CARE COORDINATION: ASSESSING VETERANS NEEDS AND IMPROVING OUTCOMES

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BEFORE THE

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OF THE

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C O N T E N T S

TUESDAY, JUNE 13, 2023

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TUESDAY, JUNE 13, 2023

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Radewagen, Van Orden, Luttrell, Kiggans, Brownley, Deluzio, Landsman, and Budzinski.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Come to order.

As a 24-year veteran and a physician who has worked with the VA, I have seen first-hand how important coordination is to providing timely, quality care, especially for veterans with complex health needs. It is one of my top priorities in Congress to ensure veterans have access to care where they need it and when they need it.

VA's care coordination programs should help veterans navigate the complex world of healthcare both within the VA and with VA's community partners. VA's Patient Aligned Care Team, or PACT, model provides, or should provide, personalized, patient driven care and positively can impact a veterans experience in the primary care setting. However, high need, high risk veterans often lack support for their complex clinical and psychosocial needs beyond that setting. This is not due to a lack of compassionate coordinators and social workers within the VAs, but rather due to poorly defined roles and jurisdictions for these advocates. Veterans who receive care across multiple locations are at the greatest risk for lapses in care, especially when their medical records are either not returned to the VA or the VA does not correctly input vital medical information. Communication between the VA and its provider partners could be greatly enhanced with coordinators who are empowered to work across clinical and arbitrary bureaucratic lines.

As we will hear from the Veteran's Affairs Office of Inspector General (VA OIG) and from our second panel of veteran advocates, veterans with complex cases who do not receive proper care coordination more often than not experience detrimental health outcomes. Some of their stories are heartbreaking. The Quality of Life Foundation, Wounded Warrior Project, and Paralyzed Veterans of

America have managed to establish programs that cross multiple disciplines to effectively manage the care for some of our most complex, injured, and ill veterans. VA can and must do better.

I look forward to hearing how we can better coordinate the coordinators and ensure that no veteran falls through the cracks.

With that, I yield to the ranking member and her substitute.

OPENING STATEMENT OF CHRISTOPHER R. DELUZIO, ACTING RANKING MEMBER

Mr. DELUZIO. Thank you, Madam Chairwoman. Of course, I am sitting in for Ms. Brownley today, who is still in Transportation and Infrastucture (T&I) markup, I am sure, will join us when she can.

As the largest integrated healthcare system in this country, the Veterans Health Administration is perhaps one of the most well positioned to effectively coordinate patients care. Given the patient population it serves, my fellow veterans care coordination is critical. As compared to their non-veteran peers, veterans have a greater number of medical comorbidities, and psychosocial needs that need to be considered and well-coordinated when delivering healthcare. However, as we will hear from some of our witnesses today, there are many ways in which the Veterans Health Administration, VHA, needs to improve its coordination of veterans care to ensure veterans receive the soonest and best care possible, whether directly from the VA or from fee for service or community care providers.

As defined by the Federal Agency for Healthcare Research and Quality, care coordination entails deliberately organizing patient care activities and sharing information among all of the participants concerned with the patient's care to achieve safer and more effective care. Despite the existence of numerous care coordination and case management programs across VHA, the committee regularly hears about instances where veterans with complex care needs have not received the help, they need to navigate VHA's direct care system or fee for service or community care, experiencing delays or serious gaps in care. There are too many instances where veterans fall through the cracks and do not receive the care they need, when and where they need it. In the most serious cases, like those we will hear about from our Office of Inspector General witness, lapses in care coordination can lead to poor patient outcomes and patient harm.

I hope today's hearing will help us examine ways VHA can address some of the root causes of care coordination breakdowns. At the outset, I see at least three areas to be addressed.

First, care coordination programs within VHA tend to be fragmented or siloed within certain program offices or clinical service lines. They generally target specific categories of patients diagnoses or clinical specialties, leading veterans to be passed off from one care coordinator to another. This heightens the risk of care coordination breakdowns as veterans transition from one coordinator or one setting of care to another accomplishing the exact opposite of the goals these programs are intended to meet.

Second, information technology limitations also present barriers to care coordination. We are still years away from having inte-

grated electronic health record at VA and Department of Defense (DoD). Meanwhile, VA's legacy system makes it such that veterans traveling to or relocating from one VA facility to another have to be registered at their new facility before providers at that facility can access their VA electronic medical record. VA's ability to electronically access and receive medical records from non-VA community providers is still very limited. This means that VA staff often have to request paper copies of medical records from non-VA providers, leading to delays and gaps information from fee for service or community care encounters.

Third, and last, a lack of strong oversight across VA medical facilities and gaps in existing policies lead to inconsistent patient care experiences for veterans. Some care coordination programs are only available at VA medical facilities that have chosen to offer them, and even in care coordination programs that all facilities are required to offer, caseloads and patients experiences can vary considerably.

Certainly, much for us to examine today and many opportunities for VHA to improve. I would add that with the ongoing implementation of the The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, thousands of veterans with complex cancers and respiratory illnesses will be entering the VA healthcare system in the coming years. It is therefore an opportune time for this committee and VHA to consider ways to strengthen care coordination frameworks and ensure VHA will be prepared to serve this cohort of veterans and their caregivers.

Madam Chair, thank you again for organizing this hearing. I look forward to it and I yield back.

Ms. MILLER-MEEKS. Thank you, Mr. Deluzio.

I just wanted to have a point of information, and that is most of you know that votes will be coming up shortly, so we will take a recess for votes. At this time, I would like to introduce the witnesses today and I would like to thank you for joining us.

Joining us from the Department of Veterans Affairs is Mr. Christopher Saslo, who is the assistant undersecretary for Patient Care Services and the chief nursing officer. Accompanying Dr. Saslo today is Dr. Sachin Yende, the chief medical officer in the Office of Integrated Care. If I mispronounce anybody's name, I do apologize. Ms. Jennifer Strawn, the executive director, Office of Nursing Services and deputy chief nursing officer, and Ms. Jill Debord, executive director of Care Management and Social Work Services. We also have Dr. Julie Kroviak, the principal deputy assistant inspector general of healthcare inspections in the office of the Inspector General.

Dr. Saslo, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF M. CHRISTOPHER SASLO

Mr. SASLO. Thank you. Good afternoon, Chairwoman Miller-Meeks and ranking members and distinguished members of the subcommittee.

Thank you for the opportunity today to discuss VHA's various care coordination programs within VA, community providers and

emergency services. Accompanying me today, as mentioned, is Dr. Sachin Yende, chief medical officer for the Office of Integrated Veterans Care, Dr. Jennifer Strawn, executive director for the Office of Nursing Service and our deputy chief nursing officer, and Ms. Jill Debord, executive director for Care Management and Social Work services.

Care Coordination and Integrated Case Management (CCICM) is a practical approach rather than a program with a framework that promotes care coordination stratification across the entire care continuum. It focuses on the complex and high to moderate veterans who have complex care coordination needs. Preliminary data illustrates that our CCICM model provides positive impacts to care outcomes and increasing veteran trust scores.

To illustrate this, I would like to share one of our many care coordination integrated care management success stories. A veteran with multiple complex comorbidities has been utilizing community emergency rooms to address all of their medical needs. The veteran has found to have 16 ER visits in a 2 month period of time. The lead coordinator assigned to this veteran was able to build a rapport and gain the veteran's trust while assessing for global needs. The urgent consults were scheduled, and follow up was obtained while connecting the veteran three to five times a week via phone. The coordinator assisted the veteran with support using therapeutic listening and motivational interviewing to empower the veteran to feel confident about their healthcare decisions. The coordinator also assisted with obtaining an emotional support animal for the veteran, which made a positive impact in their mental health and coping abilities.

As a result, since being assigned a lead coordinator, the veteran has had zero visits to any urgent care or emergency department. The veteran expressed confidence in the care team and in control of their health and wellness. The veteran is now able to proactively manage care and enlist the lead coordinator with urgent requests on an as needed basis.

While this story highlights positive outcomes, we also know that there are opportunities to enhance and improve that care coordination within our system. With the number of veterans using VA care as it grows and the veteran patient population typically having more complex medical and social needs than any other population, that care coordination is critical. To meet these needs, VA provides a broad array of services.

VHA is developing a long-term strategy to ensure all veterans across their continuum of care receive the soonest and best care possible, both within the VA and in the community. It is imperative that VHA optimizes and integrates its care coordination and services and its resources. VHA's strategy must address the current navigational and access to care challenges. Without intervention to better coordinate the care, veterans will continue to have higher rates of emergency department visits, hospital admissions, and substantial increases in healthcare costs. When fully implemented, the new coordinating care will benefit thousands of veterans and their qualified family members, increasing their access to care and improving health outcomes.

Last year, VHA leadership assembled an interdisciplinary integrated project team, or IPT, bringing together the offices in patient care services, such as nursing service and care management and social work services, and our integrated veterans care team to address these challenges and serve as the team's resource and planning framework. This initiative aims to decrease navigational and fragmented care challenges through proactive identification of veterans with complex care coordination needs. The objective is to enhance and align resources to organizational needs to support stabilization of our workforce and drive innovation.

Finally, under the framework for CCICM, veterans will have high quality, coordinated care that is delivered in a consistent manner across all care settings. We are serving record numbers of veterans both in the VA and in the community, with significant progress toward our timeliness goals. I will—was going to say Chairwoman Miller-Meeks, but you have changed——

Mr. VAN ORDEN. [Presiding] I appreciate that.

Mr. SASLO [continuing]. and ranking member, we appreciate your continued support and look forward to answering your questions.

[THE PREPARED STATEMENT OF M. CHRISTOPHER SASLO APPEARS IN THE APPENDIX]

Mr. VAN ORDEN. Thank you, Dr. Saslo.

The chair now recognizes Dr. Kroviak for 5 minutes.

STATEMENT OF JULIE KROVIAK

Dr. KROVIAK. Thank you. I appreciate the opportunity to discuss the OIG's oversight of VHA care coordination.

The OIG's Office of Healthcare Inspections reviews the quality and safety of healthcare provided across VHA, and our reviews frequently highlight challenges associated with coordinating veteran care across multiple service lines and a wide variety of healthcare settings.

My written testimony highlights some of the many issues and breakdowns that providers and patients have faced in navigating the complexities of care coordination, from enrolling in VA to receiving care at the VA and then receiving care in the community. Gaps in any of these steps of care transition compromise patient safety and fracture confidence in the system. Unfortunately, it is during these transitions of care that the most vulnerable patients face the greatest risks.

Transitioning from DoD to VA can introduce new stressors to service members and their families, and the reintegration challenges can be magnified for a veteran with traumatic brain injury, Post Traumatic Stress Disorder (PTSD), or substance use disorder. Gaps in care coordination for those members diagnosed with high-risk mental health or substance use issues can be fatal during this period.

The OIG is finalizing a national review evaluating the risks for service members with documented opioid use disorder, or OUD, as they transition their care from DoD to VHA. We found that VHA providers are not consistently placing critical information regarding the OUD diagnosis in the veterans VA medical record. Failure to identify and document a patient's known OUD history may de-

crease the likelihood of a patient receiving timely VA care and support.

These care coordination challenges continue for VHA patients, with many of our reports finding failures involving VHA clinical and administrative leadership, and frontline staff. Our reports have substantiated unreasonable delays in responding to critically ill veterans needing emergent care, dangerous errors in discharge planning for high-risk veterans, and failures in coordinating end-of-life care for a terminally ill veteran transferring between levels of care within VA. We have also seen failed coordination between the Veterans Crisis Line, local suicide prevention teams, and emergency department staff, as well as failures with vet center staff coordinating with local VA medical centers to ensure that clients deemed high risk for suicide receive appropriate clinical support.

The expansion of VHA's partnership with community providers has further challenged care coordination. Once a veteran and their VHA provider agree on a need for a community care referral, a variety of VHA clinical and administrative staff enter into a complex process to complete a simple goal scheduling an appointment for a veteran. We reviewed VA's implementation of the Referral Coordination Initiative, which is designed to improve timeliness of scheduling community care appointments. Despite a goal of complete implementation 2 years ago, full implementation has yet to be achieved.

The challenges of community care coordination continue beyond timely scheduling. Our reports have highlighted deficiencies for veterans receiving care in the community, including delays in diagnosis and treatment, lack of or miscommunication between providers, and quality of care concerns. We are in the final stages of developing a community care cyclical review, and the initial phases of data analysis support many of the issues identified in our publications. We are hopeful that these reviews will support VHA leaders efforts to introduce efficiencies and reduce the risks associated with community care. From a quality of care standpoint, until timely clinical information sharing between the community and VHA is ensured with each care encounter, VHA has no reasonable assurance that veterans are getting the care they need. Reviews from our Office of Healthcare Inspections as well as from our Office of Audits and Evaluations confirm current processes put veterans at risk.

We do appreciate VHA staff's exhaustive efforts to coordinate safe care across multiple venues for millions of veterans. The complexity and scale of that work will only increase as more veterans engage with the community and VA healthcare services expand in response to the PACT Act. The OIG will continue to enhance and adapt our work to support VA leaders and frontline staff with meaningful and impactful oversight, with a shared goal of increasing efficiencies and processes and assuring high quality care delivery.

This concludes my statement. I would be happy to answer any questions.

[THE PREPARED STATEMENT OF JULIE KROVIAK APPEARS IN THE APPENDIX]

Mr. VAN ORDEN. Thank you, Dr. Kroviak. I appreciate that.

I now recognize myself for 5 minutes.

Dr. Kroviak, I got to tell you, I read all your testimony, I reread the testimony from last time you were here, and I appreciate it greatly. I found this particular set, or this testimony fascinating. It was terrifying. It was fascinating because it was like watching a slow moving train wreck and it was terrifying because I find it interesting that someone as brilliant as you are, and you are, could not identify the root problem that you alluded to. It is so obvious. It is the fact that there is no accountability. There is no accountability across any of these levels.

I had my staff, which are awesome, they did the word search. A lot of people say accountable—accountable, accountability, right. There are zero instances in anybody's testimony from this panel or the next of the word fired, censured, referred for discipline, nothing.

You have a veteran in southwestern Nevada who committed suicide because they were essentially blown off. They had all these problems, everybody knew about it, and they were not treated appropriately, and they committed suicide.

I come from a naval background, as does my friend Morgan, as does my colleague, Mr. Deluzio. When a ship's captain is asleep in their cabin at night and the ship runs aground, the captain is held ruthlessly accountable. They are fired immediately even though they are asleep. I did not find any testimony of a single instance of anyone being fired, referred for discipline, or censured, and we have dead veterans.

I would like to make a suggestion for you. When these instances happen, I think every single person that is involved in that chain of custody, for lack of a better term for these veterans, should write a personal letter to the widow or the widower or the mother or the father and the children of these dead veterans and apologize to them for their lack of care. I think every single person from the Veterans Administration in that chain of custody for a veteran that is responsible for these suicides needs to go to all of these funerals. I would be more than happy to submit an amendment. I am sure everybody would sign on it. We will pay for that. We will pay for your travel costs. As soon as your folks at the Department of Veterans Affairs start going to some of these funerals, like we have gone to God, I do not know how many of my friends, you will change. Until that happens, nothing will. If you have no accountability, do not have an organization, you have a paid mob.

Can you, with a piece of paper and a pencil, could you possibly draw me a line and block chart of all of these various coordinators that currently exist and are being paid for by the American taxpayers that have been failing our veterans for decades?

Dr. KROVIAK. Sir, I can certainly appreciate-the disdain you feel—our reports hold VHA accountable to their policies and practices, and we assign recommendations to whom is ultimately responsible for correcting those actions. We have no authority to manage or punish VHA staff in our oversight position.

Mr. VAN ORDEN. Does anybody?

Dr. KROVIAK. That would be from VA.

Mr. VAN ORDEN. Okay, so check me out. I represent Tomah. It is where the whole candy doctor guy opioid thing blew up. Had a

veteran commit suicide from that. We had 900 veterans being seen by a single lady that did not appropriately rate them, 600 of the 900, 2/3s have been determined that she did that incorrectly. She got fired. I was there with Denis, the Secretary of Veterans Affairs—fired. I want you to tell me how we can make sure that your reports—because they do not hold anybody accountable, they do not. It is a harshly worded, email—I want you to tell us how we can help you to empower you to make sure that these people are actually held accountable. By that, I mean the door hitting them in the behind as they are leaving the institution permanently.

Can you help me with that?

Dr. KROVIAK. I believe I can definitely help with that.

Mr. VAN ORDEN. Thank you.

Dr. KROVIAK. We are always thrilled to provide briefs of our reports to congressional staff, and we take their interest—the local interest, and the authority they have to hold local leaders accountable for their recommendations and action plans that are put into place.

Mr. VAN ORDEN. Thank you, ma'am. My time has expired.

I am frustrated, but my brothers and sisters are dead.

With that, I yield back.

I recognize Mr. Deluzio for 5 minutes.

Mr. DELUZIO. Thank you, Mr. Van Orden. I will echo your very good and correct point that the consequence here is people's lives. I think it is a good reminder of what is at stake when there are mistakes in the lack of coordination. Those are the stakes. They are serious ones.

I guess my question -I will start with Dr. Saslo and then Dr. Kroviak, love to hear from you as well, from the OIG perspective.

I am thinking about, first, coordination of care or the lack thereof, that happens on the community care fee for service side. My understanding is many providers—well, there is not a requirement to submit records to VA in an electronic form, for instance, and some do not do it in a timely manner or at all. I am wondering what the ways in which those lapses in coordination are impacting veterans who are serving in the VA?

Mr. SASLO. Thank you for the question.

One of the things I think is important to acknowledge is that we recognize that the challenges in getting the medical records back in a timely manner and being able to integrate them into the veterans record is extremely important for that continuity of care. One of the reasons for the Care Coordination Integrated Case Management Project itself is because of the gaps that we have identified both within VA and within the community care itself. Our goal is to actually be able to identify for those complex needs, or moderate to complex needs, that we have one individual who is that lead coordinator who will not only be able to work with the veteran, but also working with the different care teams across the continuum so that the information that we receive is not only provided in a timely manner, but also handed off to the correct individual that will then continue that care within the VA if it is necessary, or managing the care within the community.

Mr. DELUZIO. Dr. Saslo.

Mr. SASLO. Yes, sir.

Mr. DELUZIO. I am sorry to interrupt, but just for the sake of time, I am curious, if a provider does not provide any records at all, or they do it in a very untimely fashion, what is the consequence for them?

Mr. SASLO. Dr. Yende.

Dr. YENDE. I can take that question, Congressman.

Previously we used to link claims reimbursement for community care providers with receipt of medical records. That means we need to confirm that they have sent the medical records. As you rightly pointed out, the fax system is very challenging to work with. We had instances where the provider said that they had sent the records, we could not verify on the VA side, and we had delays with claims processing. I believe we had several congressional inquiries asking why those claims processing were delayed. In order to make sure that our veterans were getting timely access, we decided to waive it.

You ask a very important point, and we realize that there are challenges getting medical records back. I totally understand that care coordination cannot be done without it. We have two or three approaches we are pursuing.

Number one, VA is one of the five Federal agencies that participates in health information exchanges. That is a mechanism where we can get those records electronically. Those Health Information Exchanges (HIEs) account for about 70 plus percent of HIEs locally. Through those we get those records, but they are not complete in most instances.

Number two, we have worked out processes with our Third Party Administration (TPA) partners where if we feel that a provider is not providing records consistently, which is what you alluded to, we will work with their TPA partners to make sure that they send those records to us.

Finally, as you said, really, technology is a solution out here. Trying to work through faxes, trying to make sure those faxes get into our medical records, is a very laborious process. We are really exploring some technology solutions out here, and we hope to brief you in the near future.

Mr. DELUZIO. Thank you.

Dr. Kroviak, I am going to give you the remainder of my time. My question is the same. One, how bad is this problem where providers outside the VA are not turning in records at all or in a timely fashion, and is there any real consequence, and is the lack thereof hurting care for veterans?

Dr. KROVIAK. It is absolutely impacting care for veterans. It is not getting better from our work. I do believe technology is the solution, but I do not believe we are anywhere near making that solution a reality.

Mr. DELUZIO. Thank you.

Mr. Van Orden, I yield back.

Mr. VAN ORDEN. Thank you, Mr. Deluzio.

