

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

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
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THURSDAY, JUNE 13, 2024

COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The committee met, pursuant to notice, at 10:47 a.m., in room 360, Cannon House Office Building, Hon. Mike Bost (chairman of the committee) presiding.

Present: Representatives Bost, Bergman, Miller-Meeks, Van Orden, Luttrell, Takano, Brownley, Cherfilus-McCormick, Ramirez, Landsman, and Budzinski.

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

The CHAIRMAN. Good morning. The committee will come to order, and I want to welcome the witnesses to our hearing today. I do want to apologize for the late start, but we are going to get started here. Today, we will be discussing the care and benefits available to veterans living with spinal cord injuries and disorders. You know, we have not had a hearing on this issue during my time on this committee, and the oversight in this area, it has been long overdue.

Before we dive into it, though, there is something that I want to say, and I think it is important that I do. I am very disappointed to see that the U.S. Department of Veterans Affairs (VA) did not send a witness from the Spinal Cord Injury and Disorder, or the SCI/D, system. That is what this hearing is all about. For the VA, should have prioritized having someone here from that office that is tasked with helping the veterans and their availability to receive those benefits. I think it is important that the people in this room, the veterans as well as the taxpayers and the veterans who are watching this hearing, this is the third time this year where we have been declined by the VA to have the witnesses that we requested. It does not matter whether we are Republican. It does not matter whether we are Democrat. It does not matter whether the ranking member, when he was in the majority. It is really upsetting whenever the VA makes decisions to overrule our decision on who we want and accept your judgment over ours.

It is the responsibility of this committee to make sure VA takes care of all veterans. It is our responsibility for doing that to give oversight, and we actually do understand who we need to talk to. It is the third time this year that VA has tried to make a decision

over this committee on who we need to talk to. That is not fair to the veterans and it is not fair to the taxpayers.

What you need to understand is we are the Congress of the United States. You are an agency, yes, agency controlled by the administration, but your budget is ours. Oversight is ours. We have to do our job for the American people, whether it is a Republican sitting here or a Democrat sitting here. It is not the job of the VA to decide who is going to sit before us. It is our job to request and your job to deliver. I hope I am really clear on what I just said.

With that, VA has long been recognized for its unique ability to provide top-notch SCI/D care. VA has 25 SCI/D centers across the country, each specifically designed to meet the—just a minute, to meet the veterans issues head on and meet those veterans with spinal cord injuries where it is convenient for them. Let me put in perspective what I mean.

One of the centers is in Hines, Illinois, which is about 3 hours from the top of my district, which means it is 6 hours from the bottom of my district. That is a long time to drive for an appointment. I want to ensure VA is meeting the veterans where they are with the healthcare they have earned. It is that simple.

Now, we have heard stories from veterans about missing doctors' appointments due to late or inadequate transportation with no coordination from VA. Those missed appointments have contributed to about \$4 billion cost to the Department from what we can calculate.

We have also heard concerns about staffing shortages that have prevented SCI/D centers from operating at full capacity, as well as issues with patient safety practices in the VA's facilities. Some of the VA's shortfalls in this area are addressed in H.R. 8371, the Elizabeth Dole Act, including home care, long-term care, and access to SCI/D systems of care. It is incredibly important that we pass this important legislation to ensure VA can meet the need of all veterans. I hope my colleagues on the other side of the aisle, and I am sure they will, will put politics aside and support this life-saving bill.

Today, we will also examine VA's failure to ensure all disability exams are conducted in properly equipped facilities. A recent VA Inspector General (IG) report showed that a large number of contract exam facilities did not comply with Federal disability law. In this day and age, that is unacceptable.

Let us be perfectly clear. This is not a mere suggestion for the Department. It is what we expect. VA must ensure that the veterans they serve have access to accessible and safe exam facilities. Without that, veterans are being restricted from the benefits they have earned. We know that disability claims processing itself is difficult to navigate. Veterans should not also face physical barriers to getting an exam.

Access to benefits, including VA's Specialty Adaptive Housing Grant program, are also crucial. Yet we understand that the application, the wait times for this program can present challenges for veterans and their families that they need help. Veterans are required to receive three estimates before they can get approval, and it can be difficult to find builders to do the work, especially if you are in a rural area. The advantage of keeping disabled veterans in

their homes not only saves money, but it also gives the veterans and their families peace of mind. Congress has recently invested in this program. VA must make the rubber meet the road so severely disabled veterans continue to have access to the benefits that they have earned.

Now, I am eager to hear from the VA today about how they plan to fix these years-long problems. We will also learn from the expert witnesses who will speak about what more we can do to improve access to care and services for catastrophic disabled veteran community. I also want to welcome the many members of the Paralyzed Veterans of America (PVA) who are attending the hearing here today. Thank you all for making the trip to DC, and I appreciate that you are spending some time here with us this morning.

Now I would like to recognize Ranking Member Takano for his opening comments.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Well, thank you, Mr. Chairman. I am pleased to be here today to examine how we are meeting the needs of veterans with spinal cord injuries and disorders, sometimes referred to as SCI/D.

It is estimated that around a quarter of those with spinal cord injuries and disorders are veterans. Many patients live with the effects of these injuries for decades. It is crucial that VA can provide resources and help meet the needs of veterans with spinal cord injuries and disorders at each stage in their lifetime of care. Now, this includes access to equipment to assist them with mobility, ensuring a high level of care coordination to provide appropriate care for both preventative and chronic healthcare needs, and access to long-term care in settings that make the most sense for the veteran and their loved ones.

As you will hear from many of our witnesses today, VA is uniquely positioned among healthcare systems to provide this standard of care. Its hub-and-spoke model is intended to help ensure that veterans are connected to the same high standard of care regardless of where they live. This does not happen by accident. VA's position as the best provider of care for veterans with spinal cord injuries relies on continual investments in VA's infrastructure, workforce, long-term care services and supports, and other benefits for veterans with spinal cord injuries and their caregivers.

I share the concerns of some of our second panel witnesses about VA's ongoing strategic pause in hiring and the impact it is having on staffing and care for veterans with spinal cord injuries. The highly specialized training and staffing ratios necessary to provide appropriate care to veterans with spinal cord injuries means that it can be challenging to fully staff VA's SCI/D system of care. However, workforce shortages lead to beds going unfilled, decreased access to care, and worse outcomes for veterans with spinal cord injuries. We must remain vigilant and sure that vacancies at SCI/D centers are continuously filled.

Now, because of the advanced training required of healthcare providers that are caring for veterans with spinal cord injuries, special attention must be paid to bolstering the workforce pipeline. It is vital to ensure VA is training and retaining an appropriate

workforce for this population, and I look forward to discussing ways VA is doing this.

Now, improving VA's infrastructure has long been a priority of mine, but the importance of this goal cannot be overstated when it comes to serving veterans with spinal cord injuries. VA must focus on infrastructure projects that build more capacity for SCI/D beds and ensure additional access within the hub-and-spoke model. At the same time, many existing VA facilities are in need of repairs or retrofits to ensure that they meet evolving standards of care for SCI/D veterans. Now, meeting both these needs will take thoughtful investment and planning, both from Congress and VA, and I look forward to working with VA on these vital projects.

Finally, veterans need to be able to receive care in the venue that best fits their lives and needs, and many veterans rely on home-and community-based services for healthcare and support. Through the Veteran Directed Care program, veterans with spinal cord injuries have the ability to hire their own personal care aides and engage in decisions about their care that ensures it fits their needs and their lives. Most importantly, it is crucial that veterans receive the care that they need in the community without being subject to statutory spending caps that could drive them to institutionalized settings of care.

Now, my colleague, Congresswoman Julia Brownley's bill, the Elizabeth Dole Home Care Act, H.R. 542, meets these needs. It passed the House in December, and I urge the Senate to do the right thing, to move it forward. I agree with Chairman Bost that the politics must be set aside. The last I heard, his party is in the majority, and they could bring a bill to the floor at any time to address those needs. I would ask that he bring such a bill to the floor without the sort of—well, with a bipartisan agreement, basically, on what it contains. There is bipartisan agreement on H.R. 542.

I just want to thank all of our witnesses for being here today. I look forward to hearing from each of you about how we can ensure the well-being of all veterans living with spinal cord injuries.

I thank the chairman again, and I yield back.

The CHAIRMAN. I thank the ranking member for his opening statement. We will now turn to our witnesses.

