STATEMENT OF CARL BLAKE

ACTING ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE CURRENT STATE OF VETERANS HEALTH CARE

AND THE SCI SYSTEM OF CARE

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Chairman Sanders, Ranking Member Burr, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on the current state of health care provided by the Department of Veterans Affairs (VA) and the spinal cord injury and disorder (SCI/D) system of care. No group of veterans understands the full scope of care provided by the VA better than PVA's members—veterans who have incurred a spinal cord injury or dysfunction. PVA members are the highest percentage of users among the veteran population. They are also the most vulnerable when access to health care and other challenges impact quality of care. I will first offer PVA's thoughts on the specialized services provided by the VA, particularly in the area of SCI/D care, and then I will focus my remarks on the VA health care system in general.

The VA Spinal Cord Injury/Disorder System of Care

The SCI/D system of care is one of the crown jewels of the VA health care system. Spinal cord injury care is provided use the "hub-and-spoke" model. This model establishes the 24 spinal cord injury centers that exist with the VA system as the hubs of care. All other major medical facilities in the system serve as outpatient clinics (spokes) that direct and refer care back to the hubs. This model has proven to be very

successful in meeting the complex needs of PVA's members. In fact, this model system of care has been so successful that the VA used the same model to establish the poly-trauma system of care.

Unfortunately, the ability of the SCI/D centers to function properly is dictated by the numbers of qualified SCI/D trained staff that are employed within the system. As a result of frequent staff turnover and a general lack of education and training in outlying "spoke" facilities, not all SCI/D patients have the advantage of referrals, consults, and annual evaluations in an SCI/D center.

This is further complicated by confusion as to where to treat spinal cord diseases, such as Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS). Some SCI/D centers treat these patients, while others deny admission. We recognize that there is an ongoing effort to create a continuum of care model for MS, and this model should be extended to encompass MS and other diseases involving the spinal cord, such as ALS. Ultimately, we believe admission to an SCI/D center is the most appropriate setting for treatment for all SCI/D veterans.

In December 2009, VA developed and published *Veterans Health Administration Handbook 1011.06, Multiple Sclerosis System of Care Procedures*, which clearly identifies a model of care and health care protocols for meeting the individual treatment needs of SCI/D veterans. However, VA has yet to develop and publish a Veterans Health Administration (VHA) directive to enforce the aforementioned handbook. Without a directive, the continuity and quality of care for both SCI/D veterans and veterans with MS could be compromised. The issuance of a VHA directive for the handbook is essential to ensuring that all local VA medical centers are aware of and are meeting the health care needs of SCI/D veterans. Additionally, and perhaps most importantly, no dedicated funding has been provided to VA medical centers to implement the guidelines in the handbook. However, we believe that the current SCI/C system can appropriately handle all SCI/D veterans if properly resourced.

Additionally, historical data has shown that SCI/D units are the most difficult places to recruit and retain nursing staff. Caring for an SCI/D veteran is physically demanding and requires nursing staff to provide hands-on care that involves bending, lifting, and stooping in order to transfer patients, prevent bed sores, and deliver care to individuals who are completely reliant on another individual for functions and activities that most people take for granted. These repetitive movements and heavy lifting often lead to work related injuries, even with the advent of patient lifts and other innovations. Also, veterans with SCI/D often have complex psychological issues and other hidden health dangers as a result of their injury/disorder. Special skills, knowledge, and dedication, which call for a set of competencies that can prove extremely esoteric even for the most skilled non-SCI/D providers, are required in order for nursing staff to care for SCI/D veterans.

Recruitment and retention bonuses have proven effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans as well as in the morale

of the nursing staff. Unfortunately, facilities are faced with local budget challenges that result in the deprioritization of recruitment and retention bonuses. The funding necessary to support this effort is taken from local facility budgets, essentially forcing a choice between maximizing care for the most vulnerable versus providing care for the greatest number. A consistent national policy of salary enhancement should be implemented across the country to ensure that qualified staff is recruited. Funding to support this initiative should be made available to the medical facilities from the network or central office to supplement their operating budgets.

Moreover, the VA has a system of classifying patients according to the hours of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of care required during hospitalization, amount of time spent with the patient, technical expertise, and clinical needs of each patient. Acuity category III has been used to define the national average acuity/patient classification for the SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of full-time equivalent employees (FTEE) needed for continuous coverage.

