and communicated within VISN and VHA Central Office leadership teams, such as officials responsible for residential programs and inpatient mental health units.

VA Update to Final Report: Concur. The two memoranda mentioned in the status update for Recommendation 1 clarified and reinforced expectations on what information related to sexual incidents should be reported. The interdisciplinary work group is continuing its review and will identify any additional guidance and clarification that is needed in its report to the Under Secretary for Health (USH) no later than (NLT) September 30, 2011.

Recommendation 3: Implement a centralized tracking mechanism that would allow sexual assault incidents to be consistently monitored by VHACO staff;

VA Update to Final Report: Concur. The interdisciplinary work group is developing and will implement a computerized mechanism to monitor sexual assault and other safety incidents. Currently, the Office of the DUSHOM is conducting centralized tracking and monitoring through a manual process.

An automated process is under fast track development. Nine VISNs are piloting key components, including the automation of issue briefs. It is expected that the new automated centralized tracking system will replace the manual centralized tracking system by October 31, 2011. An updated timeline and status will be provided in a report to the USH NLT September 30, 2011.

Recommendation 4: Develop an automated mechanism within the centralized VA police reporting system that signals VA police officers to refer cases involving potential felonies, such as rape allegations, to the VA OIG to facilitate increased communication and partnership between these two entities.

VA Update to Final Report: Concur. As of June 20, 2011, when VA police officers enter information into the Veterans Affairs Police System (VAPS), the VAPS automatically sends the VA OIG all incidents of sexual assaults and other major felonies. The VAPS system automatically sends a special alert to VA OIG Special Agents at VA OIG Headquarters and to all regional Special Agents in Charge of VA OIG Field Offices.

To help identify risks and address vulnerabilities in physical security precautions at VA medical facilities, we recommend that the Secretary of the Department of Veterans Affairs direct the Under Secretary for Health to take the following four actions.

Recommendation 5: Establish guidance specifying what should be included in legal history discussions with veterans and how this information should be documented in veterans' psychosocial assessments;

VA Update to Final Report: Concur. The interdisciplinary work group is conducting a literature review and consulting with peers to explore what information should be obtained when assessing a Veteran's risk for misconduct, and how this information might be used within the required limits for maintaining confidentiality and rights of privacy.

The work group's assessment, in consultation with the VA Office of General Counsel, and the VHA Office of Ethics in Health Care, will determine what specific guidance may need to be developed. An action plan for the development, implementation, and communication of the guidance will be established once the assessment is complete. This process will also address what appropriate action needs to be taken to standardize documentation in Veterans' psychosocial assessments.

An updated timeline and status will be provided in a report to the USH NLT September 30, 2011, in regard to establishing guidance specifying what should be included in legal history discussions with Veterans and how this information should be documented in Veterans' psychosocial assessments.

Recommendation 6: Ensure medical centers determine whether existing stationary, computer-based, and portable personal panic-alarm systems operate effectively through mandatory regular testing.

VA Update to Final Report: Concur. The Office of the DUSHOM has worked with the interdisciplinary work group to re-emphasize the need for routine testing of panic alarms as well as to ensure the alarms are functioning correctly.

The DUSHOM issued a memorandum, "Actions Needed to Improve Physical Security Requirements" on June 10, 2011, (Attachment C), that tasked each Network Director to ensure that each facility within each network has a physical security assessment plan that includes:

Policies for use and testing of alarm systems, including panic alarms:

- Regular testing of these alarm systems, including panic alarms;
- Documentation of testing; and
- A plan and implementation strategy for 24/7 response capabilities and preventative maintenance.

All VISN Directors have documented and attested, with supporting documentation, that each VAMC has been reviewed for compliance, each VISN is compliant with physical security policies, and action plans and timelines have been developed to implement physical assessment plans to ensure adequate security controls.

The interdisciplinary work group will provide an update on the outcome of this action item in its September 30, 2011, report to the USH.

Recommendation 7: Ensure that alarm systems effectively notify relevant staff in both medical facilities' VA police command and control centers and unit nursing stations.

VA Update to Final Report: Concur. In order to ensure that each facility is addressing the issue, the DUSHOM, in the previously referenced June 10, 2011, memorandum, re-emphasized existing policy and procedures about the use of alarm systems and tasked VISN Directors to ensure that local facilities have established systems that meet the specific location and function needs as well as develop a process to include regular testing of these systems based on industry and manufacturers' standards.

As noted in Recommendation 6, each VISN Director has documented and attested that each VAMC is in compliance with the new requirements.

The interdisciplinary work group will provide an update on the outcome of this action item in its September 30, 2011, report to the USH.

Recommendation 8: Require relevant medical center stakeholders to coordinate and consult on (1) plans for new and renovated units and (2) any changes to physical security features, such as closed-circuit television cameras.

