ANNUAL LEGISLATIVE PRESENTATION

DAVID ZURFLUH

NATIONAL PRESIDENT

PARALYZED VETERANS OF AMERICA

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Chairman Tester, Chairman Takano, and members of the Committees, I appreciate the opportunity to present Paralyzed Veterans of America's (PVA) 2021 policy priorities. For 75 years, PVA has served as the lead voice on a number of issues that affect severely disabled veterans. Our work over the past year includes championing critical changes within the Department of Veterans Affairs (VA) and educating legislators as they have developed important policies that impact the lives of those who served.

Today, I come before you with our views on the current state of veterans' programs and services, particularly those that impact our members—veterans with spinal cord injuries and disorders (SCI/D). Our concerns and policy recommendations are particularly important in light of the continuing discussion about reforming the delivery of VA's health care system. Proper consideration must be given to how those reforms will impact veterans, like PVA members, who rely almost exclusively on VA for their health care, and specifically depend upon VA's specialized systems of care.

BACKGROUND—Our organization was founded in 1946 by a small group of returning World War II veterans, all of whom were treated at various military hospitals throughout the country as a result of their injuries. Realizing that neither the medical profession nor government had ever confronted the needs of such a population, these veterans decided to become their own advocates and to do so through a national organization.

From the outset, PVA's founders recognized that other elements of society were neither willing nor prepared to address the full range of challenges facing individuals with an SCI/D, whether medical, social, or economic. They were determined to create an organization that would be governed by the members themselves and address their unique needs. Being told that their life expectancies could be measured in weeks or months, these individuals set as their primary goal to bring about change that would maximize the quality of life and opportunity for all veterans and individuals with SCI/D.

Over the years, PVA has established ongoing programs to secure benefits for veterans; review the medical care provided by the VA's SCI/D System of Care to ensure our members receive timely, quality care; invest in research; promote education; organize sports and recreation opportunities; and advocate for the rights of veterans and all people with

disabilities through legal advocacy and accessible architecture. We have also developed long-standing partnerships with other veterans service organizations (VSOs). PVA, along with the co-authors of *The Independent Budget (IB)*—DAV (Disabled American Veterans) and the Veterans of Foreign Wars of the United States (VFW), continue to present comprehensive budget and policy recommendations to influence debate on issues critical to the veterans we represent. We recently released our Veterans Agenda for the 117th Congress and budget recommendations to inform the debate on VA funding for Fiscal Years (FY) 2022 and 2023 advance appropriations.

COVID-19's IMPACT ON VA's SCI/D SYSTEM OF CARE

VA's SCI/D System of Care has a solid foundation and COVID-19 has reinforced our belief in the system. The Department has done a good job minimizing the pandemic's impact for veterans who are inpatients in one of the VA's 25 SCI/D facilities and 6 SCI/D long-term care (LTC) centers. VA kept infections of inpatients and staff to a minimum, and stepped-up countermeasures to protect this extremely vulnerable population. Since the beginning of the pandemic, we have been in regular communication with officials from both the Veterans Health Administration (VHA) and VA's SCI/D National Program Office on the current state of the system, and in most cases, have been alerted in advance of potential changes that may affect our membership. Still, the pandemic has shed light on some issues the committees should be aware of as you evaluate the Department's response to COVID-19 and its future needs to combat the virus.

Due to the complexity and severity of SCI/D, veterans who live with these conditions are among the most susceptible to suffer negative outcomes from COVID-19. Unfortunately, the roll out of the vaccine across VA has been uneven and resulted in different levels of access to the vaccine for our members based upon their location versus their level of need. In late January, we surveyed our members regarding their access to the COVID-19 vaccine. Over half of the more than 800 respondents were age 65 or older but every one of them fall well within the definition of "high-risk." Slightly less than 29 percent of them (231) said they received the COVID-19 vaccine and 85 percent of those who did not indicated they would like to. VA's slow roll out of vaccine has caused considerable angst among its SCI/D outpatient population and left thousands of its most vulnerable veterans still at risk of contracting the disease. We are pleased that on February 19, VA officially announced that all veterans with SCI/D would be prioritized for access to the vaccine due to data showing the high fatality rate among SCI/D veterans who contract the virus.

Many PVA members are also worried about their caregivers' access to the vaccine. Eighty-one percent (576 members) of respondents reported that their primary caregiver had not been vaccinated. Of those veterans whose primary caregiver had been vaccinated, 17 reported that their caregiver had received the vaccine at VA. The Department recently authorized providing the vaccine to participants of VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) but only 15 percent of members (121) reported being enrolled in that program. We urge the Department to continue to expedite entry into the PCAFC for eligible veterans and evaluate potential partnerships that will help all caregivers for high-risk veterans to access the vaccine as soon as possible.

Aside from uneven access to the vaccine, VA's ability to ramp up its telehealth and teleconference capabilities during the pandemic has been commendable. Use of digital options are a lifeline for thousands of veterans who receive outpatient care through VA. However, SCI/D veterans are "high touch" patients so VA telehealth and teleconference options must not be viewed as a long-term solution to providing needed care. These veterans must be able to resume face-to-face meetings with their providers as quickly and as safely possible.

