KEEPING OUR PROMISE TO AMERICA'S VETERANS

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STATEMENT OF
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BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS
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Chairman Moran, Ranking Member Blumenthal and Members of the Committee:

On behalf of DAV's (Disabled American Veterans) nearly 1 million members, thank you for inviting us to provide testimony for this important hearing, *Protecting Veteran Choice: Examining VA's Community Care Program*.

DAV members are wartime service-disabled veterans who were wounded, injured, or made ill during their military service. They utilize Department of Veterans Affairs (VA) Veterans Health Administration (VHA) services at high rates and many prefer and depend on the Veterans Health Care System for all or most of their care.

Through VHA, the VA operates the largest integrated health care system in the country, with 171 medical centers and 1,113 outpatient clinics, serving 9.2 million veterans. Over the past decade, due to increased demand for services, VA's reliance on purchased medical care services from its community providers has risen dramatically. While the use of community care has increased, many veterans have experienced barriers to accessing that care—especially rural veterans, those with post-deployment mental health challenges, and at risk for suicide, and traditionally underserved veteran populations.

Challenges and Barriers to Accessing Community Care

Eligibility for Community Care

Like most veterans service organizations (VSOs), DAV strongly supported the VA MISSION Act (Public Law 118-182) after working for several years with this Committee, your counterparts in the House, VA leaders, and other stakeholders. The resulting legislation was a carefully crafted compromise to improve veterans' access to timely, high-quality, and veteran-focused care. Our support, however, was predicated on maintaining a fundamental set of principles underlying the VA MISSION Act to ensure that veterans' health outcomes would be improved:

- VA would continue to be the primary provider and coordinator of veterans' care;
- VA's internal capacity to provide care would be expanded through investments in staffing, infrastructure, and IT in order to meet the rising demand for care by enrolled veterans, particularly disabled veterans;
- Veterans who would otherwise have to wait too long or travel too far to get necessary care from VA should have swift and seamless access to high-quality community care options; and
- Community care providers would have to meet the same access AND quality standards, as well as training and certification requirements, as VA clinicians.

The above principles were designed to achieve that goal by balancing the need for greater access to timely care with the imperative of providing high-quality and veteran-focused care and services.

Unfortunately, there are reports from some veterans indicating they have been denied eligibility and access to the Veterans Community Care Program (VCCP). The access standards enacted in the MISSION Act are clear and VA is responsible for educating its employees on the law and veterans' right to access community care when VA cannot provide needed care in a timely manner or due to distance from a VA facility and in cases where it is determined to be in the best medical interest of the veteran. The focus, first and foremost, must be on getting veterans the care they need—period. Administrative burdens that appear to be causing barriers to care must be acknowledged, addressed and resolved by VA.

Coordination of Care and Timely Receipt of Patient Records

Given the number of veterans who utilize both direct and community care services, the coordination of that care is extremely important. Integrated care for veterans with complex medical histories is essential for quality care and positive health outcomes. Unfortunately, we continue to hear from veterans about delays in scheduling community care appointments once a referral has been made. Because VA does not have a fully operational bi-directional health records system in place, it struggles with seamlessly transmitting patient records to community providers, and return of those records for integration into the patient's VHA electronic health record. For example, it can take several weeks once a veteran has been referred to the community to arrange for the veteran's patient files to be sent to the patient or provider's office and to set up an appointment. In some cases, VHA mails the records to the patient for them to hand carry to the community care appointment. Conversely, there are also reports of delays in getting records transferred back to VA once the appointment or episode of care is complete. Veterans have reported that some VA facilities still rely on fax machines to transmit critical information from a veteran's community care visit with a specialist and that health information may not get conveyed to their primary care clinician at VHA for months or in some cases not at all. Community care providers also report problems and complications with transmitting health care information and test results back to VA for their veteran patients. There are also complaints from veterans regarding billing issues associated with referrals to care in the community.