Testifying before us today we have Dr. Erica Scavella, the Assistant Under Secretary for Health for Clinical Services, and she is accompanied by Mr. Jeffrey London, the Executive Director of the Medical Disability Examinations Office. Also on the panel, we have Mr. Steve Bracci, the Director of Claims and Medical Exams Benefits Inspection Division of the Office of Inspector General (OIG).

Dr. Scavella, you are recognized for 5 minutes to give your opening testimony.

STATEMENT OF ERICA SCAVELLA

Dr. SCAVELLA. Good morning, Chairman Bost, Ranking Member Takano, and committee members. My name is Dr. Erica Scavella. I am the Assistant Under Secretary for Health for Clinical Services, and in that role I directly, through my Deputy Assistant Under Secretary, oversee the Spinal Cord Injuries and Disorders System Executive Director. I am accompanied by Mr. Jeffrey London, the Executive Director for the Medical Disability Examination

Office with the Veterans Benefits Administration. Thank you for this invitation to testify before you today.

Spinal cord injuries and disorders, or SCI/D, present unique challenges and complexities, often requiring specialized care and support. At VA, we are dedicated to addressing the diverse needs of veterans with spinal cord injury and disorders, ensuring access to rehabilitative services, specialty benefits and services, and assistive technologies.

VA's SCI/D system of care is a comprehensive network designed to deliver exceptional care. This system operates under a hub and spokes model wherein 25 regional SCI/D Centers serve as hubs providing comprehensive care, while primary care services are rendered at VA Medical Centers, acting as spokes, by the SCI/D patient-aligned care teams. Mental health services are seamlessly integrated into the care plan, ensuring a holistic approach. Mobility interventions and walking aids, including walkers and canes, manual and motorized wheelchairs, and exoskeletons, are tailored to fit the individual needs of veterans, enhancing their independence and quality of life. The system also offers a range of long-term care options, including noninstitutional and home-based care, as well as support through the Caregiver Support Program, ensuring a continuum of care for those in need.

While serving as a Marine on his second tour in the Vietnam War, Mr. Ron Kovich suffered a spinal cord injury that left him paralyzed from the chest down. For the past 53 years, Mr. Kovich has received his primary and specialty care through VA. This past July, on his 78th birthday, Mr. Kovich penned an open letter sharing his thoughts on his VA experiences. In his letter, he stated, "I have been a patient in the Long Beach VA spinal cord injury hospital for the past week for a bladder infection. The care has been excellent. Aides, nurses, doctors have been terrific. Things have vastly improved over the years over here. Ever since I was a patient in 1971, I have had to come to this hospital many times over the years and I have seen many changes. I can honestly say that the care here of our veterans is now second to none."

VA strives to ensure every veteran's experience echoes that of Mr. Kovich. To accomplish this, we provide various initiatives and programs to improve the accessibility in medical facilities, including providing eligible veterans with reimbursement for self-arranged travel, special mode transportation, door-to-door appointments, and funding for the Highly Rural Transportation Grant service for travel coordination in highly rural counties. VA often continuously upgrades its facilities, integrates assistive technologies, and deploys mobile units for accessibility, prioritizing women veterans' unique needs with specialized facilities for their privacy, comfort, and tailored care. Outside of the facility, VA provides disability compensation, independent living training, and housing benefits, including the Special Adaptive Housing Grant program you mentioned, providing financial assistance for home modifications to address accessibility needs.

Additionally, we oversee contract examinations to ensure facility safety, cleanliness, and accessibility, and we work to increase the examination of our care through telehealth and acceptable clinical evidence exams. The Veteran Readiness and Employment Program

additionally assists disabled veterans in preparing for, obtaining, and maintaining suitable employment.

Finally, one of our most successful and impactful programs, the VA Adaptive Sports Clinics, provides the ability to empower veterans with spinal cord injury and disorders and engages them in physical activities tailored to their unique needs and abilities. These programs, which I have witnessed myself, allow veterans the opportunity to participate in a variety of sports and recreational activities, promoting physical fitness, social interaction, and overall well-being, completing the continuum of care.

Chairman Bost, Ranking Member Takano, this concludes my testimony. My colleague and I are ready to answer any questions you may have.

[THE PREPARED STATEMENT OF ERICA SCAVELLA APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Scavella.

Mr. Bracci, you are recognized for 5 minutes to give the OIG's testimony.

STATEMENT OF STEVE BRACCI

Mr. BRACCI. Chairman Bost, Ranking Member Takano, and committee members, I appreciate the opportunity to discuss our review of Veterans Benefits Administration's (VBA) oversight of the contract medical exam facilities used for veterans disability claims.

VBA has paid contractors billions of dollars since 2017 for these exams, which may be needed to decide claims. The exams are typically conducted at the medical examiner's place of business, and those facilities must be accessible, safe, and clean. The four exam vendors that VBA uses are required to inspect these facilities for compliance with American with Disabilities Act (ADA) and Occupational Safety and Health Administration (OSHA) standards. We focused on veterans' feedback and experiences regarding the accessibility, safety, and cleanliness of the contract exam facilities. While we are not ADA or OSHA compliance officials able to cite specific violations, we did identify deficiencies at 113 of the 135 facilities we visited. These deficiencies created needless burdens and safety concerns for veterans with mobility issues and those with spinal cord injuries and disorders. We found that the deficiencies went largely undetected by Medical Disability Examination Office (MDEO) because that office did not provide sufficient oversight of the vendors' self-certification of ADA and OSHA compliance.

In 2021, VA modified the vendors' contracts by removing the requirement for MDEO to conduct random as well as complaint-based site visits. Notably, in Fiscal Year 2022, MDEO did not conduct any site visits based on veterans' complaints. Our finding was bolstered by four determinations.

First, MDEO lacked independent access to the current inventory of contract facilities. By depending on the vendors to provide this information, MDEO could have incomplete lists. In fact, two vendors could not provide a definitive number of exam locations. Our first recommendation asked MDEO to maintain a list of the contracted facilities. While this may be the contractor's proprietary information, VA routinely handles this critical information like this

in other areas and can protect this information in the same manner.

Second, MDEO allowed the vendors to give customer satisfaction surveys rating their own performance to veterans instead of using an independent survey vendor. This may have resulted in VBA lacking a full picture of veterans' experiences. Therefore, we recommended that veterans receive the comment cards directly from an impartial survey provider.

Third, MDEO lacked formal guidance for staff conducting exam facility site visits. MDEO staff were not trained on the standards of review and their checklists were not specific enough. For example, MDEO staff did not know specific criteria, like the minimum space needed for a wheelchair to turn. Also, we found their site visits were based on general observation of the facilities. We made three recommendations to develop formal site visit procedures, update checklists, and create standardized training for staff.

Fourth, MDEO did not validate the vendors' self-certification of ADA and OSHA compliance. The vendors' self-certification process was not comprehensive or reliable, likely contributing to the deficiencies. Importantly, MDEO was not doing reviews based on veterans' complaints. We recommended that VBA conduct complaint-based inspections and enforced the requirement for vendors to inspect and recertify the accessibility, safety, and cleanliness of all facilities. Because of accessibility deficiencies, some veterans could not complete exams at those facilities. Additionally, some facilities had safety deficiencies, including locations with blocked exit routes or expired fire extinguishers. Other facilities lacked clean common areas or single-use medical supplies.

ADA deficiencies at facilities may make them unable to accommodate veterans with mobility issues. Our report has numerous examples of facilities where wheelchair users could not enter the location, so an exam was not possible. Rescheduling exams after veterans have needlessly traveled to a facility takes time and could delay their claim. We recommended that VBA analyze all veterans' complaints and create action plans to remedy them.

Our last recommendation asked VBA to work with its vendors to determine if a veteran requires accessibility arrangements before the exam. All recommendations are open and we will monitor VBA's progress on implementing the corrective action plans to address the hardships and safety issues that veterans with mobility challenges have experienced during medical exams.

Mr. Chairman and members of the committee, I am happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF STEVE BRACCI APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Bracci. We are now going to go to questions, and I will yield myself 5 minutes for the first questions.

Dr. Scavella, we have heard that VA transportation is often inconsistent and not accessible to SCI/D veterans, which result in missing medical appointments. Can you tell me how many missed appointments are the result of VA transportation issues?