Likewise, COVID-19 caused the deferral of thousands of elective procedures, resulting in a huge backlog of care. However, in truth, the term "elective procedure" does not apply to our members because every touchpoint increases the Department's ability to detect well-known secondary complications of an SCI/D such as bowel or urological complications, infections, autonomic dysreflexia, degeneration of the spine, pressure sores, overuse of the shoulders, compression syndromes, and so on. The early identification and treatment of complications related to lifestyle, aging, and living with an SCI/D are critical, but VA postponed its yearly comprehensive preventative health evaluations for these veterans in most locations. It is imperative that VA resume these annual evaluations as quickly as possible to maximize veterans' health, prevent complications, and help them get the most out of life.

Our final COVID-related observation concerns funds that VA provides through Special Monthly Compensation (SMC)/Aid and Attendance (A&A) programs for veterans who require the regular aid of another person to complete activities of daily living such as eating, bathing, dressing and undressing, transferring, and toileting. These benefits help offset the costs of acquiring care, which is often provided in a veteran's home. SMC is an additional benefit provided to veterans with service-connected disabilities who meet certain disability requirements. In the case of veterans receiving VA pension benefits, A&A is provided when warranted in addition to the basic pension rate.

Shortly after the pandemic began, VA started to ration personal protective equipment (PPE) such as masks and gloves that would normally be issued to veterans who perform procedures like bowel and bladder care at home. In many cases, they ceased to provide it altogether. At the same time, we heard from veterans who were informed that rates would be increased by their home care providers to offset the higher cost of buying PPE needed to protect the home health workers and their veteran clients. A few months ago, VA resumed issuing a modest amount of PPE to certain veterans, and thankfully, the cost of procuring it on the civilian market has come down. Unfortunately, the cost of providing care has not. Rates remain high and there continues to be a shortage of providers; so, those who are willing to provide these services can command premium rates. Thousands of Registered and Licensed Practical Nurses who left their jobs in tertiary systems because of COVID are now making themselves available in local communities to perform home care. They tend to cost more because rates are commensurate with the level of training and experience of the provider.

Sadly, some veterans are forgoing needed home care because they are unable to meet those costs. Allowing this to continue is untenable for a group of veterans whose care should be VA's primary concern, particularly because in many cases they also represent those most vulnerable to the virus. As a nation, it is important that we do everything we can to help veterans stay safely in their homes and help minimize the burden of these increased costs.

I urge you to pass S. 219 and H.R. 789, the "Aid and Attendance Support Act," which temporarily raises VA A&A rates as quickly as possible.

STRENGTHEN AND IMPROVE VA'S HEALTH CARE SYSTEM AND SERVICES

Protect Specialized Services—PVA firmly believes VA is the best health care provider for veterans. The VA's SCI/D System of Care, comprised of 25 SCI/D centers and six LTC facilities, provides a coordinated life-long continuum of services for veterans with an SCI/D that has increased the lifespan of these veterans by decades. VA's specialized systems of care follow higher clinical standards than those required in the private sector. Preserving and strengthening VA's specialized systems of care—such as SCI/D care, blinded rehabilitation, amputee care, and polytrauma care—remains the highest priority for PVA. However, if VA continues to woefully underfund the system and understaff facilities, their capacity to treat veterans will be diminished, and could lead to the closure of facilities and reductions in services offered to them.

PVA is very concerned about efforts to permanently reduce inpatient beds in some SCI/D centers, including at facilities that provide specialized long-term care. Such a decision would come at a time when VA's aging SCI/D population needs care the most. The capacity of the system to provide a continuum of care must be preserved and strengthened to meet the needs of paralyzed veterans. If necessary, Congress must block any attempt to reduce capacity within the system without a thorough evaluation of SCI/D veteran needs nationwide.

Staffing Vacancies—Before the pandemic, VA had roughly 45,000 unfilled vacancies, including about 2,500 primary care physicians, more than 700 psychologists, and 1,900 social workers. Despite hiring thousands of staff through relaxed hiring and management practices to respond to the pandemic, staffing levels remain relatively unchanged. VHA has experienced chronic health care professional shortages for many years, which diminishes the Department's ability to deliver timely, accessible, and high-quality care, and in some cases, places the health and well-being of veterans at risk. Even though VA has taken many steps to track and address staffing shortages, a more cohesive plan is needed to maintain adequate staffing levels for the timely delivery of veterans' care.

VA's ability to meet the highest standard of care to our veterans relies on more than just having the right number of physicians and nurses. They also need qualified and well-trained housekeepers. In 2019, staffing levels for environmental (custodial) employees dipped below 50 percent, which heightens the health risks to veteran patients, particularly those with compromised immune systems during a pandemic.