VA Update to Final Report: Concur. At the national level, the interdisciplinary work group is working with VA Office of Construction and Facilities Management (CFM) and OSP about how best to formalize consultation during the planning and design processes for all construction projects. CFM currently maintains a Technical Information Library including planning and design standards for all VA services/departments, and these standards currently provide planning and design guidelines for VA construction projects. Incorporating planning design standards emphasizing privacy and safety concerns will need to be considered during the development of new standards and updates to current standards. The interdisciplinary work group will include a recommendation about this issue in its September 30, 2011, report to the USH.

Memorandum

Department of Veterans Affairs

Date: June 16, 2011
From: Assistant Secretary, Operations, Security, and Preparedness (007)
Subj: Clarification of Policy for Sexual Assault Reporting (VAIQ#—7124911)
To: Under Secretaries, Assistant Secretaries, and Other Key Officials

1. VA Directive 0321, Section 2.a., January 21,2010, (attached) requires all Serious Incidents in the VA to be reported to the VA Integrated Operations Center (VA IOC) as soon as possible but no later than 2 hours after the awareness of the incident.
2. Section 2.c.(9). of VA Directive 0321 includes a requirement to report sexual assaults: "Incidents on VA property that result in serious illness or bodily injury to include sexual assault, aggravated assault and child abuse."
3. To ensure accurate reporting, sexual assault is defined as "any type of sexual contact or attempted sexual contact that occurs without the explicit consent of the recipient of the unwanted sexual activity. Assaults may involve psychological coercion, physical force, or victims who cannot consent due to mental illness or other factors. Falling under this definition of sexual assault are sexual activities such as forced sexual intercourse, sodomy, oral penetration, or penetration using an object, molestation, fondling, and attempted rape. Victims of sexual assault can be male or female. This does not include cases involving only indecent exposure, exhibitionism, or sexual harassment."
4. It is important that leadership know in a timely manner all allegations of sexual assault that occur on VA property or at any time while official VA duties are being performed. As such, effective immediately, all Under Secretaries, Assistant Secretaries, and other Key Officials will ensure that the IOC is notified within 2 hours of any and all allegations of sexual assault. Notification may be made via telephone by calling (202) 461–5510 or via email to vaioc@va.gov. It is understood that these initial notifications will be followed by more comprehensive information as it becomes available.

Jose D. Riojas

Attachment (1)
cc: VA Integrated Operations Center

Department of Veterans Affairs
Washington, DC 20420

VA Directive 0321
Transmittal Sheet

1. **REASON FOR ISSUE:** This Directive establishes specific Department policy for Serious Incident Reports (SIRs).
2. **SUMMARY OF CONTENTS/MAJOR CHANGES:** The Directive provides VA policy and responsibilities for SIRs.
3. **RESPONSIBLE OFFICE**: The Office of Operations, Security and Preparedness, Office of Emergency Management Is responsible for the contents of this Directive.
4. **RELATED HANDBOOK:** VA Handbook 0321 Serious Incident Reports
5. **RESCISSION:** None

CERTIFIED BY:

Roger W. Baker
Assistant Secretary for
Information and Technology

BY DIRECTION OF THE SECRETARY OF VETERANS AFFAIRS:

Jose D. Riojas
Assistant Secretary for
Operations, Security, and Preparedness

DISTRIBUTION: Electronic Distribution.

VA DIRECTIVE 0321

SERIOUS INCIDENT REPORTS

1. PURPOSE. To establish policy for Serious Incident Reports (SIR) In order to facilitate reporting of certain high-interest incidents, significant events, and critical emerging or sensitive matters occurring throughout VA that are likely to result in National media or Congressional attention.

2. POLICY.

a. This directive requires that Serious Incidents in the VA infrastructure that are likely to result in National media or Congressional attention be reported to the VA Integrated Operations Center (VA IOC) as soon as possible but no later than 2 hours after awareness of the incident.

b. The SIR will inform the Secretary of any adverse event or incident likely to result In National media or Congressional attention. Discussed within the VA Handbook 0321 Serious Incident Reports, are the identified procedures and operational requirements implementing this policy.

c. The following are the reportable events and incidents:

1. Public information regarding the arrest of a VA Employee (police report, public release, etc.);
2. Major disruption to the normal operations of a VA facility;
3. Deaths on VA property due to suspected homicide, suicide, accidents, and/or suspicious deaths;
4. VA Police involved shootings;
5. Activation of Occupant Emergency Plans, Facility Disaster Plans and/or Continuity of Operations Plans;
6. Loss or compromise of VA sensitive data, Including classified information;
7. Theft or loss of VA controlled firearms or hazardous material, or other major theft or loss;
8. Terrorist event or credible threat that impacts VA facilities or operations;
9. Incidents on VA property that result in serious illness or bodily injury to include sexual assault, aggravated assault and child abuse.

d. Nothing In this policy for reporting serious Incidents changes existing reporting requirements under 36 CFR 1.200" 1.205 (Referrals of Information Regarding Criminal Violations).

e. In the event of an actual or alleged data breach, notify the information security officer, privacy officer, and supervisor, and follow other established procedures as provided by VA Handbooks 6500 "Information Security Program," and 6500.2 "Management of Security and Privacy Incidents."