Dr. SCAVELLA. Thank you for that question. Our goal is to make sure we are providing access to our veterans, so we do have a num-

ber of vehicles to be used by our veterans who may be trying to get to appointments. If a veteran who has spinal cord injury and disorders self-schedules their appointment, we will reimburse them. If they live in a highly rural program or area, we have a highly rural transportation program. We also operate a Veterans Transportation Program through volunteers, and then we do have the beneficiary travel as well as the Veterans Transportation Program. I will need to ask for a number. I do not have a number of how many veterans may have missed an appointment.

The CHAIRMAN. Okay. That is something we need to know from the committee. Also, with that, if you can check your records and have try to get a calculation, because we try to get our calculation, I said in my opening statement, we believe it is \$4 million that it has cost to miss those appointments. The number of appointments and then how much it has actually cost, how much it has ran over.

Mr. BRACCI, can you please explain to me the problems with the audio booth that is pictured right here behind me?

Mr. BRACCI. Yes, sir. There are a couple of issues with that particular audio booth that we saw. The first is accessibility. There was not a ramp available where a veteran in a wheelchair could get up into the booth. The second issue is the actual size of the booth. It was not large enough to accommodate a veteran in a wheelchair. The minimum dimensions are 60 inches in diameter, and it did not meet that standard.

This is an important issue because we did identify instances where veterans had accidents and they tripped and fell trying to get in and out of an audio booth like this, and ended up—we saw one case where a veteran fractured their hip and required surgery. It is not just a matter of complying with standards. It has real impact on veteran safety.

The CHAIRMAN. You answered my second question. That would have been, have there been injuries and even severe injuries occur because of things like this?

Mr. BRACCI. Yes, based on the work we have done, there certainly have been. We identified—I think we have three examples in our report that showed issues where veterans have had accidents and have been harmed.

The CHAIRMAN. Thank you. Dr. Scavella, what is the average time it takes from when a veteran applies for special housing adaption to when the contractors begin construction of that adaption?

Dr. SCAVELLA. Thank you for that question. I am going to turn that over to Mr. London, who is the executive for the Veterans Benefits Administration.

Mr. LONDON. Thank you very much for the question. Of course, it is variable, depending on the types of adaptations that a veteran needs to meet his or her or their needs. Also the location of the particular residence that is being modified and availability of contractors. Generally speaking, it can take over 90 days in many cases to accomplish what you asked.

The CHAIRMAN. Then the follow-up question on that is, and I know you cannot do anything about location, but what else can we do to speed up the process? Every day is a bad day with not having access to this.

Mr. LONDON. I understand the question, and I agree with your sentiment. Some of the things that we have done to expedite the process to assist the veteran, because one of the things that needs to happen is the veteran has to choose the contractor, but we do not leave the veteran by his or herself to make that decision. We have a list of contractors that have successfully completed projects in the area to help expedite the process, and they also have familiarity with the details of what is required for these special needs.

The CHAIRMAN. Thank you. Dr. Scavella, I am concerned about the staffing level at SCI/D centers. Do you believe that VA medical facilities are properly staffed for all SCI/D beds?

Dr. SCAVELLA. Thank you for that question. Our goal is to make sure we are providing the care that the veterans need. We do have strategic hiring and spinal cord injury disorders is one of the areas that we have specifically communicated we expect those areas to be fully staffed. We currently have a 9 percent vacancy rate across the country, which is a decrease in the past 5 years. If you look at our statistics between Fiscal Year 2019 and Fiscal Year 2024, we have over 232 percent growth in that particular area across the country to include all staff.

The CHAIRMAN. Well, that is, I guess, how you would respond to the VA facilities. There are a lot of claims out there that you are short staff nurses in and around the country.

Dr. SCAVELLA. There is a healthcare shortage generally, both within and outside of VA, which we are contending with. We are being creative in our salaries, making sure that we are being competitive, making sure that we provide the opportunity for growth once employed by VA, to make sure that our environment of working is something that is desirable by people so that they will be willing to come into VA. We are making sure that our benefits packages for employees are enticing as well.

We are also collaborating with university affiliates to make sure that we bring in the top talent into our organization. We realize that people who train within VA, like myself, tend to come to VA to work permanently.

The CHAIRMAN. My time has expired by over a minute, but thank you very much for the—and I will now recognize the ranking member for his questions.

Mr. TAKANO. Thank you, Mr. Chairman. Mr. Bracci, thank you for the recent OIG report on accessibility and safety at contract facilities for disability exams. Veterans may only use these facilities for a one-time exam, yet OIG found physical barriers that hindered access for veterans who use wheelchairs, among other things. Now, I am concerned that there may be similar issues with private sector providers that veterans are referred to once they start using the VA healthcare system. Has OIG looked at VA's community care network providers and whether they are meeting ADA and OSHA standards?

Mr. BRACCI. To my knowledge, we have not looked at that issue.

Mr. TAKANO. Okay. Well, thank you. Would you tell the Inspector General Missal that I would like him to look into this issue?

Mr. BRACCI. Yes, I will.

Mr. TAKANO. Thank you. Dr. Scavella, I understand that as of last month, only 153 of the 181 long-term care beds that VA is re-

quired to have in operation at its SCI/D centers are actually available for veterans. Can you explain why?

Dr. SCAVELLA. Thank you for that question, Congressman Takano. We have some challenges in some places, doing staffing, and then there are a variety of reasons that may affect our ability to have a bed open. If we do have a bed available, but it is occupied by a veteran who may have a certain infectious disease, we may have to not use the other beds in that room.

Mr. TAKANO. Okay. I am hearing staffing, though, is the kind of predominant reason, lack of staff. These beds are empty because there is no one there to staff the veterans who might fill them. Just to be clear, veterans with SCI/D need access to long-term care beds at VA. Is there a waiting list?

Dr. SCAVELLA. We do not have patients who are waiting to get in. If we are unable to provide the care within our organization because of the acute need of this illness that they have, we will make sure that we coordinate with our community partners, recognizing or transfer to other facilities within our VA.

Mr. TAKANO. You are saying there is no waiting list because you place them in community partners?

Dr. SCAVELLA. If we are unable to house them within one of our hubs or provide care in our spokes—it is a complicated answer.

Mr. TAKANO. Okay. Yes, I could go into whether or not those community care facilities rise or meet the level that is provided at VA. I want to go down another train of thought here.

I am sure you understand that my concern that VA is proposing to move up to \$10 billion from direct care and medical facility infrastructure to community care in Fiscal Year 2025 to cover an expected shortfall. Now, this certainly will not help fill the vacancies in staffing that we are talking about in VA's SCI/D system of care. How can VA make the needed investments in the SCI/D workforce to provide the best care for veterans if we are diverting so much funding to community care?

Dr. SCAVELLA. As I have said earlier, our goal is to try to keep our veterans in our system. We want to make sure that we are providing the care for veterans. We have increased our staffing in spinal cord injuries and disorder by over 230 percent in the past 5 years, and we are making sure that we are enticing employees to come into our system as a provider of choice.

Mr. TAKANO. I get that. The administration is making a decision to move money out of direct care, which you need you need the staffing. Beds are empty, and that is forcing you to put people into the community already.

I share the concerns that PVA expresses in its testimony about VA's decision to severely limit hiring in fiscal years 2024 and 2025. VA issued a May 31 memo directing facilities to continue filling vacancies in VA's Spinal Cord Injury System of Care. How is VA going to hold the field accountable and ensure that there is sufficient workforce to meet the needs of SCI/D veterans?

Dr. SCAVELLA. Thank you for that question. We are coming on the heels of a remarkable 61,000—over 61,000 employees who have been brought into our system, mostly in direct care positions, and we have increased the staffing in our spinal cord injury and disorders. We only have a 9 percent vacancy, which is lower than it

has been. We continue to prioritize that through our strategic hiring to make sure that we are providing that care.

Mr. TAKANO. Excuse me for interrupting, but have you set a target date for the field to address staffing challenges that led to the closure of long-term care beds specifically? I mean, is there a target for that?

Dr. SCAVELLA. The request is to make sure we are strategically hiring, realizing that it takes time to bring in nurses and physicians, specifically because of the requirements to make sure that their credentials are what they say. We have a directive or memo from the Undersecretary for Health regarding how we should be moving forward. It is clear to our organizations, and the expectation is that those direct care appointments and opportunities would be provided first. Our plan is to get those employees out there.