The chair now recognizes Mr. Luttrell for 5 minutes.

Mr. LUTTRELL. Thank you, Mr. Chairman.

Good morning, Ms. Kroviak. Your one year anniversary in this position, correct? Last year?

Dr. KROVIAK. In this position, it might be August, but I was the deputy prior to that, so it is been several years.

Mr. LUTTRELL. How many Inspector General (IG) reports have you presented on these topics?

Dr. KROVIAK. On community care?

Mr. LUTTRELL. Mm-hmm.

Dr. KROVIAK. I cannot count, but I suspect almost every report we published in the Office of Healthcare Inspections touches on aspects of care coordination.

Mr. LUTTRELL. Is there a repetitive nature to these reports?

Dr. KROVIAK. Yes.

Mr. LUTTRELL. Very similar to the ones that you just read for us today?

Dr. KROVIAK. Yes.

Mr. LUTTRELL. Is there anyone sitting on this panel with you today responsible for any of the issues that you listed directly?

Dr. KROVIAK. Directly? I would have to assume not. I think we are talking with leaders at the table. In terms of individuals at facility levels...

Mr. LUTTRELL. Is there anybody that directly reports to anybody sitting on this panel?

Dr. KROVIAK. From any of our reports? I could not say, but I am not 100 percent sure, but I would not—they would probably be——

Mr. LUTTRELL. If you are following my line of questioning here, and you can see how this panel is unified on these issues—we are done. I want names. I do not want any more IG reports that get lost in the sauce and hung on the shelf or the Department does not take it seriously. You have repeatedly done your job. Well done. It has obviously fallen through the cracks because these issues are the same issues that we keep hearing over and over again.

Mr. Saslo, do you have any response at all to the IG report and how we can course correct this ship that is continually sinking?

Mr. SASLO. Yes. I believe, as I started earlier, the entire integrated project team that we have put together really has looked at a number of those failures that does not ensure that the veterans timely access to care or their care coordination is being addressed.

I will ask Dr. Strawn or Ms. Debord to address it a little bit further, but from an awareness standpoint, we have two different professions that really help to coordinate the care within VHA, our nursing partners as well as our social work partners. Coming together and working with our integrated veterans care team, we have actually identified several different mechanisms that are going to help to minimize any of the fragmentation in care and hopefully over the course of the roll out to make sure that we do not have those veterans falling through the cracks, making sure that we——

Mr. LUTTRELL. How long have you been in this position?

Mr. SASLO. I have been in my position as an assistant undersecretary since October. I have been with the VA for 27 years.

Mr. LUTTRELL. Twenty seven years—so you are familiar with these issues?

Mr. SASLO. Yes, sir, I am.

Mr. LUTTRELL. What are we doing wrong?

Mr. SASLO. We are——

Mr. LUTTRELL. That is rhetorical. How do we fix the problem?

Mr. SASLO. We are looking at being able to do——

Mr. LUTTRELL. No more looking. We are done looking.

Mr. SASLO. I apologize for the verb. We are in the process of addressing that through the CC&ICM framework, which will allow us to help make sure that that complex care that our veterans are sometimes losing is going to be addressed by lead coordinators, by making sure that the teams are actually effectively engaged, so that it is not just you are going to go to the mental health clinic or you are going to go for your orthopedic clinic, how do we have that continuity of care to make sure that one person helps to mitigate many of those issues.

I will ask Dr. Strawn or Ms. Debord to go ahead and add to that.

Dr. STRAWN. What Dr. Saslo has described is what we are calling—it is a framework. It is a care coordination and integrated case management framework.

Within VA, there are multiple programs, and there are care coordinators within each program. A veteran who may suffer from medical chronic conditions, may have mental health issues, may have social determinants of health issues, those patients or veterans may have multiple case managers. What we have found is that there is siloing and fragmentation. With the new CCICM framework, a veteran who needs moderate or complex care coordination will have an assigned lead coordinator, and that coordinator will assist them, internal and external to VA to navigate the healthcare system.

Mr. LUTTRELL. Ms. Strawn, real quick, I am running out of time here, how long have you been with the VA?

Dr. STRAWN. I have almost been with the VA 30 years.

Mr. LUTTRELL. Thirty, years twenty six years. Mr. Yende?

Dr. YENDE. About a decade.

Mr. LUTTRELL. Ten years. Ms. Debord.

Ms. DEBORD. Thirty years.

Mr. LUTTRELL. Thirty years. How many of those reports have you read from the IG? Every one of them? Collectively, you are over 100 and some odd years of experience in the VA, and the report has not changed in decades.

I think we need to take a hard look in the mirror. I hate to be brash, but as a veteran, I am being brutally honest. Understand.

Ms. Kroviak, will you get me those names? I want everybody that is responsible for this IG, the reporting officer, whether it is the secretary or whomever. Enough is enough. Deal.

Thank you.

Mr. Chairman, I yield.

Mr. VAN ORDEN. Thank you, Mr. Luttrell.

I just like to sum something up. You guys, the four of you have over 100 years of experience in the Veterans Administration, and nothing is going to change until one of you get fired.

I now yield to Ms. Budzinski for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman. Thank you to the witnesses.

In Dr. Kroviak's testimony, she mentioned the VA OIG encouraged VHA leaders to broadly disseminate findings from the OIG's oversight publications to all facilities to alert them of the potential

risks and to promote processes that would prevent or correct similar deficiencies at other facilities.

My question is really for any of the witnesses right now, to what extent is the VHA doing this now? There are many lessons to be learned just from the reports of the OIG findings reported. I am just curious, any reaction to that?

Ms. DEBORD. Are you asking, representative, how often we disseminate the information across the workforce?

Ms. BUDZINSKI. Yes.

Ms. DEBORD. When it has to do with something that is in my area, care management and social work and the programs that I have oversight for, we review the OIG reports, we work with those facilities that are managing those, those chiefs and execs, because we take this incredibly seriously. In my 30 years, I have done care coordination across the spectrum. We can do this better, and we really believe we can.

The integrated case management program, the Care Coordination and Integrated case management program, which we are just starting to work on as a framework with Integrated Veteran Care (IVC), we really do believe that we have some immature data that suggests that this will have an impact on veterans' trust, on some of the things that impact their health. It is new. We began this process in December. We are going to be deploying this to 12 sites across the country no later than September. They have been selected. We really believe that we can start to see the needle move.

We take our own responsibility incredibly seriously.

Ms. BUDZINSKI. Could I just follow up with Dr. Kroviak? Do you have—would you want to add anything in addition?

Dr. KROVIAK. It is challenging, and I appreciate the frustration that hundreds of reports are published. The reality is when we go into sites, though we find dedicated skilled staff, we do have repeat findings onsite specific to individual facilities. Certainly, we can go onsite to one facility and find similar findings at others. I do not have as much confidence that these reports are being disseminated or studied as a true risk assessment tool that we would hope for.

Ms. BUDZINSKI. Mm-hmm. Okay. Okay.

I have a question for Dr. Saslo. The OIG also shared their assessment of VA Video Connect, VVC. VVC is a crucial tool for older veterans, those with mobility issues, and vets living in rural areas like the district I represent. The OIG found that VHA would not—was not able to support the increased demand for VVC despite having created emergency preparation plans for disaster scenarios prior, plans created prior to the pandemic.

Dr. Saslo, I think we can all agree no one—no one anticipated obviously a pandemic like the one that we just experienced, and VHA was doing their best to care for our veterans. Now that the pandemic is over, what improvements has VHA made to the VVC program and is there a plan in place for future emergencies?

Mr. SASLO. Thank you for the question.

One of the things that I think is really relevant is the fact that VVC, as it rolled out, was something that we did as a reflex to the pandemic whereby it was already established earlier on, just not to the degree. What we learned as a result of the project itself, or the

program, is that we have a lot of opportunity to improve and also increase the way that we expand it.

We partner with our Office of Rural Health, which is looking at different modalities in which we can expand that connection piece to our most vulnerable patients. Within VHA itself, we have multiple program offices that are working in tandem with the Office of Connected Care in order to make sure that VVC is actually more robust than it ever has been before.

We are also using our opportunities with Integrated Veterans Care so that those veterans that need the care consistently and are at risk for not being able to do it in person have a consistent process that we use in order to engage them.

I do not know if you want to add anything else to that.

Ms. BUDZINSKI. Yes, and I think just a follow-up question. In rural communities in particular, when you are looking at coordination and unique challenges that they face, could you speak a little bit more to, like, what those are and how you are working through those challenges?

Mr. SASLO. One of the things that is probably the most challenging at times is bandwidth, in making sure that our veterans, who may have the opportunity to have a connected device, which we have the opportunity to provide for, does not always necessarily have the necessary bandwidth in their area in order to make those connection pieces the most stable or consistent. Our Office of Connected Care is working with a lot of the different community providers, Verizon, T Mobile, et cetera, to try to find ways that we can enhance and expand that bandwidth itself. That is definitely one of the biggest challenges I think we have seen in our successful expansion of the VVC program.

Ms. BUDZINSKI. Okay, thank you.

I think I am out of time.

I will yield back, chairwoman.

Ms. MILLER-MEEKS. Thank you, Ms. Budzinski.

The chair now recognizes Representative Radewagen.

Ms. RADEWAGEN. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley, for holding this hearing today. Thank you to the witnesses as well for your testimony.

Dr. Saslo, in your testimony you discuss VA's efforts to simplify veteran referrals to community care via the Referral Coordination Initiative, or RCI. This initiative has been in the work since before the pandemic, yet VA OIG states in their testimony that no VA facility has fully implemented RCI. They also state that there are no clear staffing models or mechanisms in place to evaluate whether staff are meeting goals.

Community care is VA care. What is VA doing to ensure that veterans do have the access and care coordination they deserve? I think this is kind of following a little bit along Eli Crane's questioning.

Mr. SASLO. Thank you for the question.

I am going to defer to Dr. Yende because I think the Integrated Veterans Care Program really can touch on some of the opportunities that we are addressing.

Dr. YENDE. Thank you for that question, Congresswoman. A couple of questions there. I will try to answer all of them.

Number one, you are right, RCI was an initiative started to help veterans understand their options for direct care and community care. At sites where it has been implemented, we have seen reduction in access times. You are absolutely right, we need to do a better job in terms of implementing RCI across the enterprise and making sure that we give some guidance in terms of staffing.

Number two, you asked a question about how we are trying to improve care coordination for community care. We started a community care program—Patient Community Care (PC3) and Choice were present prior to it, but we really started a community care program in 2018 through community care networks. Since then, we have seen a huge increase in utilization of community care.

When we implemented policies, we have very clear guidance to the field that there would be care coordinators in our community care offices. These care coordinators look at the request for community care, they do a risk stratification, which is standard care coordination process. Consider a veteran who needs to go and see an orthopedic surgeon. Let us say the veteran does not have transportation. It is the role of the community care Registered Nurse (RN) care coordinator to help the veteran make sure that there is transportation in place so that they can get to the appointment. That is an expectation from that office.

As OIG and several of you have pointed out, our care coordinators are currently siloed. We have care coordinators on the direct care side as well as we have care coordinators on the community care side. What we are trying to do with the CCICM framework, and as part of this IPT, we started last fall, is really trying to bring all the care coordinators together, identify who would be the lead and help the veteran. Now, in a given scenario where the veteran is going out to the community, let us say they are trying to get orthopedic care, the best person to coordinate that care could be the community care, care coordinator, but in some cases, it might be the PAC clinic care coordinator. We are trying to work out those processes as to who could serve as the care coordinator for those complex veterans and can help with that care coordination process.

Ms. RADEWAGEN. Thank you.

Dr. Saslo, in your testimony you note the importance of a strong care coordination between VA and community providers. However, we often hear from veterans that are either wrongfully denied community care or their community care referral is delayed. In your opinion, what can be done to streamline community care referrals? How do care coordinators fit into this process anyway?

Ms. RADEWAGEN. Thank you for the question.

I think it is important to recognize that the framework that we are talking about is not building a whole new set of case management or care coordination. What it is doing is trying to identify how best to serve that veteran's needs and if those needs happen to be for community care referral, identifying, as Dr. Yende said, the individual who has the most effective ability to ensure the veteran's care would be the person that is identified as that lead coordinator.

In turn, that lead coordinator then works with either the community partners directly or with the hospital, if the patient is going into the hospital for the orthopedic surgery, coming back, what those needs might be for the patient in order to be able to go home

safely and effectively in order to get the kind of care that they need. That lead coordinator is really going to be the piece that we are hoping will help to reduce the silos that we have had in place related to the different areas where care coordination and case management already occur. Having a lead coordinator will help us to be sure that we have got one person who is identified and within the patient's record who is easily recognized for helping to coordinate that care.

Ms. RADEWAGEN. Thank you, Chairwoman Miller-Meeks.

I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Radewagen.

It sounds as if we have too many care coordinators and not enough care coordination.

I am just going to ask that question of both Dr. Yende and Mr. Saslo. Does the VA have too many siloed care coordinators? Maybe that is the appropriate question.

Mr. SASLO. I think the fair answer to that is we do not have enough individuals working for care coordination or case management. What we have is a lack of someone being identified to be able to coordinate the multiple layers that oftentimes go with a veteran's complex care. Many of our veterans, as you are aware, have multitudes or have numerous care issues, whether it be behavioral health, medical, psychosocial, and so having one person identified as that lead will help to break down those silos working with those care coordinators or those case managers within the other arena so that the care is now identified as a responsible process and that we can have communication that is going to be a lot more effective.

Dr. Yende.

Ms. MILLER-MEEKS. Dr. Yende.

Dr. YENDE. Yes, and if I may give an example. You rightly pointed out we have silos, but let us take a veteran—I think one of the panelists are going to describe a veteran who had PTSD, who had issues with cancer care, which was going out into the community, and had other issues that they had to address. Care coordination is a fairly sort of sophisticated function. People need to have an understanding in terms of care coordination in that particular area. Imagine that veteran who needs care coordination for their mental health and needs care coordination when they go out in the community. Both these skills will not be available in that same one individual. We need to have care coordinators in these individual areas within VHA. What you have rightly pointed out is assuming that these care coordinators are providing the support to the veteran, how does all this get coordinated? That is exactly what we are trying to do with CCICM.

Also, please understand that care coordination is not a static function. A veteran on a given day might need help with oncology care, and the oncology navigator or care coordinator may have to step in and guide the veteran. Three months from now, the mental health issues may become more predominant, at which point the mental health coordinator who has the necessary expertise in that area needs to step in. We really are trying to design a system that can accommodate the veterans dynamic needs, rather than saying there is one person who is always going to coordinate all of your

care throughout your lifetime. That is really what we are trying to achieve here.

Ms. MILLER-MEEKS. Our witnesses on the second panel recommend that the VA establish essentially a coordinator for the coordination, either at the facility or the Veterans Integrated Services Network (VISN) level. Maybe what is required is that there is one coordinator assigned to the veteran instead of a facility coordinator who then coordinates only a specific medical entity or a specific problem.

One of today's witnesses referenced the Federal Recovery Care, FRC, Coordinator program and its utility during the surge of complex injuries post 9/11. Why did the VA move away from this program, and how is your latest care coordination IPT using any lessons learned from this joint DoD VA program?

Mr. Saslo.

Mr. SASLO. I am going to ask Ms. Debord to go ahead and take that.

Ms. DEBORD. Yes, ma'am.

What I would say, representative, is that as far as the FRCs, they were really very critical right in the wake of the Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) conflict. We were really intensively elevating everything that was happening on for care coordination very high and just hitting it hot. I would say today what we are doing with CCICM, which I am talking with our Quality of Life Foundation and Wounded Warrior Project colleagues, is that we have an opportunity to take CCICM, this lead coordinator, and elevate that person's authority, their knowledge base of all systems, so that that person really can do a similar job as what they did in the FRC.

I think what we are hoping to do, and again, it is new, we recognize that we are in the infancy, but as we continue to roll this out, that the training allows these people an elevated status, that they know multiple systems, they speak multiple different languages, DoD, community care, VA, and are able to help the veterans navigate those systems and feel the authority to elevate things when things are not getting through that need to happen.

Ms. MILLER-MEEKS. [Audio malfunction] program that was working. It is not the status that is required, it is that the coordination is given.

With that, I am going to thank our witnesses on the behalf of the subcommittee for their testimony for presenting to us today. You are now excused.

We will resume with the second panel after we go vote. We will resume after votes.

[Recess]

Ms. MILLER-MEEKS. Welcome everyone and thank you for your participation today.

On our second panel, we have Ms. Andrea Sawyer, advocacy director with the Quality of Life Foundation, Mr. Matt Brady, director of Complex Case Coordination Program with the Wounded Warrior Project, and Mr. Roscoe Butler, senior health policy advisor with Paralyzed Veterans of America (PVA).

Ms. Sawyer, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF ANDREA SAWYER

Ms. SAWYER. Good afternoon, Madam Chairwoman, and members of the subcommittee. My name is Andrea Sawyer, and I am the advocacy director for the Quality of Life Foundation, a national nonprofit organization founded to address the unmet needs of caregivers and the Nation's most seriously wounded, ill, and injured veterans.

We have evolved directly to work with veterans and caregivers as they attempt to apply for and navigate the Program of Comprehensive Assistance for Family Caregivers and other clinical support programs within the Department of Veterans Affairs. Serving all generations and focusing the majority of our time on those with significant wounds, illnesses or injuries, we often assist those with complex clinical needs.

Additionally, I am the wife of a seriously injured medically, retired and medically complex combat injured veteran, and I have been managing his care since his return in 2007.

As one of the few organizations working exclusively with the Veterans Health Administration, Quality of Life Foundation has had a front row seat to witness and help others utilize many of the programs and services available within the VA. While we do not provide clinical recommendations of any kind, our role is to ensure that veterans and caregivers are prepared for the Program of Comprehensive Assistance for Family Caregivers (PCAFC) process, assist in the drafting of clinical appeals to ensure the VA is following its own regulations and directives, and we assist veterans and caregivers in navigating other programs and supports available to them within and outside of the VA, specifically the Veterans Health Administration.

Through our work directly with veterans and their caregivers, done so, by reviewing the medical record, we help advocate for the population we serve within all VHA programs. Many of the cases that come to us have a lack of whole health coordination and management. Many have some basic care coordination, better known as a primary care treatment plan, some have care managers who resolve simple issues or referrals through low level intervention. However, many of our veterans have multiple complex care needs and no one to create a case coordination and case management plan. VA is severely lacking in case management services. Case management is a time intensive level of care management that looks at a veteran holistically to document and manage all the veteran's conditions and any social/environmental issues that develop as a result of the care needs of the veteran.

As such, Quality of Life Foundation makes the following recommendations: number one, create a cadre of specially trained case managers similar to the Federal Recovery Care Coordination Program as envisioned by the Dole-Shalala Commission, who can manage the most complex cases by developing comprehensive treatment plans for each need that a veteran has. These case managers should have a VISN level lead. Second, ease the process of obtaining a case manager. Per our written testimony, it is hard to ask for what one does not know about. Third, review the current community care network and outside provider records' integration process. Fourth, review the actual caseloads of different care and case

management and social work teams across the VA and ensure that different roles are being filled as individual jobs and not as collateral duties. Fifth, establish a "pathway to advocacy" for outside organizations to officially assist veterans and caregivers within VHA so that all veteran service organizations and non-profit organizations are able to effectively advocate within VHA.

In conclusion, Quality of Life Foundation believes VA needs to simply realign their resources and bring back older, more robust models of case management for those most severely impacted veterans. These program models have existed in the past, but then case management was siloed, and veterans suffered. The original veteran driven case management plans, not current vet centric plans, should allow the veterans treatment goals to be the focus of the plan. Allowing Veterans Service Organizations (VSOs) and nonprofit organizations to advocate for care that exists within the system would also help veterans and facilities focus on the needs of veterans. Veterans would get more timely appropriate care with the help of a holistic full-time case manager with authority to cut through VA red tape. Veterans with lesser care needs would then have access to lower-level care managers available to them.

Overall, VA would save money if veterans are able to get timely appropriate care that is managed across the spectrum of the medical community, and veterans would have better health outcomes and quality of life.

Thank you for your time, and I look forward to answering any questions you may have, especially about the Federal Recovery Care Coordination Program. Thank you.

