Statement for the Record

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"Dignity Denied: The Case for Reform at State Veterans Homes"
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Chairwoman Miller-Meeks and Members of the Subcommittee: It is an honor to submit this Statement for the Record. My name is Representative Sheri Biggs. I bring three decades of experience in clinical and administrative roles serving veterans and other vulnerable populations. My professional background includes work as a dual board-certified nurse practitioner in family practice and psychiatric mental health, a Air National Guard Lieutenant Colonel, and an administrator and consultant of a state-run veterans' homes. These experiences have shaped my understanding of the structural, clinical, and ethical demands required to care for aging veterans. In both my clinical and community roles, I have personally worked with many veterans grappling with suicidal ideation and untreated mental health conditions. Tragically, in my district alone, eight veterans have died by suicide this year.

This testimony addresses the urgent need for modernized federal-state oversight and support mechanisms for State Veterans Homes (SVHs), which serve as the long-term care backbone for many aging veterans. Despite substantial VA investments and detailed federal policy frameworks, significant operational discrepancies continue to jeopardize veteran safety and undermine public trust.

Elderly Veterans Require a Standard of Care Consistent with Their Sacrifice

Veterans aging into long-term care often present with complex behavioral health profiles, including high rates of depression, anxiety, PTSD, dementia, and substance use disorders. According to VA's own figures, roughly half of veterans in long-term care settings carry at least one mental health diagnosis (VA OIG, 2024).

My work and writing in the veteran mental health space have emphasized that post-traumatic stress is not only an individual condition—it is a family condition. In my recent article, *"No Greater Love: PTSD's Impact on Spouse, Family of Veteran,"* I outlined how trauma from combat deployment reverberates through the veteran's home life. PTSD has been shown to directly contribute to relationship dysfunction, communication breakdowns, and mental strain on spouses and caregivers. Once it

enters a household, only 3 in 10 military marriages survive long-term. These family dynamics follow our veterans into long-term care, where social withdrawal, unresolved trauma, and deteriorating family ties make treatment and recovery even more complex. If our system continues to isolate mental health treatment from the broader social environment veterans live in, we will continue to miss key risk indicators and opportunities for support (Biggs, 2023).

GAO's testimony highlighted that more than 40% of veterans in state homes received the same deficiency citation two years in a row, signaling persistent noncompliance in critical areas like infection control and suicide risk screening (GAO-25-108441). While VA conducts annual unannounced inspections across 200 clinical and safety standards, its enforcement tools remain limited. Unlike CMS, VA has no moderate enforcement options—its only penalty is withholding per diem payments, a measure it has never used due to its severity.

The 2018 University of Michigan and RAND Corporation study adds further urgency, showing veterans relying solely on private-sector mental health care face significantly higher suicide risk than those receiving care through the VA system (Smith et al., 2021). Given that SVHs operate at the junction of state and federal systems, it is unacceptable that we do not have seamless VA clinical integration, preventive protocols, or adequate behavioral health resources.

Enhancing Oversight Through Practical, Targeted Reform

Congress should act to ensure VA identifies a continuum of enforcement tools—including partial per diem suspensions or corrective action timelines—to enforce compliance without resorting to extreme measures. As GAO has noted, VA walked back its 2023 plan to seek such authority and instead relies on enhanced follow-up, which does not compel compliance (GAO-25-108441).

State-level data from Louisiana underscores the need for reform: 58% of SVH residents there have multiple mental health diagnoses, and nearly 27% are prescribed antipsychotics. Yet homes routinely deny admissions due to insufficient psychiatric support. Over a two-year period, Louisiana's five SVHs logged 134 behavioral health transfers and denied 72% of admissions on mental health grounds (LDVA, 2025). We cannot continue to turn away veterans at their moment of greatest need due to structural incapacity.

Enabling Data-Driven Coordination and Transparency

Oversight should be rooted in quality outcomes. While VA tracks clinical metrics across SVHs, those data are not uniformly shared with facilities, nor integrated into real-time decision-making platforms. Louisiana's best practice of embedding VA liaisons

and granting CPRS access to SVH staff illustrates how visibility into clinical records can enhance care coordination (LDVA, 2025).

Facilities need secure access to suicide risk flags, discharge plans, and behavioral safety protocols. Absent that, SVHs operate with blind spots that endanger patients.

Conclusion

The testimony provided by VA, GAO, and state administrators today paints a clear picture: our current oversight structure is fragmented, outdated, and insufficiently resourced to meet the needs of an aging veteran population with complex mental health needs.

State Veterans Homes should not be left to navigate these challenges in isolation. They require partnership—true partnership—with the VA. That means better data access, smart oversight, and the clinical integration that veterans deserve.

It is my hope that this hearing marks a shift from rhetorical concern to meaningful reform.

References:

VA Office of Inspector General (OIG), *Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies*, December 18, 2024.

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