However, the emphasis of this classification system is based on bedside nursing care that may work in non-SCI/D systems of care, but that are not necessarily appropriate for SCI/D care. It does not include administrative nurses, non-bedside specialty nurses, or light-duty nursing personnel as these individuals do not, and are not able, to provide full-time, hands-on bedside care for the high acuity veterans patient with SCI/D whose health needs vastly exceed that of an ICU, hospice, or geriatric patient with special needs. Because of this specialized quality, nurse staffing in SCI/D units has been delineated in *VHA Handbook 1176.01* and VHA Directive 2008-085 based on VA and PVA's joint assessment of need. It was derived from the basis of 71 FTEEs per 50 staffed beds, based on an average acuity category III SCI/D patient, which reflected a younger average age among veterans with SCI/D. However, this national acuity average was established over a decade ago. Currently, SCI/D inpatients require a higher level of care than category III due to higher average age and multiple chronic complications that accompany aging with an SCI/D. While VA has recognized our requests in the past that administrative nurses not be included in the nurse staffing numbers for patient classifications, the current nurse staffing numbers still do not reflect and accurate picture of bedside nursing care. VA nurse staffing numbers incorrectly include non-bedside specialty nurses and light-duty staff as part of the total number of nurses providing bedside care for SCI/D patients. When the minimal staffing levels include non-bedside nurses and light-duty nurses, the number of actual nurses available to provide bedside care is misrepresented in staffing reports. This leads to "floating" SCI/D nurses to other units, understaffing that results in mandatory overtime for existing staff, and other practices that erode quality of care over time. It is well documented in professional medical publications that adverse patient outcomes occur with inadequate nursing staff levels.

VHA Directive 2008-085 mandates 1,504 bedside nurses to provide nursing care for 85 percent of the available beds at the 24 SCI/D centers across the country. This nursing

staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians. Unfortunately, the SCI/D centers recruit only to the mandated minimum nurse staffing required by VHA Directive 2008-085. As of April 2014, the actual number of nursing personnel delivering bedside care was 161.9 FTEEs below the minimum nurse staffing requirement. Factoring in the actual average acuity level, there is a deficit of 746.2 FTEE between nurse staffing needed and the actual number of nurses available. The low percentage of professional RNs providing bedside care and the high acuity level of SCI/D patients put these veterans at increased risk for complications secondary to their injuries. Translated into lay terms that are relevant to why we are here today, the low percentage of professional RNs providing bedside care coupled with the high acuity of SCI/D patients presents us with a completely foreseeable, remarkably costly scenario where the next headline will read "paralyzed veterans suffer secondary complications due to failure to properly staff SCI/D centers," a claim that would be far from hyperbolic. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, development of pressure ulcers, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their conditions. We have steadily maintained, and VA at one point agreed, that a minimum 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

Unfortunately, the nurse shortage has also resulted in VA facilities restricting admissions to SCI/D centers (an issue that we believe mirrors the larger access issues that are being reported around the country). Reports of bed consolidations or closures have been received and attributed to nursing shortages. When veterans are denied admission to SCI/D centers and beds are consolidated, leadership is not able to capture or report accurate data for the average daily census. The average daily census is not only important to ensure adequate staffing to meet the medical needs of veterans; it is also a vital component to ensure that SCI/D centers receive adequate funding. Since SCI/D centers are funded based on utilization, refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA's ability to address the needs of new incoming and returning veterans.

As an example of this point, VA's projections for long term care SCI/D beds in VISN 22 (Southern California and Southern Nevada) called for 30 beds per the Capital Asset Realignment for Enhanced Services (CARES) model, which estimated demand for health care services in order to determine capacity of its infrastructure to meet that demand. It seems logical to presume that more aging veterans over time will need extended care services in Southern California, not fewer. However, VA advised us that new, lowered projections based on the Enrollee Health Care Projection Model (EHCPM) dictated a decrease in scope of new construction for the San Diego SCI/D center in VISN 22. This leads to serious concerns about future timely access to specialized care. Moreover, the EHCPM fails to account for suppressed demand that can lead to false assumptions about future utilization. Such situations severely compromise patient safety and serve as evidence for the need to enhance the nurse recruitment and retention programs to build capacity.

In order to better track these issues and ensure they are addressed by the VA, PVA developed a memorandum of understanding with the VA more than 30 years ago that authorizes site visit teams managed by our Medical Services Department to conduct annual site visits of all VA SCI/D centers as well as spoke facilities that support the hubs. This opportunity has allowed us to work with VHA over the years to identify concerns, particularly with regards to staffing, and offer recommendations to address these concerns. More importantly, PVA is the only veterans' service organization (VSO) that employs a staff of licenses physicians, registered nurses, and architects to conduct these visits and report on the conditions. Our most recent site visits have yielded the information that is included below. This information reflects the Bed and Staffing Survey as of April 2014 for beds, doctors, nurses, social workers, psychologists, and therapists in the SCI/D system of care.

