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STATEMENT OF
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COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
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Chairman Tester, Ranking Member Moran, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's hearing for the Senate Committee on Veterans' Affairs. As you know, DAV is a Congressionally chartered non-profit veterans service organization (VSO) comprised of over one million wartime service-disabled veterans. Our driving purpose is to empower veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the *Frontier, Health Care: Ensuring Veterans' Access No Matter Where They Live*, addressing the VA health care challenges for rural veterans under consideration today by the Committee.

CHALLENGES FOR RURAL VETERANS' HEALTH CARE

Veterans separating from military careers choose to live in rural communities for a variety of reasons, including proximity to family, friends, and the communities they grew up in. Although these veterans enjoy the benefits of rural living, they may face health care challenges due to the scarcity of medical resources in rural and remote areas; a problem that is intensified for those with combat-related injuries and illnesses.

There are 4.4 million veterans living in rural areas, 2.7 million of whom are enrolled in the Department of Veterans Affairs (VA) health care system. Approximately 58% of rural veterans have at least one service-connected condition and around 56% are 65 or older. As a result, rural veterans frequently have serious chronic medical conditions, such as diabetes, obesity, high blood pressure, and heart conditions. To address these complex conditions, care must be provided more frequently and consistently, often making it more expensive.

It is an unfortunate reality that rural and remote communities in this nation continue to struggle with health care inequity. In general, rural communities exhibit a number of distinct characteristics that make health care more challenging compared to other areas of the country, including:

- Greater geographic and distance barriers;
- Limited public transportation options;
- Fewer housing, education, and employment options;
- Difficulty of safely aging in place in rural America;
- Limited broadband internet;
- Income and wealth gaps;
- Higher uninsured rates or lack of insurance coverage;
- Fewer physician practices, hospitals, and other health delivery resources; and
- Hospital closings because of financial instability

To meet the needs of veterans who live in rural areas, VA must ensure that its overall health care strategy has properly balanced the needs of rural veterans, as well as strengthen special programs to fill in gaps for these veterans.

VA COMMUNITY CARE PROGRAMS

Probably the single most important VA health care program for veterans who live in rural and remote areas is its Veterans Community Care Program (VCCP). Despite an overall decline in the U.S. veteran population, the number of veterans using VA health care has increased over the past decade, resulting in an overall rising demand for care. To help ensure timely care for all eligible veterans, VA combines care from VA providers with non-VA providers from a Community Care Network (CCN) funded by the VA. Although the CCN is an important resource for millions of veterans who too often face access barriers or extended wait times for appointments, serious questions exist about its cost and quality. With recent expansions in veterans' eligibility for community care, accurate data is critical to policy and budget decisions to ensure that veterans receive the high-quality health care they deserve. Ensuring the proper balance of VA and non-VA options is critical for rural veterans.

VA has a smaller footprint in rural areas and veterans who live there face unique challenges to accessing timely and high-quality care and rely more heavily on the CCN to address their health needs. This increased reliance has come with increasing costs for these services. A recently released "Red Team" report titled, *The Urgent Need to Address VHA Community Care Spending and Access Strategies "Red Team" Executive Roundtable Report,* has raised serious concerns about VA's CCN program. This independent review was requested by the Veterans Health Administration (VHA) Under Secretary for Health, Dr. Shereef Elnahal and conducted by a panel of nationally renowned health care experts with experience in the VA, Department of Defense, and private sector health care systems. Of most concern, the Red Team unanimously concluded that VA needs to take urgent action to protect both VA's health care system, and its community care program. Specifically, the report concluded that:

> …[VA] VHA has insufficient information to know whether referrals to community providers will result in the Veteran receiving either the soonest or the best care… [because] Private sector outpatient providers are not required to make access (e.g.,

wait time) and quality of care data publicly available, nor are VCCP contracted providers required to report these data to VHA.

Additionally, VCCP Community Care Network (CCN) providers are not required to demonstrate competency in diagnosing and treating the complex care needs of Veterans nor in understanding military culture, which is often critical to providing quality care for Veterans.

