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PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

ON

"A CALL TO ACTION: MEETING THE NEEDS OF THE SPINAL CORD INJURY AND DISORDERS (SCI/D) VETERAN COMMUNITY"

JUNE 13, 2024

Chairman Bost, Ranking Member Takano, and members of the committee, I appreciate the opportunity to speak with you about meeting the needs of veterans with spinal cord injuries and disorders (SCI/D). For more than 75 years, Paralyzed Veterans of America (PVA) has served as the lead voice on a number of issues that affect severely disabled veterans. Throughout the decades, we have championed critical changes within the Department of Veterans Affairs (VA) and educated legislators as they have developed important policies that impact the lives of paralyzed veterans.

VA's SCI/D system of care is the crown jewel of the VA's health care system. It is unequaled in the care it provides for the tens of thousands of veterans with SCI/D. Protecting this system of care is PVA's number one priority. This system is the difference between life and death for our members and we view its existence as tied to that of our own welfare. It's because of this system of care that veterans are able to live in their own homes, travel, work, volunteer, and otherwise contribute to society.

Access to proper medical care is the cornerstone of health for veterans with SCI/D. However, the benefits available through VA such as disability compensation, pension, housing adaptation assistance, and employment supports are also crucial for the wellbeing of our members. Our members are grateful for the care and benefits available to them because of their military service. However, none of VA's 25 SCI/D centers are operating at full capacity, primarily due to personnel shortfalls. We call on Congress to ensure that care and benefits for veterans with catastrophic disabilities are properly funded, managed, and available when needed for veterans, their families, caregivers, and survivors.

VA's SCI/D SYSTEM OF CARE

In May 1970, a Life Magazine article relayed the deplorable conditions encountered by veterans at the Bronx VA Medical Center, specifically those with spinal cord injury. That article stirred the conscience of the nation and the public outcry that ensued served as the impetus for a complete transformation in the way the VA treated veterans with SCI/D. The deplorable conditions led PVA to begin conducting annual site visits at every VA SCI/D center. In the five decades that followed, the department rebuilt itself to become the leading provider of care for veterans with SCI/D and the benchmark for all other health systems in the world offering care to people with similar conditions.

VA's SCI/D system of care is a hub and spoke model. Its 25 SCI/D centers are the hubs and each one has highly trained and experienced providers including doctors, nurses, social workers, therapists, psychologists, and other professionals who can address the unique problems that affect veterans with SCI/D. These centers work closely with VA spoke medical facilities to provide excellent care to veterans with SCI/D as close to their homes as possible. Health care providers at these locations work closely with the SCI/D centers to ensure that the comprehensive primary and specialized care needs of each veteran are addressed.

All of VA's SCI/D centers were "locked down" during the pandemic and the prolonged periods of isolation took their toll on both SCI/D patients and staff. The lack of recreational activities, day trips, and in-person therapy sessions weighed heavily on the psyche of patients and adversely affected their physical and mental wellbeing. Limited or no caregiver and visitor access for almost three years made residing there very difficult for many paralyzed veterans, particularly those who lived in long-term care centers, who reported they were "prisoners" where they live.

While most of those COVID-related restrictions are behind us and facilities have moved to normalize their operations, some facilities have not fully achieved their pre-COVID activity level. Trips into the community with recreational therapists to combat loneliness, isolation, and boredom, as well as learn how to navigate the community as a wheelchair user are reduced from pre-COVID years, mostly because of staffing vacancies or a lack of transportation. Understandably, masking might be required and limitations are placed on visitation whenever a veteran is ill on a unit. We have strongly encouraged SCI/D centers to increase recreational opportunities, ensure community dining is regularly available, and provide full access to outdoor spaces. Many of the SCI/D facilities took our recommendations to heart and made changes that will improve the physical and mental health of SCI/D patients. However, the vibrancy of some centers, primarily due to staffing, remains diminished for veterans who require ongoing rehabilitation, training, and support for their "new normal," and recovery from wounds and other illnesses common for people with SCI/D.