[THE PREPARED STATEMENT OF ANDREA SAWYER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Sawyer.

Mr. Brady, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF MATT BRADY

Mr. BRADY. Thank you, Chairwoman Miller-Meeks, ranking member, and distinguished members of the Health Subcommittee for this opportunity to speak about care coordination at the VA.

As you know, effective care coordination not only produces better outcomes, but gives the veteran confidence in their system of health. To frame the issue of today's hearing from Wounded Warrior Project's perspective, our goal is to help warriors receive the appropriate care in a timely manner in the setting they want. We provide care coordination as part of three programs.

The first is our Complex Case Coordination Program, which helps veterans with complex cases that are multifaceted and need urgent action to address mental and physical healthcare needs utilizing high quality VA or community-based services.

The second is our Independence Program, which helps veterans with moderate to severe brain injury, paralysis, and neurological conditions live more independently with a better quality of life.

The final is Warrior Care Network, which aims to reduce gaps and inefficiencies in mental healthcare delivery through innovation and collaboration.

Based on these programs, we have a number of recommendations for Congress to consider, all of which are outlined in our written statement. Today, I want to point out three specific bills and discuss some targeted ideas that may inspire future bills for the subcommittee.

The first bill is H.R. 3520, the Veteran Care Improvement Act, specifically section 2, which would codify an access to care standard for the VA's mental health Residential Rehabilitation Treatment Programs (RRTPs). If somebody today decides to turn their life around, ask for help with substance or mental healthcare, why would we allow them to wait 30 days to get that care? If this was your family member, you would not find this acceptable. We can do better. I know we can do better also. Additionally, we can do a better job communicating of records between the VA and the community residential care facilities, address follow on care, and medication needs.

The second bill that I will highlight is H.R. 452, Elizabeth Dole Home Care Act. A key provision would instruct the VA to provide informal geriatric and extended care program assessment tools to give options to the eligible veteran and caregiver, letting them decide which programs are appropriate for them. If a caregiver is denied or discharged from the caregiver program, the VA needs to help find and enroll them in other VA provided home based care and support.

Last, I will note our support for S. 1792, the Care Act. Section 3 has the potential to transform how organizations like ours advocate for veterans and their family members in navigating VHA programs and services.

Our organization has been delivering this kind of help for thousands of veterans, and we know the life changing impact that an advocate can have when people need help.

To that end, I would like to close by speaking to our interest in seeing the VA create a system that helps centralize care coordination and patient advocacy, particularly for those with complex needs. There are several pilot programs across VHA that are currently exploring how we can improve integrated case management, but the fact is, veterans need consistent, coordinated care no. We understand the VA, like many organizations, continue to experience staff shortages in critical areas. We appreciate everyone who chooses to work to make veterans lives better.

Our recommendation can be instituted rather quickly. Designate a lead social worker, your best social worker—you know who they are—at each VA medical center. Have them serve as the lead for advocates to address critical coordination issues, serve as the organization's subject matter expert, and most importantly, having the authority to cross service lines and facilitate immediate assistance.

Care coordination is only part of the solution. We must also empower veterans and advocates with the knowledge about the access to care standards and their options in care, help them actively participate in their care pipe, providing them with information, resources, and education, allowing the veteran to make informed decisions, effectively communicate their needs, and take ownership of their health.

Thank you again for the opportunity to testify. I look forward to your questions.

[THE PREPARED STATEMENT OF MATT BRADY APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Brady.

Mr. Butler, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF ROSCOE BUTLER

Mr. BUTLER. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on VA's efforts to coordinate veterans care.

Veterans with complex healthcare conditions, like spinal cord injuries or disorders, receive care from various healthcare professionals to include primary care physicians, a wide range of specialists, visiting nurses, and caregivers, many of whom are family members. This care is provided through a number of service points. It may be provided at one of VA's 25 Spinal Cord Injury and Disease (SCID) centers, through VA's 6 long-term care centers, or at other VA facilities. Care may also be provided through community care providers, in state veterans or community nursing homes, or in veterans residents. This often poses a difficult challenge to the many dedicated professionals who are working tirelessly to ensure that the delivery of high quality acute and long-term care is administered by the right providers in order to achieve optimum care outcomes for veterans.

However, when coordinating care outside of the Department, VA's ability to coordinate care drops dramatically because most civilian facilities and agencies are not knowledgeable or equipped or properly staffed to handle SCID patients' acute and long-term care needs. PVA is concerned about VA's current lack of long-term care beds, which is severely impairing its ability to coordinate care for veterans with SCIDs. More than half of the veterans on VA's SCID registry are over the age of 65, and the number of veterans needing this level of care is increasing rapidly. Nationwide, there are very few long-term care facilities capable of approximately serving veterans with SCID, and only one of VA's six specialized long-term care facilities lies west of the Mississippi River.

Today, VA care coordinators spend a tremendous amount of their time attempting to locate providers, facilities, or agencies in the private sector to meet SCID veterans' long-term care needs. To be clear, these were scarce prior to COVID, and VA SCID care coordinators tell us they are getting scarcer. Nursing home and home health agencies often pursue contacts with VA, but do not maintain them long enough once they find they lack the necessary training to perform the critical tasks, like bowel and bladder care, that some veterans with SCID need. Facilities lacking proper staffing are often unwilling to procure additional personnel for SCID veterans whose greater care needs consume a larger than anticipated share of their existing workforce time. Even if they are willing to hire additional personnel, nationwide provider and nursing shortages will often preclude them from finding the personnel that they

need. These starts and stops are frustrating to veterans and those who coordinate their care.

The 65 percent statutory cap on what VA can pay for home care can almost impact care coordination because it limits care options which may contribute to unfortunate results.

In light of the limited access to VA facility, long-term care, and the desire of many veterans with SCID to receive noninstitutional long-term care, VA must expand access to home and community based services to meet the growing demand for long-term care services and supports. Facility based long-term care services are expensive, with institutional cares exceeding costs of Home and Community Based Services (HCBS). Studies have shown that expanding HCBS entails a short-term increase in spending followed by a slower rate of institutional spending and overall long-term care cost containment. Reduction in costs can be achieved by transitioning and diverting veterans from nursing home care to HCBS if they prefer it and the care provided meets their needs. Passage of H.R. 542, the Elizabeth Dole Home and Community Based Services for Veterans and Caregiver Act, would address many of these barriers to care. I cannot stress enough how important it is for Congress to pass this important legislation sooner rather than later.

PVA appreciates the subcommittee's interest in this critical area, and I would be happy to answer any questions you may have.

[THE PREPARED STATEMENT OF ROSCOE BUTLER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Butler.

I will defer my questions until the end so that other members can address the panel. I now recognize Ranking Member Brownley for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair. I am sorry that I was not able to be here for the panel one discussion, but I did read the testimony.

This question really is for any of you. We heard today from the VA and their testimony about they are rolling out a new care coordination framework and management system to have one point of contact within a patient's primary care team to help ensure veterans needs are met. Based on what you heard today, and this is are you confused as I am? 'Cause and I am curious to know if you have heard of this program before today because for me, it was the first time I had ever—I mean, I read the testimony, but it was the first time I became aware that this was -this was underway. Do any of you think that this is going to solve the problem?

Ms. SAWYER. I am going to put on two hats here. I am the advocacy director at Quality of Life Foundation, but I am also a caregiver for a warrior who returned in 2007 and was severely injured with multiple conditions that we had to manage.

I would tell you that CC&ICM with lead coordinator has existed probably since the dawn of time. What we used to call it was you needed a case manager for your case managers. For those of us who had warriors coming back at the beginning of the war, 2006, 2007, I had a bazillion case managers on the DoD side and transitioning over to VA, I just add more to the layers. Everybody was talking past each other. Originally the person managing those was me until we met up with the person, who at that time, was

head of the newly stood up Federal Recovery Care Coordination Program. I managed to get a case manager for my case managers. That person had Federal level authority across DoD, VA, Medicare, and could work in Social Security programs.

For my warrior, and for many others that had that same level of case management need, that program was there. If we were only within the VA, the person that would have handled care would have been OIF/OEF, which is now the Post 9/11 military2VA (M2VA) Office or potentially a polytrauma case manager.

Those models have changed through the years. Basically, the FRC program rolled down into kind of a consultant basis, but then a consultant on just the VA employee/facility side. A VA facility consults the FRC program, you no longer have interaction with the warrior. As organizations we can refer people to the program. They look through the record, and then they can contact the facility which, if they have a difficult case, can engage the program. Basically, if you do not know they exist—and there are, I believe, only ten, I think, within the VA now, where there used to be, I think, a robust program of 75 or more across the country. That number may be a little elevated. They just do not exist like they did anymore. There is certainly not that level of case management at any facility.

Do I know that CC&ICM is rolling out again? Yes. Do I think it is something we had before? Yes. Was it adequate? No. That is why Dole-Shalala stood up the FRC program.

When I was listening to the VA testify and they said that we came in hot and heavy and we kind of triaged folks and took care of them. What I would like to say to the VA as the caregiver of one of those warriors is just because you changed your model of case management did not mean that my veteran did not have the same needs. Basically, they took away our—not in our case, because I fought like the devil to keep our FRC—but in a lot of cases, they just took away these case managers and left caregivers to navigate the system on our own. As a caregiver, while I am good at that, that is not my intended role. It is to provide that daily support and supervision; it is not to medically case manage them.

I had to go to Veteran's Affairs Central Office (VACO) and fight very hard to get a coordinated treatment care plan that still exists today for my warrior and in a lot of cases, for advocacy. I am so sorry. That is what I advocate for some of our most seriously injured or impacted cases and what their caregivers do for their warriors also. We talk about how we get it done, how to get it done.

Ms. BROWNLEY. Well, thank you for that. Your warrior was very lucky to have you.

I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

I now recognize Representative Van Orden for any questions he may have.

Mr. VAN ORDEN. Thank you, Madam Chairwoman.

Ms. Sawyer, I read your testimony. It was gut wrenching. I want to know, is that veteran in Arkansas?

Ms. SAWYER. Yes, sir?

Mr. VAN ORDEN. Who is their congressperson?

Ms. SAWYER. I cannot tell you who their congressperson is on the House side. I am so sorry.

Mr. VAN ORDEN. Will you do me a favor?

Ms. SAWYER. I will find that. We work with Senator Boozman a lot.

Mr. VAN ORDEN. Okay. Please do. I would like to speak to him or her personally about this.

Ms. SAWYER. Yes.

Mr. VAN ORDEN. I want to make sure that this issue is resolved. In that spirit, I would like the name of every single person that that veteran has come in contact with, because I will be holding them directly accountable.

Ms. SAWYER. Well, I appreciate that.

Mr. VAN ORDEN. Okay.

Ms. SAWYER. I will say your staff has been involved in that case with me since 2016, and the staff on this committee has been wonderful to work with.

Mr. VAN ORDEN. They are awesome.

Ms. SAWYER. Yes, they are.

Mr. Van Orden. Okay.

In the break, I did not just vote, I had my crack graphics team develop something to help the Veterans Administration figure some stuff out. That is a wheel. It has been invented long time ago. I will give this to you if you would like. You can take it home, put it on your desk. You are reinventing the wheel, and the ranking member, boom, spot on. You have got institutional knowledge of the Veterans' Affairs Committee. If she does not know that it is going on and our chairwoman, nobody does.

Command Sergeant Major, you put in here that a lot of veterans in this population remain confused by the number and types of VA services, employees roles, their delivery and eligibility criteria. Okay. You wrote that. I got, I do not know, 300, 400 Facebook messages and emails and phone calls. I know that Congresswoman Kiggans did also because the Veterans Administration was capable of pumping out some ludicrously political garbage on their website, terrifying our veterans. Everybody knew about that. It was a lie. The Veterans Administration lied for political purposes to our veterans, terrified them, and that went out like on a coconut wire, dude. Our veterans do not know the services that are available to them, and that is shameful. We are waiting for a public apology from the Department of Veterans Affairs and waiting for them to use their public affairs officers to get out the word, the truth, to tell people the services that are available, because they are available. The Veterans Administration, they work so hard. I am incredibly proud of our VA. I get all of my healthcare through the VA. I am 100 percent service-connected, disabled veteran, and I go to Tomah, and I am proud of them. I was just there last week. I told them I am proud of them.

Ms. Sawyer, I am going to have to disagree with part of your testimony here.

Ms. SAWYER. Okay.

Mr. VAN ORDEN. This is why—you are good. The establishment of a cadre of specially trained case managers. No. The Veterans' Affairs Committee has not done what the command sergeant major

would call troop to task. They got plenty of people sitting around, and they are working, and they are qualified, and they are dedicated, but they need to do troop to task, command sergeant major. They need to be able to draw a line and block chart where I can put my finger on it and say, this person is directly responsible for this veteran's care. If that veteran winds up committing suicide, that person, not a system——

Ms. SAWYER. Right.

Mr. VAN ORDEN.—of a series of things. The system is not responsible, an individual is responsible. That is what you guys need to do. I will be frank with you, the only thing missing from the word salad testimony that you guys gave today was a bucket of ranch dressing. It is unacceptable. Use 50,000 words to say nothing. We are not taking this anymore. I will not allow our veterans to be disabused or ignored or commit suicide because a bunch of bureaucrats cannot get their act together.

Mrs Sawyer, you are doing God's work, Command Sergeant Major, you are too, Mr. Butler, you have my undying support. Thank you very much for what you are doing.

With that, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Van Orden.

I now recognize Representative Kiggans for any questions she may have for 5 minutes.

Ms. KIGGANS. Thank you very much, Madam Chair.

I do not necessarily have any questions, just a couple of comments to piggyback off of Mr. Van Orden's remarks.

I was geriatric primary care nurse practitioner. For me and having to coordinate care with the Veteran Administration on a civilian side, I know we are doing some good work with community care and really trying to incorporate them. Half the battle, maybe it is in charting. I know we are working through some of the charting systems with the VA. I hope that is a step in the right direction. Having patients that receive just VA healthcare, I would almost throw up my hands. Getting the charts, the diagnosis, the med list from VA was next to impossible. We would just kind of write it off if he got care at the VA, and the caregiver would then—it would be their responsibility to try to communicate with the civilian provider what happened to the VA and vice versa. We can do so much better.

I know Mr. Van Orden hit on the fact that when we had that little political stunt about Republicans taking away veteran benefits, which again fabricated lie, but I too received multiple hundreds, like you said, of comments and emails saying, why are you taking away my healthcare. The VA has the capability to get that word out to veterans. Use it in a constructive, good manner, not for political games, which we hate. That is I know why I ran for office, to not do those things and to advocate for our veterans, for our military men and women.

We need to prioritize. I know that so many of us on this committee today are willing to work to do that, especially those of us who are veterans, who are healthcare providers. I think we understand that language. We are going to work together to make sure the word gets to our veterans.

I am having to hold an event in my district to inform veterans what resources are out there. I am having to put that event together. The VA should be doing these types of things and educating. I know as a primary care provider, it was so hard for me to understand what resources were available to veterans, to caregivers, and their families. It should not be that hard. I do not know, the VA should be educating providers, primary care providers especially. We can do so much better. We are going to work together and get that job done for you all.

Thank you for your advocacy and work as well.

I yield back.

Mr. VAN ORDEN. We will do a second round of questioning and I would like to recognize our ranking member for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chair. I appreciate it very much.

Ms. Sawyer, going back to your conversation on my first question.

Ms. SAWYER. Sure.

Ms. BROWNLEY. You are recommending, you know, a case management social work lead operation. Sounds more like going back to the good old days where it was working better, correct?

Ms. SAWYER. Yes, ma'am.

Ms. BROWNLEY. More or less. You are suggesting that the point that this should happen at the VISN level. Let me just say, I think for some of us who have served on this committee for a while, and I am one of those, we get really nervous when the VISN has control of something that we believe is very important and critical to the health outcomes for our veterans. Because the VISN has medical centers, VISNs, they have their autonomy and kind of - kind of do things the way they want to do things.

Ms. SAWYER. Right.

Ms. BROWNLEY. I get very frustrated because we have got - we have got a gazillion people with coordinator titles out there, but some of them have, you know, a tenth of an Full-time Equivalency (FTE) or, you know, whatever.

Ms. SAWYER. Right.

Ms. BROWNLEY. Tell me why that is where you want to start.

Ms. SAWYER. I actually want to start in the facility levels. Okay. That is a little bit of a—I think in the oral statements it gets a little lost. I want to start at the local facility levels. It is not that I think there are tons of care coordinators out there and care managers, which are—care managers are really defined by single disease or injury or condition. I want at the local level some of those folks, instead of being siloed in their care management roles, to be trained for full holistic case management of the veteran. Right now, at the VISN level, there is no person for a case manager to go to. I would like that there is like the VACO level should exist at the facility level but does not and there is no layer in between. There is no authority of that case manager to do anything. That would be the reason to add a level at an intermediate level at the VISN to give that case manager some authority.

Also going back to another part of that plan, when we talked about those Federal individual recovery plans, that is what an FRC put together, it was a veteran led plan where the veteran said what he wanted his care management goals to be. Currently, VA

leads a vet centric model where the veteran is at the center and the VA tells the veteran what they are going to give them. We want it to be the other way around.

Really, the third thing we would like to do is for VA to have some more centralized authority as far as case management is concerned. Right now, what we see is standardized authority throughout the VA, which allows every single medical facility and every single VISN, as you said, to kind of look at what the standard is and then apply it as they see fit. There is no, as we said, again and again, accountability because everybody can say, oh, well, it was standardized, it is not centralized authority, it is just standardized. It is a suggestion that I just have to fulfill. We want it to be a more centralized authority so that there is someone to hold accountable. Here is your model, here is what you are required to do, and should you fail to do that and should there be a medical consequence for this patient, there is someone to hold accountable when, God forbid, somebody winds up in the hospital because their care was not coordinated, and then they have an infection that is bad enough that they lose their leg, which is what is looking like it is going to happen in our case in Ohio.

Ms. BROWNLEY. Thank you for that.

Mr. Brady and Mr. Butler both, thank you for mentioning the Elizabeth Dole bill. I appreciate that very much.

I wanted to ask you, Mr. Brady, you talked about the -you talked about I guess it is a nomenclature problem that you talked about in terms of younger veterans and the way we recognize some of the long-term care services, geriatrics, and so forth, that can be pretty confusing and may stigmatize, et cetera. Do you have some suggestions around destigmatizing and improving outreach efforts for younger veterans who may need the long-term care services?

Mr. BRADY. Rank member, thank you.

Yes, absolutely. The first easiest thing to do is to not have every picture of geriatric care being somebody over the age of 70. That is the first easiest thing. We had a meeting with Health and Human Services to talk about where there was potentially some overlap in services that they could be giving. The conversation centered around everybody in the room looking at every picture, every website, and there is no way that warriors see, veterans see themselves as that. I still feel I am 34. My wife tells me, no, you are not. When I look at those pictures, I do not see myself in there.

Ms. BROWNLEY. Yes.

Mr. BRADY. We need to get veterans that are closer to that age, right and then discuss geriatric in a different light with them, right. Advanced care, advanced age, advanced veteran, and stay away from geriatric.

Ms. BRADY. That would be my suggestion.

Ms. BROWNLEY. Very good. Yes, very good. Thank you very much. I yield back, Madam Chair.

Ms. MILLER-MEEKS. Thank you.

Mr. Butler, thank you very much for your testimony. In my younger years as a nurse in the Army, I was on the neurosurgery floor on Walter Reed on Ward 10 and turned a number of striker frames and worked with spinal cord injured veterans quite a bit, as did my husband, who is a nurse.

In your testimony you mentioned the importance of coordinated care in this population, the SCID community, and what strengths in the hub and spoke model of care could work in other areas of VA care, and should the VA focus more on complex populations like your membership, rather than investing in numerous coordinators who try to manage a more basic general population?

Mr. BUTLER. Thank you, Chairwoman Miller-Meeks, for that question.

VA has an excellent model, VA's spinal cord injury system of care. One thing that they could do is examine that model and why is that model so superior to the coordination of care throughout the SCID program in comparison to care outside of that system? They may find that there is some uniqueness in the way the SCID care is delivered throughout that system that they can use throughout the entire VA healthcare system to gain some leverage in the coordination of care outside the SCID system of care.