VHA policy requires staff to import all community care documents in the patient's electronic health record within five business days of receipt. However, an Office of Inspector General (OIG) report (23-01739-26), *Care in the Community Inspection of VA Desert Pacific Healthcare Network and Selected VA Medical Centers of VISN 22*, found that Albuquerque, Los Angeles, Loma Linda, and San Diego medical facility managers reported having a significant backlog of scanned community care documents, with some dating back to 2019. The OIG noted, "failing to promptly scan incoming medical documentation from community care providers could negatively affect care coordination and quality of care monitoring. Therefore, it is critical that staff receive and scan these documents in patients' electronic health records in a timely manner." In a survey sent to those same facility leaders within the VISN, 92% reported delays receiving community provider medical documentation, and a staggering 73% reported appointment delays negatively affecting patient outcomes. This is unacceptable.

These concerns are similar to those raised in another OIG report (23-03679-262) of VA Western New York Healthcare System in Buffalo. The OIG substantiated that community care staff's delays in scheduling patients' radiation therapy and neurosurgery appointments resulted in delays in care, and in some cases, either caused or increased the risk of patient harm.

It is important to emphasize that delays in treatment can have detrimental effects not only on patients' physical health but also on their mental well-being. When medical care is postponed, patients may experience a worsening of their condition, leading to more severe physical symptoms and serious complications that could have been prevented with timely intervention. Additionally, the stress and anxiety caused by waiting for medical care can exacerbate mental health issues, potentially leading to depression, increased stress levels, and a sense of helplessness. This is particularly critical for veterans, who may already be dealing with complex health issues related to their military service, including mental health disorders such as post-traumatic stress disorder (PTSD), cancer due to toxic exposures and other serious physical injuries. Ensuring timely access to this care is essential for maintaining both the physical and mental health of veterans, and any delay could have serious implications for their overall well-being.

DAV recommends that VHA get to the root of the problem with records transfers and find an effective solution to ensure that patient records are transferred in a timely manner to community care providers. Likewise, VHA must provide community care providers in its network the tools and an effective standard operating procedure for transfer of records back to VHA until a fully functional bi-directional electronic health record solution is realized. VA should also include a mandate in its next generation third-party administrator (TPA) contracts that will require return of patient records to VHA before payments for services rendered will be made. Finally, VHA must improve its standard operating procedure for payment of VCCP services to ensure veterans are not erroneously billed and face the burden of trying to resolve billing issues related to community care referrals.

Improving VCCP provider training for mental health care and suicide prevention

Training health care professionals—including physicians—is one of the VA's four statutory missions. Since 1946, VHA has worked with academic institutions to provide high-quality, state-of-the-art health care to America's veterans; train new health professionals; and advance health care practices and medical innovation.

With more than 9 million enrolled veterans, VHA serves individuals whose lived military experiences are foreign to many civilian health care professionals. Essentially, disabled veterans are served by a system designed for them that has advocates and providers who know military culture, the unique health challenges veterans face and the language they use.

VA's number one clinical priority has been preventing veteran suicide, but despite significant efforts, as well as a plethora of new programs and services dedicated to achieving this goal we have only seen limited progress over the years. One area where VHA believes specific intervention can be effective is in lethal means safety counseling. According to VA's most recent National Suicide Prevention Annual Report, 72% of veterans who took their life by suicide did so using a firearm. While the VA prioritizes mandatory training for its providers in lethal-means safety counseling for at-risk veterans, it does not require community care providers to be trained in such prevention efforts. This intervention—highlighting safe storage practices and creating time and distance to pause and reflect during a mental health crisis can save lives. All providers seeing veteran patients should be mandated to take this training.

The VA also trains its providers in trauma-informed care practices to address the specific needs of veterans with known trauma histories—this should also be a training requirement for community care network providers. A RAND study, Ready to Serve notes, a provider's lack of cultural competence in veteran-related health care issues is a complication to providing care. VHA providers specialize in understanding the specific needs of their patient population.

In-line with our 2025 critical policy priorities, DAV strongly recommends that the VA should amend its contracts with community care providers to require those who treat veterans to be trained in military culture, suicide prevention and lethal-means safety counseling. Alternatively, Congress could and should mandate such training. Additionally, the VA should require all community network providers to be trained in trauma-informed care practices used by VHA providers to address the specific needs of veterans with known trauma histories.