Staffing problems have a direct, adverse impact on the SCI/D system. Lengthy, cumbersome hiring processes make it difficult to hire and retain staff, which prohibits SCI/D centers from meeting adequate staffing levels necessary to care for this specialized population. PVA estimates there is a shortage of 600 nurses in the SCI/D System of Care. Considering SCI/D veterans are a vulnerable patient population, the reluctance to meet legally mandated staffing levels is tantamount to willful dereliction of duty. SCI/D centers with nursing shortages limit bed availability for admission to an SCI/D center, reducing access for specialized care delivery. Veterans are often admitted to a VA non-SCI/D ward and treated by untrained SCI/D clinicians for days or weeks until an SCI/D bed becomes available.

As SCI/D LTC facilities are exceptionally limited, veterans with SCI/D who have chronic medical issues are being treated in community institutions, by providers not trained in SCI/D. This results in compromised quality of care and poor outcomes. Given the direness of this situation, PVA strongly advocates for Congress to provide enough funding for VA to reform its hiring practices and hire additional medical professionals, particularly physicians, nurses, psychologists, social workers, and rehabilitation therapists, to meet demand for services in the SCI/D System of Care and ensure the positions, pay, and other incentives they offer are competitive with the private sector.

Accelerate Caregiver Program Expansion—Passage of the VA MISSION Act of 2018 (P.L. 115-182) expanded access to VA's PCAFC to family caregivers of veterans severely injured before September 11, 2001, and was to be implemented in two phases starting on October 1, 2019, when the VA Secretary was to certify a new information technology (IT) system to support the program. However, due to IT delays and failures, VA did not begin the first phase – which includes eligible veterans who became severely injured or ill on or before May 7, 1975 – until October 1, 2020, a full year later than the law required. As a result, the second phase – which will include veterans who became severely injured or ill on or after May 8, 1975, and on or before September 10, 2001, will not begin until October 1, 2022, two years later as required by the law. VA has adequate resources to accept new enrollees and deliver program services so veterans and their caregivers should not be forced to wait an additional year before applying for this critical support program. Thus, Congress should direct that the second phase of the caregiver expansion begin on October 1, 2021, as originally intended.

Improve Access to VA's Long-Term Services and Supports—PVA continues to be concerned about the lack of VA LTC beds and services for veterans with SCI/D. Many aging veterans with an SCI/D are currently in need of VA LTC services. Unfortunately, VA is not requesting, and Congress is not providing, sufficient resources to meet the current demand. In turn, because of insufficient resources, VA is moving toward purchasing private care instead of maintaining LTC in-house for these veterans. However, it is especially difficult to find community placements for veterans who are ventilator dependent or have bowel and bladder care needs.

Our nation's lack of adequate LTC options presents an enormous problem for people with catastrophic disabilities who, because of medical advancements, are now living longer. Nation-wide, there are very few LTC facilities that are capable of appropriately serving SCI/D veterans. VA operates six such facilities; only one of which lies west of the Mississippi River. All totaled, the Department is required to maintain 198 authorized LTC beds at SCI/D centers to include 181 operating beds. When averaged across the country, that equates to about 3.6 beds available per state.

Many aging veterans with SCI/D need VA LTC services but because of the Department's extremely limited capacity, they are forced to reside in nursing care facilities outside of VA that are not designed, equipped, or staffed to properly serve veterans with SCI/D. As a result, veterans staying in community nursing facilities often develop severe medical issues requiring chronic re-admittance back into an acute VA SCI/D center.

VA has identified the need to provide additional SCI/D LTC facilities and has included these additional centers in ongoing facility renovations, but most of these plans have been languishing for years. A contract was just awarded for a fully funded project at San Diego to build a replacement acute care facility there that will add 20 new LTC beds into VA's SCI/D System of Care.

Unfortunately, construction of an LTC SCI/D Center at the VA North Texas Health Care System, designed to include 30 SCI/D resident beds and shell space for an additional 30 beds, has experienced protracted delays despite being an essential step for VA to address the national shortage of LTC beds for veterans with SCI/D. We anticipate a design update and secondary bids to be completed later this year. If everything stays on track, the project could be completed as early as December 2024. The other half of the project remains unfunded. It would add 30 additional LTC beds, along with shared resident dining, kitchen, and living areas to support them, as well as common resident gathering areas and space to support staff on that level. Not fully funding this project postpones the opportunity to further address the shortage of VA LTC beds for the aging population of veterans with SCI/D. The shortage is particularly severe in the south-central region as there is not a VA SCI/D LTC center within 1,000 miles of Dallas despite a significant regional population of veterans with SCI/D. A partial build is an inefficient use of taxpayer money compared to completing the entire project during one construction period. Also, if the day comes that the project is completed in this manner, it would subject veterans and staff occupying the initial 30 bed area to significant noise, vibration, and disruption directly below their living and working environment.

PVA strongly recommends that Congress provide supplementary funding to construct the full complement of 60 SCI/D resident beds at the VA North Texas Health Care System in order to complete the project in one construction phase. We estimate that adding the 30 additional SCI/D resident beds and support spaces to the initial project phase will cost between $15 and $19 million. This additional funding is only approximately 12 percent of the anticipated $160 million total initial phase project cost, whereas if delayed, the additional cost to construct the remaining 30 beds will continue to escalate every year.