[T]he VCCP generally does not provide Veterans with quality of care or accessibility data that would allow them to make truly informed choices about where they receive care.

Furthermore, the lack of care coordination between VA and CCN providers is a significant cause for concern for veterans who must rely on both avenues of care. Because rural veterans rely more heavily on the CCN, the documented problems with this system of community care are magnified for these veterans.

To improve the CCN, the Red Team offered a number of recommendations, including:

VHA has a centralized model for clinical and administrative teams known as Referral Coordination Teams (RCTs) that discuss care options with veterans and empower them to make informed choices about where to receive care. However, RCTs are not implemented across the enterprise and where implemented, it is not in a standardized manner. VHA has the capacity to provide more care, but just having capacity is not enough. VHA should guide veterans to the "right" care based on quality and accessibility, whether that be in the VHA direct care system or the community.

Given Emergency Care is the largest category of community care spending, continued focus in this area should be a top priority. Additional efforts the VCCP could take in this regard include:

Expand Tele-Emergency Care (Tele-EC) so that it is available systemwide. In addition to expanding Tele-EC in a consistent and standardized manner systemwide, a robust communication campaign should be undertaken to ensure all stakeholders (internal and external) are aware of the key attributes of the program and how to access it.

In addition, DAV continues to advocate to keep VA as the primary provider and coordinator of veterans' health care, regardless of where veterans live or how they access their care. We also continue to call on Congress and VA to mandate that CCN providers meet the same training, certification, and quality standards as VA providers to ensure that veterans have the best health outcomes possible. VA must require that all CCN providers complete VA's training courses in cultural competency, suicide prevention, lethal means safety counseling, and substance use disorders. VA has an

obligation to ensure that the quality of care provided to veterans through the CCN is at least equivalent to the care veterans receive at VA.

OFFICE OF RURAL HEALTH

In 2006, Congress established the VHA Office of Rural Health (ORH) to specifically respond to the needs of almost five million veterans living in rural areas. The ORH's primary responsibilities include conducting research, coordinating efforts, and promoting initiatives for these veterans. ORH is responsible for developing policies, best practices, and successful programs.

For over a decade, the ORH has pursued a four-part mission, which includes promoting the health and well-being of rural veterans; generating knowledge about their health; strengthening community health care infrastructure; and informing policy related to their care. To better serve rural veterans, the ORH developed the 2020-2024 Rural Veteran Strategic Plan, aimed at improving health care access in rural communities, which established the following goals:

- To build stronger federal and community care solutions and relationships to facilitate the exchange of rural-centered information and foster collaboration that supports the health and well-being of rural veterans.

- To reduce rural health care workforce disparities by expanding understanding of current rural health care workforce.

- To enhance rural veteran health research and innovation and develop new models of care for veterans living in rural communities.

In recent years, ORH has focused on increasing virtual access to providers; in FY 2022, ORH funded 32 telehealth initiatives to provide mental health, radiology, neurology, ophthalmology, and primary care locally to rural veterans. ORH also funded training initiatives to enhance the clinical skills of the rural workforce at 975 VA rural sites of care. To increase access, ORH funded transportation programs at 113 VA sites of care to assist rural veterans with transportation challenges caused by distance, geography, and lack of public transportation. Notwithstanding ORH's accomplishments, this office must address longstanding challenges in order to achieve its full potential.

In May 2023, the Government Accountability Office (GAO) issued a report (GAO-23-105855) that contained a number of recommendations to strengthen ORH. GAO recommended that the ORH improve communication and develop performance goals, specifically by requiring its five resource centers to share research funding opportunities across VA. Each of the resource centers identifies research projects to fund; however, GAO found the centers only communicate funding opportunities to VA researchers by word-of-mouth, rather than through a formal process.

GAO also recommended that ORH develop performance goals that reflect leading practices, such as being objective and measurable. The office's strategic goals for the years 2020 through 2024 included:

1. Promoting federal and CCN solutions for rural veterans;
2. Reducing rural health care workforce disparities; and
3. Enriching rural veteran health research and innovation.