Although the VA's SCI/D system is critical for our veterans, we have been forced on more than one occasion to raise concerns to VA Central Office regarding degradations in the care veterans are receiving. Based on our site visits, member reports, and even concerns raised by center staff, we believe that the system sits on the precipice of significant decline. Two factors are adversely impacting its ability to properly care for veterans: insufficient funding and lack of sufficient staffing.

Funding—The leaders of VA's 25 SCI/D centers have privately expressed concern that the funding their centers receive is not sufficient to properly care for all of the SCI/D veterans on their registries. Facilities are forced to cover funding deficits in every facet of care, no one feels funding is robust, and everyone is feeling the pain, including worried veterans who see services diminish and experience longer waits to receive needed care. They, like PVA, and SCI/D system staff are concerned the lack of proper funding signals a waning commitment on the part of the department to care for catastrophically disabled veterans. VA's current appropriation was not enacted until over five months after the start of the fiscal year due to continuing political disagreements that seem to grow worse every year. Advance appropriations help ensure VA can provide uninterrupted medical services and benefits in the event of a government shutdown, but it cannot account for instances where VA does not request sufficient funding.

When veterans with a SCI/D need care for recurrent problems and/or have complex issues that require specialized knowledge, it is essential that they have access to the comprehensive health care services that can only be provided by a VA SCI/D center. VA must request, and Congress must ensure that the department receives timely, adequate funding to meet the needs of veterans who require specialized services like SCI/D care.

Staffing—VA's staffing for the SCI/D system of care is governed by Veterans Health Administration (VHA) Directive 1176, which was last amended on February 7, 2020. PVA strongly believes in each of the requirements outlined in this directive. Our work with the VA on the SCI/D system of care is premised on its requirements, because they represent the level of care needed to properly serve veterans with SCI/D. PVA has recently learned that there are leaders in the VA who believe that the staffing requirements of this directive are inconsequential and don't need to be followed. To the contrary, the requirements of this directive set apart the care PVA members receive in the VA from the disjointed, inferior care they would receive in the community or in non-SCI/D VA medical care units.

One SCI/D center is only operating 33 of its 68 available SCI/D beds due to nursing shortages. The lack of adequate medical personnel and bed availability at this location forces staff to triage admissions based on acuity, determining who needs immediate admission and those who can wait. This creates a pseudo waiting list, which is unacceptable and has a detrimental impact on the care and treatment of veterans with SCI/D. Rehabilitation care which veterans need to get back, keep, or improve their abilities for daily life is extremely limited, inpatient annual exams, and respite care are unavailable as well. Another center can only operate 36 of 47 beds due to ongoing construction and staffing shortages, while still another can fill only about 20 of its 30 long-term care beds due to staffing issues.

These examples are representative of concerns we hear from other SCI/D centers. It's clear staffing challenges are severely impairing VA's ability to adequately meet the needs of SCI/D veterans. Unlike veterans with other medical conditions, veterans with SCI/D cannot easily be admitted to another medical/surgical unit. Staff in other medical areas do not receive the training required to recognize and treat the unique medical needs of veterans with SCI/D, and other units are unable to maintain the appropriate staffing numbers to provide the extended time needed to care for a veteran with SCI/D. A veteran with SCI/D admitted to an SCI/D unit will require a minimum of 7.3 hands-on nursing hours per day and possibly up to 18.4 hands-on nursing hours per day due to the need for help with repositioning, transfers, feeding, wound care, and bowel and bladder care.

Problems with staffing are not unique to SCI/D centers, but also extend to the spoke locations as well. Since the mid to latter part of 2021 a spoke in the Midwest has not had an official SCI clinic due to high staff turnover and remaining staff being unable to take on the extra responsibilities. A similar situation exists in California. There are no staff at what would be a busy SCI/D spoke in Southern California. These veterans must travel hours to get to the nearest SCI/D center, creating a great inconvenience and void in care.