Oversight of VA MISSION Act Implementation (P.L. 115-182)—Congress should continue its rigorous oversight of the VA MISSION Act to ensure VA meets its obligations to our veterans under the law, including a stringent evaluation of the Veterans Community Care Program (VCCP) and implementation of the caregiver program expansion in accordance with what Congress intended. The VA MISSION Act directed needed changes to VA's delivery of health care in the community and at VA health care facilities around the country. PVA supported the VA MISSION Act. We believe that integrated community care will strengthen VA's ability to serve veterans with catastrophic disabilities.

Regarding the accessibility of care in the community, we have heard of several instances where care was delayed because consults were lost or slow to be processed. In some cases, the veteran was approved for care in the community, but the provider never received the necessary paperwork, which hampered their ability to deliver care. Some veterans took matters into their own hands to coordinate care that VA staff should have handled. There have been several instances where veterans were erroneously charged for care they

received through the VCCP. Other times, veterans were told they would be contacted regarding care they would receive in the local community, but the call never came.

Additionally, VA's Bowel and Bladder (B&B) program provides an avenue for veterans with SCI/D who have a neurogenic bowel and bladder to receive care from a third party. This care is paid for through a program designed and executed by VA. For caregivers to receive payment for the care they provide, they must follow a process of submitting timesheets. Over the past year, our National Office has received a steady stream of complaints from members and their caregivers about the B&B program. They range from VA failing to pay caregivers after they submitted their claim to home health agencies not receiving timely payment. In one case, VA failed to compensate the agency nearly $180,000 for services provided to veterans in their care. When providers begin turning away veterans because VA cannot pay their bills in a timely manner, it is veterans who suffer and have to find other ways to meet their health care needs. Providing this specialty care is critical to the health and well-being of veterans with SCI/D. Any lapses in the delivery of this care, even one day, can have a detrimental impact on the health of veterans with SCI/D. Given the serious nature of the payment issues described above and the adverse impact they have on veterans and providers alike, we urge the Committees to conduct oversight hearings on the Department's payment processes as soon as possible.

PVA also remains deeply concerned about the exclusion of protections for injuries that occur as a result of community care. Title 38 U.S.C. § 1151 protects veterans in the event that medical malpractice occurs in a VA facility and some additional disability is incurred or health care problems arise by providing clinical appeal rights, no-cost accredited representation, and congressional oversight and public accountability. However, if medical malpractice occurs during community care, the veteran must pursue standard legal remedies, and is not privy to VA's non-adversarial process. If these veterans prevail on a claim, they are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again. Congress must ensure that veterans who receive care in the community retain current protections unique to VA health care under 38 U.S.C. § 1151.

Mental Health—Recent data from the VA Office of Mental Health and Suicide Prevention show a startling rate of suicide among veterans with SCI/D. Wounds and injuries that result in paralysis for military personnel during deployments are highly complex and difficult to evaluate and treat. These challenges are complicated by the reality that gender differences call for an advanced understanding of differing health care needs to be effective, particularly in cases involving catastrophic injuries or illnesses and mental health. Thus, it is essential more research is conducted on how mental illness presents in veterans with SCI/D, especially women veterans.

There is also inconsistency in VA's ability to meet the inpatient mental health needs of veterans with catastrophic disabilities. VHA is obligated to provide inpatient mental health care to those in need, which includes veterans with SCI/D. According to VA, there is no readily available list of VA facilities that can provide on-site inpatient mental health care to veterans with SCI/D. Services provided vary based on Veterans Integrated Service Networks (VISNs) and local arrangements to provide care.

Congress should conduct oversight of VA's ability to meet the mental health needs of veterans with SCI/D, including the Department's ability to handle the detoxification and withdrawal needs of individuals within this population living with substance use disorder. Currently there are limited or no opportunities for inpatient residential substance abuse treatment for SCI/D patients.

Permanent Access to In-vitro Fertilization (IVF)—Hundreds of veterans have been able to start or grow their families since VA began providing services to veterans with service-connected infertility. We are thankful for this provision and would like to see it made a permanent part of the health benefits package of veterans enrolled in VA health care. We would also like to see the services expanded. VA's current temporary authority prohibits the use of gametes that are not a veteran's and his or her spouse's. Because they require donated gametes, they are ineligible for IVF through VA, which is confusing as donated gametes are authorized for use in VA-provided artificial insemination.

Also, due to the complex care needs of women veterans with SCI/D, many of these veterans are unable to carry a pregnancy to term. These women veterans need the services of a surrogate to have a child. We call on Congress to mandate that VA establish permanent authorization of assisted reproductive technologies to include IVF services, gamete donation, and surrogacy for veterans with service-connected infertility, and include the treatment of veterans' spouses in applicable cases.