However, GAO found that ORH had failed to develop performance goals to measure whether they were making progress towards these goals. For example, while the office tracks the number of clinicians trained, it hasn't defined an annual target to address health care workforce disparities as part of its strategic goal. By establishing measurable goals, ORH is more likely to receive and attention and resources that will allow them to enhance the health and well-being of rural veterans.

To better address gaps in coverage in rural and remote areas, we recommend that ORH develop and implement strategies to increase the use of mobile health clinics and telehealth options. Neither VA nor the CCN can be easily accessible in every area of the country, therefore we must optimize the use of mobile and virtual resources to provide care for those veterans who do not have better options. For virtual health care, ORH must ensure that adequate research is conducted to ensure the level of care meets the standards expected from in-person care.

VA TRANSPORTATION PROGRAMS

One of the greatest, and most obvious, obstacles to health care for rural veterans is travel and transportation. VA recognizes the need to help veterans, particularly rural veterans, overcome access challenges due to distance from medical facilities, and has established a network of transportation options. The Veterans Transportation Service provides safe and reliable transportation to veterans who require assistance traveling to and from VA health care facilities and authorized non-VA health care appointments, particularly those living in rural and remote areas. This program offers these services at little or no cost to eligible veterans.

The Highly Rural Transportation Grants program provides grants to VSOs and state veteran service agencies to provide transportation services to veterans seeking VA and non-VA approved care in highly rural areas.

VA's beneficiary travel (BT) program reimburses eligible veterans for costs incurred while traveling to and from VA health care facilities. Veterans who have service-connected conditions, including those rated at least 30%, can qualify for reimbursement for mileage, tolls, meals, lodging, and other expenses related to seeking care. The BT program may offer pre-approved transportation options and coordinate special mode transportation if requested by the VA. Veterans might also qualify for common carrier transportation (like buses, taxis, airlines, or trains) under specific circumstances.

One of the main shortcomings of the BT program is the inadequate mileage reimbursement rates VA uses. In 2010, Congress passed legislation setting the mileage reimbursement rate at a minimum of $0.41 per mile. This rate was like what federal employees were being reimbursed for work-related travel. The law gave the VA Secretary the authority to adjust rates in the future based on the mileage rate for federal employees using private vehicles for official business, as determined by the GSA Administrator. In recent years, the VA travel mileage reimbursement rate has not kept up with the rising gas prices and costs of auto maintenance and insurance. These costs have increased significantly since the enactment of this law. Meanwhile, the GSA rate has increased over time to $0.655 per mile. Unfortunately, with gas prices continuing to rise, the current mileage rates for beneficiary travel do not always cover the actual expenses for gas and the associated costs of using a personal vehicle, as such expenses may serve as a barrier to care.

DAV TRANSPORTATION PROGRAM

In addition to VA options, DAV also operates a significant transportation program to help veterans get to their medical appointments. The DAV Transportation Network is the largest program of its kind for veterans in the nation. This unique initiative provides free transportation to and from VA health care facilities to veterans who otherwise might not be able to obtain needed care and services. The program is operated by 149 hospital service coordinators and more than 3,200 volunteer drivers at VA medical centers across the country. During FY 2023, DAV volunteers donated over 575,000 hours of their time transporting veterans to their VA medical appointments. Since 1987, we have deployed DAV vehicles in every state and nearly every congressional district to serve our nation’s ill and injured veterans, many of whom are your constituents.

To facilitate these rides, DAV has donated 3,763 vehicles to VA. Additionally, Ford Motor Company has donated 264 vehicles, to support this critical transportation program, amounting to a combined cost of over $96.9 million since the program began transporting veterans to their medical appointments.

DAV relies on volunteer drivers; however, we continue to have difficulties getting volunteer drivers approved through VA’s screening and onboarding process in a timely manner. Part of the problem is that different VA medical facilities use different processes, and the long delays can discourage volunteers who want to participate in the program. VA must develop national policies – and aggressively implement them consistently across the country – to streamline and standardize the process for becoming a volunteer.