Our service officers say it is becoming more difficult to keep contact information for spoke locations up-to-date for key service lines, because personnel turnover has been so high. One veteran reached out to us twice in recent months, because he did not know who to reach out to at his spoke facility and he is under wound care. This is especially concerning, because pressure ulcers are a frequent, costly, and potentially life-threatening complication of a SCI/D. Treatment of pressure ulcers is best done through a multidisciplinary team approach that includes a physician, wound care nurse, physiotherapist, occupational therapist, and other specialists as required. It is, however, difficult to get needed treatment when the spoke point-of-contact keeps changing.

In light of the current staffing problems, we remain deeply concerned with the VHA's decision to severely limit hiring in 2024. For months, our staff in the field have been telling us what is actually occurring at their facilities is tantamount to a hiring freeze, meaning critically needed positions at SCI/D centers may continue to go unfilled. Now, essential positions across VHA are being "deactivated" or even "abolished." Many vacant positions in social work, nursing, and several therapy disciplines that were previously open for recruitment and hiring have been rescinded in order to meet VHA's goal of zero net growth in the number of full-time employees. Additionally, when medical staff leave, their vacated positions are not being back filled causing strain on the system and ultimately denying veterans access to earned health care services.

On several occasions, senior VA leaders told PVA this should not be happening within the SCI/D system. We appreciated a May 31, 2024, memo from Under Secretary for Health Dr. Shereef Elnahal which attempted to raise the need to prioritize SCI/D staffing. Unfortunately, nothing in the memo is enforceable, so we fear the staffing and hiring problems will continue. The bottom line is local facilities are prioritizing dealing with their funding problems over adequately staffing critical care like SCI/D. In fact, we are aware of some centers now actively reducing their capacity as a consequence of the funding challenges experienced across the VA. While some veterans might have the benefit of being seen in the community when internal capacity is reduced, that is not a luxury that SCI/D veterans have.

Even if a facility is granted permission to fill a vacant position, the process to do so is now so cumbersome it appears to be designed to dissuade hiring. SCI/D leadership at one center told me that even after justifying the position, reapproval of the ability to hire is required at each step of the process. These pointless delays prevent the timely hiring of critical staff and needlessly create an air of uncertainty with each new hire. Staffing impacts every aspect of healthcare to include the quality of the care received by the patient and employee's safety and well-being. I urge you to monitor VHA's hiring practices closely so veteran patients are not adversely affected.

Insufficient Long-Term Care Beds and Services for Veterans with SCI/D—Our nation's lack of adequate long-term care options presents an enormous problem for people with catastrophic disabilities who,

because of medical advancements, are now living longer. Community nursing homes often refuse to admit veterans with SCI/D because of the high number of nursing hours they require. In truth, there are very few long-term care facilities that are capable of appropriately serving veterans with SCI/D. The 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 long-term care beds at SCI/D centers to include 181 operating beds. As of last month, only 153 beds were actually available. This number fluctuates depending on several variables like staffing, women residents, isolation precautions, and deaths. When averaged across the country, that equates to about 3.4 beds available per state. Many aging veterans with SCI/D need VA long-term care services but because of the department's extremely limited capacity, veterans sometimes remain in acute settings for months or years at a significant cost because other placements are simply not available. Others must reside in nursing care facilities outside of the 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.

The VA has identified the need to provide additional SCI/D long-term care facilities and some of these requirements have been incorporated in a pair of ongoing construction projects but most of their plans have been languishing for years. Congress needs to direct the VA to reassess its current SCI/D long-term care capacity and future SCI/D long-term care needs so adequate resources can be authorized and appropriated.