Physician personnel across the SCI/D system are below the required staffing level by 21.8 FTEEs. Social workers are below the requirement by 15.2 FTEEs. Psychologists are below the required level by 15.4 FTEEs. Finally, therapists are 33.4 FTEEs below the required level. As mentioned previously, the actual number of nursing personnel delivering bedside care is 161.9 FTEEs below the minimum nurse staffing requirement. The nurse shortages alone resulted in 114.0 SCI/D beds staffed below the minimum required number. Factoring in the actual average facility acuity level, this amount increases to 372.9 SCI/D beds staffed below the requirement. This means that there are currently 281 unavailable SCI/D beds throughout the system. If this number is adjusted based on the actual average facility acuity level, this amount increases to 539.9 unavailable SCI beds throughout the system. This absurdly staggering number has proven easy to dismiss by leaders within VHA who insist that we provide by-name lists of veterans with SCI/D who languish on waiting lists rather than interrogate the merits of our claim and objectively examine their own data.

These facts are simply unacceptable. The statistics reflect the fact that many veterans who might be seeking care in the VA are unable to attain that care. But to be clear, these facts reflect an access problem, not a quality of care problem. Access and quality is not the same thing. Veterans who have incurred a spinal cord injury or disorder and who get regular care at the VA are very satisfied with the care they are receiving. In fact, patient satisfaction surveys bear out this point. Unfortunately, for too long the VA has been provided insufficient resources to properly address the tremendous staffing shortages that exist, not only in the SCI/D system of are, but across the entire system.

Within the VA health care system, the capacity to provide for the unique health care needs of severely disabled veterans—veterans with spinal cord injury/disorder, blindness, amputations, and mental illness—has not been maintained as mandated by P.L. 104-262, the "Veterans Health Care Eligibility Reform Act of 1996." This law requires VA to maintain its capacity to provide for the specialized treatment and rehabilitative needs of catastrophically disabled veterans. As a result of P.L. 104-262, the VA developed policy that required the baseline of capacity for the spinal cord injury/disorder system of care to be measured by the number of staffed beds and the number of full-time equivalent employees assigned to provide care (the basis for PVA's

site visits today). This law also required the VA to provide Congress with an annual "capacity" report to ensure that the VA is operating at the mandated levels of "capacity" for health care delivery for all specialized services.

Unfortunately, the requirement for the capacity report expired in 2008. PVA's Legislation staff, in consultation with PVA's Medical Services Department, identified reinstatement of this annual "capacity" report as a legislative priority for 2014. We have worked extensively with our partners in the VSO community as well as with Hill offices to formulate legislation that would reinstate the annual "capacity" report. This report affords the House and Senate Committees on Veterans' Affairs as well as veteran stakeholders the ability to analyze the accessibility of VA specialized care for veterans seeking that care at little to no cost. Currently, legislation is pending in the House Committee on Veterans' Affairs—H.R. 4198, the "Appropriate Care for Disabled Veterans Act"—that would reinstate this report. We urge the Senate Committee on Veterans' Affairs to consider similar legislation as soon as possible.

Protection of VA Specialized Services

The simple truth is the VA is the best health care provider for veterans. In fact, the VA's specialized services are incomparable resources that often cannot be duplicated in the private sector. However, these services are often expensive, and are severely threatened by cost-cutting measures and the drive toward achieving management efficiencies. Even with VA's advances as a health care provider, some political leaders and policy makers continue to advocate expanding health care access for veterans by contracting for services in the community. While we recognize that VA must tap into every resource available to ensure that the needs of veterans are being met, such changes to the VHA would move veterans out of the "veteran-specific" care within VA, leading to a diminution of VA health care services, and increased health care costs in the federal budget.

Specialized services, such as spinal cord injury care, are part of the core mission and responsibility of the VA. These services were initially developed to care for the complex and unique health care needs of the most severely disabled veterans. The provision of specialized services is vital to maintaining a viable VA health care system. The fragmentation of these services would lead to the degradation of the larger VA health care mission. With growing pressure to allow veterans to seek care outside of the VA, the VA faces the real possibility that the critical mass of patients needed to keep all services viable could significantly decline. All of the primary care support services are critical to the broader specialized care programs provided to veterans. If primary care services decline, then specialized care is also diminished.

We believe that the VA itself has created conditions that require contract (or privatized) health care as a solution. The Committee needs to look no further than the wholly inadequate budget requests over many years and multiple Administrations for Major and Minor Construction to see this scenario playing out. For example, this year the Administration requested $561 million for Major Construction. This included funding for only four primary projects and secondary construction costs—this despite a backlog of

construction projects that requires a minimum of $23 billion over the next 10 years in order to maintain adequate and serviceable infrastructure. If the Administration refuses to properly address this construction funding problem, then Congress should be filling this void. Unfortunately, Congress has punted on this responsibility as well. Ultimately, if VA is not provided sufficient resources to address the critical infrastructure needs throughout the system, then it will have no choice but to seek care options in other settings, particularly the private section. However, calls for using contract care options to alleviate these problems are not the answer for SCI/D veterans because comparable specialized health care options do not really exist in the private sector.