Timely access to mental health services and substance use disorder treatment

Timely access to mental health care and supportive services is essential for at-risk veterans and those suffering with PTSD, depression and suicidal ideation. Access

to specialty services, such as substance use disorder (SUD) treatment is also critical for veterans with co-occurring mental health and substance-use conditions.

VA has one of the country's premier SUD programs, providing comprehensive, high-quality evidence-based therapies and treatments. However, there are many challenges to adequately fund and staff this specialized programming, which is particularly concerning for the 4.7 million rural veterans in the United States, 58% of whom are enrolled in VHA. It is clear that, due to these challenges and barriers, rural veterans are less likely to receive the gold standard of care for SUD.

Additionally, VHA has a veteran patient population with a high rate of suicide and military sexual trauma (MST) compared to their civilian peers. According to the latest VHA Annual Suicide Prevention Report—from 2021 to 2022, the suicide rate rose by 37.8% for male veteran VHA users who disclosed a history of MST compared to a 1.8% increase for those without a history of MST. Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is VHA policy that all former service members seen for health care are screened for MST. VA's national monitoring data show that about 1 in 3 women and 1 in 50 men respond yes to having experienced MST when screened by their VA health care provider.

The VA's Mental Health Residential Rehabilitation Treatment Program (RRTP) mission is to provide state-of-the-art, high-quality residential treatment services for veterans with co-occurring mental health and substance use disorders, medical concerns, and/or psychosocial issues such as homelessness and unemployment. This includes 24/7 nursing coverage and support for medication compliance and administration. In addition, VA's SUD treatment programs focus on a whole health model of care and provide alternatives to traditional medicine such as meditation, yoga, acupuncture and tai chi.

While DAV strongly believes the VA's integrated, whole-health model of care and specialized wraparound support services provide veterans the type of comprehensive care and support they need for recovery, some veterans may need to receive these specialized services in the community due to long wait times or availability to access such services. Unfortunately, there is an absence of quality standards for VA-contracted clinicians who provide residential mental health and substance use disorder care.

For these reasons DAV recommends Congress and/or the VHA:

- Require mental health/substance use disorder-licensed independent practitioners who want to treat veterans to take a minimum of four hours of VHA TRAIN courses corresponding to the patient population they serve, four hours on military culture and two hours of suicide prevention and lethal-means safety counseling.
- Require licensed independent practitioners in residential care facilities to take VHA TRAIN courses in MST.
- Create VA certification requirements for private facilities participating in the Mental Health Residential Rehabilitation Treatment Program. The certification standard should include:

- ❖ Scientific evidence for a program's treatment approach;
- ❖ A standard ratio of licensed independent practitioners per resident;
- ❖ A semiannual peer review quality assurance system;
- ❖ Treatment planning;
- ❖ Accreditation by the Commission on Accreditation of Rehabilitation Facilities or an equivalent organization;
- ❖ Requirement for forwarding treatment records to the VA within 30 days of a veteran leaving a community residential care program; and
- ❖ Recertification of residential rehabilitation programs every three years.

- Mandate that mental/behavioral health outcome measures be administered to every VA-paid veteran participant at the point of entry, exit and follow up with VHA following discharge from the residential program.
- Require that the mental/behavioral health outcome scores of veterans be sent to VHA for data analysis and evaluation of each program.
- Publish program outcome data on the VA's Access to Care website with health care access and quality information about VA facilities.

Care Coordination Critical for Women Veterans

Women are the fastest-growing demographic of veterans—with over 650,000 now using VA health care services. Women veterans using VA care have high rates of service-connected disabilities, many have medically complex health histories and use specialty care—such as mental health and substance use disorder services at higher rates.

Women veterans are also high users of community care. Gaps in gender-specific care and specialized programming in some locations regularly require women veterans to be referred out to the community to receive needed care. Women veterans are referred to the community for all maternity care, and at times for other gender-specific or reproductive health services; in fact, some VA health care facilities don't provide any specialty gender-specific care, instead exclusively using its VCCP providers to meet patient needs. VHA also requires maternity care coordinators as a resource for pregnant veterans because of known pregnancy-related risks associated with post-traumatic stress and other mental health conditions common among veterans, as well as postpartum depression.