Mr. TAKANO. I am glad it is prioritized, but has he set a target date?

Dr. SCAVELLA. I would have to look back at the memo to give you that date.

Mr. TAKANO. Could you get back to me on that? I hope, if there is not one, that there will be a concrete target date set to fill these beds—to staff these beds.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Ranking Member.

Dr. Miller-Meeks.

Ms. MILLER-MEEKS. Thank you very much, Chairman Bost. Thank the witnesses for being here.

It is a little bit surreal to me because I started out my career as a second lieutenant nurse in the Army, stationed at Walter Reed on Ward 10, the neurosurgery floor. Taking care of traumatic brain injuries, which we did not call them that at the time, spinal cord injuries, I flipped my share of Stryker frames and also worked with halos. My husband, interestingly enough, got out of the military to get his Bachelor of Science in Nursing (BSN). He was an E6 Licensed Practical Nurse (LPN) when we met, and took care of a spinal cord injured veteran as a private LPN to do that before the VA provided that care. I know how challenging this can be.

Dr. Scavella, according to some of the data obtained by committee staff, we know that 18 percent of patients seen in the past 3 years for spinal cord injuries and disorders were also seen for substance use disorder or had that diagnosis. Do you believe that the VA has the capacity provide inpatient mental health and substance use disorder care?

Dr. SCAVELLA. Dr. Miller-Meeks, thank you for that question. We do feel as if we have that ability because we are an integrated healthcare system. Mental health is embedded in the patient-aligned care teams that provide primary care for this population of veterans. If they require substance use disorder on an inpatient setting, we are able to provide that care as well. We do have systems across the—services across the system.

Ms. MILLER-MEEKS. Are the SC—and this is, again, reminiscent of the old, old Walter Reed. Are the SCI/D units using four patient bed models in their centers, and do you believe that having four patients in a room is appropriate for minimizing risk of infection and creating a healing environment?

Dr. SCAVELLA. Yes. Congresswoman Miller-Meeks, thank you for that question. We have older facilities, as you just reminded us of, that do have four beds in some rooms. We are constructing facilities that do not have that configuration. Our goal is to try to reduce the size of the rooms to make sure that we are giving patients the privacy both from, you know, a mental capacity and from a healthcare capacity.

That is not the standard at this point in construction. When and where possible, we will not use all four beds in a room to make sure that we are giving patients the privacy that they require.

Ms. MILLER-MEEKS. Thank you. Just to follow up on Representative Takano's question, what are the main barriers, and you may have answered this, to staffing SCI/D centers as opposed to other VA medical facilities?

Dr. SCAVELLA. Yes. Thank you for that question. We understand that this is a highly skilled area, as you just mentioned, during your experience. These veterans require lots of care, lots of patience, and so it takes a certain type of clinician or professional to be a provider of that care. Making sure that we recruit, retain the highest skilled employees in those areas is really important. We want to make sure that they have the highest quality and so we review that on a regular basis through our ongoing professional practice evaluation. We also want to make sure that once we bring them in, that we are giving them the tools to grow as professionals, to make sure that they stay with us and continue to serve veterans.

Ms. MILLER-MEEKS. I would say it was some of the most rewarding medical care as a nurse or a doctor that I had ever administered.

Mr. Blake, the committee is aware of a few promising technologies. I think we cannot have this hearing without mentioning the innovation that is occurring in this space, mainly brain-machine interfaces, which hold immense promise for catastrophically disabled veterans. What research or outreach has PVA done in this space and technology and its key players?

Excuse me, second panel. Thank you very much. I yield back my time, but I will submit the questions for the record.

The CHAIRMAN. Representative Brownley.

Ms. BROWNLEY. Thank you. Dr. Scavella, you testified, I think, in response to the chairman's question, that you do not know how many missed appointments there are due to transportation. Why would you ever turn down a catastrophically disabled veteran who had travel issues once they got to the VA? Why would you ever turn them down for his or her appointment?

Dr. SCAVELLA. Thank you for that question. I am not aware of us turning anybody away, and that is why I do not think I can answer that question. We would make sure that we are providing that care, whether they are late, by a day or by a minute. It is important that we are providing the care when and where they need it.

If we are, for whatever reason, whatever the condition is of that veteran, if they are too ill for the capabilities of the facility that they show up in, we will make sure that we get them to the appropriate level of care, whether it is in the VA system or in the com-

munity. Obviously, our goal is to try to keep them within our system because of all the things I have talked about with continuity, making sure that we can provide that care, not just for whatever the issue is, but the whole health of the veteran.

Ms. BROWNLEY. What are your—how would you describe your best practices for the LGBTQ community for women who are catastrophically disabled?

Dr. SCAVELLA. Thank you for that question. We appreciate legislation that has helped us to ensure that women veterans who have spinal cord injury and disorders can receive the care in-house or at home that they require, as well as for things such as mammography, which is difficult related to positioning them. We are very grateful for that.

Our goal, through the messaging from the Secretary through to each employee, is to make sure that we are providing care for every veteran who has served. Our mission statement has changed to reflect that, and both the Secretary, the Deputy Secretary, who is very concerned about us, making sure that we are here for women veterans who may not see their place, that we are providing that open and welcome care.

Ms. BROWNLEY. What about the LGBTQ?

Dr. SCAVELLA. LGBTQ, we have several different projects related to making sure that we are being open. Currently, June is Pride Month, so we are recognizing our population of both employees and veterans during this month to make sure that we are providing that care, that people know that they can see themselves as their authentic selves here at work. There are a lot of things ongoing to make sure that we are being open and responsive to the population.

Ms. BROWNLEY. My understanding is when women with spinal cord injuries or disorders show up at a health clinic or a medical center, that they are then required to go to an SCI/D center first in order to be referred to by an ob-gyn. Is that true?

Dr. SCAVELLA. We are going to try to provide the care to a veteran who may show up in whatever care place she may show up.

Ms. BROWNLEY. I understand that is your goal, but I want to know what the reality is happening today.

Dr. SCAVELLA. When we have a new patient come in, if they are coming in for their care, if they are spinal cord injury and disorder disorders veteran, we would want to make sure that we are tying them in with that population to provide that care. If they are coming in for women's health services and we can provide that care in the women's health clinic, we will do that.

Ms. BROWNLEY. Basically, you are saying that is not really happening. If they show up at a medical center or health clinic, they are not getting referred to an SCI/D center?

Dr. SCAVELLA. Unless you have a specific instance that you would like me to look into, I am unaware of that.

Ms. BROWNLEY. Okay, Okay. Can you speak a little bit to the differences between the Elizabeth Dole 21st Century Healthcare and Benefits Improvement Act and the standalone bill, that was supported in bipartisan way, I will add, the Elizabeth Dole Home Care Act. Can you talk a little bit about the differences in what the VA really supports in terms of those two bills?

Dr. SCAVELLA. Thank you for that question, Congresswoman Brownley. I will have to take that back. I do not have the Department's technical review of those at my fingertips at this point, so I cannot speak freely about that.

Ms. BROWNLEY. Great. Well, the last thing I will just say, too, is having had a meeting in my office yesterday, that I know that there are PVA members in this room who have personally experienced being turned away after traveling to VA appointments. I would really encourage you to speak with them and hear their stories because I think what you are saying and what we are hearing from PVA members do not line up. Obviously we need to get to the bottom of that. I would appreciate it.

With that, I yield back.

The CHAIRMAN. Thank you, Representative Brownley. Representative Luttrell, you are recognized.

Mr. LUTTRELL. Thank you, Mr. Chairman. Dr. Scavella, if I were you, I would take a hard look at the room behind you before you get out of here and leave, because they were shaking their heads to Ms. Brownley's point. That is something you are going to want to have an answer to when you engage with the committee. Okay? How long have you been in this position?

Dr. SCAVELLA. I have been in this position since January 2022. I have been at the VA for 25 years.

Mr. LUTTRELL. Twenty-five years. Mr. Barachi, that IG report, are there any bullet points on that report that have been replicated over previous years?

Mr. BRACCI. Some common themes. You know, as far as the contract exam program, we have been focusing on that for several years now because of the millions of veterans that impact—

Mr. LUTTRELL. What discrepancies that we are seeing in the VA system that are ongoing?

Mr. BRACCI. I would say that just the oversight by MDEO, we see that continuously. I will say that they address issues as we identify them and as we make recommendations, but it is the proactive oversight up front.