3. RESPONSIBILITIES.

a. The Secretary of Veterans Affairs will ensure the development of policies and procedures for Serious Incident Reports.

b. Assistant Secretary for Operations, Security, and Preparedness

1. Ensures development of coordinated procedures, standardized reports, forms and tools for Implementing polley In this Directive In consultation with Under Secretaries, Assistant Secretaries, and Other Key Officials;
2. Implements and maintains policies and procedures for SIRs;
3. Informs Administrations, Staff and Program Offices, of SIR submissions;
4. Ensures the VA 10C receives, tracks, displays, distributes, stores, and proactively collects additional data to produce SIRs for VA senior leadership;
5. Ensures the VA roc gathers and analyzes data and develops accurate reports.

c. Under Secretaries, Assistant Secretaries. and Other Key Officials

1. Supports the Office of Operations, Security, and Preparedness in developing procedures for implementing policy in this Directive;
2. Ensures that all relevant VA employees are aware of and adhere to this policy;
3. Ensures standard operating procedures are developed In support of VA SIR policies and procedures.
4. Ensures Field activities comply with SIR policies and procedures.

Memorandum

Department of Veterans Affairs

Date: July 7, 2011
From: Deputy Under Secretary for Health for Operations and Management (10N)
Subj: Actions Needed to Improve Reporting of Allegations of Sexual Assaults
To: Network Directors (10N 1–23)

1. Background. On June 7, 2011, the Government Accountability Office (GAO) issued its report: VA HEALTH CARE: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents, and provided recommendations to the Department of Veterans Affairs to improve both the reporting and monitoring of sexual assault incidents and the tools used to identify risks and address vulnerabilities at VA facilities.
2. The safety and security of all individuals on our campuses is paramount. A multidisciplinary team, the Safety and Security from Sexual Victimization Workgroup, has been established to address all of the recommendations in this report and will provide an action plan by July 15, 2011. To ensure we continue to provide a safe environment at our facilities, there are several actions we can undertake prior to the workgroup issuing its final recommendations—namely ensuring compliance with reporting allegations of sexual assaults.
3. To ensure accurate reporting, sexual assault is as defined by GAO and adopted by the VA's Safety and Assault Prevention Workgroup:

   "Any type of sexual contact or attempted sexual contact that occurs without the explicit consent of the recipient of the unwanted sexual activity. Assaults may involve psychological coercion, physical force, or victims who cannot consent due to mental illness or other factors. Falling under this definition of sexual assault are sexual activities such as [but not limited to] forced sexual intercourse, sodomy, oral penetration, or penetration using an object, molestation, fondling, and attempted rape. Victims of sexual assault can be male or female. This does not include cases involving only indecent exposure, exhibitionism, or sexual harassment."

4. You, and your subordinate managers, must ensure that all allegations of sexual assault on VA property (or off-property in the execution of official VA duties) involving a Veteran, VA employee, contractor, visitor, or volunteer are reported within 2 hours in accordance with the Serious Incident Reporting guidelines. If the incident occurs during an off-tour, the Administrative Officer of the Day will report the incident to the following email group VAIOC@va.gov as a "Heads Up" (an alleged incident of sexual assault has occurred, more complete information to follow). Within 24 hours of reporting the incident, an Issue Brief (IB) will be sent to the Deputy Under Secretary for Health for Operations and Management through your Veterans Integrated Service Network Support Team.
5. The following elements should be included in the IB: date of incident; location of the incident; description of the incident; immediate actions taken; type of investigation the facility plans to conduct; any involvement or reporting to an outside law enforcement agency or health care organization.
6. Each VISN must submit a follow up issue brief to: provide details regarding additional actions taken by the facility to investigate the allegations; any actions taken by the facility, to include personnel actions; as a result of its investigation; legal disposition and whether the incident is substantiated; and any process improvements or policy changes being made to try to mitigate future events.
7. Information to be reported to the Office of the Inspector General 38 C. F. R. 1.203 (2010) [1.203 covers reporting to VA. Police] requires the following: Information about actual or possible violations of criminal laws related to VA programs, operations, facilities, or involving VA employees, where the violation of criminal law occurs on VA premises, will be reported by VA management officials to the VA police component with responsibility for the VA station or facility in question. If there is no VA police component with jurisdiction over the offense, the information will be reported to Federal, state or local law enforcement officials, as appropriate.
8. All criminal matters that involve felonies shall be reported to the Office of Inspector General (OIG) as required by regulation 38 C. F. R. 1.204 (2010). The

regulation requires all potential felonies including rape, aggravated assault and serious abuse of the patient to be reported to VA OIG for investigation. Hence all allegations of sexual assault will be reported to the OIG to enable them to determine which allegations rise to the level of a potential felony.