Ms. MILLER-MEEKS. As a template, then?

Mr. BUTLER. Yes.

Ms. MILLER-MEEKS. Ms. Sawyer, in your testimony—you and Mr. Brady both mentioned the Federal Recovery Coordinator program. As you heard me in the last panel—and I thank the previous panel for still being here—you heard me say the old adage, if it ain't broke, don't fix it. It sounds like we developed an FRC program in order to fix the deficits after 9/11 in coordination of care, and it seemed to be working.

What were the strengths in that program that should be continued and what were the barriers that proved to limit continued implementation today?

Mr. BRADY. Sure, I will go. Chairwoman, great question.

When it was in full implementation, the FRC had great latitude in which to really execute, right, the plan for the warrior to execute where it was going to go, not just in the DoD, but the VA, the benefits, the Social Security Administration. This incredible amount of latitude in which to work really centered on the injured veteran. I think the problem with that is we got away from that and now we are at a level where there is not the direct interaction, there is not the direct care with developing the care plan with the veteran.

There is a level of ownership I think when you are an advocate, when you are somebody in a Federal Recovery Coordinator, there is some ownership in the people you deal with and how you treat them and where you see them going. I think that we have gotten to a point where there is much fewer, they are farther in between. This may have been the consequence of obviously a drop in the amount of wounded veterans coming back.

That is what I would say.

Ms. MILLER-MEEKS. It sounds like what you are saying is that we are going from a program that worked but had less wounded veterans coming back from war to now a bureaucracy centered coordinator rather than a veteran centered coordinator or case manager.

Ms. Sawyer, you talk about seeing veterans with case care managers who typically manage one clinic or one specific disease program, which is what I mentioned earlier. That seems to align with

what the committee sees as multiple layers of coordinators, advocates, and champions that have little overlap in function and limited ability to extend past their respective silos. I know I am running out of time, but what does the VA need to do to truly provide care coordination with veterans with complex needs? Then in writing, if the three of you could submit to the committee, are there any organizations outside of the VA—outside of the VA, any health systems that you think do case management and care coordination especially well? If you could refer that to us.

Ms. SAWYER. I will be glad to do that. There are several of that are out there.

One of the things I wanted to respond to with that and with your question, we do see these very siloed case managers. One of the reasons I said a specially trained cadre is not because I think VA needs to add more employees. I do not. I think we need to realign the employees we have. I do agree with the VA when they stated that care managers are very single, focused, and siloed, but what you need is a person who is trained to be able to look at all of those clinical needs together, and it is simply just a—so when I said a specially trained cadre, I simply mean that you take some of those people who are individually siloed and train them to be an across the board case manager, to look at all of these individual care plans that each specialist puts in place, see where they overlap, see where they are contra indicated, and be able to weave those things out, give your family a single point of contact, and be accountable to see that each one of these plans and needs that the warrior has can do that—or they can be accountable for that and for helping manage that.

I also think it is important that that person be responsible for portraying to the VA what the veteran wants. I feel like in this system a lot of times as a caregiver with a veteran and with the cases that I work also, is that I have the VA telling me a lot of the times what we are going to do, and it does not fit in with what we want to do. That is not something in the civilian medical model that we deal with.

Sorry.

Ms. MILLER-MEEKS. Thank you.

I know all of you would want to answer that question. I have already gone over my time.

Ranking Member Brownley, would you like to make any closing remarks?

Ms. BROWNLEY. Thank you, Madam Chair.

I will just say that I think this is a really, really important discussion, and we have not even touched upon some other care coordinators in the VA. For example, for women veterans, all of their, if they become pregnant, all of their healthcare needs are outside of the VA. There is a coordinator for that to make sure, but you know, they do not even have the chance, really, except for their primary caregiver, not even have a chance within the VA that somebody might pick them up and advocate for them in terms of services they need. They are—they are lost on the outside.

I have spent some time going to other medical centers across the country. We made a lot of trips, I think, 2 years ago, but spent a lot of time in Texas and Oklahoma. I mean, every medical center

that we went to, the maternity coordinator was well way overworked, way, way, way overworked. No way that she or he could possibly manage the caseload that they had.

I think this is an important conversation to have. I think we have to even dig deeper, and I think we need to watch carefully what the VA is doing in terms of a solution and say our piece.

With that, I will yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

I would like to thank everyone for their participation in today's hearing and for the productive conversation. It is one of my priorities, and I know the same goes for my colleagues on both sides of the aisle, to take care of all veterans and to ensure that care is being properly coordinated to meet both the patient's needs, the family's needs, and improve health outcomes. No veteran should be left in the dark about their ongoing medical care or the coordination of that care.

I look forward to working on these issues and many more with the Department, the stakeholders, and my colleagues on this subcommittee.

The complete written statements of today's witnesses will be entered into the hearing record.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Again, I would ask our panelists to provide for us any medical care healthcare systems that you think does an exemplary job of case management care coordination hearing.

Hearing no objections, so ordered.

I thank the members and the witnesses for their attendance and participation today. This hearing is now adjourned.

[Whereupon, at 3:17 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESSES

Prepared Statement of M. Christopher Saslo

Good morning, Chairman Miller-Meeks, Ranking Member Brownley and distinguished Members of the Subcommittee. Thank you for the opportunity today to discuss VHA's various care coordination programs within VA, community providers and emergency services. Accompanying me today is Dr. Sachin Yende, Chief Medical Officer, Office of Integrated Veteran Care (IVC), Dr. Jennifer A. Strawn, DNP, RN, NEA-BC, Executive Director, Office of Nursing Services/Deputy Chief Nursing Officer, and Ms. Jill DeBord, LCSW, Executive Director Care Management & Social Work Services.

Overview

The number of Veterans using VA care over the past 5 years has grown 6 percent and, generally, the Veteran patient population who utilizes VA has more complex medical and social needs than the general population. VA provides a broad array of services that must be coordinated across the VA network to meet the unique needs of the Veterans we serve. Care coordination is a system-wide approach to the deliberate organization of all Veteran care activities to facilitate the appropriate delivery of health care services across all settings. Care coordination exists within the individual programs, including primary, specialty, mental health, and emergency care as well as long-term, and social work services and what we have learned is Veterans move across these different programs. In addition, as use of community care increases, care coordination of services within VHA and the community is increasingly more complex and common.

VHA is deploying an overarching framework called Care Coordination and Integrated Case Management (CCICM), which coordinates the work between various programs within the enterprise, so Veterans have one point of contact to assist with their care needs. In December 2022, VHA established an integrated project team (IPT) between CCICM and the Office of Integrated Veteran Care (IVC). The IPT aimed to enhance operations between CCICM and IVC to increase VHA's ability to offer collaborative, coordinated and seamless care experience(s) for Veterans. The goal is to expand and leverage pre-existing CCICM processes, procedures, and reporting throughout the health care continuum to include Referral Coordination (RCI) and IVC initiatives to further enhance VHA's ability to offer collaborative and coordinated care for Veterans. VHA will start implementing recommended IPT enhancements this fiscal year across the enterprise for the most vulnerable Veterans who require moderate to complex care coordination.

A Patient Aligned Care Team (PACT) involves a team of health care professionals working together with each individual veteran, to plan for life-long health and wellness that addresses the whole person. A PACT achieves coordinated care through deliberate collaboration. Team members meet often to talk with Veterans and each other, discussing the patient's health care goals and the progress toward achieving them. They coordinate all aspects of the Veteran's health care within the PACT and with other care teams outside the primary care system, as needed.

PACT members coordinate the Veteran's care from the primary care team to specialists and other health care professionals who are part of the Veteran's health care plan. If needed, the care team coordinates the transition during emergency room services, inpatient stays, or dual care with non-VA clinicians. In addition, they work with the Veteran on private sector referrals and arrange for community resources when needed. The focus is on building trusted, personal relationships that promote open communication and sharing of information. The goals include improved quality of care and patient safety.

Enhancing Collaboration Between VA and Community Providers

Strong care coordination between VA and community providers ensures Veterans receive timely and high-quality care regardless of where that care is provided. VA's care coordination model is a Veteran-centered, team-based approach, which involves

receiving the request for community care, assessing the Veteran's needs, developing and implementing a care coordination plan, and ensuring appropriate follow-up.

With the Community Embedded Staff Program, one or more VA staff members are physically or virtually stationed at community facilities within their respective markets. Within this program, an embedded nurse or community liaison collaborates with community hospitals to improve care coordination and Veterans' experiences. This team of nurses, social workers, care coordinators, or a combination thereof, works to coordinate care for Veterans who present to a community hospital, including working closely with those providers to create an integrated care plan for the Veteran, attempting transfer to the appropriate level of care (nursing home, VA hospital, rehabilitation clinic), or connecting with a VA PACT provider.

Another such example is the VA Liaison Program which has integrated VA Liaisons for Healthcare, who are VA social workers and nurses, with public-private partnership (P3) sites to coordinate an individualized transition into VA health care for Veterans who receive specialized treatment at a P3 site. VA Liaisons for Healthcare are assigned to each site in Wounded Warrior Project's Warrior Care Network, which consists of four academic medical centers that specialize in posttraumatic stress disorder, and six Avalon Action Alliance sites that offer an intensive outpatient program to treat brain injuries.

Referral Coordination Initiative

VA is continuing our efforts to simplify a provider's referral of a Veteran to another provider. The Referral Coordination Initiative (RCI) aims to ensure Veterans have comprehensive information about their care options at the time of scheduling. Referral coordination teams include local staff with administrative and clinical expertise who talk with Veterans about their available care options with a VA provider, in-person or virtually, or when eligible, through the Veterans Community Care Program.

In August 2022, we released a systemwide update that allows clinicians to capture the clinically appropriate care options for these referrals. Additionally, the staff scheduling the requested care can document discussions with Veterans regarding the full range of care options and the outcome of that conversation. As of December 2022, we have seen a 24 percent improvement in scheduling internal consults for key RCI specialties across VHA, with average times decreasing from 10.4 days to 7.9 days. We continue to improve and standardize documentation and discussion notes, as well as roles and responsibilities for the referral coordination teams. Additional guidance will be included in the new Consult Management policy expected later this year.

Ensuring Coordination for Mental Health and Emergency Services

Section 201 of the Veterans COMPACT Act of 2020 (Public Law 116–214) expanded eligibility for emergent suicide care for Veterans (as defined in 38 U.S.C.§ 101) and former Service members described in 38 U.S.C. § 1720I(b), in acute suicidal crisis. Care can be provided in VA and non-VA facilities for medical and mental health needs associated with the acute suicidal crisis for a period of up to 30 days for inpatient or crisis residential care and up to 90 days for outpatient care.

To optimize acute suicidal crisis care while ensuring Veterans' care is optimally delivered, VA is piloting a program to establish a network of dedicated Care Coordinators at VA medical centers. Leveraging the CCICM team structure, the pilot will fund five VHA facilities with acute psychiatric admissions and five VHA facilities with no acute psychiatric unit. This effort will ensure optimal coordination across potential medical and mental health services, ensure efficient navigation through both the VA and non-VA systems, provide Veterans or other individuals with a single resource to ensure optimal resolution of the suicidal crisis event, and provide VA with invaluable information on best practice models for expansion.

Care Coordination for Specific Veteran Populations

Rural and Elderly Veterans

VA employs close to 19,000 clinical social workers. These dedicated employees provide clinical assessment and interventions that include care coordination and case management across all areas of programming, including for Veterans residing in rural and highly rural areas, and elderly Veterans.

In FY 2019, Veteran Health Administration (VHA) enrollees ages 65 and older accounted for 48 percent of all VHA enrollees, 57 percent of all VHA rural health enrollees, 64 percent of all VHA acute care hospital admissions, and 59 percent of all VHA expenditures. VHA enrollee projects between FY 2019 and FY 2039 include

projected 38 percent increase in the number of VHA enrollees ages 85 and older and 278 percent increase in women VHA enrollees ages 85 and older.

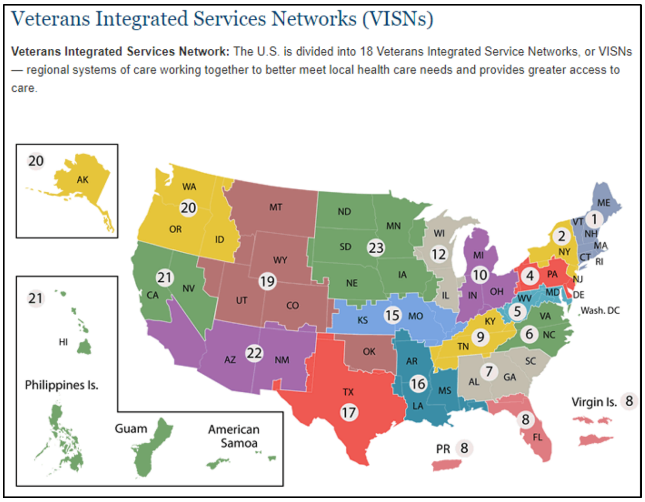
1. **Veteran Aging Statistics, Demographics and Projections**

a. National Projections

Projected VA Enrollee Aging Related Demographics Trend*			
	FY2022	**FY2036**	**FY22-FY36 % Change**
Ages 85 & Older. All Genders	559,523	934,864	**67.10%**
Women, Ages 85 & Older	10,850	34,137	**215%**
All Ages. All Genders	8,723,330	8,158,112	**-6%**
Data Source: VA Enrollee Health Care Projection Model (EHCPM); Base Year 2021, VHA Support Service Center (VSSC), Projection Model Published on 11/03/2022. Data pulled March 15, 2023.			

Regional Projections of Veteran Enrollees Ages 85 and Older of All Genders			
VISN	FY22	FY36	**FY22-FY36 % Change**
	EOY Enrollees		
V01	31,369	37,802	**20.5%**
V02	42,151	42,386	**0.6%**
V04	34,837	46,262	**32.8%**
V05	16,103	28,069	**74.3%**
V06	25,491	51,640	**102.6%**
V07	27,479	64,175	**133.5%**
V08	59,359	87,850	**48.0%**
V09	19,019	39,151	**105.9%**
V10	42,400	76,160	**79.6%**
V12	29,011	42,149	**45.3%**
V15	21,105	34,292	**62.5%**
V16	29,354	56,258	**91.7%**
V17	26,160	56,232	**115.0%**
V19	23,743	47,371	**99.5%**
V20	22,730	49,543	**118.0%**
V21	30,009	49,171	**63.9%**
V22	43,383	75,036	**73.0%**
V23	35,821	51,315	**43.3%**
Data Source: VA Enrollee Health Care Projection Model (EHCPM); Base Year 2021, VHA Support Service Center (VSSC), Projection Model Published on 11/03/2022. Data pulled March 15, 2023.			

b. Geographic Variations



VA social workers provide clinical interventions for Veterans in rural and highly rural areas through primary care. The Social Work in Patient Aligned Care Team (PACT) Staffing Program increases access to clinical social work services for this population. Over 142 social workers have been initially funded by the Office of Rural Health (ORH) to provide high quality social work interventions across 41 rural sites. This approach has led to positive outcomes in health and wellness for Veterans through proactive outreach and intervention. Since 2016, VA PACT social workers in funded or sustainment phases of the program, have served over 100,000 unique Veterans (64.27 percent rural).

The Intensive Community Mental Health Recovery program serving rural Veterans with serious mental illnesses is called Rural Access Network for Growth Enhancement (RANGE). An adaptation of this program - Enhanced RANGE (E-RANGE) - more specifically addresses the needs of homeless Veterans with serious mental illness diagnoses who live in rural areas. RANGE and E-RANGE teams across VHA have been initially funded by ORH and provide mental health treatment and care coordination for this special population of Veterans with more than 90 teams covering more than 130 rural locations across the Nation.

VA Social Workers also provide clinical assessment and inventions, including care coordination and case management, for elderly Veterans. Social workers are embedded within Geriatric and Extended Care programs focused on supporting elderly Veterans and routinely assist with coordinating care both internal and external to VA. Programs include Medical Foster Home, Home Based Primary Care, Community Living Center, Adult Day Health Care, Home Maker & Home Health Aide, Community Nursing Home, Veteran-Directed Care, Hospice & Palliative Care. These programs touch Veterans across the system, including those in rural and highly rural areas. ORH partners with Care Management and Social Work Services to integrate rural social workers into the Patient Aligned Care Team model to improve care coordination for rural Veterans and their interdisciplinary care teams.

Women Veterans

The number of women Veterans using VHA services has nearly tripled since 2001, growing from 159,810 to over 600,000 today. Women Veteran care coordination and management creates, enhances, and expands care coordination in areas of maternity care, mammography, cervical cancer screening, breast cancer care, and infertility treatment. ORH and Women's Health collaborate to expand access to these services to rural areas.

Maternity Care Coordination

VA has a robust Maternity Care Coordination (MCC) Program to support pregnant Veterans through every stage of pregnancy and after delivery. As of May 2023, over 150 Maternity Care Coordinators, including at least one at every VA medical center, communicate and connect with Veterans, collaborate with VA and community clinicians, monitor the delivery of care, and track outcomes. MCCs contact, edu-

cate, and support Veterans at regular intervals throughout pregnancy and postpartum. MCCs connect pregnant and postpartum Veterans to appropriate resources and needed services both within VA and within the local community. MCCs also ensure Veterans are scheduled for an appointment with their PACT within 12 weeks after the pregnancy ends.

Fertility/In Vitro Fertilization Services

VA continues to develop care coordination for Veterans and VA beneficiaries eligible for fertility care, those who are enrolled in the medical benefits package and recognizes the importance of coordinating that care. Most highly specialized infertility care is authorized by VA for provision in the community by reproductive endocrinologists. Care coordination is essential to the provision of high-quality, time-sensitive fertility services for Veterans and VA beneficiaries. Between fiscal years (FY) 2017 and 2021, over 26,000 Veterans and or their beneficiaries received fertility counseling and treatment through a VA facility.

In September 2016, Congress passed the Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2017 and Zika Response and Preparedness Act (PL 114–223, Div. A, § 260) which authorized VA to provide Assisted Reproductive Technologies (ART), including In-Vitro Fertilization (IVF), to certain eligible Veterans and their spouses. Pursuant to 38 CFR §§ 17.380 and 17.412, VA has furnished care for over 300 Veterans and their spouses with a service-connected disability resulting in infertility between FY 2017 and FY 2021.

In 2019, VA established Fertility/In Vitro Fertilization Interdisciplinary Teams (IVF-IDT) in each Veterans Integrated Service Network to coordinate care for fertility services. The Fertility/IVF-IDT meets regularly to discuss and review Veterans' requests for fertility care and services, ensuring Veterans and VA beneficiaries meet eligibility requirements set forth in law and outlined in VHA Directive 1332, Fertility Evaluation and Treatment, and VHA Directive 1334, In Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses.

A key role of members of the Fertility/IVF-IDTs is to ensure Veterans have access to information about available fertility and family building services through VA. Members ensure information on fertility benefits are readily available to Veterans and VA facility staff. The IDT ensures the existence of a transparent process that is efficient and effective in the timely management of fertility consults. In addition, Fertility/IVF-IDT members ensure Veterans and VA beneficiaries are receiving appropriate fertility care. They monitor authorized fertility care and cryopreservation through record review to track fertility treatments and ensure fertility services do not exceed authorized limits.

Interdisciplinary members communicate with Veterans and VA beneficiaries about fertility eligibility and services while providing resources and support. If it is determined a Veteran is ineligible for VA fertility services, the Fertility IVF-IDT provides written notification of ineligibility with an explanation where eligibility criteria were not met for fertility services authorized by VA and notice of how to appeal this decision.

Cervical Cancer and Breast Cancer Screening

Screening for cervical cancer through Pap tests and/or Human Papilloma virus screening and screening for breast cancer with mammograms is critical to identifying cancerous or precancerous conditions. These screening tests require precise tracking of timelines, results, and referral orders to ensure that all eligible Veterans are followed. Often, a return visit or advanced evaluation is recommended. Women's health care coordinators ensure timely scheduling of initial screening, follow up, and community provider scheduling, and they then finalize all required documentation. Care coordinators have proved to be critical in executing accurate and reliable screening across the system.