An alternative to nursing home care and/or non-acute inpatient care is expanded care. It is part of VA's Home and Community-Based Services (HCBS) and falls under Skilled Home Health Care. The Expanded Care program can provide a veteran with up to 24/7 skilled nursing care in their home. The only requirement is that the veteran be enrolled in and receiving care within the VHA system of care and have been medically determined to need this amount of care. Unfortunately, there is a general lack of awareness of the program among VA medical center Geriatrics and Extended Care (GEC) Coordinators. The GEC National Program has committed to improving training and outreach to all GEC Coordinators and Veteran Integrated Services Networks staff and leadership VHA wide. Proper awareness and utilization of this program would fill the void in this much needed service for our veterans with SCI/D.

PVA strongly believes that the VA and Congress must make HCBS more accessible to veterans. We strongly support passage of the Elizabeth Dole Home Care Act (H.R. 542), which would make critically needed improvements to VA HCBS, such as lifting the department's cap on the amount they can pay for home care, increasing access to the Veteran Directed Care program, and improving support to caregivers of veterans. This legislation has been rolled over into the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (H.R. 8371). From improving access to mental health and long-term care for the veterans who need it, to supporting those who care for them, as well as their survivors, this bipartisan and bicameral measure would have a tremendous impact on the entire veteran community. We have been patient and collaborative as these proposals have been reviewed and adjusted to fit into a meticulously crafted legislative package. I urge you to pass this vital legislation without any further delay.

Infrastructure—VA's SCI/D system of care is comprised of 25 acute care centers and six long-term care centers ranging in age from three to 70 years with an average age of 38. Many of the older centers have only had cosmetic or basic renovations. Fourteen of the 25 acute care SCI/D centers continue to use four-bed patient rooms, accounting for 61 percent of the available in-patient beds. These four-bed patient rooms do not meet VA requirements and are no longer safe due to infection control issues. This high percentage of four-bed patient rooms limits available bed capacity whenever patients need to be isolated.

The SCI/D system of care is not immune to the design and construction delays inherent in the VA project funding and delivery system. There are currently six major and nine minor SCI/D center projects either awaiting funding, in design, or pending approvals to proceed beyond their current status. VA has spent a significant amount of money and resources on these projects, most of which have languished within the department's Strategic Capital Investment Planning (SCIP) process. Also, replacement SCI/D center projects designed for the Bronx VA (acute) and the Brockton VA (long-term) intended to modernize and expand capacity were shovel-ready but abandoned by the VA.

In reviewing VA's infrastructure, decisionmakers must remember that VA's SCI/D system of care is unique and not replicated outside of the VA. The department must return to the past practice of placing greater emphasis on funding facilities that support the types of services, like SCI/D care, which the VA uniquely provides.

Even with a comprehensive strategy and adequate infrastructure funding, the VA's internal capacity to manage a growing portfolio of construction projects is constrained by the number and capability of its construction management staff. To manage a larger, more complex capital asset portfolio, VA must have sufficient personnel with appropriate expertise—both within VA's Central Office and onsite throughout the VA system. PVA strongly supports the Build, Utilize, Invest, Learn and Deliver (BUILD) for Veterans Act of 2023 (H.R. 3225/S. 42), which seeks to improve staffing to manage construction of VA assets and ensure that there are concrete plans to improve the planning, management, and budgeting of VA construction and capital asset programs.

Finally, PVA strongly supports passage of the Veterans Accessibility Advisory Committee Act (H.R. 7342) to ensure that the VA complies with federal disability laws and makes its programs accessible for people with disabilities. The bill would establish a 15-person Advisory Committee on Equal Access, which would consist of veterans with disabilities, disability experts, and representatives of advocacy organizations. The committee would be responsible for evaluating and reporting on VA's compliance with federal disability laws and would issue recommendations for how VA can improve its accessibility for people with disabilities.