9. It is important for all sexual assaults to be reported up and through the VHA management chain starting with facility leadership to the VISN and to VACO in a timely manner. Parallel reporting to the OIG will occur where required.
10. Additional guidance regarding the reporting, tracking and monitoring of sexual assault activity will be provided as a result of the Workgroup's recommendations.

William Schoenhard, FACHE

Memorandum

Department of Veterans Affairs

Date: June 10, 2011
From: Deputy Under Secretary for Health for Operations and Management (10N).
Subj: Actions Needed to Improve Physical Security Requirements.
To: Network Directors (10N 1–23).

1. Background. On June 7, 2011, the Government Accountability Office (GAO) issued its report: **VA HEALTH CARE: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents**, and provided recommendations to the Department of Veterans Affairs to improve both the reporting and monitoring of sexual assault incidents and the tools used to identify risks and address vulnerabilities at VA facilities. A multidisciplinary team, the Safety and Security from Sexual Victimization Workgroup, has been established to address all of the recommendations in this report and will provide an action plan by July 15, 2011.
2. The safety and security of all individuals on our campuses is paramount. There are a few things that we can undertake immediately without waiting for the workgroup's recommendations, namely ensuring compliance with all existing safety and security policies and procedures.
3. A systematic environmental assessment must be undertaken now at all of our facilities to eliminate environmental factors that may contribute to physical security deficiencies. Per VA Handbook 0730/2, Security and Law Enforcement, Directors of VA field facilities are responsible for the physical security protection of persons on VA property and this memorandum provides additional information and standards to further enhance safety and security precautions.

   a. *Policy for Testing Alarm Systems*. VHA recognizes and acknowledges the importance of regularly testing physical security systems. Therefore, it is expected that all VA facilities should have established policies regarding the use and testing of alarm systems to include panic alarms. These policies should be specific to the unique circumstances at each VAMC, but designed to comply with the stringent standards of The Joint Commission (TJC). If a VAMC does not have a policy, the VAMC must establish and implement a policy NLT 30 days after date of this memo.
   b. *Testing and Preventative Maintenance*. It is imperative that testing and preventative maintenance of these systems be conducted regularly in accordance with VAMC policies and manufacturers' requirements for each system. VA Handbook 0730/2 sets forth detailed physical requirements for alarms for specific functions at each VAMC based on the risks inherent in a given area (e.g., pharmacy would be a higher risk area than environmental services). The handbook further specifies that the exact location of panic/duress alarm switches are to be determined by physical security surveys of the protected area/s. Due to the variability in types of alarm systems based on location and services offered, each Service in each VAMC must have established and must enforce standard operating procedures (SOP) for regular alarm testing based on industry and manufacturer standards. At a minimum testing will be conducted semi-annually with a systematic process for the documentation of all alarm system testing.
   c. *Monitoring of Alarm Systems*. Additionally, each VAMC must have a 24/7 plan and implementation strategy for: VA Police command and control cen-

ters to monitor alarms and surveillance cameras; and Response capabilities for all alarm systems.

d. *Summary of Requirements to Ensure Physical Security*. To summarize, every Network Director is responsible for ensuring that each VAMC has a physical security assessment plan that includes:

- Policies for use and testing of alarm systems, including panic alarms;
- Regular testing of these alarms systems, including panic alarms;
- Documentation of testing:
  - A plan and implementation strategy for VA Police command and control centers to monitor alarms and surveillance cameras; and
- A plan and implementation strategy for *24f7* response capabilities and preventative maintenance.

4. Every Network Directors must document and submit the attached attestation that each VAMC has been reviewed for compliance, the VISN is compliant with all physical security policies, and an action plan and timeline have been developed to implement a physical assessment plan to ensure adequate security controls. Network Directors will send the completed attestations with supporting documentation to Deesha Brown ***no later than 2pm (EST) on June 24, 2011***. If you have any questions, please contact Deesha Brown, Executive Assistant to the DUSHOM, at Deesha.Brown@va.gov or (202) 461–6945 or Michael Moreland, Network Director VISN 4, in his capacity as the Chair of the Environment of Care subgroup of the Safety and Security from Sexual Victimization Workgroup, at MichaeI.Moreland@va.gov or (412) 822–3316.
5. Additional guidance may be forthcoming as a result of the analysis of the VISN's environmental assessments and will be provided as a result of the Workgroup's recommendations.

William Schoenhard, FACHE
Attachment: (2)

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