In 2022, 90 percent of VA sites had full-or part-time breast cancer screening coordinators, and 78 percent had full-or part-time cervical cancer screening coordinators. State-of-the-art information technology assistance is available through national electronic health record clinical reminders, the System for Mammography Results Tracking, and the Breast Care Registry. To enhance the availability of Women's Health Coordinators at all sites, VA has funded over 170 Women's Health Care Coordinators through the Women's Health Innovations and Staffing Enhancements (WHISE) program. Through ORH's Rural Health Initiative, 40 VA medical facilities received funding to recruit and hire 53 care coordination personnel in the areas of mammography and cervical cancer screening, maternity care, and breast cancer care. This allowed facilities that serve mainly rural women Veterans to create, en-

hance, and expand women's health care coordination and management for rural women Veterans.

VA follows the United States Preventive Services Task Force Recommendations for Cervical Cancer Screening and the American Cancer Society Guidelines for Breast Cancer Screening in average risk women. In response to the Dr. Kate Hendricks Thomas SERVICE Act (SERVICE Act; Public Law 117–133), VA has expanded access to ensure that eligible Veterans who were deployed in support of a contingency operation in certain locations and during certain time periods can receive a breast cancer risk assessment and clinically appropriate mammography screening. Beginning in March 2023, providers began offering breast cancer and toxic exposure screenings to Veterans identified through the SERVICE Act. In addition to ensuring timely scheduling of initial screening, follow up, and community provider scheduling, breast and cervical cancer care coordinators would generally transition care coordination over to Oncology or necessary specialty care after a diagnosis.

Conclusion

Veterans have more options than ever before to receive timely and coordinated care. We are serving record numbers of Veterans both in VA facilities and through community care with significant progress toward our timeliness goals. Within VA, the goal of care coordination is to improve patient experience and health outcomes through effectively organized health care and sharing of information with Veterans, their care teams, and caregivers.

Chairman Miller-Meeks and Ranking Member Brownley, we appreciate your continued support and look forward to answering your questions.

Prepared Statement of Julie Kroviak

Chairwoman Miller-Meeks, Ranking Member Brownley, and Subcommittee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of how the Veterans Health Administration (VHA) coordinates the delivery of veterans' health care. The OIG's Office of Healthcare Inspections routinely reviews and publicly reports on the quality of health care provided across VHA and on risks to patient safety.

Coordination of health care defines a series of activities that must occur for a patient to achieve the most desirable outcomes of their treatment. There is nothing passive about these activities; the choreography of delivering care is often a complex interchange of clinical and administrative activities that must always be precise. From aligning appropriate specialty teams to ensuring essential medications and equipment are in place, providers must also work to anticipate the patient's future needs as well as potential complications. This complex coordination often occurs, as many of the OIG reports discussed below show, for patients facing serious illnesses. These patients rely on a comprehensive assessment of not only their specific condition but the supports in place to ensure their recovery, such as the safety and appropriateness of a patient's discharge environment, clear education and instructions to the patient and their caregivers, and reliable processes that ensure all participants have all relevant information. When there are breakdowns at any point in coordination, the safety of the patient is compromised and the trust placed in the system responsible for providing that care is lost.

This testimony highlights some of the many issues that care providers and patients have faced in navigating the complexities of care coordination. These reports recognize that VHA personnel often have to overcome inefficient and ineffective processes or system limitations to ensure safe transitions and quality care both within VHA and with outside care providers. The discussion that follows focuses on (1) the transition from the Department of Defense (DoD) to VA care, (2) barriers to care coordination within VA, and (3) breakdowns that can occur when engaging community care providers. Ultimately, effective care coordination is dependent on dedicated and skilled staff consistently adhering to sound clinical and administrative policies and practices that result in desired outcomes for patients and their caregivers and families.

Although the specific OIG reports highlighted below detail deficiencies at various points of coordination or at a particular facility, the findings and recommendations should be considered by VHA leaders and staff participating in patient care across the Nation.

CARE COORDINATION CHALLENGES DURING THE TRANSITION FROM THE DEPARTMENT OF DEFENSE TO VA

Many challenges can occur within the first 12 months of discharge from DoD associated with leaving active duty and transitioning to civilian life, such as homelessness, family reintegration, employment, posttraumatic stress disorder, and substance misuse, which can increase the risk for suicide.[1] While improvements have been made in the interoperability of VA and DoD electronic health record (EHR) systems, significant risks remain when VA providers find DoD records are not complete or accessible, or when VA providers have not thoroughly reviewed and evaluated those records during former service member's earliest encounters in VA.

The OIG is finalizing a national review in which a team evaluated the transition of clinical care for service members with opioid use disorder (OUD) from DoD to VHA.[2] Failure to identify and document a patient's known OUD history and related treatment during this critical transition period may decrease the likelihood of a patient receiving timely VA care and support. Of particular concern, veterans have been found to be "twice as likely to die from accidental overdose compared to non-veterans."[3]

The OIG reviewed a sample of discharged service members with a DoD-originated OUD diagnosis. The team then reviewed the patients' VHA electronic health records for evidence that care providers were aware of the OUD diagnosis and treatment. The OIG team found concerning gaps in the records review with a significant percentage of the VHA providers not recording the OUD diagnosis in VHA records, thus potentially hampering future medical decisions.[4] Additionally, the OIG found providers perceived barriers to documenting OUD diagnoses during the transition of clinical care, and the OIG determined that while there was evidence of the use of risk-mitigation strategies, such as dispensing opioid reversal agents, improvements could be made.

Veterans who are referred by VA to a DoD medical facility also may experience coordination problems due to limitations in the interoperability between the DoD and VA electronic healthcare records (EHR), such as the lack of full accessibility offered by the Joint Longitudinal Viewer (formerly known as Janus and the Joint Legacy Viewer). The OIG has released 14 oversight reports on the deficiencies with the new EHR system that is meant to provide a seamless health record for veterans between DoD and VA.[5] Despite progress, there is still significant work to be done.

Staff from several OIG divisions worked on a joint project led by the DoD Office of Inspector General that was released in 2022.[6] The project assessed internal controls and compliance with legal requirements, as well as actions by DoD, VA, and their joint Federal Electronic Health Record Modernization (FEHRM) program office to help ensure that healthcare providers serving veterans can access a complete healthcare record. The joint audit found that while the agencies took some actions to achieve the level of interoperability between DoD, VA, and external care providers specified by Congress in the National Defense Authorization Act (NDAA) of 2020, challenges remain. The audit found that VA and DoD did not consistently migrate patient healthcare information into the new EHR to create a single, complete patient health record, because DoD and VA have separate processes for bringing information into the new EHR. To access clinical information that hasn't been migrated to the new system, users have been instructed to use the Joint Longitudinal Viewer. This work-around does not meet NDAA requirements that healthcare providers access and exchange patient healthcare information without additional inter-

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[1] VA, *Executive Order 13822 Fact Sheet*, accessed June 1, 2023.

[2] VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, Version 4.0, 2021. Care transition refers to the transition of healthcare from DoD to VHA for a service member upon separation from the military; Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, Text Revision (DSM–5-TR), *"Substance Related and Addictive Disorders,"* accessed December 15, 2022. OUD is defined as a "problematic pattern of opioid use leading to clinically significant impairment or distress" as manifested by at least two symptoms from a list of psychological, physical, occupational, interpersonal, or recreational consequences, within a 12-month period.

[3] Elizabeth M. Oliva et al., *"Saving Lives: The Veterans Health Administration (VHA) Rapid Naloxone Initiative,"* The Joint Commission Journal on Quality and Patient Safety 47–8, (August 2021): 469–80.

[4] Currently, this report is in draft, but, consistent with OIG practices, has been reviewed by VA. This allows VA offices to comment on OIG findings and recommendations, as well as to provide responsive action plans. OIG staff is integrating that feedback into the final report. While it is not the OIG's routine practice to testify regarding pending reports, due to the timing of this hearing and VA having had the chance to review the report, the findings are discussed in general terms today.

[5] VA OIG, *Statement of Deputy Inspector General David Case—Hearing on "VA's Electronic Health Record Modernization: An Update on Rollout, Cost, and Schedule"*, September 21, 2022.

[6] DoD OIG and *VA OIG, Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability*, May 5, 2022.

vention. Second, the DoD and VA did not develop interfaces from all medical devices to the new EHR so that patient information will automatically upload to the system. For example, some medical devices, such as some blood pressure cuffs and IV pumps, did not have set national healthcare data standards and still require the departments to develop effective interfaces. One contributing factor to interoperability problems was the failure of FEHRM program office officials to develop and implement a plan to achieve all NDAA requirements and actively manage the program's success, as authorized by the FEHRM's charter. Because the FEHRM program office limited its role, DoD and VA took separate actions to migrate patient healthcare information and develop interfaces. These issues remain unresolved.

As part of the OIG's oversight of VA's development and implementation of the new EHR system, reports have been issued on care coordination concerns affecting patients at VA facilities that have transitioned to the new system.[7] The OIG found several areas of unresolved issues that create barriers to various aspects of care delivery, such as appointment scheduling, laboratory orders, prescribed medications, and the utility of high-risk-for-suicide and behavioral patient record flags.

CARE COORDINATION CHALLENGES FOR VETERANS RECEIVING CARE WITHIN VHA

After veterans are enrolled and established in VHA, issues related to care coordination can arise in both acute and long-term care settings. For example, the OIG has repeatedly identified clinical failures caused by unclear or inadequate processes or in the oversight of personnel tasked with ensuring a safe transition for patients.

Facility Personnel Did Not Follow VA Processes or Failed to Properly Coordinate Care within a Facility or Clinic

Many OIG reports focus on personnel within medical facilities either not following policy and procedure or failing to properly communicate to other providers and clinical staff.

For example, the OIG has reported on the death of a veteran who was wrongly denied care at a VA emergency department. Despite being told of the veteran's serious condition and provided with identifying information, nurses and an administrative staffer wasted critical time analyzing the veteran's eligibility status, later having the veteran transported to a community hospital. In the end, it was determined the patient in fact was a veteran and proper policies had not been followed.[8] Similarly, a veteran residing in a VA community living center was found deceased after a nurse failed to initiate that resident's transfer to an emergency department following the recommendation of the on-call resident.[9]

Failures in Coordinating Discharge from Facility Care Place Veterans at Risk

Careful and thorough discharge planning is critical to support safe outcomes as patients move between providers and various care settings, especially when transitioning back to their homes.

During an inspection at the VA Southern Nevada Healthcare System's inpatient mental health unit, the OIG found serious gaps in discharge planning for a patient who died by suicide the same day as being released.[10] The patient had been treated by various VHA facilities for significant mental health conditions for many years before this inpatient stay. The OIG found inadequate care by both inpatient and outpatient staff, a failure to reconcile critical clinical treatment and discharge plan information, delayed assignment of a required mental health treatment coordinator,

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[7] VA OIG, *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, March 17, 2022.

[8] VA OIG, *Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville*, Florida, June 3, 2021. Further, the OIG has numerous reports that describe issues associated with coordinating the after care for patients who visited emergency departments. VA OIG, *Quality of Care Concerns and Leadership Response at the Amarillo VA Health Care System in Texas*, April 14, 2022; VA OIG, Poor Emergency Department Care of a Patient, January 25, 2023. The OIG also reported on an emergency department physician whose delay in recognizing the need to transfer a patient to a facility that could provide needed lifesaving treatment led to the patient's death. VA OIG, Mismanagement of Emergency Department *Care of a Patient with Acute Coronary Syndrome at the Robert J. Dole VA Medical Center in Wichita, Kansas*, September 23, 2020.

[9] VA OIG, *Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California*, August 17, 2022.

[10] VA OIG, *Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas*, July 15, 2021.

and ineffective responses to the patient's complaints and requests. For example, staff did not request substance use disorder assessments despite a positive drug test; failed to understand the patient's suicide risk factors, like access to lethal means; and did not identify coping strategies among other aspects of unsatisfactory safety planning. These lapses placed this patient at significant risk during their transition to home. Even after the suicide event, the OIG found facility leaders did not properly handle institutional disclosure processes by failing to alert the veteran's next of kin to the deficiencies. The OIG made 10 recommendations, now closed, for corrective action focused on improving patient care coordination and mental healthcare delivery.

As part of a review of allegations that an elderly patient suffered verbal abuse and physical harm at the hands of facility staff at the VA community living center (CLC) in Miles City, Montana, after being discharged from an inpatient stay at the Fort Harrison VA Medical Center, the OIG found the patient experienced deficient care coordination and discharge planning.[11] Because Miles City CLC did not have a designated screening process for reviewing the appropriateness of admissions from a VA medical center, opportunities were lost in determining whether the CLC could support the veteran's clinical needs. Further complicating the tragic events surrounding his abuse, care providers in the CLC failed to ensure the patient received necessary imaging that would have revealed a terminal diagnosis. While the horrific events of patient abuse are inexcusable, recognizing that failures in inpatient discharge planning contributed to this same veteran being denied timely access to end-of-life care is devasting.

Failures with Coordination of Care in Non-Facility VHA Settings Can Result in Patient Harm

Veterans engage with VHA outside of traditional medical facility settings, often seeking additional or complementary services, particularly in support of mental health treatment. Similar to care coordination provided in VHA clinic and inpatient settings, prompt and clear communication is imperative to ensuring a patient's needs are met when engaging with crisis hotline personnel, community-based vet centers that provide counseling, and VA-directed home-based mental health care.

Veterans Crisis Line

Since its establishment in 2007, the Veterans Crisis Line (VCL) has answered millions of calls from veterans in crisis. VCL responders are required to initiate emergency rescue services for those veterans identified as being in immediate danger to themselves or others. In addition, coordination activities for callers not in need of immediate rescue are critical to ensuring appropriate care. For example, in 2021, a VCL staff person told the veteran it was urgent that they go to a VHA emergency department in Augusta, Georgia, after the veteran expressed suicidal ideation.[12] The VCL staffer notified an emergency department nurse that the patient was directed there. The patient reported to the emergency department as directed; however, the nurse did not document for the emergency department physician evaluating the patient that this was due to a VCL referral because of suicidal ideation, and there was no evidence the physician was ever notified. On arrival, the patient reported a chief complaint of pain and denied suicidal ideation during a routine screening. Without knowledge of the VCL referral, the physician did not have a complete understanding of the patient's current condition and therefore did not ensure the patient's follow up with mental health clinicians. Additionally, the facility's suicide prevention staff, despite being made aware by VCL staff of the veteran's contact with VCL, did not contact the veteran to schedule follow-on care as required.[13] Approximately two months later, the veteran was found deceased from a self-inflicted gunshot wound in the parking lot of the Aiken, South Carolina, Community Based Outpatient Clinic. The OIG made nine recommendations to the Augusta facility in May 2023, including several focused on managing referrals and care coordination.

Vet Centers

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[11] VA OIG, *Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison*, January 26, 2023.

[12] VA OIG, *Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia*, May 10, 2023.

[13] In a different OIG healthcare inspection, emergency department staff failed to inform suicide prevention staff of a patient in crisis, and the patient died by suicide six days later. VA OIG, Inadequate *Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center*, July 28, 2020.

Vet centers are community-based clinics that provide a wide range of psychosocial services to clients that include eligible veterans and current service members. Vet center counselors communicate with local VA medical facilities to coordinate care for shared clients, most importantly, those who are high risk for suicide. The counselors are required to provide timely notification to VA medical facility suicide prevention coordinators when shared clients have a significant safety risk. They must follow confidentiality requirements when communicating with local VA medical facilities to coordinate care. Since 2021, the OIG has published findings from its vet center inspection program, which provides a focused evaluation of key aspects of the quality of care delivered at vet centers. The OIG has consistently found in the sites reviewed that vet center staff across the country have not consistently complied with these requirements.[14] For example, the OIG found that of the 30 client records reviewed in vet centers in district 1 zone 3, 18 records had documented coordinated care with the supporting VA medical facilities as required, and only three of the 18 followed confidentiality requirements.[15] The OIG also found most records did not reflect mandatory notifications to VA staff were made for patients with significant safety risks.

Home-Based Mental Health Care

To coordinate the complex care of veterans with serious mental illness and to mitigate negative outcomes, VHA utilizes Intensive Community Mental Health Recovery programs (ICMHR). ICMHR provides case management to veterans diagnosed with serious mental illness who are deemed able to live in the community with the frequent support of a multidisciplinary team coordinating the clinical and social services of each veteran. To reduce the burden on the veteran, these visits occur in the veteran's home and, as required during the pandemic, can be supported when necessary via the use of telehealth.[16] The OIG reviewed ICMHR programs from 2019 to 2021 and found they did not meet VHA's required visit frequency for high-intensity services. Without meeting the evidence-based number of visits to support veterans and ultimately reduce their risk of being in crisis, opportunities for early and less intensive interventions are lost. Realizing that these patients also often require long-acting injectable antipsychotic medications, the OIG reviewed ICMHR-specific contingency plans for emergency situations such as a pandemic, when injectable medications may be challenging to secure. The OIG found the majority of VHA healthcare systems did not have ICMHR-specific contingency plans for ensuring veterans' access to needed medication.

Opportunities Exist to Support Care for Veterans Who Face Challenges in Accessing Care

Care coordination between care providers and their patients can be challenging for veterans who experience obstacles in getting to any healthcare facility. In particular, accessing in-person care can be a formidable task for older veterans, those with mobility issues, and individuals living in rural areas.

One way that VA has been working to reduce barriers to care is by increasing the use of telehealth. Because providing telehealth services is not without obstacles, the OIG recently assessed the implementation and use of VA Video Connect (VVC) prior to and during the pandemic.[17] VVC provides a secure environment for patients and providers to carry out video telehealth visits, regardless of where the veteran and provider are located. Specifically, the review team explored factors affecting

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[14] VA OIG, *Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers*, December 20, 2021; *Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers*, January 19, 2023.

[15] Locations visited included City Center and Northeast Philadelphia, Pennsylvania; Scranton, Pennsylvania; and Huntington, West Virginia. VA OIG, *Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers*, May 25, 2023. While a veteran using a vet center may be referred to a VHA medical facility when in crisis, VHA facility staff must ensure they coordinate care with vet center staff when appropriate. For example, the OIG substantiated that a patient died by suicide within three days of discharge from an inpatient mental health unit in the VA OIG report, *Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri*, issued on January 5, 2021. While the patient received medication and discharge instructions that included suicide prevention materials, the OIG identified care coordination and discharge planning deficiencies that included the failure to coordinate the patient's mental health treatment or include vet center staff in the discharge planning. The vet center could have helped to facilitate the patient's engagement with outpatient resources and timely follow-up.

[16] VA OIG, *Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs*, January 31, 2023.

[17] VA OIG, *Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID–19 Pandemic*, April 26, 2023.

why primary and specialty care providers used telephone communication more frequently than VVC at the onset of the pandemic and in lieu of in-person encounters, and how VHA resolved technology issues. The OIG also examined VHA provider experience with VVC prior to and during the pandemic to identify the benefits of and barriers to VVC use. When the pandemic started, VHA was not readily able to support the increased demand of VVC use, leading providers to provide patient care by telephone. This occurred despite VHA having developed telehealth strategic plans, which focused on improving technology to support VVC, increasing provider capability, and identifying emergency preparations for disaster scenarios.

Notably, the VHA Office of Connected Care's chief officer said video visits increased from 2,000 to 40,000 per day and emphasized that, "the technical infrastructure was not scaled to that kind of . . . unexpected and unplannable [sic] for growth." As the pandemic continued, providers continued to use VVC, recognizing its value in increasing access to care and enabling more comprehensive evaluations than telephone encounters could offer. There were identifiable barriers, however, including patient difficulties with technology, lack of clinical and administrative support during the encounters, and challenges with scheduling VVC appointments. VHA concurred with the OIG's three recommendations to address those barriers that were issued in April 2023.

OIG REPORTS HAVE FOUND CONCERNS WITH COMMUNITY CARE COORDINATION

Coordinating medical care between VHA and community providers remains a tremendous challenge, particularly for managing patients with complex health needs. The OIG has identified persistent administrative and communication errors or failures among VHA, its third-party administrators, and community care providers, as well as between the care providers and their patients. These deficiencies, often a result of personnel errors or policy implementation, undermine the considerable efforts of VHA personnel to ensure a seamless experience for veterans. VA has made considerable efforts to increase the use of technologies that enable better information sharing with the community. As one example, VA's participation in health information exchanges advances the sharing of veterans' information outside VA, whether through the community care program or not. Many OIG reports have described the frustrations and various risks experienced by patients referred to the community.