Access to Inpatient Mental Health and Substance Use Disorder Treatment—It is a well-established fact that depression is closely associated with poor health outcomes, and exposure to higher pain levels often triggers depression among members of the SCI/D community. Having a history of mental illness or substance abuse, current mental illness other than depression, and current abuse of alcohol or illegal substances are also risk factors for depression among the SCI/D community. Substance use disorders (SUD) are prevalent and associated with poor outcomes in individuals with SCI/D, with 14 percent of individuals with SCI/D reporting significant alcohol-related problems and 19.3 percent reporting heavy

drinking. Large studies of U.S. veterans and Canadian citizens with SCI/D found that 55 to 79 percent were prescribed opioids, and low-quality evidence shows that risk of opioid misuse is higher in individuals with an SCI/D than in those without. It is estimated that 35.2 percent of individuals with an SCI/D use opioids daily, and that 17.6 to 25.8 percent self-report significant misuse of pain medications. Risk factors for SUD include having paraplegia versus tetraplegia, chronic pain, and low income.[1]

Suicide is a significant issue among our nation's veterans. In U.S. studies, individuals with SCI/D were reported to be three to five times more likely to die of suicide than were those in the general population; however, data for those injured in the last two decades is limited. One study reported a decreasing trend of suicide mortality in SCI/D cohorts from the 1970s to the 1990s, but the observed suicide rate was still at least three times that of the general population, even in the later cohorts. Suicidal ideation is common after an SCI/D. Over 13 percent of an SCI/D cohort reported suicidal ideation in the prior two weeks in a cross-sectional analysis, and 7.4 percent reported a lifetime suicide attempt.

While the injury or disorder in of itself increases suicide risk, higher risk of death by suicide after SCI/D has been associated with certain demographic (non-Hispanic White race) and injury characteristics (paraplegia, T1-S3 level with American Spinal Injury Association Impairment Scale A, B, or C), as well as a history of drug abuse or current alcohol abuse. In cases where VA mental health or SUD inpatient care is not available, it is provided in alternative VA settings with adequate safety precautions (e.g. one-to-one level of observation) and strong mental health consultation services, or in non-VA settings by referral. PVA believes, however, that it is in the best interest of our members for the VA to develop national procedures and protocols related to providing mental health and SUD inpatient care for veterans with SCI/D and that information on VA inpatient care for these veterans be tracked and reported.

Accessibility of Gender-Specific Care—PVA's women members face many challenges while attempting to access gender-specific care within the SCI/D system. The higher level of coordination and cooperation needed for women veterans using the SCI/D system and women's health clinics is neither reliable or equitable across the system. Coordinating this care is often difficult, because of limited staff assigned to VA's women's clinics. Each VA facility must proactively establish integrated care for patients within the SCI/D system and it is unfortunate that this has not been a priority for many locations.

One of our women members recently shared that OBGYN services have only been available at her local VA for four years. The only way to access gender specific services at her facility is through a consult from her primary care provider at the SCI/D center and sometimes this is difficult to arrange. Most women veterans receive their primary care through a women's health clinic which eliminates this additional step in accessing their care. She also shared there are no other accessible clinics to receive GYN services, so coordination between the women's health clinic and her SCI/D clinic is critical. When providers are made available to the SCI/D clinic, they are often general practitioners and unable to answer patient questions. She said the process is, "very embarrassing and it makes you feel second-class."

[1] Management of Mental Health Disorders, Substance Use Disorders, and Suicide in Adults with Spinal Cord Injury

The failure of some SCI/D clinics to provide either direct or coordinated gender specific care has led some PVA members to delay important care like pap smears and other screenings which often gets overlooked by SCI/D providers. This can have detrimental health effects for our women members. With several women's clinics being inaccessible to PVA's women members, VA must ensure accessibility is a priority when fulfilling the requirements for the retrofit initiative for women's health under the Deborah Sampson Act passed in the Isakson-Roe Health Care and Benefits Improvement Act of 2020 (P.L. 116-315).