Mr. LUTTRELL. Well, the oversight report that you submitted and the previous oversight report that we have engaged with are stating the same thing over and over again. Dr. Scavella, can you tell me why the VA system is, I guess in my opinion, I am going to say, taking this kind of haphazardly and not engaging with—I mean, when you have spinal cord injuries—again, I am saying because I am looking behind you and I am seeing everybody. Right?

I really want to know why this—and the Secretary's number one priority is suicide, and I appreciate that wholeheartedly. When our veterans have lost the ability to be mobile, amongst other things, everyone is neck and neck. If we continue to have an IG report that is pretty much beating the hell out of the VA, I want to know why the leadership is not taking advantage of the situation and fixing the problem.

You have not given us any dates. I have listened to the committee members, including the ranking member, ask questions. What are the dates? The dates. In the military, we ask for dates. Those are hard lines because we function that way. That is how we operate. I want to know when the VA is going to throw us a hard

time and say, hey, this is when we are going to fix this. Can you answer that question for me?

Dr. SCAVELLA. Thank you for that question, Congressman Luttrell. We are making sure that we are answering the mail when it comes to these findings. I am in the Veterans Health Administration (VHA).

Mr. LUTTRELL. Well, what does that mean?

Dr. SCAVELLA. I am going to turn this question over to the Veterans Benefit Administration, who runs this program. I do not oversee it.

Mr. LUTTRELL. Mr. London.

Mr. LONDON. Congressman Luttrell, thank you very much for the question. To answer your question specifically, the recommendations that OIG identified in the report, will all be satisfied by the end of this fiscal year, so by September 30. Three of the recommendations we have already implemented, and we will provide all of the evidence to OIG after they are completed on September 30.

Mr. LUTTRELL. September 30, that is a hard time. That OIG report is going to be completely resolved?

Mr. LONDON. Yes, sir, and, yes, sir. Last year, when I testified before your subcommittee, you challenged me to make sure that you were going to hold me accountable. You can hold me accountable for those dates as well.

Mr. LUTTRELL. Absolutely. Thank you, sir. I respect your leadership and honesty. Thank you for doing that.

My second question is, I ran into a lovely young lady. She was over here in the Longworth Building. She had—and for life of me, I cannot remember the exact mechanism that she—she has a robotic mechanism that allows exoskeleton. Thank you, Mr. Van Orden. Hearing her story of what she had to go through to get that, she ended up having to pay for it on her own, her and her family. She was telling me the story. She was a Marine, by the way, so you can only imagine how engaging that story was. My curiosity is, why has not the VA stepped up in that space?

Dr. SCAVELLA. Sure. Thank you for that question, Mr. Luttrell. When it comes to exoskeletons, because of the level of independence that is required, there are certain requirements that need to be in place in order to determine which veterans are best suited to actually have an exoskeleton. We have to weigh the benefits and the risks. The benefits are increased mobility and increased autonomy. However, the manufacturers of exoskeletons require the assistance of another person. Even though a veteran may be moving around, in order to get into and out of that equipment, they do require another person to be around. That is stated by our veterans as the largest barrier to them, actually.

Mr. LUTTRELL. Sure. Yes, her father was with her. I think there may be a communication breakdown because the VA did not come through with her, and she benefits greatly because of her exoskeleton. I do not know by, with, and through the organization how we need to move the pieces on the chessboard to fix this. I think there is a way to do that to fix this problem set. I just would ask the VA to take a harder look at the advancements in technology for our members in need.

Dr. SCAVELLA. Thank you for that statement. We are continuing to look at innovative projects and programs to support our veterans. In 2016, I am not sure when she received her exoskeleton, we did devise a specific type of evaluation for those veterans who are interested in exoskeleton. There are a number of other types of innovative technologies to include neurostimulation and other types of equipment that can help our veterans who have spinal cord injury and disorder. Again, everything is evaluated on a case-by-case basis to make sure that it is the safest for veterans.

The downside, unfortunately, of some of these is because of the mobility issues, is that they can have skin breakdown, which can lead to infections and other problems, as well as some other neuromotor issues that can happen with spinal cord injury disorders veterans. We need to make sure that we are providing care that is not only what they want, but what we think is safe.

Mr. LUTTRELL. Thank you, Doctor.

I yield back, sir.

The CHAIRMAN. Representative Landsman., you are recognized.

Mr. LANDSMAN. Thank you, Mr. Chair, and thank you for the hearing, and thank you all for being here.

The U.S. Government Accountability Office (GAO) report that my colleagues have been talking about, we are talking about here the number of deficiencies. You know, something like 85 percent of the facilities had one or more deficiencies. I do not want to get into that. I mean, I appreciate the comment about the report and the fact that the recommendations will be dealt with in some period of time.

I have a larger question which I typically ask around continuous improvement and hospitals in general. We think of them as places where, you know, good things happen and bad things do not, though we know and you all know, the folks here know, that bad things happen all the time. The bad things are really bad in some instances. I mean, these are adverse events or serious safety events, medical errors, these kinds of things.

I bring those up because in Cincinnati, we have a Children's Hospital which is now ranked, I believe, number one, but it is one, two, three every year. They got that way based on a commitment to being the best at getting better. That is what the board decided. That is what the leadership decided. That is what surgeons and nurses and everyone affiliated with the Children's Hospital in Cincinnati decided. It took them years, but they started with the serious safety events, and they wanted to get that to zero, because the only number that was acceptable is zero. They have not had a serious safety event in over 2 years, and it led them to get very serious about everything, from post-surgical infection rates, to the customer experience and things like this, this GAO report and deficiencies.

They, you know, so, for example, they had a million—they got a 96 percent satisfaction rate. One of the board members 1 year said that that is good, but we see a million people every year, so that means 40,000 people were unsatisfied. Let us do better. It was that attitude. Now they are—you know, they have much higher satisfaction rates.

I am curious about, you know, because you all deal with some of the most significant and complicated medical issues, and I am curious, what approach do you all have now as it relates to getting better, the measures that you use? What does it look like in terms of the culture? How would you describe where you are at now versus where you would like to be?

Dr. SCAVELLA. Yes, thank you for that question, Mr. Landsman. We are constantly striving to improve the care we provide within our organization, and we also have the same type of stretch goal, to have no complications, no falls, no infections, things like that. We have a continuous improvement process that takes place at the medical centers individually.

I do want to make a distinction that the concerns raised in the report were related to the oversight of external organizations that we are sending veterans to as opposed to our medical centers themselves as—

Mr. LANDSMAN. Yes, to that. This was just one data point, and it had to do with care unrelated to yours. The adverse events or medical errors associated with community providers was 2X in one particular area. We have contracts with those organizations and presumably they could, you know, ascribe to or be required to ascribe to the same continuous improvement and performance measures as us. What does that look like?

Dr. SCAVELLA. Right. One of the things I will talk, and I will let Mr. London add to this answer, is that we are increasing the number of visits that we are conducting to the those facilities. You know, this is coming off the tail of the pandemic where first we did not travel because it was unsafe and then there was still a restriction on travel.

Mr. London, would you like to add to that?

Mr. LONDON. Yes. Very similarly, we started traveling in April 2022 to do site visits. Since that time, we have done over 700, including an additional 300 virtual visits. We plan to continue to do those and increase the number of visits that we are going to have going forward to make sure that we are continuously improving.

Mr. LANDSMAN. I appreciate it. My time is up. Thank you. I yield back.

The CHAIRMAN. Mr. Van Orden.

Mr. VAN ORDEN. Thank you, Mr. Chairman.

Dr. Scavella, we keep hearing the same words and phrases all the time: continuously improving, doing our best, we are shooting this. We keep hearing the same stuff over and over and over again. We are trying to get better. We are trying. We are trying.

Will you turn around, please? I would like you to get the view that—I am serious. Will you please turn around? This is the view that Congressman Luttrell had of these people that are permanently assigned to having to have artificial apparatuses to function and live. As your Department continuously strives to improve and get better and do all this stuff, and the IG report just says you are not, they are still stuck in those chairs, ma'am, while you get to go home, and while your staff that is continuously improving gets to go run in a field with their family, and they do not get to do that.

I am thoroughly unimpressed with your Department's performance. I think that the IG report says that you guys are failing. When is someone at the Veterans Affairs, when is someone at the VA going to be held accountable to the point where they are not working there anymore?