Administrative Failures Challenge the Coordination of Healthcare Services

VHA has detailed numerous steps in the process to obtain healthcare services for a veteran through its community care programs. This process requires staff from clinical service lines and administrative support offices in the medical facility to work with the veteran or caregiver, the VA's third-party administrator, and the community provider. The OIG reviewed VA's implementation of the Referral Coordination Initiative (RCI) that sought to facilitate consult (referral) scheduling for specialty care within VHA facilities and in the community for eligible veterans.[18] RCI was designed to improve veterans' timely access to care, empower patients to make informed care decisions, reduce providers' administrative burden and increase their time on patient care, and enhance access to community care for veterans eligible under the MISSION Act of 2018.[19]

Under the non-RCI consult referral process, a provider first determines whether a patient requires a specialist and then assesses whether the patient is eligible for community care provided by a non-VA practitioner. If the patient is eligible for care in the community, the healthcare provider submits a referral to the facility's community care department staff to confirm eligibility and to call the patient to discuss appointment preferences (including provider and location). Then, the community care staff either help schedule the appointment or provide the patient with the information to do so.

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[18] VA OIG, *Additional Actions Needed to Fully Implement and Assess Impact of the Patient Referral Coordination Initiative*, October 27, 2022.

[19] The OIG reported in 2020 on the community care consult process, with an audit team finding patients experienced community care appointment delays in Veterans Integrated Service Network 8 due to the facilities' insufficient staffing and consult-processing structure at community care departments that review, authorize, and schedule community care. There was insufficient staffing for administrative functions such as contacting patients and coordinating appointments. Also, merging the consult authorization and scheduling tasks within community care departments could allow scheduling to begin promptly. The OIG's five recommendations focused on key process improvements. VA OIG, *Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities*, January 16, 2020.

Under the RCI process, after a facility provider (usually a primary care physician) enters a consult for a patient requiring specialty services, a Referral Coordination Team (RCT) determines the veteran's eligibility for community care.[20] A clinical RCT member, typically a triage nurse, determines the available care options for the patient (in-house, in another VA facility, or in the community); assigns the consult a priority level indicating how urgently the patient needs to be seen; determines whether any medical tests are needed; and contacts the patient to discuss care options.

In 2019, VHA began implementing the RCI at 139 VA medical facilities, with expected completion across all facilities and all specialty services by June 30, 2021. VHA staff generally agreed the RCI had the potential to achieve its stated goals. However, facilities struggled with implementation for several reasons, including insufficient staffing and resources, unreliable data (such as a lack of accurate wait times for community care), and a lack of required training. The RCI describes two implementation models, centralized and decentralized, but facility staff were sometimes confused about which model to apply and noted slow responses from VHA to questions. Without clear direction on staffing models, some facilities tested different implementation methods. Given the staffing strain, initiative leaders from one facility said they were planning to roll out the initiative to only two services every month; at this time, completion may still take several years.

The Office of Integrated Veteran Care (IVC) predecessor, the program office responsible for overseeing the RCI, also lacked the ability to monitor progress due to insufficient data. Because of these deficiencies, no VA facility had fully implemented the RCI almost a full year after VA's own June 2021 deadline, and facilities are currently working to fully implement the process. IVC had not developed a mechanism for facilities to evaluate whether staff were meeting the initiative's goals. VHA did not have data to measure whether the initiative reduced the average time to schedule appointments—one of its key goals. Also, VHA lacked measures to evaluate whether veterans received key information to inform care decisions, a second key goal. The review team identified instances when facility staff did not provide patients with key information—for example, there was a provider who said he generally decides what is best for patients and does not usually give them an option. Similarly, IVC had not evaluated if the initiative reduced administrative burdens on providers, a third key goal, and none of the four facilities the review team visited had conducted this type of analysis.

The under secretary for health concurred with the OIG's seven recommendations issued in October 2022 to improve RCI implementation by better assigning responsibilities and roles, improving training, establishing local procedures for sharing community care data to more fully inform patients, sharing best practices among all facilities, ensuring accurate tracking of RCI consults, and developing measures of how well facilities meet the initiative's requirements. Five recommendations remain open at this time.

After a veteran receives services from a community care provider, VHA has contracted for those providers to return the treatment records to VA. These records from non-VA care settings enable continuity of care by VHA providers and inform treatment decisions. An OIG audit team found in a June 2021 report that staff at six of the seven VA medical facilities reviewed did not always index or categorize these records accurately.[21] Inaccurate indexing of medical records poses a risk to veteran care and increases the burden on the VHA staff who locate and correct the errors, reducing their time for other tasks. Errors included using ambiguous or incorrect document titles, indexing records for non-VA care to the wrong referral or veteran, and entering duplicate records. These errors occurred, in part, due to inadequate procedures, training, quality checks, and quality assurance monitoring, as well as a lack of local facility-level policies. The OIG recommended the under secretary for health improve non-VA medical records scanning and indexing by ensuring VHA facilities create and fully implement standard operating procedures. Besides clearly defining responsibilities and procedures for accurately scanning, importing, and indexing non-VA medical records, the OIG also made recommendations related to training and oversight of facility community care staff responsible for medical record management.

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[20] VHA, *Referral Coordination Initiative Implementation Guidebook*, December 2021. The guidebook states that the RCT is a multidisciplinary team of clinical and administrative staff, which includes doctors, physician assistants, licensed nurse practitioners, registered nurses, and schedulers.

[21] VA OIG, *Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records*, June 17, 2021.

In addition to errors while indexing returned medical documents, the OIG has also examined the impact of the backlogs at VA facilities in scanning these documents.[22] Beyond the continuity of care risks, backlogs can lead to delays or denials of veterans' claims for reimbursement of non-VA emergency care and the expiration of checks sent to VA for payments, as the OIG reported after reviewing the contents of unopened mail at the Atlanta VA Healthcare System.[23] The OIG has repeatedly found VHA staff did not enter documents into EHRs in a timely manner, nor did they perform appropriate reviews and monitoring to assess the overall quality and legibility of scanned documents. The OIG also found leaders' poor communication and follow-through, as well as staffing shortages, contributed to these backlogs.

Veterans Have Experienced Poor Outcomes When Care Was Not Coordinated with Community Care Providers

In a March 2021 report on the deficiencies found in the care and administrative processes for a patient who died by suicide, the OIG review team found that numerous administrative errors and confusion in the Phoenix VA healthcare facility's community referral process delayed a patient's specialized psychological testing. VA's third-party administrator (the contractor that manages the community provider network and appointment scheduling) incorrectly scheduled the veteran for therapy, not testing. The patient died by suicide not having received the appropriate testing and resulting treatment.[24]

Another oversight report focused on a patient who ultimately died by suicide after not receiving several authorized community care counseling sessions. This was due to deficiencies in the coordination of the patient's care among the Memphis VA facility's community care staff, providers in the community, and the third-party administrator.[25] The patient also suffered from hyperthyroidism, a condition that can aggravate anxiety. The patient declined a referral to endocrinology at the facility, due to the distance from home, but was never offered a referral to the community. In addition, a September 2022 OIG healthcare inspection examined the failure of a facility's community care staff to adequately convey the seriousness of a patient's cancer diagnosis to VHA and community health providers.[26] Due to bureaucratic issues and a lack of standard guidance, the facility incorrectly denied the patient's initial radiation therapy request.

Managing care for veterans who have been seen in the community and are coming back into VHA facilities for treatment presents similar coordination risks. The OIG examined concerns related to a lack of care coordination for patients receiving ketamine for treatment-resistant depression (depression that has failed to respond to multiple attempts of more conventional treatments) in the community after authorizations for the care lapsed in September 2019 at the VA San Diego Healthcare System in California.[27] The OIG substantiated that the facility ended authorizations for community care for patients receiving ketamine in October 2019 and again in March 2020, negatively affecting 35 patients. The OIG also identified deficiencies in facility processes. The OIG concluded that risks for negative patient outcomes increased due to communication and care coordination deficits, terminating community care authorizations, accelerating timelines for care transition, and uncertainties from suddenly changing treatment for complex patients. Four recommendations were made to the facility director related to community care processes for coordination of non-VA care and ensuring coordinated, clinically informed plans for transitioning remaining patients to care at the facility.

VHA MUST DO BETTER AT TRACKING AND RESOLVING HEALTHCARE COMPLAINTS

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[22] VA OIG, *Health Information Management Medical Documentation Backlog*, August 21, 2019.

[23] VA OIG, *Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims*, April 27, 2022.

[24] VA OIG, *Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide*, Phoenix VA Health Care System, Arizona, March 31, 2021.

[25] VA OIG, *Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide*, Memphis VA Medical Center in Tennessee, September 3, 2020.

[26] VA OIG, *Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas*, September 12, 2022.

[27] VA OIG, *Deficiencies in Coordination of Care for Patients with Treatment-Resistant Depression at the VA San Diego Healthcare System in California*, August 24, 2021. In a separate report discussing the administration of ketamine for treatment-resistant depressions, the OIG found VHA-internal care coordination failures, including inconsistent prescribing practices. VA OIG, *Deficiencies in the Implementation and Leadership Oversight of Ketamine at the Eastern Oklahoma VA Health Care System in Muskogee*, March 9, 2023.

It is imperative that veterans and their caregivers have a voice in their care and an avenue for redress when mistakes have been made. The Patient Advocacy Program is VHA's effort to improve customer service, support veterans' access to quality care, and provide a mechanism to resolve healthcare delivery or coordination issues. When a veteran submits a complaint at a VA medical facility regarding care delivered within VHA or through a community partner, a patient advocate begins the process of documenting the concern, communicating a resolution, and providing follow up and feedback. Patient advocates also are expected to identify trends to signal potential opportunities for medical facility improvements. However, a March 2022 report found that VHA did not effectively issue and implement adequate policy, monitor complaint practices, and provide guidance to medical facility directors responsible for local program management.[28] The OIG also found that patient advocates were not entering complaints into their tracking system or the documentation to show how complaints were being resolved. Further, coordinators, managers, and VHA-level Office of Patient Advocate staff were not monitoring and reviewing patient advocate activities. In addition to quality concerns, this leads to missed opportunities to improve veterans' experiences because facility leaders may not fully understand the scope of problems that veterans encounter. The three recommendations made to VHA to update policy, implement controls, and fulfill oversight duties of the program all remain open.

CONCLUSION

High-quality care demands that patients receive the necessary care provided by qualified clinicians in a timely manner. The reports highlighted in this testimony call attention to the risks introduced when care is not coordinated properly, whether due to clinical or administrative problems. The OIG is committed to ongoing and meaningful oversight of these issues. As VA continues to purchase an increased amount of community care, it must redouble its efforts to make care coordination efforts more efficient, and it must refocus attention on patients transitioning between care providers and venues. Without an efficient strategy to consistently monitor the access to and quality of care provided to veterans in the community, VHA and other stakeholders—and most importantly, veterans and their caregivers—can have no assurance of the quality or safety of that care.

Almost every report published by the OIG's Office of Healthcare Inspections details aspects of care coordination, whether it is a hotline inspection detailing missteps or failures in that coordination, or the cyclical reviews that provide VHA leaders with a risk assessment of their medical facilities' current practices. The OIG encourages VHA leaders to broadly distribute these healthcare oversight publications to alert all facilities of potential risks and to promote the robust exchange of local success stories in preventing or correcting them. The OIG will continue to enhance our proactive tools, while revealing the complex findings of our inspections in responding to allegations of substandard care. Additionally, teams across the OIG will continue their efforts to assess the various VHA program offices' operations and monitor the issues raised in this testimony.

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, this concludes my statement. I would be happy to answer any questions you may have.

Prepared Statement of Andrea Sawyer

Madame Chairwoman, Members of the Subcommittee, my name is Andrea Sawyer, and I am the Advocacy Director for the Quality of Life Foundation (QoLF), a national non-profit organization founded in 2008 to address the unmet needs of caregivers, children and family members of those who have been wounded, ill, or injured serving this Nation. Since then, we evolved and now work directly with veterans and caregivers as they attempt to apply for and navigate the Program of Comprehensive Assistance for Family Caregivers (PCAFC) and other clinical support programs within the Department of Veterans Affairs. Serving all generations and focusing mostly on those with significant wounds, illnesses, or injuries, we often assist those with the most complex needs.

As one of the few organizations working exclusively within the Veterans Health Administration, and as a caregiver to a Post 9/11 veteran myself, we have had a front row seat to witness and help others utilize many of the programs and services available within the VA. While we do NOT provide clinical recommendations of any

[28] VA OIG, *Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints*, March 24, 2022.

kind, our role is to ensure that veterans and caregivers are prepared for the PCAFC process, assist in the drafting of clinical appeals to ensure the VA is following its own regulations and directives, and assist veterans and caregivers in navigating other programs and supports available to them.

In that role, we see the positive things that can happen when veterans and caregivers are connected by caring and passionate providers and social workers to the programs and services that enhance their care and their quality of life. PCAFC, Respite, Veteran Directed Care, and the Homemaker Home Health programs are just some of the programs that support veterans in their homes and can serve as a lifeline for veterans in need. Unfortunately, we also see what can happen when those especially vulnerable veterans are not connected to those resources, and, more often than not, poor or a complete lack of care or case management is at the root of the problem.

In order to understand the problem, it is important to understand a little bit of the history and terminology involved in this process. After the Walter Reed scandal, the Department of Defense and the VA stood up unprecedented levels of case management for injured veterans. At one point, it was not uncommon to hear family caregivers say that we needed a case manager for our case managers, ultimately resulting in the creation and implementation of the Federal Recovery Care Coordination program for those with multiple severe injuries and complex needs. FRC's were Masters Level GS–15's nurses or social workers reporting to the Deputy Secretary with broad referential authority and, in the best of cases, the ability to created integrated care plans and cut across program and agency lines to resolve issues for the most vulnerable warriors and their caregivers.

Since the winding down of operations in Iraq and Afghanistan and even before then, however, the case management programs seem to have been minimized with some being removed, some being revamped, and still others being renamed. Unfortunately, the case managers seem to have all again been siloed in their efforts. While FRC's still exist, there are very few of them and they have been relegated further down into VHA and do not interact with veterans directly. Instead, they serve as consultants upon request of the facility, when and if the facility knows to call them—leaving those with the most complex needs, a population that includes severe mental health issues, PACT act eligible veterans, and those with long-term complex injuries and conditions with no known case manager who can help them navigate resources across the VA, access the Community Care Network, and develop a workable coordinated care plan.

Every veteran in the VA is entitled to care coordination; this is basic care coordination through the Primary Care Manager and a basic treatment plan that the veteran is responsible for carrying out.

In our experience at QoLF, we see many veterans with care managers—people who usually manage one clinical support or disease specific program—but no overall case manager. A care manager does not necessarily look at overlapping needs or outside the clinic in which they are operating.

Care objectives in disease specific treatment plans may be contradictory OR multiple disease/injury specific care plans may create an overall higher burden on the veteran and caregiver for management. With no higher oversight on the part of individual care managers, veterans and caregivers have multiple plans to try to navigate and multiple points of contact individual to each disease, injury, or intervention.

Many of the veterans that QoLF serves have complex care needs. They are in need of case managers. Case managers are trained to evaluate the multiple care plans that a veteran has for each injury or condition, look at the veteran's whole health needs—including environmental and social needs, and develop a coordinated care plan. The coordinated care plan will take into account each condition, set goals or targets for each condition, list who is responsible for those goals/conditions, and set target dates for completion. This gives the veteran and caregiver ONE point of contact for issues that arise. Cases that need case management are time-intensive, require coordination of care both inside and outside the VA, and usually have psychosocial and environmental needs as well.

In Ohio, we were contacted by an elderly veteran who had been removed from the Caregiver Support Program. The veteran had been in Home Based Primary Care, the Caregiver Support Program, and was receiving support from Geriatrics and Extended Care. The caregiver was using her stipend to pay for in home physical therapy, occupational therapy, and extra homemaker home health aide hours. When it was time to review the veteran, the caregiver was removed from the Caregiver Support Program because the Caregiver Eligibility Assessment Team felt that by removing the caregiver from the program, then the caregiver could be given many more

hours of support by Geriatrics and Extended Care, something that is prevented by a case matrix tool that exists between GEC and PCAFC.

However, and this is where case management would have been helpful, upon the removal of the caregiver from the stipended portion of the VA Caregiver Support Program, there were no steps put in place to immediately increase the veteran's hours of care through Geriatrics and Extended Care. Nor did VA send or coordinate more physical therapy or wound care therapy at the home of the veteran which had been being paid for by the caregiver from her stipend. The caregiver began calling the local non-emergency line to help change and bathe the veteran after no home health care workers were initially added to assist the caregiver. Additionally, the caregiver suffered an increasing level of exhaustion, as the VA contracted workers failed to show up for more than half the hours for which they were contracted and the workers were a revolving door of workers, some of whom did not speak any English in an only English speaking home.

Once we asked for a higher level of case management to engage with the VA, there were a higher number of hours that were granted for homemaker home health aide hours, but they still were not filled. The issue became that GEC said it was the agency's responsibility, and the caregiver was supposed to take it up with the agency; the agency said they did not have workers to fulfill it, and no one was able to support the caregiver and veteran in their ever declining state.

When we first got the family, the veteran and caregiver needed more support, but due to a lack of coordination between PCAFC's dismissal and GEC's ability to actually get the necessary about of services into the home that had been being provided by private care with the caregiver stipend, the people who paid the price were the veteran and caregiver. Unfortunately, while the hours were raised, they were still unable to be met, and now the veteran is in the hospital. Had VA coordinated the proper order of resource stand up and withdrawal, this case may have had a better outcome. This is where an overall case manager would have been helpful in aligning the order of how resources could have been added and removed.

Additionally, no one is assisting the veteran to navigate Community Care Network referrals and records management. This falls to the veteran and caregiver, and those with these complex needs often cannot do it because it involves multiple behind the scenes VA processes and offices. Being a veteran with complex needs or an overwhelmed caregiver often leads to complications in the veteran and caregiver's social, emotional, and financial well-being. Having holistic long-term case management and a case coordination plan allows an extra level of support and management to improve the whole health of the veteran and caregiver so that they can focus on simply getting through treatment and recovery when possible.

In Arkansas, we have a 34 year old veteran with a cancer that has necessitated the removal of is colon and rectum, severe PTSD that has resulted in a behavioral flag being placed for outbursts, and a recent diagnosis of sarcoidosis of the heart, lungs, and intestinal tract. The veteran has additional complications of a severe allergy that permeates his diet, nutritional and medicinal absorption issues due to his missing colon and rectum, and social and environmental factors that include a distrust of the medical system. The veteran has five children aged 16 to 1. Complicating the care management, is that the veteran has had 15 VA PCMs in the six-years that Quality of Life Foundation has had this case. He has multiple outside providers, some Community Care Network appointments and some providers that he uses his Medicare to see, because often VA does not have a timely appointment and referral process for him. His wife has never been accepted into the VA Caregiver Support Program, and she works from home full time. Up until recently, the family had had no case manager.

After attempted conversations with the facility and then with VACO, a case manager was appointed through the M2VA office. Unfortunately, the case manager is more a care manager. He is not used to working complex case management that involves multiple conditions. The case manager is hampered by the delay in CCN notes being returned to the VA. The case manager is also assigned this veterans care on top of a very large population that he serves simply for care coordination and care management. When seeking answers about referrals or pieces of information, or trying to get two doctors to have a discussion about a patient, he has no authority to do so.

We have attempted to engage, through VACO and this committee for multiple years, a complete care coordination and case management plan. That has yet to happen. In fact on multiple occasions, my staff member has been told that the case manager, assigned by VACO at the local level, does not know how to do such a detailed case plan. As a result, the veteran's care lags, referrals fall through the cracks, the veteran's health declines, and an overall sense of dissatisfaction with VA healthcare and anger over feeling discarded permeates his life. The caregiver is an-

gered that she has a management of the case manager that has to occur when she already has such a heightened responsibility. Overall the LACK of case management on a continued basis has caused the VA to fail this patient.