VA's Bowel and Bladder Program—SCI/Ds can significantly impact a person's quality of life, and neurogenic bladder and bowel dysfunction are crucial aspects of their care. These conditions affect many veterans with SCI/D and can lead to complications, re-hospitalizations, and mortality. Therefore, managing neurogenic bladder and bowel requires specialized attention, as it can be costly, is unrelenting over time, often necessitates substantial caregiver support, and is essential for maintaining veterans' health and well-being.

VA's Bowel and Bladder program is administered by VHA's SCI/D National Program office. Veterans with SCI/D who qualify for bowel and bladder care may receive that care through a home health agency, a family member, or an individually employed caregiver. The current program is fraught with challenges for caregivers and is unevenly applied across the VA system. Timely reimbursement and the tax treatment of payments are the chief complaints of PVA members who must rely on bowel and bladder care to meet their needs.

Unlike virtually all other VA payments, including those provided through VA's Program of Comprehensive Assistance for Family Caregivers, Bowel and Bladder program reimbursements are taxable. Even family caregivers are considered federal contractors for providing this care and must pay self-employment tax. Harry, caregiver for his wife Anne, a PVA member, pays $3,500 to $3,700 in self-employment taxes each year. He figures he is probably making a quarter of what the VA would pay an agency to provide the care.

The Bowel and Bladder program is a life-sustaining program providing support to veterans with SCI/D. Codifying the program would allow Congress to finally resolve the tax burden and delayed payments for family members who perform bowel and bladder care. And as principal users of the program, we hope that Congress and the VA will provide PVA ample opportunity to "shape" the program's language.

Transportation Programs and Supports—Transportation is the largest barrier to accessing healthcare for over five million veterans living in rural and urban areas and especially those who are catastrophically disabled. According to the VA, missed appointments cost the department over $4 billion per year and most are due to lack of transportation. Missed appointments set off a cascade of higher costs in the VA health care system, through the ripple effect created by patients with a higher risk of negative health outcomes to clinicians being unable to see other veterans.

The Veterans AUTO and Education Improvement Act (P.L. 117-333) not only allowed access to an additional automobile grant, it also changed the definition of "medical services" to include certain vehicle modifications (e.g., van lifts) offered through VA's Automobile Adaptive Equipment program. Specifically, it amended the definition of "medical services" under 38 U.S.C. § 1701(6) to include the

provision of medically necessary van lifts, raised doors, raised roofs, air conditioning, and wheelchair tiedowns for passenger use. The change was intended to codify VA's existing practice of furnishing certain items, like van lifts and wheelchair tiedowns to catastrophically disabled veterans. However, where the VHA has used these items as examples, the statute defines them as the only types of modifications that are permissible. Like the VA, we agree that a technical amendment to 38 U.S.C. § 1701(6) is needed to give the department greater flexibility in making the necessary modifications to veterans' vehicles to ensure they can safely enter, exit, or operate the vehicle and transport needed equipment, including power wheelchairs.

Even if they have access to an adaptive vehicle, some PVA members do not qualify for beneficiary travel when traveling to and from a VA medical facility for an appointment. A case worker shared with us that she has been working with an 85-year-old veteran paraplegic whose transportation issues have had a significant negative impact on his physical and mental health over the past 2-3 years. He is just over the income limit for VA-funded travel and therefore has to try and find his own transportation to the VA for SCI/D care. County agencies are extremely limited in the help they can provide due to staffing issues, and his wife's ability to transport him is even more limited due to age and health related issues of her own. The veteran has missed a multitude of medical appointments, including those for pain management and outpatient physical/occupational therapy. His physical and mental health is rapidly deteriorating, to the point he is verbalizing symptoms of high anxiety, lack of sleep, depression, and passive suicidal ideation. The VA referred him to mental health support groups and individual psychotherapy; however, the underlying problem of not having consistent transportation to the VA remains. His lack of transportation has clearly had a "snowball effect" on his health and unless the issue of his lack of access to transportation is addressed, his condition will continue to get worse.