In addition, we support the soon to be introduced Women Veteran and Families Services Act which directs VA to provide fertility treatments and counseling to covered veterans and active duty service members or a spouse, partner, or gestational surrogate of such veteran or service member.

Prosthetics—The Prosthetic and Sensory Aids Service's (PSAS) responsibility is to fill the prescriptions written by the medical services in the hospital that will provide prosthetics, orthotics, and sensory aids to replace missing parts of the body and to support bodily functions that will enable veterans to regain independence and mobility. PSAS also manages the Home Improvements and Structural Alterations (HISA) grant program that allows modification to a veteran's home to allow accessibility through the use of ramps, widening doorways, and modifying bathrooms and kitchens. PSAS also works in a partnership with the Veterans Benefits Administration to provide Automobile Adaptive Equipment and Clothing Allowance to eligible disabled veterans.

The complexity of the PSAS requires a clear set of national policies and consistent training at the field level. Of equal importance, communications between VA clinical and administrative personnel, veterans, and their veterans service organization (VSO) representatives is imperative. Unfortunately, due to a lack of training and knowledge and poor communications, prosthetics care was inconsistent from facility to facility. Lack of flexibility within national prosthetics policy restricted VA providers from providing individualized care that met the true needs of veterans. There were rigid, antiquated policies instead of determining what is best for the patient and how to deliver that care most effectively. Furthermore, VA Handbooks and Directives were outdated and they failed to incorporate advances made in prosthetics during the Post-9/11 era. Veterans were ultimately denied items and services they should have received.

Today, significant changes have been made. PSAS Leadership at VA Central Office has implemented many positive improvements. The new Prosthetics final rule has replaced the outdated VA Directives and Handbooks. This will now enable prosthetic items and services to be provided in a standardized manner at each facility. Clinical care of the veteran will now be considered in a holistic manner. Communication between PSAS Central Office leadership and VSOs is conducted at a bi-monthly meeting where briefings are presented by PSAS. Problems and issues are discussed resulting in the best working relationship in years; however, we must work together to maintain this relationship. This will ensure that VA will continue to lead the world in prosthetics and rehabilitation through their integrated delivery system.

The advances in prosthetics technology and complexities of function have greatly enhanced disabled veterans' ability to assimilate back into their communities. However, the cost of technology, materials development, scientific research, engineering skills, and the knowledge required to produce, and manufacture prosthetics are only going to continue to increase. To meet the demand, VA must ensure adequate funding, a continuous training program for prosthetics and clinical staff, and provide updates to their new regulations in a timely manner.

Furthermore, providing prosthetics through community health care systems creates additional burdens on the PSAS system. The administrative responsibility for VA prosthetics staff to properly manage and maintain the quality of prosthetics and control overall program costs cause additional delays. It could also generate inappropriate and non-standard care, and/or increase complaints about VA's delivery of these critical services. We want to ensure veterans receive the best quality of care, especially when it comes to prosthetic devices, and believe the best place for them to go for this care is VA.

Care of Women Veterans With SCI/D—The number of women veterans using VA health care continues to rise and is expected to continue to rise as more women are joining the military. Women veterans with SCI/D are a small, but important subset of these users. It is essential that women veterans, including those living with SCI/D, have access to comprehensive gender-specific mental and physical health care with high standards of care regarding the quality, privacy, safety, and dignity of that care. VA has developed a robust SCI/D system to serve the needs of veterans with SCI/D but there needs to be a stronger focus on the needs of these veterans among services provided outside of the SCI/D System of Care.

Specialty services such as OB/GYN, inpatient mental health, and even ER care must ensure they are accessible for non-ambulatory users. As Congress develops strategies and policies for VA to follow, additional emphasis is needed to ensure women veterans with SCI/D are incorporated into these plans. As Congress oversees the implementation of recently passed legislation aimed at improving care for women veterans, they must ensure implementation of the women veteran specific sections of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P. L. 116-315) is conducted with this population in mind. And lastly, research is the key to improved health outcomes. Congress must mandate and fund VA to conduct research on the unique health care and economic opportunity needs of this population.

BENEFITS IMPROVEMENTS AND APPEALS REFORM IMPLEMENTATION

Oversight of the Veterans Appeals Improvement and Modernization Act (P.L. 115-55)—It has now been two years since the Veterans Appeals Improvement and Modernization Act (AMA) of 2017 went into effect. While many aspects of its implementation seem to be running smoothly, we do have some concerns and look forward to working with VA and Congress on continued oversight and improvements.

Even though the new program launched on February 19, 2019, PVA representatives still do not have full access to the Caseflow program used to track and process benefit claim appeals, and they have not yet been informed of the new Outside Medical Opinion process. We are also concerned with administrative process errors stemming from the Board of Veterans' Appeals (BVA) takeover of certifying appeals. Furthermore, we have concerns with issues related to hearings, such as delays in scheduling, then time limits on the hearings. These hearings are essential due process for veterans and a non-adversarial environment to finally tell their story. We urge Congress to follow this issue closely.