Dr. SCAVELLA. Thank you for that question. When we do see performance issues, we have to document those and go through a process to separate someone from employment. In those instances, whether it is related to poor care or poor coordination of care, we take those actions.

Mr. VAN ORDEN. When is the last time you have fired someone from the VA for poor performance?

Dr. SCAVELLA. I am not overseeing direct patient care, so my answer to that question would not really be illustrative of what is happening in the field.

Mr. VAN ORDEN. Okay. For what period of time did you not do performance oversight visits during the COVID-19 public health emergency? Was it the entire time?

Dr. SCAVELLA. I will have to turn that over to Mr. London because these were for the Benefits Administration.

Mr. LONDON. Thank you very much for the question. Up until from March 2020 to April 2022, we were precluded from in-person travel.

Mr. VAN ORDEN. Okay, so what happened during that period of time? The vendors have been doing stuff the whole time, right?

Mr. LONDON. Yes, sir. The vendors were responsible contractually to ensure that each facility that they are used to send our veterans for examinations were safe, sound, and met the requirements of the contract to include OSHA and ADA.

Mr. VAN ORDEN. Did you sign an employment contract, sir?

Mr. LONDON. Did I sign an employment contract?

Mr. VAN ORDEN. Yes. Like it says, Department of Veterans Affairs.

Mr. LONDON. I am employed by the Department of Veterans Affairs, yes, sir.

Mr. VAN ORDEN. Okay. You signed an employment contract to be held accountable to the people that are sitting behind you, essentially in wheelchairs. Correct? Yet you failed to do your job during the entire COVID-19 thing, but you expected other people to do theirs, is that right?

Mr. LONDON. Mr. Van Orden, I appreciate your question. I want to make clear that I joined this office in December 2021. As soon as we were required or allowed to travel, I actually went with the team and did site visits personally to make sure that these sites met requirements. As soon as I was able—

Mr. VAN ORDEN. Who is your predecessor?

Mr. LONDON [continuing]. under my accountability, sir, that is what I am here to do.

Mr. VAN ORDEN. Mr. London, who is your predecessor?

Mr. LONDON. My predecessor is now retired.

Mr. VAN ORDEN. Okay. Did they retire with full benefits?

Mr. LONDON. I am unaware of his situation.

Mr. VAN ORDEN. Okay. I think you are seeing where I am going here.

Mr. LONDON. I do, sir.

Mr. VAN ORDEN. Consistently, the theme that I get from the Veterans Affairs Administration is that the Veterans Affairs Administration is putting the Veterans Affairs Administration above the veterans. That is not why you are here. It is not why we are here. You guys have to understand, your bureaucracy is not more important than the people sitting behind you in wheelchairs who are trapped in that reality, and they cannot escape that reality.

They are clapping for the hope that there will be accountability in the Veterans Affairs Administration. I join them.

With that, I yield back, Mr. Chairman.

The CHAIRMAN. Representative Budzinski.

Ms. BUDZINSKI. Thank you, Mr. Chairman, and good afternoon, everyone. I am glad we are having this important conversation today about the unique issues that are affecting our veterans with spinal cord injuries and disorders, SCI/D.

As my colleagues have spoken to and the OIG report outlined, there is a lot of work to be done for this vulnerable community. I want to focus on an area that I am particularly interested in seeing improvements, which is with the veterans—the women veterans living with SCI/D. I have attended several congressional women veterans roundtables with VSOs who are leading in the women's space, including Paralyzed Veterans of America.

I just recently hosted my second women veterans roundtable at home in my district and have heard specific concerns related to today's topic. Women veterans already face very unique barriers when seeking care, and those barriers are only exacerbated among women veterans living with SCI/D. Many of our health clinics or specialty areas within VA continue to lack basic accessibility measures for those with SCI/D, and the cooperation among the SCI/D system and women's health facilities continues to be severely lacking.

As you know, one of the main SCI/D centers in the midwest is located in the St. Louis VA system, which serves many veterans, including many in the southern part of my district in Illinois, and I want to ensure we are equipping it with the resources needed to provide adequate care for women vets living with SCI/D.

Dr. Scavella, I believe that the VA continues to be the best system for our vets with SCI/D to get care, but we have to improve what I believe to be communication between systems. My first question for you is, you know, what steps is the VA going to take to ensure better cooperation and continuum of care between SCI/D systems and women health clinics in particular?

Dr. SCAVELLA. Thank you for that question. We continue to partner with our women's health clinics to make sure that they are able to meet the unique needs of the spinal cord injury and disorder community. We are making sure that facilities have the appropriate equipment as well as space to make sure that our veterans who are women coming in for gender-specific care or other care are afforded the privacy, the comfort that they are entitled to. Those are things that are undergoing.

The Women's Health Innovation and Staff Enhancement (WHISE) funding has been particularly useful in making sure that we have the ability to provide that care, as well as other pieces of

legislation that specifically address mammography and access for women who are spinal cord injury and disorders.

Ms. BUDZINSKI. Is there anything specifically that you could speak to just in observations on what women's health clinics are equipped with today that would be something immediately helpful to help those women veterans with SCI/D kind of better integrate into a women's health clinic?

Dr. SCAVELLA. Yes, thank you for that question. When we are constructing newer facilities, we are ensuring that doorways are wide enough, that rooms are able to be modified and transitioned so that we can accommodate veterans who may be coming in using motorized wheelchairs, which tend to be larger. Then we can do appropriate gender-specific care in those spaces with our employees who are skilled and trained in those areas.

That is what we are doing with our newer facilities. We do recognize that some of our older facilities have some more challenging navigation, especially for some of the newer motorized wheelchairs that may not be able to get through those spaces.

Ms. BUDZINSKI. Okay. I wanted to highlight, there have been instances of women with SCI/D getting a late diagnosis because they had to put off appointments due to these accessibility issues at their nearest women's VA clinics. This is especially true, as you have just highlighted, for women with SCI/D who are using wheelchairs.

Dr. Scavella, how is the VA going to improve access? You talked about the needs, but what are kind of immediate next steps that we can do regarding access to gender-specific care for women living with SCI/D and how can we ensure facilities? Again, you pointed out the things that need to happen, but what can we do to take immediate action to make sure that is guaranteed so our women veterans get the care they need?

Dr. SCAVELLA. Yes, so we will make sure that we talk to each of our veterans to understand exactly what they need. One thing that we are making sure is happening is for veterans who are coming in with spinal cord injury and disorders, we want to make sure that all routine annual screening is completed, whether we are talking about our women or our men, and that those things are not afterthoughts. As part of their patient-aligned care teams, they are specialized in spinal cord injury and disorders. At those spokes or those centers, those hubs, we are making sure that that is part of the care.

It may look different. We may not bring you physically to a place to get that care. We can provide that care to you either in the facility, in the hospital, or in your home. Then there is telehealth as well as other modalities to make sure that we are doing what we need to do.

Ms. BUDZINSKI. Okay, thank you. Last, PVA leaders testified at a recent Senate hearing that when providers are made available to SCI/D clinics to provide ob-gyn services, they are often general practitioners that are unable to answer questions specific to women vets living with SCI/D.

Dr. Scavella, again, what can the VA do to better prepare practitioners to provide culturally competent care for women veterans living with SCI/D that need these services?

Dr. SCAVELLA. Thank you for that question. We do have a number of gynecologists, obstetrician/gynecologists who are employed by VA. Then we do have a number that are in partner with our university affiliates providing that care. Those are two of the ways we can make sure they are receiving the highly skilled gender-specific care that they require.

Then if we do have an internist or another specialty that has the skills and the training to provide gender-specific care, we just make sure that they are educated on this particular population. We have ongoing engagement with the Spinal Cord Injuries and Disorders National Program Office to provide training specific to our veterans as well as other types of engagements face-to-face, virtual, on an ongoing basis as well as a community of practice. We are really making sure that we are giving our employees the skills that they need, as well as bringing in the skilled providers, physicians to provide that care.

Ms. BUDZINSKI. Thank you very much. I yield back my time.

The CHAIRMAN. Thank you. Thank you, Dr. Scavella and Mr. London and Mr. Bracci for testifying today. You are excused.

We need to—we would like the second panel of witnesses to approach the witness table and get ready. Thank you.