We understand that the VA is implementing a new process to appoint a "lead coordinator," and as part of this initiative is specifically looking at sites to further enhance the coordination of care through the Community Care Network. While we have some concerns that the lead coordinator role would not alone be sufficient to address these most complex cases, it will be helpful to have a named individual who is accountable for the provision of services. Our most pressing concern is that the lead coordinator position becomes a collateral duty on top of an already heavy case load. **As the "lead coordinator" process develops, QoLF recommends that the Subcommittee and the VA consider the following:**

The establishment of a cadre of specially trained case managers, similar to the FRC program and potentially linked to the lead coordinator who can take on the most difficult cases would benefit the individual veteran as well as free up the care managers and other case managers to serve more veterans. While most veterans can be accommodated by a simple phone call to a social worker or care manager, those with the most complex needs often need an individual with the training, competency, desire and authority to request waivers, explore options, and develop integrated care plans.

The establishment of a case management and social work lead at the VISN level who could help to coordinate training, standardization of services, and serve as a point of contact when challenges arise.

Ease the process of obtaining a case manager. While we have hopefully made a good case for having a case manager for those who need it, the fact remains that it is difficult to obtain one and very little public information exists to educate the patient. For example, the Richmond, Virginia VAMC homepage only mentions case management once as a subheading for Post 9/11 M2VA Care. There is no mention of co-morbid complex care case management or of disease specific case management. If you click on Post 9/11 M2VA case management, the description is not about multiple disease/condition/injury care, but more a description of transitioning back into civilian life after serving in the military. For those veterans that entered Afghanistan in 2001 or Iraq in 2003, should they look for case management services for multiple complex care needs, the description would not be one that would likely cause them to connect with the M2VA program or case managers. For any other veteran, not post 9/11, there is no mention of case or care management programs on the front page for that facility. So how exactly does a veteran know that these programs exist, know to ask for them, and know how to find them?

Review the current process for entering records from outside providers (CCN, TRICARE, Medicare, other private providers) and how it impacts the ability to provide appropriate care and care management. (This should occur system wide as the process varies facility to facility and VISN to VISN.) While reimbursement for care is an issue, the lack of a transparent process, including identifying who is responsible for obtaining the records and the methods by which those records are or are not uploaded into the VA system, delays care and frustrates both doctors and veterans. This lack of record input and management impacts patient care, eligibility for programs, and the care manager's ability to effectively manage the case.

Review the current actual caseloads of the different care management and social work teams across the VA to ensure proper staffing and allow for incentives to fill needed vacant roles. In addition, identify collateral duties that do not have a designated full time employee (FTE).

Establish a "Pathway to Advocacy" for outside organizations to officially assist veterans and caregivers within VHA. QoLF strongly supports the recent Senate introduction of the CARE Act of 2023 which includes a provision requiring the Secretary to develop a process to train and recognize non-profit organizations to assist in the navigation of programs and services within the Veterans Health Administration. While QoLF currently uses Releases of Information to advocate on behalf veterans and caregivers, such a process would allow certified organizations to work more effectively WITH social workers and care managers to better support the population we all serve.

In conclusion, Quality of Life foundation believes VA needs to simply re-align their resources and bring back older, more robust models of case management for those most severely impacted veterans. These program models have existed in the past, and for some reason were changed as the more recent conflicts wound down. As a result, care management was siloed and veterans suffered. Correctly modeling, training, and assigning case managers to complex cases would save time, money,

and resources. Allowing VSO's and NPO's to advocate for care that exists within the system would also help veterans and facilities. Veterans would get more timely appropriate care with the help of a holistic full-time case manager with authority to cut through VA red tape. Overall, this would save VA money if the veteran is able to get timely, appropriate care that is managed across the spectrum of the medical community; and veterans would have better health outcomes and quality of life.

Prepared Statement of Matt Brady

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the House Committee on Veterans' Affairs Subcommittee on Health – thank you for inviting Wounded Warrior Project (WWP) to submit this written statement for the record of today's hearing on care coordination at the U.S. Department of Veterans Affairs (VA). Care coordination is critically important to those who rely on VA for health care, particularly for those with multiple conditions and providers, and those who receive care within VA and its network of community-based providers. We appreciate your attention to this topic and are pleased to share our perspective.

Wounded Warrior Project was founded to connect, serve, and empower our nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are fulfilling this mission by providing more than 20 life-changing programs and services to over 190,000 registered post-9/11 warriors and 48,000 of their registered family members. As our programs have evolved alongside those we support over the past 20 years, filling gaps in government-provided services has been an enduring focus that has fostered close familiarity with VA's ability to coordinate care for veterans.

To be clear, there is no shortage of VA programs to support veterans and their families. However, in that abundance, many in this population remain confused by the number and types of VA services, employee roles in their delivery, and eligibility criteria. As such, WWP has often filled a void by assisting warriors and their families with navigating the VA system to help better ensure positive outcomes and coordination. This support– which can be provided through different WWP programs – is particularly important for the specific population of veterans that WWP serves.

Based on data from our 2022 Annual Warrior Survey, nearly four in five WWP warriors have a VA disability rating of 70 percent or higher. Typically, our warriors have multiple cooccurring diagnoses (94 percent), with the most common being sleep problems, post-traumatic stress disorder (PTSD), anxiety, and depression. Over 90 percent of warriors report having health care coverage through VA and nearly 60 percent use VA-only providers to receive their primary care. 55 percent of those warriors who use VA providers for their primary care report that VA was either extremely helpful or very helpful in coordinating their primary care. Nearly 45 percent of warriors who use VA providers for their primary care report that VA was either somewhat helpful or not at all helpful in coordinating their primary care.

With these warriors in mind, WWP has purposefully set out to build and maintain a series of programs to help increase the quality of interactions with the VA health system and ensure the best results for those we serve. Three of those programs stand out in particular.

Independence Program: Helping veterans live more independently and with better quality of life in consideration of moderate to severe brain injury, paralysis, or neurological/neurodegenerative conditions.

The Independence Program is a partnership between WWP, the warrior, and his or her family or caregiver, and is uniquely structured to adapt to their ever-changing needs. This program pairs warriors who rely on their families and/or caregivers with a specialized case management team, paid for by WWP, to develop a personalized plan to restore meaningful levels of activity, purpose, and independence into their daily lives. These teams focus on increasing access to community services, empowering warriors to achieve goals of living a more independent life, and continuing rehabilitation through alternative therapies.

Services are highly individualized and supplement VA care, including: case management, in-home care, transportation, life skills coaching, traditional therapies (physical, occupational, speech, etc.), alternative therapies (art, music, equine, etc.), and community volunteer opportunities. These services are provided for free and augment or complement what our warriors receive from VA. For many, this is an opportunity to participate in the types of daily tasks and meaningful activities others take for granted. It also provides anecdotal evidence to indicate that veterans fitting this profile may require more consistent care coordination service:

- WWP assisted an Army veteran who, because of his injuries, was honorably discharged after two deployments to Iraq. He now requires supervision and assistance with his activities of daily living, as well as instrumental activities of daily living due to a severe neurological disorder. His caregiving situation became unstable with his previous spouse not being able to provide care to him or their children. The family moved in order to get support from the veteran's mother, who is now the primary caregiver. Without the support from the caregiver, the veteran would be at significant risk for institutionalization. The Independence Program assisted the veteran with transferring care to the new VA facility and implementing some community support services so he can engage in meaningful activities at home. Unfortunately, the veteran and his family became homeless after they were evicted from their home. The Independence Program stepped in to provide financial assistance and temporary housing for the family. Additionally, the Independence Program staff contracted a local case manager to assist the veteran with identifying primary care and mental health providers at the local VA; supported the veteran with enrolling his kids into school; placed mental health counseling referrals for the kids; referred the veteran to a financial counseling program; and assisted with application process for a new apartment. After a year in the Independence Program, veteran is attending all medical appointments at the VA, making timely payments on his bills, obtained his driver's license, purchased a car, and is working with a community support specialist to build structure and consistency at home.
- WWP has also helped a 23-year-old Army veteran who was injured in a fall resulting in a spinal cord injury, paraplegia and traumatic brain injury (TBI). The soldier was residing in an ADA accessible Barrick at the Soldier Recovery Unit in San Antonio, Texas when the Independence Program connected with him. He required assistance with activities of daily living including transfers and bowel/bladder care. He also had undetermined cognitive deficits as a neuropsychological evaluation had not yet been completed. He did not have access to transportation and could not get to appointments, grocery shop, or access his community independently. At the time of discharge, he did not have a comprehensive discharge plan, ADA accessible housing, or an identified caregiver. This veteran was at significant risk of homelessness, institutionalization or further injury without supervision and supports put in place. The Independence Program connected this veteran to a community-based case manager who supported the veteran in securing ADA housing, setting up VA Homemaker and Home Health Aide (HHA) in-home supports, and Community Support Specialists to assist the veteran in scheduling and attending medical appointments. The veteran also engaged in recreational therapy to address his reintegration into his community and participated in financial counseling. WWP also collaborated with the veteran's VA social worker to ensure physical therapy was conducted in his home, that he was provided a shower chair, had access to VA transportation and ensured a neuropsychological evaluation was scheduled with his local VA. His community-based case manager, provided by WWP, continues to work with the VA to ensure these in home supports are managed by the VA moving forward.

In addition to these specific case studies, WWP also surveyed our veteran and caregiver population to gather insight about how care and services might be better coordinated at VA, specifically with the VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC). In May 2022, WWP surveyed a subset of veterans and caregivers (13,000) who previously indicated: a need for aid & attendance services, being housebound, requiring instrumental support or currently participating in WWP's Independence Program. Data from this survey strongly supports the idea that veterans and caregivers benefit from enhanced care coordination and that more effective communication about VA's programmatic offerings is needed.

Over half of respondents reported they never participated in PCAFC (51.2 percent) or were denied (11.3 percent). For those that never participated in PCAFC, 67 percent were not aware of PCAFC and their potential eligibility. Nearly 24 percent were ineligible under the previous PCAFC rules. The lack of awareness about PCAFC eligibility in our sample population, despite disclosing a disability rating of 70 percent or higher, where a significant majority reported a need for 50 hours per week of caregiver assistance due to physical injury and/or mental injury, is concerning. Additionally, we surveyed our constituents about utilization of other VA entitlement programs that can support aid & attendance, such as VA special monthly compensation (SMC). SMC is a benefit paid directly to veterans that specifically supports aid & attendance. Despite the high disability rating, the requirement for aid & attendance, and the reliance of our population on a caregiver, 71.8 percent do not receive SMC. In sum, we believe these findings suggest improved care coordi-

nation and commitment to raising awareness of programs for more severely wounded, ill, or injured veterans would result in better utilization among those who would qualify for them.

Based on the experience of our Independence Program, we have the following calls to action for the subcommittee to consider:

- **Ensure that policies are in place to increase awareness and accessibility of programs for those with heightened needs**. WWP supports the *Elizabeth Dole Home Care Act* (H.R. 452, S. 141), particularly key provisions that would instruct VA to provide informal Geriatrics and Extended Care (GEC) program assessment tools to help veterans and caregivers identify expanded services they are eligible for, and assist caregivers denied or discharged from PCAFC into other VA-provided home-cased care and support. Such support can also be found in the community and advanced through measures like Section 2 of the *Caregiver Application and Appeals Reform Act of 2023* (S. 1792), which WWP also supports. Improving veteran and caregiver knowledge of VA program intricacies and providing clearer direction of how they can be used is a less formal variety of care coordination that should help many.

  Additionally, WWP has found that establishing treatment and support programs may simply not be enough. Overlapping resources and nonuniform availability of federal, state, and local resources require a broad community effort to connect those in need with the services created for them. For this younger generation, VA's nomenclature has an impact. The word "Geriatric" – in reference to VA's GEC program office – can be a source of confusion or deterrence for both the veteran and their case manager or social worker to seek services even as veterans under the age of 65 already represent 27 percent of those served by VA's long term support services.[1]

  To overcome even this most basic barrier as well as others, a menu of available program options tailored to the veteran/family and based on his or her needs and eligibility would maximize the use and impact of those services. In addition, younger veterans with long term care needs and their caregivers are often overlooked for programs like Veteran Directed Care and Home-Based Primary Care because they are a small – but vulnerable – portion of the eligible population. In many cases, they are in desperate need of these services but simply are not aware they exist. Because this population is relatively small and geographically diverse, increased training to identify younger veterans in need of long-term support services may be needed.

- **Continue to foster VA collaboration with community-based non-profit organizations, and State and local governments to increase the availability of care coordination services in the community**. WWP was pleased to advocate for passage of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (P.L. 116–171) that signed into law in 2019. Section 201, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, established a 3-year grant program to provide grants for upstream community-based suicide prevention efforts. These grants are awarded to organizations working to provide or coordinate suicide prevention efforts within their communities, including by providing case management services. WWP supports these ongoing efforts and encourages continued collaboration between VA, community organizations, and state and local governments to collaborate and provide additional case management services to veterans.

  While the Fox Grant Program is focused on suicide prevention services and expressly includes case management service as a (see *Hannon Act*, Sect. 201 (q)(11)(A)(v)), this model of collaboration between VA and community may also find success in a program dedicated specifically to care coordination.

Complex Case Coordination: Helping veterans in need of immediate mental or physical health care access high quality VA or community-based services as soon as possible.

Wounded Warrior Project's Complex Case Coordination (C3) team serves warriors with complex challenges that are often multi-faceted and require urgent action. They connect warriors to internal and external resources and treatment options to provide them with immediate assistance. When working with warriors, the C3 team assesses each of their unique needs and works with them to develop an individualized plan. They work to identify the resources that will best meet the warrior's

[1] U.S. DEP'T OF VET. AFFAIRS, FISCAL YEAR 2024 BUDGET SUBMISSION, Medical Programs and Information Technology Programs at VHA–198, https://department.va.gov/administrations-and-offices/management/budget/ (last visited June 9, 2023).

needs and often act as a liaison between VA, the Department of Defense (DoD), and private community resources throughout the course of the warrior's treatment.

The C3 team works a case in three phases. First, they work to ensure the warrior is safe and stable, conducting an assessment and determining their needs. The second is to maintain the situation while they work to build an action plan, mobilize resources, and advocate for the warrior's needs. The third is the transition, where the team coordinates wrap around services and conducts follow-up.

As VA is one of our most critical partners, C3 has a strong record of collaborating with VA's Central Office (VACO), every Veteran Integrated Service Network (VISN), and nearly every VA Medical Center (VAMC). The C3 team works with VA providers and social workers to not only coordinate care, but to facilitate the resolution of complex needs, including housing insecurity, justice involvement, military sexual trauma (MST), substance use, and mental health, or cognitive challenges. With over 1,200 cases over the last four years, we have seen the impact and efficacy of case coordination result in improved outcomes and often, a restored confidence for the veteran in VA healthcare.

When working a case, the C3 team assesses what VA resources may be available to immediately address a warrior's needs. Whether it's a mental health social worker, Military2VA Case Manager, MST, or U.S. Department of Housing and Urban Development-VA Supportive Housing (HUDVASH) program lead, these dedicated VA employees work in coordination with WWP to assist warriors. In some extremely complex cases, C3 will enlist assistance from VISN Chief Mental Health Officers or even VACO when clinical care needs are not being met, there is inconsistent policy execution, or care plan execution is unable to be resolved. In the past, they have been extremely helpful in elevating these issues and working with WWP to find a quick resolution.

Based on our experience of helping wounded veterans through C3 and the associated perspectives of working with VA to advocate for their needs, we have the following recommendations for the subcommittee:

- *Create a system that helps centralize care coordination and patient advocacy – particularly for those with complex needs*. Wounded Warrior Project supports the creation of a system to help centralize care coordination and patient advocacy, especially for those veterans with the most complex needs. This approach should include a mechanism to help identify those most in need of assistance with care coordination, through screening during enrollment, identification by providers and social workers of current enrollees, and a process for veterans and caregivers to self-identify as in need of these services. Additional elements should include a central hub for coordinating care across different healthcare settings to ensure that all providers involved in the veteran's care have access to the necessary information and can collaborate effectively, as well as the ability for health advocates (like WWP) to intervene and assist with necessary appeals.

  WWP would also recommend the designation of a VA social worker, at each VAMC, with enhanced authority to serve as the subject matter expert for the facility. This social worker would provide mentorship, oversight, and assistance to other social workers executing care coordination at the service level and would have the authority to expedite needed care across all service areas while facilitating communication between different providers, and helping veterans navigate the healthcare system. An additional consideration may be for training and accreditation for veteran service organizations (VSOs) to be able to engage directly with this designated social worker on behalf of a veteran. It is also essential that we empower veterans (or their designated advocates) to actively participate in their care by providing them with adequate information, resources, and education about their health conditions, treatment options, and available support services. This allows veterans to make informed decisions, effectively communicate their needs, and take ownership of their health.

  Inspiration for additional improvements to case management, especially for those with more complex needs, can be found in the Federal Recovery Coordination Program (FRCP) that previously assigned recovering Service members with recovery care coordinators responsible for overseeing and assisting the Service members through their entire spectrum of care, management, transition, and rehabilitation services available from the federal government. This model which developed a holistic care plan for the veteran, with the authority to see it through, was more effective in our experience, than the current model of indirect liaisons.

  Given how often veterans receive care outside of VA facilities, it is also necessary to ensure that medical information is appropriately communicated, and

that care coordination exists between all primary, specialty, and residential care providers. Care plans, treatments, and the availability for continuing pharmaceutical support of treatments must be communicated effectively to those provider teams involved in an individual's care, whether inside or outside of VA.

- **Establish a consistent access standard for VA's Mental Health Residential Rehabilitation Programs**. Another way to address care coordination at VA is by establishing a consistent access standard for VA's Mental Health Residential Rehabilitation Programs (MH RRTPs). Currently, the access standards established by the *VA MISSION Act* (P.L. 115–182 § 104) and memorialized in the Code of Federal Regulations (38 C.F.R. § 17.4040) do not, in practice, extend to mental or substance use disorder (SUD) care provided in a residential setting. VA has maintained adherence to access standards for this type of care through Veterans Health Administration (VHA) Directive 1162.02, which establishes a priority admission standard of 72 hours and, for all other cases, 30 days before a veteran must be offered (not necessarily provided) alternative residential treatment or another level of care that meets the veteran's needs and preferences at the time of screening.

  Unfortunately, this policy has not been uniformly applied across the VA system and WWP has seen many examples of veterans forced to wait longer than 30 days for residential treatment, and not being offered care in the community as required. Interim care offerings have included telehealth and virtual intensive outpatient programs that are less than what the veteran ultimately needs and desires. These care options tend to be less intensive, less effective, and have poorer outcomes than the residential care options they are intended to supplant. Other issues WWP has seen involving care within MH RRTPs includes poor communication of records between VA and community residential care, lack of appointment follow-up, and prescription updates.

  We believe by establishing a consistent access standard for MH RRTPs, veterans will not only receive more standardized, quality, and timely care, but we will also see an improvement in some of these other issues currently associated with RRTP care more generally. To that end, WWP appreciates and supports Section 2 of the *Veteran Care Improvement Act* (H.R. 3520), which would codify an access standard for RRTP programs. However, we would also recommend expanding the terms of that section to include other varieties of RRTP care like its specialty tracks for PTSD, MST, and severe mental illness.

Warrior Care Network: Helping reduce gaps and inefficiencies in mental health care delivery through innovation and collaboration.

Wounded Warrior Project's Warrior Care Network (WCN) is a two-week intensive outpatient program where warriors learn how to minimize the interference of mental health issues in their everyday lives. WWP partners with four academic medical centers across the country to provide this treatment to help warriors manage their PTSD, traumatic brain injury (TBI), SUDs, and other mental health conditions.

WCN academic medical center (AMC) partners provide veteran-centric comprehensive care, share data and best practices, and coordinate care in an unprecedented manner. This program's partnership with VA has helped create a broad continuum of support that is critical to successful outcomes for veterans. In 2016, the VA and WWP created a first-of-its-kind partnership, signing a Memorandum of Understanding (MOU) aimed at ensuring continuity of care and successful discharge planning for Warriors receiving treatment from both WCN and VA. This partnership included providing VA staff to assist part time at each AMC facilitating coordination of care and integrating the AMC care team.