Finally, we encourage flexibility. While Appeals Modernization was advertised as providing veterans with more control over their cases, in some respects it has only provided new and unfamiliar roadblocks. For example, so far, the agency has not been flexible with veterans who have issues completing the right form at the right time, or who misunderstand the "intent to file" process. This “gotcha” game that literally elevates form over substance can result in lost benefits, and Congress should monitor this issue.

We are mindful that 2021 will be a time of transition for VA, and we look forward to working with the agency and Congress to ensure veterans are receiving fair and timely adjudications of their appeals and that VA provides the information necessary for all stakeholders to make sure that VA is meeting its goals.

Benefits Improvements for Catastrophically Disabled Veterans

Automobile Allowance Grants and Adaptive Equipment—Access to an adapted vehicle is essential to the mobility and health of catastrophically disabled veterans who need a reliable means of transportation to get them to and from work, meet family obligations, and attend medical appointments. The substantial costs of modified vehicles, coupled with inflation, present a financial hardship for many disabled veterans who need to replace their primary mode of transportation once it reaches its lifespan. The current, one-time VA Automobile Allowance Grant of roughly $21,500 covers anywhere from one-half to one-third of the cost to procure a vehicle to accommodate certain disabilities that resulted from a condition incurred or aggravated during active military service. In order to ensure veterans have access to safe, reliable transportation, Congress must pass the “Advancing Uniform Transportation Opportunities for Veterans Act” or the “AUTO for Veterans Act” (H.R.1361/S. 444), which would allow eligible veterans to receive an Automobile Allowance Grant every ten years for the purchase of an adapted vehicle.

VA's Automobile Adaptive Equipment (AAE) program helps physically disabled veterans enter, exit, and/or operate a motor vehicle or other conveyance. VA provides necessary equipment for veterans with qualifying service-connected disabilities such as platform wheelchair lifts, UVLs (under vehicle lifts), power door openers, lowered floors/raised roofs, raised doors, hand controls, left foot gas pedals, reduced effort and zero effort steering and braking, and digital driving systems. The program also provides reimbursements (to service-connected veterans) for standard equipment including, but not limited to, power steering, power brakes, power windows, power seats, and other special equipment necessary for the safe operation of an approved vehicle. Support for veterans with non-service-connected disabilities is limited to assistance with ingress/egress only. Veterans need the independence AAE provides, allowing them to transport themselves to and from work, medical appointments, and other obligations. Congress must pass legislation that allows veterans who have non-service-connected catastrophic disabilities to receive the same type of adaptive automobile equipment as veterans whose disabilities are service-connected.

VA Home Improvement Programs—PVA greatly appreciates last year's passage of the Ryan Kules and Paul Benne Specially Adaptive Housing Improvement Act of 2019 (P.L. 116-164) which made much needed improvements to VA's Specially Adaptive Housing (SAH) grant program. There are other concerns with the SAH program that we hope you will address to make the program even more beneficial and effective for veterans.
First, finding and selecting an eligible builder often creates the biggest delay in getting adaptations made to a veteran's home. The bid process gives the veteran the freedom of selecting a builder based on proposed adaptations and associated costs. However, locating a builder is often a lengthy process. Once the veteran has selected the builder with whom he or she would like to work, the builder must then register with the federal government.

Also, because the SAH program is one of VA's most critical programs, more resources are needed to promote it to the homebuilder and remodeling industries. We believe Congress should create a pilot program using some of the program's current personnel whose sole focus will be to promote the merits of the program to potential builders. This could increase the number of certified builders/remodelers available nationwide, reducing the time it takes to build the home or make the required adaptations. The pilot should have a dedicated funding stream of at least $150,000 annually to ensure the team marketing this program can do its work.

Additionally, "SAHSHA," the software program VA uses to manage the SAH program needs to be updated. We understand some money may be designated in the FY2021 budget towards the development of a new system, but it falls well short of what is needed to replace the program altogether.

Finally, additional full-time employees (FTEs) are needed for this program to distribute the workload more evenly throughout the country and address the impact of previous legislation that moved part of the management of the Veteran Readiness and Employment's (VR&E) Independent Living Services under the SAH program. We understand the program office has requested additional FTEs for FY2021 and 2022. These requests bear watching because in order to ensure this program is operating efficiently, these personnel increases must be filled.

Improvements must also be made to VA's HISA program. As the name suggests, HISA grants help fund improvements and changes to an eligible veteran's home. Examples of qualifying improvements include improving the entrance or exit from their homes, restoring access to the kitchen or bathroom by lowering counters and sinks, and making necessary repairs or upgrades to plumbing or electrical systems due to installation of home medical equipment. The lifetime HISA benefit is worth up to $6,800 for veterans with service-connected conditions and $2,000 for veterans who have a non-service-connected conditions. These rates have not changed since 2009 even though the cost of home modifications and labor has risen more than 40 percent during the same timeframe. As a result, that latter figure has become so insufficient it barely covers the cost of installing safety bars inside a veteran' s bathroom. We urge Congress to raise HISA grant rates to at least $10,000 for service-connected disabled veterans and $5,000 for non-service-connected disabled veterans, and tie HISA grants to the Turner Building Cost Index or similar formula to help ensure rates remain current.