In 2017, Congress amended beneficiary travel to authorize travel for any veteran traveling with vision impairment, a veteran with a SCI/D, or a veteran with double or multiple amputations. To be eligible for beneficiary travel under this change, the travel must be in connection with care provided through a special disabilities' rehabilitation program of the department (including programs provided by SCI/D centers) and if such care is provided on an in-patient basis; or during a period the VA provides the veteran with temporary lodging to make such care more accessible to the veteran.

Unfortunately, the language excluded catastrophically disabled veterans from beneficiary travel when traveling to a special disabilities' rehabilitation program for outpatient services. Veterans, service officers, and VA staff consistently cite the lack of travel reimbursement as a major impediment for veterans to get the care they need. The exclusion of travel reimbursement for outpatient care may well have been a cost saving move, but it results in higher health care costs for the VA and poorer health outcomes for these particular veterans**.**

Finally, a robust network of public transportation such as buses, subways, and paratransit services for people with disabilities is often not available outside of urban areas. In fact, what is available within urban areas may not be suitable for SCI/D veterans either. VA's Veterans Transportation Service provides transportation to help veterans who live within a VA medical center's catchment area to get to and from medical appointments. Unfortunately, it is not available at all VA facilities and cannot help veterans who live beyond a certain distance of the medical center.

Passage of legislation like the Rural Veterans Transportation to Care Act (H.R. 7504/H.R. 7654/S. 3751) would help more veterans in rural areas get transportation to VA health facilities and access the healthcare and benefits they've earned. The bill expands eligibility to the VA's Highly Rural Transportation Grant Program, which provides grant funding for veterans service organizations (VSO) and State Veterans Service Agencies to provide veterans transportation in eligible counties. It also increases grant rates to help organizations purchase a vehicle that complies with the Americans with Disabilities Act.

Many veterans have experienced travel delays and no shows for scheduled pick-ups with the systems that are available. Too often, the medical center's contracted travel service is late in picking them up so they are late for appointments and forced to reschedule them. Also, there are times when the travel contractor never picks them up at all and they do not contact the waiting veteran, so they are forced to reschedule their travel and their appointment. Congress and the VA must work together to improve travel options for catastrophically disabled veterans, including those who live in rural areas.

Veterans Benefits Administration Services and Benefits

Accessibility of Contract Exam Facilities for Veterans' Disability Compensation Exams—PVA believes medical examinations for complex, service-related medical conditions like SCI/Ds should be conducted by a VHA medical practitioner; however, contract exams may be appropriate for some other types of claims. Regardless, the VA must ensure that any contracted compensation and pension examiners must be qualified to conduct them and any legislation supporting contract exams must include such provisions.

In addition to the qualifications of the provider, the exam must be conducted in an accessible facility. A May 2024, VA Office of Inspector General Report (23-01059-72)[2] found accessibility problems at more than half of the 135 facilities they visited. We believe a similar parallel can be made between compensation and pension exam accessibility and barriers in community care facilities. Our members have seen exam rooms that are physically inaccessible and/or lack overhead patient ceiling lifts. Restrooms often have accessibility barriers, causing members to pause and wonder why the VA is sending them to a facility that is ill equipped to accommodate them. Reports of inaccessible medical diagnostic equipment are also common. This includes medical examination tables, weight scales, dental chairs, x-ray machines, mammography, and other imaging equipment. A lack of any one of these diminishes these providers' ability to accurately evaluate service-related medical conditions.

A closely related problem is getting the veteran to the contract facility. Several members have been expected to travel in excess of 100 miles to reach the contractor's facility, and occasionally while the veteran is critically ill. Some of our veterans are too debilitated to be able to physically appear for an exam; so, our service officers request on a VA Form 21-4138 (Statement in Support of Claim) either a telehealth or in-person visit from a compensation and pension examiner. Many times, these requests are not seen or are just ignored. Some service officers even write the request on the VA Form 21-526

[2] Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams | Department of Veterans Affairs OIG (vaoig.gov)

(Application for Disability Compensation and Related Compensation Benefits) but the contractor insists the veteran must show, or they just deny the claim based on the fact that the veteran did not show. This unnecessarily delays providing benefits and services to the veteran, and forces service officers to file supplemental claims. VA and third-party vendors' policies regarding these situations need to be examined, and greater use of telehealth exams and traveling examiners should be made.

