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BEFORE A JOINT HEARING OF
THE HOUSE AND SENATE COMMITTEES ON VETERANS' AFFAIRS
CONCERNING
ISSUES FACING VETERANS IN OHIO

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Mr. Chairman and members of the Committees, on behalf of the Buckeye Chapter of Paralyzed Veterans of America (PVA) I would like to thank you for the opportunity to testify before you today on the issues facing veterans who live here in Ohio and surrounding states. The challenges facing veterans here, particularly with regards to health care, are not uniquely different to many other areas of the country. However, if the VA can figure out the best way to address them here, they can certainly apply those actions across the board.
Due to the broad array of possibilities, I will limit my comments to a few key areas that we believe require the greatest focus and that are of the utmost importance. My comments will focus on broader health care concerns, specifically for rural veterans. I will also address our concerns about VA long-term care services, specifically for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans as well as for veterans with spinal cord injury or dysfunction. Finally, I will comment on veterans' benefits issues, particularly for members of the National Guard and Reserves.

Rural Health Care
Given the attention that these Committees have placed on the issue of access to health care for rural veterans, it is only appropriate that this joint hearing be held in a state with many veterans who live in rural areas. PVA recognizes that there is no easy solution to meeting the needs of veterans who live in rural areas. These veterans were not originally the target population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through the community-based outpatient clinics reflected the growing demand on the VA system from veterans outside of typical urban or suburban settings.

However, PVA remains concerned that in addressing the problem of access for these veterans, the long-term viability of the VA health care system may be threatened. PVA members rely on the direct services provided by VA health care facilities recognizing the fact that they do not always live close to the facility. The services provided by VA, particularly specialized services like spinal cord injury care, are unmatched in the private sector. If a larger pool of veterans is sent into the private sector for health care, the diversity of services and expertise in different fields is placed in jeopardy.

Ultimately, PVA has serious concerns about any attempt to give the VA additional leverage to broaden contracting out of health care services to veterans in geographically remote or rural areas. If you review the early stages of VA's Project HERO, it is apparent that this is a direction that some VA senior leadership would like to go. PVA adamantly opposes any effort to privatize the VA health care system, turning it into an insurer of care and not a provider of care. Privatization is ultimately a means for the federal government to shift its responsibility of caring for the men and women who served.

PVA believes that any broader contracting out of health care services would almost certainly lead to a diminution of established quality, safety and continuity of VA care. It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, poly-trauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans to the private sector. The VA's medical and prosthetic research program, designed to study and hopefully overcome the ills of disease and injury consequent to military service, would lose focus and purpose. Additionally, Title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of these specialized medical programs, and not let their capacity fall below that which existed at the time when Public Law 104-262 was enacted.

Furthermore, veterans who are sent out to the private sector for care would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

Current law limits VA in contracting for private health care services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. The VA could better meet the demands of rural veterans through more judicious application of its fee-for-service program.

We also believe that the VA could address the needs of rural veterans through broad application of the "hub-and-spoke" principle. A veteran can get his or her basic care at a community-based outpatient clinic (CBOC). However, if the veteran requires more intensive care or a special procedure, he or she can then be referred to a larger VA medical center. This would ensure that the veteran continues to get the best quality care provided directly by the VA, thereby maintaining the viability of the system.

Finally, we realize that it is an extremely difficult task to establish a standard for when a veteran's home is considered to be rural. Attempts to define "geographically inaccessible" have proven to

be a very subjective effort. Access to VA health care is subject not only to population density or distance, but time as well.

PVA believes that one possible way to address the concerns of rural veterans is to correct the mileage reimbursement inequity that currently exists. It is wholly unacceptable that veterans have to live with the 11 cents per mile reimbursement rate that the VA currently provides when all federal employees receive 48 cents per mile. In fact, PVA believes that some of the difficulty in providing care to veterans in limited access areas, particularly rural areas, might be eliminated with a sensible reimbursement rate. We believe that veterans would be less likely to complain about access issues as a result of their geographic location if they know that they will not have to foot the majority of the travel expense out of their own pocket. This is a change that has been long overdue, and we urge the Committees and all of Congress to take immediate action to correct this inequity.