SMC Rates—There is a well-established shortfall in the rates of SMC paid to the most severely disabled veterans that VA serves. SMC represents payments for "quality of life" issues, such as the loss of an eye or limb, the inability to naturally control bowel and bladder function, the inability to achieve sexual satisfaction, or the need to rely on others for the activities of daily life like bathing or eating. To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, PVA does not believe that a veteran can be totally compensated for the impact on quality of life; however, SMC does at least offset some of the loss of quality of life.
Many severely disabled veterans do not have the means to function independently and need intensive care on a daily basis. They also spend more on daily home-based care than they are receiving in SMC benefits.

One of the most important SMC benefits is A&A. PVA recommends that A&A benefits be appropriately increased. Attendant care is very expensive and often the A&A benefits provided to eligible veterans do not cover this cost. Many PVA members who pay for full-time attendant care incur costs that far exceed the amount they receive as SMC beneficiaries at the R-2 compensation level (the highest rate available). Ultimately, they are forced to progressively sacrifice their standard of living in order to meet the rising cost of the specialized services of a trained caregiver; expensive maintenance and certain repairs on adapted vehicles, such as accelerated wear and tear on brakes and batteries that are not covered by prosthetics; special dietary items and supplements; additional costs associated with needed "premium seating" during air travel; and higher-than-normal home heating/air conditioning costs in order to accommodate a typical paralyzed veteran's inability to self-regulate body temperature. As these veterans are forced to dedicate more and more of their monthly compensation to supplement the shortfalls in the A&A benefit, it slowly erodes their overall quality of life.

Benefits for Surviving Spouses of ALS Veterans—If a veteran was rated totally disabled for a continuous period of at least eight years immediately preceding death, their eligible survivors can receive an additional $288.27 per month in Dependency and Indemnity Compensation (DIC). This monetary installment is commonly referred to as the DIC "kicker."

Amyotrophic Lateral Sclerosis (ALS) is an aggressive disease that quickly leaves veterans incapacitated and reliant on family members and caregivers. Many spouses stop working to provide care for their loved one who, once diagnosed, only has an average lifespan of between two to five years. Because so few veterans survive beyond five years, the surviving spouses of veterans with ALS rarely qualify for the additional DIC benefit.

VA already recognizes ALS as a presumptive service-connected disease, and due to its progressive nature, automatically rates any diagnosed veteran at 100 percent once service connected. The current policy fails to recognize the significant sacrifices these veterans and their families have made for this country. We urge Congress to extend the DIC kicker to the surviving spouses of veterans who die from ALS regardless of how long they were service connected for the disease prior to death.

Veterans Employment—It is important to get veterans who have lost their jobs during COVID back to work. Employment can positively factor into recovery from illness and enhancement of mental wellness, especially when compared to unemployment. Meaningful employment provides daily structure, gives a person a sense of worth, and supports social engagement.[1] Thus, not only is it financially important to get veterans back to work, but it is also better for their overall health.

Prior to the pandemic, the U.S Department of Labor (DOL) reported that veteran unemployment numbers were at the lowest rate in almost two decades.[2] Unfortunately, employment rates for veterans with significant disabilities, including many PVA members, have consistently lagged behind those of their counterparts without disabilities. According to DOL's statistics, veterans with service-connected disabilities are less likely to participate in the labor force than veterans without disabilities.[3] Veterans with non-service-connected disabilities experience similar challenges; only 37 percent are employed compared to more than 75 percent of veterans without disabilities.[4] For some veterans with disabilities an immediate return to work is necessary. PVA is concerned that those who were previously facing challenges in the employment landscape will only see these challenges exacerbated by the COVID-19 pandemic and subsequent economic recession.

PVA's Veterans Career Program, formerly known as PAVE, provides career support to our members, other veterans with disabilities, their family members, and caregivers. As a result of the pandemic, our vocational counselors have seen an increase in employers' willingness to hire individuals for full-time work-from-home positions. We hope this trend will continue after the pandemic has abated.

As our nation focuses on how to get veterans back to work, it is essential we target our valuable resources and time on training and opportunities for both service-connected veterans and non-service-connected veterans. There are several federal government

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[1] The mental health benefits of employment: Results of a systematic meta-review - Matthew Modini, Sadhbh Joyce, Arnstein Mykletun, Helen Christensen, Richard A Bryant, Philip B Mitchell, Samuel B Harvey, 2016 (sagepub.com)

[2] Newsletter | U.S. Department of Labor (dol.gov)

[3] Employment Situation of Veterans — 2019 (bls.gov)

[4] Employment Data for Veterans With Disabilities | ADA National Network (adata.org)

programs that provide support to the larger veteran community. Many of these programs focus their resources on transitioning service members and post-9/11 veterans, even though veterans with disabilities, older veterans, and those in remote areas continue to face significant challenges, including high unemployment and underemployment. PVA believes existing federal programs must expand their focus to include those with significant or catastrophic disabilities, non-service-connected disabled veterans, older veterans, and those in rural communities.