DAV recommends that VHA ensure maternity care coordinators have adequate allocated time to track and manage veterans with complex health histories, especially those utilizing community care services.

Conclusion

The Committee noted in the invitation for this hearing concerns from veterans and stakeholders about existing barriers to care through VA's CCN and "an inability of veteran patients to more freely choose where, when and how to use the VA health care services they have earned through their military service." As previously noted, Congress expanded the ability of veterans to receive care from community health care providers, through the Veterans Community Care Network established under the VA MISSION Act of 2018, and eligibility requirements for community care are clearly defined.

To that end, VA must ensure its employees are properly trained, understand the law and eligibility rules and set forth effective operating procedures for community care referrals. We urge Congress and VA to work together to resolve existing issues that act as barriers to accessing timely care both in VA and through its community care network and have offered a number of recommendations to the Committee for doing so.

A veteran's access to care should be the priority—whether in VA's direct care system or in the VCCP. Veterans should not be burdened with bureaucracy and experience delays in accessing needed care. To eliminate barriers, VA must ensure appropriate staffing levels to meet demand for direct care services and Congress must address long-standing staffing, IT, funding and infrastructure needs to accommodate timely, quality, modern health care delivery. VA must ensure appropriate staffing levels in its community care offices to manage the volume of referrals coming in and assign care coordinators as part of those teams to assist veterans with critical care needs, such as urgent cancer screening, approval of more complex treatment plans and authorizations needed to meet a veteran's unique care needs.

However, in considering changes to VCCP, DAV's primary focus is on whether proposed changes would result in better health outcomes for veteran patients, particularly disabled veterans. The principles we noted earlier in our statement were designed to achieve that goal by balancing the need for greater access to care with the *imperative* of providing high-quality and veteran-focused care.

While we agree that veterans must have options whenever and wherever VA is unable to provide timely, accessible, and high-quality care, research continues to show that the quality of care provided by VA is better than or equal to quality of care provided in the private sector on average and in some cases superior. Additionally, in VHA's 2024 Annual Report—it reported record breaking trust and satisfaction levels reported from veterans using VA services. Trust in VA outpatient care was 92% reflecting increased reliance on VA care.

Given VA's comprehensive, veteran-focused, evidence-based care model, investing in VA is the most likely way to produce better health outcomes for veteran patients and ensure quality of care. VHA clinicians are more likely to have experience with diagnosing and treating veterans with PTSD, traumatic brain injury, and toxic exposure illnesses. In our opinion, it is essential to maintain VA as the primary provider and coordinator of veterans' health care, a position supported by current and past VA Secretaries and Under Secretaries of Health serving in administrations of both political

parties. A robust VA health care system also provides vital research, essential clinical provider training, and emergency preparedness for veterans and the nation, further justifying such investments.

Unfortunately, the decades-long failure to properly fund, maintain and expand the VA's direct care infrastructure and increase staffing levels to meet rising demand for specialty care by veterans has led to an unsustainable growth in community care and related costs, threatening the long-term viability of the entire VA health care system. More importantly, an improperly managed VCCP has resulted in some veterans falling through the cracks and receiving a substandard level of care.

In closing, veteran patients deserve better and for improvements to be made expeditiously. Veterans need to know that Congress and VA are committed to working together to find solutions and resolve these existing issues that are negatively impacting some veterans health and well-being. At the same time, we ask the Committee to be mindful about the importance of a veteran-focused health care system to service-disabled veterans—many who rely exclusively on VHA for all of their health care needs. They have chosen VA and a system tailored to help them recover from catastrophic war-related wounds, injuries and illnesses so they can live full and meaningful lives with dignity and respect. We want to ensure they and future generations of service-disabled veterans do not lose the option of receiving VA's specialized care and services. A strong and viable health care system is part of keeping our promise to those who served.

Mr. Chairman, DAV appreciates your attention to this issue and we look forward in the year ahead to working with you and the Committee to improve care for our nation's veterans. This concludes my formal statement and I look forward to answering questions from the Committee.