The MOU and partnership were expanded and enhanced in 2018, establishing four full time VA Liaison positions, embedded at each AMC. The VA Liaisons are responsible for ensuring that medical records are seamlessly shared between VA and WCN, that warriors are fully registered with VA, and that they get follow-up care appointments after WCN graduation at the VA. In 2022, the VA renewed the MOU for a third time, continuing to fund one VA Liaison at each AMC site. Each VA liaison facilitates national referrals throughout the VA system as indicated for mental health or other needs. During 2022 alone, VA Liaisons served 708 warriors. Over the FY 18–22 period (beginning when VA Liaisons were assigned):

- 88 percent of veterans served by Warrior Care Network took advantage of connecting with a VA Liaison.
- More than 3,000 referrals for VA care were opened. Among the most requested appointments were mental health care, VA benefits, and primary care.

- More than 19,000 hours of collaborative hours between VA Liaisons and academic medical center employees and veterans.

In sum, Warrior Care Network results and collaboration with VA has validated our belief that community-based, veteran-centric, intensive mental health and substance use care can lead to exceptional health improvements and increased engagement between veterans and VA when properly structured and managed. While we realize that this level of VA interaction and embedding with community care providers may not be reproducible at large scale, we remain committed to the following calls to action:

- **Leverage innovation programs and investments to explore long term solutions for improved care coordination**. One approach could be to elevate VA's commitment to exploring innovative programming approaches by elevating the Center for Care and Payment Innovation (CCPI) to the Secretary's office rather than an entity within VHA, as outlined in Section 206 of S. 1315, the *Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes Act*. The bill would also require CCPI to establish pilot programs for the development of innovative approaches to testing payment and service delivery models, expand CCPI's mandate to include pilot programs that increase productivity and modernization, and accelerate CCPI's operational tempo. Strengthening CCPI may allow for VA to transform and improve veteran care, while reducing costs and administrative burdens.

Additional Calls to Action that can Improve Care Coordination

Continue Drive Toward Electronic Health Record Modernization (EHRM)

As DoD and VA continue push toward interoperability, we cannot lose sight of the goal of widespread and efficient adoption of electronic health record (EHR) systems. This will ultimately allow for seamless sharing of medical information, treatment plans, and progress updates. It also mitigates the risk of fragmented care. We believe a successful deployment of a fully integrated and user-friendly EHR will create efficiencies and result in better quality of care, improved identification of high-risk patients, an overall higher quality of life for veterans, and most significant to today's discussion, improved care coordination.

Wounded Warrior Project continues to share the larger communities' concerns with the ongoing delays and issues surrounding the EHRM efforts. WWP was pleased to see the recent announcement that VA renegotiated their EHR contract with Oracle Cerner to include additional performance metrics and accountability measures. We are encouraged to see Congress playing a larger role in oversight and believe all stakeholders must be held accountable to ensure high levels of interoperability and data accessibility between VA, DoD, and commercial health partners.

As the EHRM process continues to play out, WWP encourages Congress to look at the lessons learned from the DoD implementation of MHS GENESIS. The DoD MHS GENESIS electronic health record will provide DoD's 9.6 million beneficiaries and over 200,000 medical providers with a single, common record of medical and dental information. It is deploying in 23 "waves" and is currently 81 percent complete with full deployment expected by the end of 2023. While the initial deployment was not without its challenges, it is now expected to fully deploy within budget and on time. One aspect of the deployment that proved successful for DoD throughout this process was a system integrator approach. This approach involves using a government contractor to coordinate the integration and implementation of the single, common record. We encourage Congress to evaluate the differences in these implementation efforts and consider additional models, including this system integrator approach.

Continue to Leverage Telehealth

Wounded Warrior Project continues to believe in the importance of telehealth and asks that you continue to leverage its benefits for the veteran community. Telehealth and telemedicine services should be expanded to improve access to care, especially for veterans in remote areas. Telehealth enables virtual consultations, remote monitoring, and the delivery of healthcare services, reducing the need for veterans to travel long distances for appointments.

While telehealth has been critical to expanding access to health care services; telehealth cannot simply replace in-person service delivery. Consumers, in consultation with their providers, must be able to choose whether telehealth or in-person services are most appropriate for their needs. Some plans have implemented strategies to limit consumers' options by offering "telehealth only" or "telehealth first" coverage, which bars or limits access to in-person care. For individuals who need a higher

level of outpatient care, residential care, or inpatient care to treat their MH/SUD condition(s), a "telehealth only" option can negatively impact treatment options, further delay an appropriate level of care, and can be a significant financial barrier if individuals find they must pay out-of-pocket for additional services.

We support telehealth provisions in S. 1315, the *Veterans Health Empowerment, Access, Leadership, and Transparency for our Heroes Act of 2023*, and H.R. 3520, the *Veteran Care Improvement Act of 2023*. Both bills include measures that would require VA to discuss telehealth options for care, both at VA and in the community, if telehealth is available, appropriate, and acceptable to the veteran. We ask that Congress continue to work with VA and other stakeholders to ensure that the necessary balance is found between the efficiencies of telehealth and veteran preference.

Stabilize the Clinical Care Workforce

WWP has been encouraged by recent efforts to address the workforce shortage and high turnover rates at VA. In the first five months of fiscal year 2023, nearly 10,000 new employees were hired at VHA and as of March, they were 44 percent of the way toward their goal of hiring 52,000 new employees[2]. However, we continue to be concerned by reports of high numbers of vacancies, often resulting in long wait times and disjointed care for veterans. We believe that more can be done to help recruit and retain the best talent to ensure veterans are receiving timely and quality care.

Congress can address some of these issues by passing S. 10, the *VA CAREERS Act*. This bill would set higher base pay caps for VA physicians, podiatrists, optometrists, and dentists, making VA a more competitive option for providers. The bill would also improve VA's ability to hire at rural VA facilities by providing them with the ability to buy out the contracts of some private-sector health care professionals in exchange for employment at rural facilities. Additionally, it would allow VA to pay for licensure exam costs for future clinicians participating in VA scholarship programs and expand eligibility for health care staff to be reimbursed for professional education costs.

To ensure veterans are receiving the best possible care, with minimal interruptions, WWP believes it is essential that VA be given the resources necessary to adequately recruit and retain top talent to care for veterans. We encourage Congress to monitor this issue and ensure VA has the resources they need to achieve this goal.

Focus on PACT Act-related Care Needs

For two decades, Service members who were deployed to post-9/11 battlefields were exposed to dangerous fumes from burn pits and other toxic chemicals. After the 117th Congress passed the *Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022* (P.L. 117–168), many veterans now suffering from respiratory conditions, cancers, and other serious illnesses have access to VA care for those disorders. Under the *PACT Act*, recently discharged combat veterans now have a 10-year enhanced enrollment period (up from 5 years), and veterans who were discharged more than 10 years ago have a limited one-year period to enroll for care (October 1, 2022, to September 30, 2023). Even more may now seek care for conditions that are now more likely to be service connected.

While VA deserves praise for all of its implementation efforts, expansion of health care under the PACT Act has highlighted gaps in care coordination for cancer care. As noted in a recent Government Accountability Office report and experienced by WWP's C3 team, VHA does not have a policy that addresses cancer surveillance or assign responsibility for cancer care coordination.[3] Given the success that VA has had using social workers in fields like traumatic brain injury and spinal cord injury to coordinate ancillary care for patients, we believe a similar policy should be in place for oncology patients.

CONCLUSION

Wounded Warrior Project thanks the Subcommittee on Health and its distinguished members for inviting our organization to submit this statement. We are

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[2] Eric Katz, *VA Is Hiring at a Record Rate. Employees Say It's Still Not Enough*, GOVERNMENT EXECUTIVE (March 21, 2023), available at https://www.govexec.com/workforce/2023/03/va-hiring-record-rate-employees-say-its-still-not-enough/384257/.

[3] OFF. OF INSP. GENERAL, U.S. DEP'T OF VET. AFFAIRS, INADEQUATE COORDINATION OF CARE FOR A PATIENT AT THE WEST PALM BEACH VA HEALTH CARE SYSTEM IN FLORIDA iii (Mar. 2023).

grateful for your attention and efforts to ensure that veterans receive the best possible care and outcomes through the Veterans Health Administration, particularly through well-coordinated care. We look forward to continuing to work with you on these issues and are standing by to assist in any way we can toward our shared goal of serving those that have served this country.

Prepared Statement of Roscoe Butler

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on the Department of Veterans Affairs' (VA) efforts to coordinate veterans' care. No group of veterans better understands the importance of having timely access to a full continuum of coordinated health care than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D).

Veterans with complex healthcare conditions like SCI/Ds receive care from primary care physicians, a wide range of specialists, visiting nurses, and caregivers—many of whom are family members. Additionally, this care is provided through a number of service points. It may be provided at one of VA's 25 SCI/D centers, through VA's six long-term care centers, or at other VA facilities. It may also be provided through community care providers, in state veterans or community nursing homes, or in the veteran's residence. This often poses a Herculean challenge to the many dedicated professionals who are working tirelessly to ensure that the delivery of high-quality acute and long-term care is administered by the right providers in order to achieve optimum care outcomes for veterans.

Veterans with SCI/D who are enrolled in and using VA care generally have an easier time with care coordination than those individuals who are receiving care solely outside the VA system. Appendix D of Veterans Health Administration (VHA) Directive 1176(2) on the SCI/D system of care lists the wide range of doctors, nurses, social workers, psychologists, therapists, and other specialists that serve as part of the interdisciplinary team for each SCI/D center. They include the members of the Patient Aligned Care Team (PACT) who are responsible for care coordination within VA, including at SCI/D spoke sites; in long-term care settings (e.g., VA Community Living Centers and community nursing homes); outreach; and virtual care. Ensuring they have the appropriate staff on their payroll allows VA to more quickly and completely coordinate its care for SCI/D veterans. An example of this coordinated care is a PVA member from Maryland who receives much of his care through his local VA Medical Center, but also utilizes VA's community care network and the Department of Defense's TRICARE program. Since a spinal cord injury in 2006, his VA care team has managed hundreds of dermatology, gastroenterology, hematology, immunology, neurology, occupational and physical therapy, oncology, primary care, pulmonology, rheumatology, and surgical visits both in and out of VA facilities. This veteran and many others like him are thriving because proper coordination of care ensures they are able to receive the right care at the right time and in the right place.

Within the VA's SCI/D system of care, knowing how to care for a veteran with these injuries or illnesses isn't optional, it's a requirement. Unfortunately, a serious knowledge deficit about SCI/D care exists in the private sector. Civilian facilities are simply not equipped or properly staffed to handle SCI/D patients' acute and long-term care needs, so most will not accept them. That number is growing as facilities and agencies decide to drop this capability as staffing shortages persist. Outside of VA, the ability to coordinate care drops dramatically for several reasons.

Caring for veterans with SCI/D requires sharp assessment, time-and labor-intensive physical skills, and genuine empathy. Nurses who work in SCI/D must possess unique attributes and specialized education. All medical providers, Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, and Nurse Practitioners working with the SCI/D population are required to have increased education and knowledge focused on health promotion and prevention of complications related to SCI/D. This includes the prevention and treatment of pressure injuries, aspiration pneumonia, urinary tract infections, bowel impactions, sepsis, and limb contractures. Unlike VA, few facilities in the private sector have the highly trained personnel on staff to properly care for SCI/D patients.

Partly due to the lack of proper education and training, many private sector hospitals, agencies, and nursing homes are not able to properly care for veterans with SCI/D. As a result, SCI/D care coordinators must spend a considerable amount of time searching for ones that do. Sometimes SCI/Ds interrupt communication between the brain and the nerves in the spinal cord that control bladder and bowel

function. This can cause bladder and bowel dysfunction known as neurogenic bladder or neurogenic bowel. Other veterans may have tracheotomies that allow air to flow in and out of the windpipe. Some veterans may need a feeding tube due to difficulty swallowing, an eating disorder, or other feeding issues. Each of these conditions require close management and regular physical interventions that private sector facilities often cannot adequately provide. Most private sector facilities cannot provide long-term care for the same reasons. A few private sector health care facilities do a good job of providing acute SCI/D recovery care, but only VA is able to provide the full, lifelong continuum of services for veterans with SCI/D that can increase their lifespan by decades. That is why PVA places tremendous emphasis on preserving and strengthening VA's specialized systems of care.

Although VA is able to best provide care for veterans with SCI/D, there are still challenges. These challenges include difficulties in coordinating with other VA services and lack of resources to assist special populations of SCI/D veterans. Also, the lack of facility-based long-term care in VA and in the community causes significant issues in care coordination.

Challenges in Coordinating with Other VA Services

Prosthetics

VA's SCI/D centers and their spoke sites are intentionally designed and staffed so the coordinated, lifelong continuum of services that SCI/D veterans need are readily available. Prosthetics is often cited as one area within VA where coordinating individual veterans' needs can be difficult. Here, timeliness is often an issue as requests for equipment move slowly within the system. Sometimes orders are not placed or they are dropped without any apparent cause. Unfortunately, accountability for these systemic failures is lacking. Supply shortages can aggravate matters further. The inability to receive needed prosthetics in a timely manner frequently prevents veterans from returning home quickly and stimulates preventable increased workloads when VA's care coordination team must do multiple follow ups just to ensure a veteran receives the devices or other equipment they need.

A wheelchair is an extension of the body of a veteran with an SCI/D. Thus, they can typically tell when a part is wearing out or is broken. Sometimes a part is visibly in need of repair or replacement, but even if veterans report these types of problems, some facilities make them wait until a vendor is dispatched to their residence and confirms its broken before initiating repairs. In these instances, veterans are not being well served by an antiquated process that could hold them hostage for several days or weeks. It also increases the VA care coordination team's workload as they are forced to intervene on behalf of frustrated veterans.

At a small number of VA facilities (2–3), support for prosthetics is essentially "available on demand." Unfortunately, these locations can be described as "unicorns" because that level of support is rarely available in most other facilities. The VA should study the policies and process at the locations were access to prosthetics is working well, and have them implemented system-wide.

Care for Special Populations

Determining if a veteran can return home is usually the starting point for the care coordination team and accommodating the needs of homeless SCI/D veterans can be particularly challenging. Occasionally, homeless veterans with SCI/D receive treatment at one of VA's acute SCI/D centers and once they are stabilized there is nowhere to send them because they have no residence. Finding affordable, accessible housing in the veteran's community often proves to be difficult for VA's SCI/D care coordinators. Resolving these types of cases are very labor intensive and can take months to resolve. There does not appear to be formal guidance to handle these types of situations and their resolution is often the result of the ingenuity and skill of the SCI/D care coordination team. Congress should examine VA's existing policies and ability to care and house such veterans.

The population of veterans with SCI/D has undergone substantial changes over the last 50 years. Increasing numbers of women have been serving in the military and they now represent about 5 percent of the veteran SCI/D population. Additional considerations when coordinating their care usually include the use of a single patient room and the availability of gender-specific care in properly staffed and fully accessible buildings. These qualifications are rarely found in tandem in the private sector. Additionally, in-resident care of SCI/D veterans with substance use disorders (SUD) is virtually nonexistent within VA and the private sector. They may be able to receive counseling but at the end of each day return to home where the potential for a relapse is high. These individuals are not normally housed in acute care centers until the SUD is resolved due to security and safety concerns. Until VA gains

the ability to provide this level of care, these veterans will be trapped in a vicious cycle that threatens their health and well-being. We hope that this Subcommittee will work with VA to determine how the Department can better serve these cohorts of veterans.

Limited Long-Term Care Services

VA's lack of long-term care beds is severely impairing its ability to coordinate care for veterans with SCI/Ds. More than half of the veterans on VA's SCI/D registry are over the age of 65 and most of their caregivers are aging as well. As indicated previously, nationwide, very few long-term care facilities are capable of appropriately serving veterans with SCI/D. VA operates just six SCI/D long-term care facilities; only one of which lies west of the Mississippi River.

According to VHA Directive 1176(2), the VA is required to operate at least 181 of its 198 authorized long-term care beds at SCI/D centers. Recently, only 168 beds were either available for or in use. 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.

In 2012, VA's own research [1] warned that a wave of elderly veterans with SCI was coming and the Department should prepare for them. At the time, aging veterans, new cases of SCI from recent conflicts, and increasing numbers of women veterans were dramatically changing the profile of VHA's SCI/D population. If the Department heeded its own warning back then and increased its SCI/D long-term care capability, we might not be in the dire situation we are today.

A pair construction projects will add roughly 50 more SCI/D long term care beds to VA's inventory in the next few years. Other projects have been identified but need funding allocated in order to progress. Until then, a high number of aging veterans with SCI/D who need long-term care services will be occupying acute care SCI/D center beds or be forced to reside in nursing care facilities outside of VA that are not designed, equipped, or staffed to properly serve veterans with SCI/D. Others will remain in precarious situations in their homes and VA care coordinators will continue its struggle to find appropriate agencies or individuals to deliver their care. PVA strongly supports H.R. 3225, the Build, Utilize, Invest, Learn and Deliver (BUILD) for Veterans Act of 2023, 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.

The lack of capacity to provide long-term care for SCI/D veterans within VA and the private sector mean VA care coordinators spend a tremendous amount of their time attempting to locate providers, facilities, or agencies in the private sector to meet SCI/D veteran's long-term care needs. Truth be told, access to long-term care was extremely scarce prior to COVID, and VA's SCI/D care coordinators worry that it is getting scarcer. We understand that nursing homes and home health agencies often pursue contracts with VA, but many don't maintain them long. Most lack, and are unwilling to achieve, the necessary training to perform the critical tasks like bowel and bladder care or tracheostomy care that some veterans with SCI/D need. Facilities lacking proper staffing are often unwilling to procure additional personnel for SCI/D veterans whose greater care needs consume a larger than anticipated share of their existing workforce's time. Even if they are willing to hire additional personnel, nationwide provider and nursing shortages will often preclude them from finding the personnel that they need. These "starts and stops" are frustrating to veterans and those who coordinate their care.

Most veterans with Amyotrophic Lateral Sclerosis (ALS) and some with a spinal cord injury will eventually require ventilator care. VA has an extremely limited number of vent-capable beds for SCI/D veterans and they are often maxed out with patients. In most states, this level of care for SCI/D patients does not exist outside of the VA; thus, it is a daily occurrence that care coordinators are combing the country looking for an available bed. We work regularly with VA to assess its SCI/D system of care and those we speak with during our annual visit to each SCI/D center agree that the Department desperately needs to expand its ventilator capability.

The 65 percent statutory cap on what VA can pay for home care can also impact care coordination because it limits care options which may contribute to unfortunate results. Recently, a PVA member in Texas with ALS whose home care was limited by the VA cap developed a problem with his gallbladder bag. Since he wasn't receiving the much-needed assistance from VA at home, the family sought help from the local private sector medical system because they believed VA had already demonstrated an inability to meet his needs. While there, the veteran developed com-

[1] "Who are the women and men in Veterans Health Administration's current spinal cord injury population?" https://www.rehab.research.va.gov/jour/2012/493/pdf/page351.pdf.

plications due to an undiagnosed pneumonia which led to him being intubated. Mentally and physically, his condition deteriorated rapidly, and the veteran passed away.

In light of the limited access to VA facility-based long-term care and the desire of many veterans with SCI/D to receive non-institutional long-term care, VA must expand access to home and community-based services (HCBS) to meet the growing demand for long-term services and supports. Facility-based long-term care services are expensive, with institutional care costs exceeding costs for HCBS. Studies have shown that expanding HCBS entails a short-term increase in spending followed by a slower rate of institutional spending and overall long-term care cost containment.[2] Reductions in cost can be achieved by transitioning and diverting veterans from nursing home care to HCBS, if they prefer it, and the care provided meets their needs.

Passage of H.R. 542, the Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act, would improve care coordination for SCI/D veterans by making critically needed improvements to VA HCBS including raising the cap on non-institutional care, expanding the Veteran Directed Care program, creating a pilot program to address direct care worker shortages, and improving family caregiver supports. We cannot stress enough how important it is for Congress to pass this important legislation sooner rather than later.

PVA appreciates the Subcommittee's interest in this critical area, and I would be happy to answer any questions you may have.

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

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

Fiscal Year 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.

Fiscal Year 2021

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

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.

[2] Do noninstitutional long-term care services reduce Medicaid spending?