I would like to welcome Mr. Robert Thomas, the national president and chairman of the board of the Paralyzed Veterans of America. Accompanying him is Mr. Carl Blake, the executive officer for Paralyzed Veterans of America.

Mr. Thomas, if you would, I would recognize you for 5 minutes to give your PVA's testimony.

STATEMENT OF ROBERT THOMAS

Mr. THOMAS. Thank you. Chairman Bost, Ranking Member Takano, and members of the committee, I appreciate the opportunity to testify on behalf of the tens of thousands of veterans with spinal cord injuries and disorders who rely on the benefits and healthcare available through the Department of Veteran Affairs.

For nearly 35 years, I have navigated the VA health care and benefits system following the spinal cord injury I sustained while on active duty. The care and benefits available through the VA not only saved my life, but have given me the ability to have a family, work, and serve my fellow veterans, most recently, as you stated, as Paralyzed Veterans of America, national president and chairman of the board.

I received my medical care through VA's direct care system. However, about 10 years ago, I was in a motor vehicle accident. I was taken to the nearest community hospital for immediate care. I recall the emergency room doctor asking me if I was in pain from the accident. I told the doctor that I was paralyzed and unable to feel such pain. Without further examination, I was given pain medication and just released. I knew that I needed to get to the VA, where I later received the proper examination. I know firsthand why people with spinal cord injuries who did not serve tell me that they wish they could access the care and support available through the VA.

Without the VA's SCI/D system of care, I do not know where I would have been, and many of the men and women sitting here be-

hind me would say exactly the same thing if they were speaking today. That is why we become so concerned when the SCI/D centers have to close beds because they do not have enough nurses to properly staff them.

Veterans Health Administration Directive 1176 provides the staffing guidelines to allow healthcare professionals to properly care for veterans with SCID. Depending on the function level of an acute SCI patient, a nurse may spend an hour or more each time with the veteran's room. That is why it is important for SCI/D centers to have higher staffing levels than other wards. We need every level of VHA, including Central Office, Veterans Integrated Service Networks (VISN), and the individual medical facilities, to take seriously the requirements of VHA's Directive 1176. We need the VA to properly deploy its resources and request the funding needed to provide the level of care outlined in the directive. If the VA system of care is not properly funded to ensure the staffing levels meet the needs of the veterans with SCI/D, then our government is defaulting on a promise made to care for us who become catastrophically injured or ill in our service to this great Nation.

It is not just acute post injury or diagnosis that we depend on. It is also the lifelong care that allows us to remain independent.

Caregivers are tremendously important for veterans with catastrophic disabilities. My wife, LaShon, is not only my spouse, she is also my caregiver. I mentioned Andrew, a veteran with Amyotrophic Lateral Sclerosis (ALS), when I testified in March. It is only because of the tremendous advocacy of Andrew's wife, Lisa, that he is still receiving care at home. Recently, she took the exceptional steps of petitioning directly to the undersecretary of health, which compelled his local facility to recalculate the cost of his care in an attempt to delay his reaching the statutory cap. No family should be forced to take such aggressive measures.

The Elizabeth Dole Home Care Act would fix this problem. We need Congress to pass the Senator Elizabeth Dole's 21st Century Veterans Healthcare and Benefits Improvement Act, which includes this important legislation. I and my fellow paralyzed veterans believe that the backing of every major veterans organization should be enough to get H.R. 8371 through Congress without further delay. Andrew cannot wait anymore. Lisa cannot wait anymore. We cannot wait anymore for Congress to do the right thing and pass this bill.

I am grateful for the support I received through the VA, but my fellow veterans and I are concerned about the future of the VA SCI/D system of care. Without a robust system, we are in danger of living diminished, shortened lives. This is not what we fought for and it is not what we will settle for. Thank you for the opportunity to provide you with my perspective on VA's SCI/D system of care and I will be happy to answer any questions.

[THE PREPARED STATEMENT OF ROBERT THOMAS APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you Mr. Thomas.

Mr. Blake. Mr. Blake, you are now recognized for 5 minutes.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you Mr. Chairman. You know, I have been here a long time and you mentioned earlier how long you have been here and do not recall a hearing on SCI/D. I have been here a lot longer than you have and I cannot recall an oversight hearing on this. I certainly thank the committee for its willingness to address this issue today.

I sat there last night and I was trying to think what could I tell you that would get your attention. That we get people to listen and understand what Robert was just saying. I have never told my story ever. It is just a personal thing I do not do because it is personal, but I am going to share a little bit of my story.

I am a PVA member. I have a combat-related spinal cord injury. I was told by the Army once, if I do not die, I will never walk again. I was told by a private medical facility there is no chance this person will ever walk again. I rolled into the VA SCI center in Richmond, Virginia, on a gurney and I walked out of there after 12 months of rehab. VA did that. While the VA gets a bad rap and gets beat up, it is a valuable system to our members.

I do want to say I appreciate Dr. Scavella's testimony. Clearly, she spent a lifetime committed to veterans and the VA, and she is to be commended for that. I think it is important that we step back now and realize what is really going on in the SCI system of care.

The fact is, the SCI system is at a breaking point. We survey all of the SCI centers on an annual basis. Every month we do bedding/staffing survey of the SCI system of care. This is what we know to be true. There are staffing shortages all over the system. It is not 9 percent, it is more like 30 percent. There is a severe lack of resources dedicated to this system of care.

The VA has a larger financial problem that, for whatever reason, no one is willing to admit and accept. The VA has been given a lot of money over the years. We recognize that fact, especially in recent years. What the hell they have done with it, we do not know. Where it has been directed is not toward the SCI system of care.

We met with the SCI leadership from all over the country a couple of months ago, and here is what they told us: they cannot hire anyone, not just because there are not providers available. There are no incentives to bring people on. There are people who are interested in working in the system, and those are the most dedicated people. The system is not set up to bring those people on board in an efficient manner, and most of the time they are lost. The HR process is broken. It does not serve the needs of the system to bring people in in an expeditious manner.

We have heard a lot about net zero growth in VA because of the fiscal challenges it has. It is not net zero, it is net negative. This is what is happening in the SCI system of care. When a position comes open, it is not only not being filled, in some cases it is being abolished, taken off the books. The VA's handbook 1176 expressly says, this is what the staffing methodology and model should be for VA, and these are the policies and processes that should be followed for providing direct care. Those leaders across the system told us that they have been told at the local level and even up to the VISN level we do not care what 1176 says. We are not beholden to that. It is not the law. That is bulls—.

If you are going to craft a policy and a process to deliver care, then you should follow it. If you are unwilling to do so, admit why. As it is, our members are struggling to get the care that they need, and the system is at a breaking point. We do not want to ask Congress for more money. We recognize the challenges that is faced across the entire spectrum. Resources are going to have to be put in the system somehow to ensure that they are able to staff, provide the equipment, and build the capacity that they need.

There are centers that are actively being degraded today. They are actively closing beds today. The system is shrinking. The population that needs this service is not. Yes, it is getting older. That does not mean the population is shrinking. Some real effort needs to be put into rejuvenating this system or it is going to collapse on itself and everyone in this room and everyone listening and all of our members are going to suffer because of it.

There were questions about women's healthcare. They will be irrelevant if we do not fix this system before it is too late. That is close to where we are now. It is important that we all understand the VA has a vital role to our members, to all veterans. If veterans want to go out into the community, PVA does not have an express opposition to veterans getting care in the community. It is a necessary tool for the VA.

That option is not available to our members. It is only the SCI system of care that makes their care possible and we have to invest in it. If we do not, there are much worse horror stories that could come from it. We are here pleading with you to actually put the emphasis behind it. All the memos in the world, all the policy directives in the world do not do any good if it is not being enforced. It is all well and good to say we support the system of care. Well, show it to us, because we do not feel like that is what is happening today. Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF CARL BLAKE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Blake.

I now recognize Ms. Sonya Sotak, the chief government affairs officer of I AM ALS, for 5 minutes to deliver your testimony.

STATEMENT OF SONYA SOTAK

Ms. SOTAK. Good afternoon. Chairman Bost, Ranking Member Takano, and members of the committee, it is my honor to be invited to testify today on behalf of I AM ALS and the ALS community, including the approximately 6,000 veterans living with ALS in the United States.