In the end, we believe that in order for the VA to best meet this demand, adequate funding needs to be provided for VA health care in a timely manner. As we previously stated, placing the VA in the position it has dealt with for many years because Congress continues to wrangle over federal budgets, does not prepared the VA to properly meet demand, including demand in rural areas.

Long Term Care

One of the primary concerns for PVA and its membership is access to long-term care services in the VA. We have particular concerns about the long-term care options for veterans of the newest conflicts in Iraq and Afghanistan. PVA believes that age-appropriate VA non-institutional and institutional long-term care programming for young OEF/OIF veterans must be a priority for VA and these Committees. New VA non-institutional and institutional long-term care programs must come on line and existing programs must be re-engineered to meet the various needs of a younger veteran population.

VA's non-institutional long-term care programs will be required to assist younger injured veterans with catastrophic disabilities who need a wide range of support services such as: personal attendant services, programs to train attendants, peer support programs, assistive technology, hospital-based home care teams that are trained to treat and monitor specific disabilities, and transportation services. These younger veterans need expedited access to VA benefits such as VA's Home Improvement/Structural Alteration (HISA) grant, and VA's adaptive housing and auto programs so they can leave institutional settings and go home as soon as possible. PVA also believes that VA's long-term care programs must be linked to VA's new poly-trauma centers so that younger veterans can receive injury specific annual medical evaluations and continued access to specialized rehabilitation, if required, following initial discharge.

VA's institutional nursing home care programs must change direction as well. Nursing home services created to meet the needs of aging veterans will not serve young veterans well. As pointed out in The Independent Budget for FY 2008, VA's Geriatric and Extended Care staff must make every effort to create an environment for young veterans that recognizes they have different needs. Younger catastrophically injured veterans must be surrounded by forward-thinking administrators and staff that can adapt to youthful needs and interests. The entire nursing home culture must be changed for these individuals, not just modified. For example,

therapy programs, living units, meals, recreation programs, and policy must be changed to accommodate young veterans entering the VA long-term care system.

PVA is also concerned that many veterans with spinal cord injury and disease are not receiving the specialized long-term care they require. VA has reported that over 900 veterans with SCI/D are receiving long-term care outside of VA's four SCI/D designated long-term care facilities. However, VA cannot report where these veterans are located or if their need for specialized medical care is being coordinated with area VA SCI/D centers.

Today's VA SCI/D long-term care capacity cannot meet current or future demand for these specialized services. Waiting lists exist at the four designated SCI/D facilities.
Currently, VA only operates 125 staffed long-term care (nursing home) beds for veterans with SCI/D. These facilities are located at: Brockton, Massachusetts (30 beds); Castle Point, New York (15 beds); Hampton, Virginia (50 beds); and 30 beds at the Hines Residential Care Facility in Chicago, Illinois. Geographic accessibility is a major problem because none of these facilities are located west of the Mississippi River. New designated VA SCI/D long-term care facilities must be strategically located to achieve a national geographic balance to long-term care to meet the needs of veterans with SCI/D that do not live on the East coast of the United States.

VA's own Capital Asset Realignment for Enhanced Services (CARES) data for SCI/D long-term care reveals a looming gap in long-term care beds to meet future demand. VA data projects an SCI/D long-term care bed gap of 705 beds in 2012 and a larger bed gap of 1,358 for the year 2022. VA's proposed CARES SCI/D long-term care projects would add needed capacity (100 beds) but are very slow to come on line. CARES proposes adding 30 SCI/D LTC beds at Tampa, Florida; 20 beds at Cleveland, Ohio; 20 beds at Memphis, Tennessee; and 30 beds at Long Beach, California. The CARES Tampa project is currently under construction but is not scheduled to open for another two years and the Cleveland project is currently in the design phase but remains years from completion. The Buckeye Chapter is particularly pleased that the Cleveland/Brecksville project is moving forward. This will prove to be a critical facility for meeting the long-term, specialized care needs of PVA members. Finally, the Memphis and Long Beach projects have not even entered the planning stage at this time.