VA's VR&E program has successfully assisted many service-connected veterans in pursuing employment and educational opportunities. PVA remains concerned, however, about the high caseloads VR&E counselors maintain. Large caseloads limit the amount of time they are able to spend with individual clients assessing their current status, their needs, their goals, and what meaningful employment is for that veteran. Many veterans also continue to experience high rates of turnover of their VR&E counselors, which can affect their long-term success in the program. As a result, PVA would like to see a VA Office of Inspector General assessment of the VR&E program staff outlining the amount of time each counselor spends working with a veteran, rate of turnover of staff, and length of employment for veterans placed into positions through VR&E.

The Department of Labor's Veterans' Employment and Training Service (DOL VETS) offers significant support to transitioning service members and military spouses. PVA recommends that DOL VETS focus more on the broader veteran population by developing additional paid training and apprenticeship programs for veterans who have already entered the workforce, significantly disabled veterans, non-service-connected disabled veterans, and those in remote areas.

Finally, the earlier we engage transitioning service members with disabilities and veterans with disabilities in the employment process the more likely they are to re-enter the workforce with meaningful careers. PVA strongly recommends that the Department of Defense, DOL, and VA work together on a comprehensive program for service members who are processing out of the military due to a disability to educate them on their rights and opportunities.

Chairman Tester, Chairman Takano, and members of the Committees, I would like to thank you once again for the opportunity to present the issues that directly impact PVA's membership. We look forward to continuing our work with you to ensure that veterans get timely access to high quality health care and all the benefits that they have earned and deserve. I would be happy to answer any questions that you may have.

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

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

Fiscal Year 2021

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $455,700.

Fiscal Year 2020

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $253,337.

Fiscal Year 2019

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $193,247.

Disclosure of Foreign Payments

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

DAVID ZURFLUH
National President, Paralyzed Veterans of America (PVA)

"PVA changed my life forever. PVA literally stays with you from initial injury to the grave, not only for the veteran but the spouse/caregiver, family and friends." — David Zurfluh

David Zurfluh felt a duty to serve his country and follow in the footsteps of his grandfather (Navy), dad (Army), brother Tom (Air Force), and extended family who served in all military branches. When Zurfluh was in high school, he narrowed down the branches he wanted to serve in between the Marine Corps and the Air Force. His friend flipped a coin to determine his path — heads for Air Force and tails for the Marine Corps. The coin landed on heads, and Zurfluh's path was set in motion.

A member of the U.S. Air Force from 1987 to 1995, Zurfluh served as a jet engine mechanic and a crew chief in Operation Desert Shield and Operation Desert Storm. While on active duty, in April 1995, he was injured in a motor vehicle accident in Hachinohe, Japan, suffering a shattered left arm, broken left wrist and a broken neck. Zurfluh was diagnosed with incomplete quadriplegia. After three weeks navigating through three hospitals, he wound up at the Seattle VA Medical Center.

Zurfluh was at his lowest point when two PVA National Service Officers came to his bedside and told him they would take care of him and do everything they can to make him as whole as possible. Zurfluh became a member of PVA when this life-changing moment occurred, in 1995.

Zurfluh spent one year as an inpatient, and two years as an outpatient in the Seattle VA Spinal Cord Injury Unit. After finishing rehab, Zurfluh wanted to do all he could for the organization that gave him dignity and purpose again. He determined to make it his life's mission to help veterans with spinal cord injury, disorders, and related diseases like MS and ALS.

A native of the state of Washington, Zurfluh started volunteering at the PVA Northwest Chapter, helping local members. He held chapter-level positions as legislative director, vice president, president, and member of the sports committee. Zurfluh realized that he could help even more PVA members by serving at the national level. In 2010, he was elected to the Executive Committee as national vice president, serving three consecutive terms. In May 2014, Zurfluh was elected as national senior vice president and re-elected for two consecutive terms.

In May 2017, he was elected as national president and re-elected in 2018 and 2019. In May 2020, during PVA's 74th Annual Convention held virtually for the first time, Zurfluh was re-elected as national president for a third consecutive one-year term to begin July 1, 2020.

Zurfluh has served on the Veterans Legislative Coalition in Olympia, WA, and as co-chair of the West Slope Neighborhood Coalition in Tacoma, WA. In addition to his work on behalf of PVA in Washington, DC, Zurfluh currently serves on the National Board of Advisors of the Museum of Aviation Foundation, is a lector at Holy Rosary Church in Tacoma, WA, and volunteers at local food banks. His hobbies include hand cycling, shooting sports (trap, handgun, and archery) golf and snow sports.

Zurfluh travels extensively throughout the country advocating for and serving Paralyzed Veterans of America and wants people to know that "We specialize in SCI/D veterans, but we serve all veterans; if a veteran needs help and comes through our doors or calls, we will help them, their caregivers and their loved ones, period."