Home Modification Grants—Passage of the Ryan Kules and Paul Benne Specially Adaptive Housing Improvement Act of 2019 (P.L. 116-164) made much needed improvements to VA's Specially Adaptive Housing (SAH) grant program. The provisions of that legislation have been fully implemented. Since its enactment, over 8,000 grants totaling more than $450 million have been provided to veterans with severe, service-connected disabilities so they can modify their homes to live independently in a barrier-free environment.

By far, the biggest challenge with the SAH program is finding contractors who are willing to work with the VA outside the major metropolitan areas. A concerted effort to educate builders could help. The VA does some outreach to trade and builder associations, but it lacks the appropriate full-time staff and resources to fully perform this mission. Congress should work with the VA to formalize and strengthen the program's outreach efforts, and examine the possibility of offering incentives to retain contractors. This may include reevaluating the way contractors are paid, since they don't get paid until the work is done under SAH and some contractors have told veterans they cannot wait for payment.

Because of the difficulties finding contractors, many veterans are turning to VA's Home Improvements and Structural Alterations (HISA) program which is in dire need of congressional attention. 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.

A lifetime HISA benefit is worth up to $6,800 for veterans who need a housing modification due to a service-connected condition. Veterans who rate 50 percent service connected may receive the same amount even if a modification is needed due to a non-service-connected disability. Veterans who are not service connected but are enrolled in the VA health care system can receive up to $2,000.

These rates have not changed since 2010 even though the cost of home modifications and labor has risen more than 50 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. Peter, an Army veteran with Progressive Multiple Sclerosis, used a HISA grant last year to partially fund the remodeling of his master bathroom to make it fully wheelchair accessible. The $6,800 he received only covered about a third of the total cost of the project. Fortunately, he had sufficient savings to cover the remainder of the project but many of the veterans who need these grants do not have the financial resources to pay for these types of projects. Congress needs to pass legislation, such as the Autonomy for Disabled Veterans Act (H.R. 2818/S. 3290) or the Autonomy for All Disabled Veterans Act (H.R. 4047), to raise HISA grant rates and index the grant to account for inflation and increased construction costs.

Veteran Readiness and Employment (VR&E)— VA's VR&E Program plays a critical role in assisting disabled veterans in finding appropriate employment that will not exacerbate their service-connected disability. Unfortunately, a significant amount of misinformation exists around the program, and many veterans do not understand that a VR&E counselor is trained to help them find the most suitable job for someone with their disabilities.

Since the passage of the Honoring our PACT Act of 2022 (P.L. 117-168), applications for the VR&E program have increased 40 percent. Counselors are already encountering extremely high caseloads along with administrative burdens. Without additional resources, the VR&E program will struggle to remain successful.

In the Independent Budget's (IB) recommendations for VA's budget for fiscal years 2025 and 2026, the IBVSOs recommended an increase of $46 million to improve the performance of the VR&E program. Current funding levels address the suggested staffing ratio of 1:125 (counselor to clients), but the IBVSOs suggest funding the program to a 1:120 ratio to increase timeliness and support for disabled veterans. The IB also suggested that VR&E hire an additional 300 full-time employees, which would increase counselor capacity and decrease the administrative burden they face.

Thank you for the opportunity to relay our view of the current status of VA's services and benefits for veterans with SCI/D and the importance of ensuring they remain robust. We would be happy to answer any questions.

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 2023

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $479,000.

Fiscal Year 2022

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $ 437,745.

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.