Methods for closing the VA SCI/D long-term care bed gap and resolving the geographic access service issue are part of the same problem for PVA. VA's Construction Budget for 2008 includes plans for new 120 bed VA nursing homes to be located in Las Vegas, Nevada and at the new medical center campus in Denver, Colorado. Also, VA has announced construction planning of a new 140 bed nursing home care unit in Des Moines, Iowa.

Mr. Chairman, PVA needs your support to ensure VA construction planning dedicates a percentage of beds at each new VA nursing home facility for veterans with SCI/D. PVA requests that Congress mandate that VA provide for a 15 percent bed set-aside in each new VA nursing home construction project to serve veterans with SCI/D and other catastrophic disabilities. These facilities will require some special architectural design improvements and trained staff to meet veteran need. However, much of the design work has already been accomplished by PVA and VA's Facility Management team. This Congressional action will help reduce the SCI/D bed-gap and help meet the current and future demand for long-term care. While a 15 percent bed allocation in new VA nursing home construction plus the proposed CARES LTC projects do not

solve the looming bed gap problem in the short run it is a good first step and these additions will improve VA's SCI/D long-term care capacity in the western portion of the country.

Public Law 109-461 required VA to develop and publish a strategic plan for long-term care. PVA congratulates Congress on understanding the importance of this issue to ensure that America's catastrophically disabled and aging veteran population is well cared for. During the organization of VA's strategic long-term care plan PVA calls on VA and Congress to pay careful attention to the institutional and non-institutional long-term care needs of veterans with SCI/D and other catastrophic disabilities. We request that PVA and other veteran service organizations have an opportunity to provide input and assist VA as it moves forward in the development of this important document.

In the past, and even today, many veterans with spinal cord injury or disease and other catastrophic disabilities were shunned from admittance to both VA and community nursing homes because of their high acuity needs. PVA believes that catastrophic disability must never be grounds to refuse admittance to VA or contract VA long-term care services. PL 109-461 requires VA to include data on, "the provision of care for catastrophically disabled veterans; and the geographic distribution of catastrophically disabled veterans." This information is critical if VA's strategic plan is to adequately address the needs of this population.

Veterans Benefits

PVA realizes that there is a desire to fix the problems with the claims backlog in the Veterans Benefits Administration (VBA) immediately. However, we must emphasize that there is no quick fix that can be implemented to fix these problems. The backlog has become too extensive to simply place some arbitrary requirement on VBA that will not address the long-term situation.

We believe that the VA cannot continue to make changes in VBA, and specifically the claims process, sporadically. We believe that the only way the VA will ever get a handle on the claims process, the backlog, and associated problems is to pick a specific date to make major changes. It cannot implement change piecemeal.

We realize that fixing the discharge and subsequent claims process is no easy task. However, we should not be shooting at individual targets to attempt to fix the overall problem. It will take innovative approaches focused on the broader system.

In the end, we believe that many of the problems in the Veterans Benefits Administration are centered on proper training and accountability. Without uniform training across all of VBA on the standards established in regulations, problems will continue to arise and the claims backlog will continue to grow. Furthermore, it is absolutely essential that VBA personnel at all levels be held accountable for their own actions and the actions of their subordinates. Although we continue to advocate for adequate resources and additional staff, these steps will not go far enough if training and accountability are not a major component. Similarly, we recognize that veterans' service organizations have a commensurate obligation to properly train and supervise their personnel.

Finally, despite efforts by VA to address all of the needs and concerns of OEF/OIF veterans, another population of these men and women still continue to receive lesser service than their

active duty counterparts-National Guard and Reserves. We have testified many times in the past as to the importance of effective outreach, particularly for the National Guard and Reserves. It is only appropriate that National Guard and Reserve service members be handled in the same way as active duty service members. The level of service being required of these men and women in current operations more than justifies the need to inform them of all of the health care and benefits services available.

Mr. Chairman and members of the Committees, the Buckeye Chapter stands ready to assist you in any way to address the needs of veterans here in Ohio and across America. It is vitally important that we work together to ensure that the best improvements are made to benefit veterans and their families.

Thank you again for the opportunity to testify. I would be happy to answer any questions that you might have.