VA STAFFING CHALLENGES

In addition to transportation, the primary major challenge to providing timely health care to rural veterans is clinical staffing, which is also a national problem for both VA and every other health care system. Staffing shortages in health care in 2024 are

increasing because of demand for health care services and an increasing number of health care professionals leaving the industry. Factors contributing to this include the aging population, burnout among health care workers, and the evolving expectations of work-life balance in the health care sector. The time-to-fill for health care positions is longer than in other industries, exacerbating the shortage.

In 2023, a report by the Health Resources and Services Administration revealed that 65% of rural areas experienced a shortage of primary care physicians. Rural areas in the United States are home to over 15% of Americans, which is about 46 million people. Unfortunately, only 10% of doctors choose to practice in these communities, and many of them are primary care and family physicians. As the demand for health care services has risen, an increasing number of health care professionals are exiting the industry. Workforce challenges may pose the greatest threat to VA and community healthcare.

In the VA health care system, positions that are typically hard to fill include roles such as registered nurses, nurse practitioners, general practitioners, physical therapists, and psychiatrists. Staffing challenges are prevalent in specialty areas like geriatrics, rheumatology, and various surgical specializations. Neglecting a strategic approach to talent management, particularly focusing on retention during the hiring process, has challenged the VA health systems in the retention of employees.

VA's Office of Academic Affiliations oversees the training of future health professionals for VA and the nation. Nearly 70% of all U.S. physicians have trained at VA, and over 118,000 clinicians train at VA each year. Health care recruitment today is fiercely competitive, presenting a significant challenge for VA's recruiters and sourcing professionals to stay competitive.

VA needs to adopt a more proactive strategy in sourcing top talent to reduce the time to fill positions without compromising care quality. By streamlining recruitment processes and workflows and updating an aged and outdated HR system, VA can improve their time-to-fill metrics, even for the most challenging positions.

CHALLENGES FOR NATIVE AMERICANS' HEALTH CARE

Native American Indian and Alaskan veterans also face many of these same challenges that rural Americans face, as well as other factors that are unique to this specific population. Many of these conditions are connected, but it is important to note that they are the symptoms of systemic disparities in health care for Native Americans.

- Native American life expectancy is 5.5 years less than the overall United States population: 73 years to 78.5 years, respectively.

- Native American communities have a high prevalence and risk factors for mental health issues and suicide. In 2019, the Department of Health and Human Services discovered that suicide ranked as the second leading cause of death

among Native Americans aged 10 to 34, with rates approximately 20% higher than non-Hispanic white individuals.

- In 2021, the unadjusted suicide rate was 46.3 per 100,000 for American Indian or Alaska Native Veterans. In 2021, among the U.S. adult general population, including veteran and non-veteran adults, the highest unadjusted suicide rates were observed among American Indian or Alaska Native individuals. (2023 National Suicide Prevention Annual Report)

- In 2018, the National Survey on Drug Use and Health (NSDUH) found that 10% of Native American individuals have a substance use disorder. Around 25% admitted to binge drinking in the past month. Notably, Native American participants reported the highest incidence of drug abuse within the same timeframe when compared to other ethnic groups.

- A staggering 23% of Native Americans report experiencing discrimination in a health care setting. Nearly 15% note avoiding seeking health care, as they anticipate discrimination. A notable number have also reported experiencing violence or being threatened during a health care visit as well.

VA needs to increase research to better understand the unique needs and obstacles faced by Native American veterans seeking health care, and work to increase awareness of these special challenges throughout its health care system.

Mr. Chairman, to provide true health equity to all veterans, including rural veterans and Native American veterans, VA must develop and implement specific strategies to address the unique obstacles to health care faced by these veterans. The responsibility towards those who serve our nation and the promises made to them must be upheld as a sacred duty by both Congress and the VA, regardless of where a veteran chooses to live.

This concludes my testimony on behalf of DAV. I am pleased to answer questions you or members of the Committee may have.