VA Health Care

PVA believes that the quality of VA health care is excellent, when it is accessible. In fact, as mentioned previously, VA patient satisfaction surveys reflect that more than 85 percent of veterans receiving care directly from the VA rate that care as excellent (a number that surpasses satisfaction in the private sector). The fact is that the most common complaint from veterans who are seeking care or who have already received care in the VA is timely access. PVA cannot deny that there are serious access problems around the country. The broad array of staff shortages that we previously mentioned in our statement naturally lead to the access problems that VA is facing across the nation. Many of the problems that the media continues to report are really access problems, not quality of care problems. While there are many detractors of the VA who would like to convince veterans and the public at large that the VA is providing poor quality care that is simply not true. If the Committee wants to get the truth about the quality of VA health care, spend a day walking around in a major VA medical facility (not conducting a panel with four pre-selected veterans' opinions) and ask veterans their impressions of the care. We can guarantee that you will likely hear complaints about how long it took to be seen, but rare is the complaint about the actual quality of care. In fact the complaints of veterans about access often ring true about health care delivery in private hospitals and clinics as well. It is no secret that wait times for appointments for specialty care in the private sector tend to be extremely long.

As we have already testified, access problems are primarily a reflection of insufficient staffing and by extension capacity. While insufficient staffing can be traced in some areas to the VHA inefficiently managing the resources it is provided, limited funding provided over many years has superseded the savings that can be generated from operational efficiencies and increased demand for health care services. We believe many of the access problems facing the VA health care system are the responsibility of Congress and the Administration together. The Administration (and previous Administrations) has requested wholly insufficient resources to meet the ever-growing demand for health care services, while at the same time attempting to fragment the VHA health system framework. Meanwhile, it has committed to operation improvements and management efficiencies that are not adequate enough to fill the gaps in funding. Similarly, Congress has been equally responsible for this problem as it continues to provide insufficient funding through the appropriations process to meet the needs of veterans seeking care.

For many years, the co-authors of *The Independent Budget*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—have advocated for sufficient funding for the VA health care system, and the larger VA. In recent years, our recommendations have been largely ignored by Congress. Our recommendations are not "pie-in-the-sky" wish lists based on nothing. They reflect a thorough analysis of health care utilization in the VA and full and sufficient budget recommendations to address current and future utilization. Moreover, our recommendations are not clouded by the politics of fiscal policy. Despite the recommendations of *The Independent Budget* for FY 2015 (released in February of this year), the House just recently approved an appropriations bill for VA that we believe is nearly $2.0 billion short for VA health care in FY 2015 and approximately $500 million short for FY 2016.

While we understand that significant pressure continues to be placed on federal agencies to hold down spending and Congress has moved more towards fiscal restraint in recent years, the health care of veterans outweighs those priorities. If Congress refuses to acknowledge that it has not provided sufficient resources for the VA, and that many of these access problems that are being reported around the country are a result of those decisions, then we will. Until Congress and the Administration make a serious commitment to providing sufficient resources so that adequate staffing and capacity can be established in the VA health care system, access will continue to be a problem.

And unfortunately for those clamoring for it, contract health care is not the answer to this problem. Studies have shown that contract health care providers cannot provide the same quality of care as the VA at any less cost, despite claims by some that it can. Similarly, contract care simply is not a viable option for veterans with the most complex and specialized health care needs. A veteran with a cervical spine injury whose autonomic dysreflexia was mistakenly treated as a stroke is not better served at a local outpatient clinic or the local doctor's office closer to his or her home. Sending those individuals outside of the VA actually places their health at significant risk while abrogating VA of the responsibility to ensure timely delivery of high quality health care for our Nation's veterans.

Mr. Chairman and members of the Committee, we appreciate your commitment to ensuring that veterans receive the best health care available. We also appreciate the fact that this Committee has functioned in a generally bipartisan manner over the years. Unfortunately, even veterans issues are now held hostage to political gridlock and partisan wrangling. It is time for this to stop! Political interests do not come before the needs of the men and women who have served and sacrificed for this country. We call on this Committee, Congress as a whole, and the Administration to redouble your efforts to ensure that veterans get the absolute best health care provided when they need it, not when it is convenient. PVA's members and all veterans will not stand for anything less.

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

William Carl Blake
Acting Associate Executive Director for Government Relations
Paralyzed Veterans of America
801 18th Street NW
Washington, D.C. 20006
(202) 416-7708

Carl Blake is the Acting Associate Executive Director for Government Relations for Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's National Legislative and Advocacy Program agendas with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues, as well as disability civil rights. He also represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, the Department of Transportation, Department of Justice, and the Office of Personnel Management. He coordinates all activities with PVA's Association of Chapter Government Relations Directors as well with PVA's Executive Committee, Board of Directors, and senior leadership.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 2nd Battalion, 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute training exercise.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.