ALS, commonly known as Lou Gehrig's disease, is a 100 percent fatal neurodegenerative condition. Upon diagnosis, individuals are told, get your affairs in order, go home and prepare to die, with the current survival rate being 2 to 5 years. ALS strips away a person's independence, gradually robbing them of the ability to walk, speak, and eventually the inability to breathe. Tragically, every veteran diagnosed with ALS will succumb to this disease. Regardless of how hard they fight or how hard their valor is, every veteran will lose their battle against ALS.

As this committee is aware, ALS in veterans has been determined to be 100 percent service-connected, with veterans being

twice as likely as civilians to develop the disease, and post 9–11 Air Force veterans showing a tenfold increase in incidents. It is estimated that 5,000 to 6,000 of the 30,000 individuals living with ALS in the United States are veterans, roughly 16 percent of cases. However, these figures are approximate due to challenges in accurately diagnosing ALS.

After being diagnosed, many of our veterans and their families must take significant time to advocate for themselves while managing the disease. Frequently, it is to explain to the VA what their VA benefits are as a veteran with ALS. To help veterans navigate this complex system, I AM ALS's veterans team developed a comprehensive toolkit that outlines the available the available benefits for veterans, including how to access them. While our community of veterans with ALS are incredibly grateful for the VA benefits available to them, this toolkit underscores the complex nature of the benefit structure, which often leads to veterans and their families diverting valuable time and energy to navigate and navigating instead of being able to focus on their health.

Lack of knowledge of the VA system can result in frustration and delays in service. Because ALS can progress rapidly, delays need to be avoided at all costs. Congress recognized this when you all work together in a bipartisan manner and pass the ALS waiver, eliminating the Social Security Disability Insurance (SSDI) waiting period in 2020. Our veterans with ALS and their families deserve the same recognition when accessing benefits, including home health care. While the VA spinal cord injuries and disorder centers are equipped to address the needs of veterans with static spinal cord injuries, they often struggle to meet the complex requirements of ALS care. ALS demands a multidisciplinary approach and specialized equipment that many SCI/D centers lack. Geographical barriers of the centers compound the challenges faced by veterans with ALS, especially those not living in certain urban areas.

Based on the needs of our ALS veteran community, I AM ALS is asking for an increase in this expenditure cap for noninstitutional care from 65 percent to 100 percent of the cost of the closest VA community living center through the Elizabeth Dole Home Care Act, which is included in the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act. By raising the cap to 100 percent, veterans with ALS and their caregivers will be able to access healthcare in the comfort of their homes. This will enhance the quality of life for veterans with ALS and alleviate the burden on their families and caregivers.

I AM ALS and our veteran community also appreciate that the Elizabeth Dole Home Care Act acknowledges the crucial role of caregivers, often family, in managing the daily needs of veterans with ALS. The act offers resources, training, and financial assistance to caregivers, easing their emotional and financial burdens and enabling them to provide improved care and support to our veterans.

I am going to take a moment to share with you the impact of this legislation could have had on our Navy veteran Garrett. Garrett served as part of the Seabees, a Navy construction battalion, with tours in Iraq and Afghanistan. Garrett's battle with ALS epitomizes the challenges many veterans face, especially when trying to

remain in their homes as the disease progresses. When Garrett was first diagnosed, he and his wife attempted to manage his care at home with most of his care falling on his spouse to avoid reaching the 65 percent cap. However, despite their efforts to navigate the system, Garrett was trapped in a cycle of bureaucratic red tape. Garrett eventually required more assistance, surpassed the home cap, and was put in an institution. Garrett elected to remove his trach, ending his life early rather than being isolated in an institution. Garrett simply wanted to be at home. At the end of his life, Garrett felt hopeless and out of options. His heartbreaking decision to end his life because of the complex system not providing the best support for his final battle shows the urgency of passing this legislation, and Garrett is not an outlier. Unfortunately, I can tell you about other veterans who have had the same circumstance. Through the Elizabeth Dole Home Care Act, you can improve the quality of life for veterans living with ALS and their caregivers as it provides them with flexibility and how they receive care.

I will end, I know I hit my time. I do not want to go over.

[THE PREPARED STATEMENT OF SONYA SOTAK APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Ms. Sotak.

Now we recognize Dr. Jenny Kiratli, representing the American Federation of Government Employees. Dr. Kiratli is also the director of spinal cord injury clinical research for the VA Palo Alto healthcare system.

Doctor, you are recognized for 5 minutes to deliver your testimony.

STATEMENT OF JENNY KIRATLI

Dr. KIRATLI. Chairman Bost and Ranking Member Takano and members of the House Committee of Veterans' Affairs, thank you for inviting the American Federation of Government Employees, AFGE, to participate in today's committee hearing on meeting the needs of spinal cord injury and disorders veteran community.

You have just introduced me, so I will skip that. Well, actually, I am a member of the AFGE since 2009. AFGE's National Veterans Affairs Council represents more than 302,000 AFGE VA employees. My role at VA as a research health scientist in the SCI/D center at VA Palo Alto since 1991 with more than 30 years of experience conducting research on clinical issues affecting people with spinal cord injury. In addition, I am on the faculty of the SCI Medicine Clinical Fellowship program and a member of our SCI/D Center Leadership Council.

As you have been hearing about re-ed rate, the VA Palo Alto SCI/D center is one of the 25 VA SCI/D centers that offer lifelong, comprehensive, integrated, coordinated care, including primary care, rehab, emergency care, acute medical and surgical care, mental health care, and home care aimed at supporting the veteran as a whole person with services that reintegrate veterans in the community. Care is also delivered via telehealth, which VA Palo Alto pioneered in 2000 and has expanded tremendously to enhance access to VA services remotely. SCI/D providers include physicians, nurses, psychologists, social workers, physical therapists, occupational therapists, recreation therapists who coordinate care with

many disciplines such as pharmacy, radiology, urology, orthopedics, plastic surgery, and many other clinical services. The expertise of the interdisciplinary care team and breadth of services available makes the VA SCI/D network based on a hub and spokes model, the most comprehensive healthcare system for people living with SCI/D in the U.S.

Primary care physicians need special training to serve the specific needs of this patient population, as they must be able to diagnose and treat an array of problems that may present differently, such as bone fractures and infections. They also must be trained to recommend appropriate preventive care at screenings and manage comorbidities such as metabolic and muscular disorders in collaboration with other specialists. Most physicians in the VA SCI/D centers pursue an additional year of specialty training through SCI medicine fellowship programs, and VA plays an important role in these training programs in collaboration with academic affiliates. However, more needs to be done to encourage young clinicians to enter the field of SCI medicine. Of the approximately 31, 32 positions in SCI clinical fellowships, usually fewer than 20 positions are filled in any given year.

Another unique aspect of the VA system is the large and very active research enterprise which I am part of. Clinical research conducted at the VA Palo Alto SCI/D center and other VA centers can drive improvements in care delivery that also may benefit non-veterans living with spinal cord injury and disorders and contribute to best practices. One of my current projects is a collaboration with the Minneapolis VA to evaluate a novel wheelchair that provides mobility while staying. This adaptation will allow greater time in an upright position and thus reduce the risk for pressure injuries, improve blood flow and bladder and bowel function, reduce spasticity and pain, as well as enhance functional capabilities of the user.

VA Palo Alto also was involved in the multisite VA research to explore the effect on quality of life with exoskeleton-assisted ambulation, as well as a project a few years ago to implement and evaluate a model of vocational rehab to return individuals with SCI/D to employment. Other recent projects that I have been involved with include exploration of video gaming as a mode to elicit upper extremity muscle activation and a current study to improve evaluation of fracture risk by determining a reliable method to measure bone loss at the knee, a common fracture site.

Through its research in clinical care initiatives, VA is at the forefront of improving clinical outcomes and quality of life for veterans and all people living with spinal cord injuries and disorders. However, more can be done to strengthen the VA SCI/D system. There is a great need, as we have been hearing, for increased staffing for SCI/D services. Staffing requirements for SCI/D centers should reflect the high acuity and complexity of care needed, which often require specialized certification and advanced training. The high acuity of care creates burnout, and younger clinical staff often leave just as they have gained sufficient skills to perform all their duties. Additional retention incentives are needed to address vacancies and turnover, with specialty pay as a high priority.

In summary, the VA's SCI/D model provides uniquely comprehensive and integrated services delivered by highly knowledgeable teams of specialists that do not exist in the private sector. While the mission act increased access to non-VA facilities, use of VA and none non-VA care has the potential to increase unintended duplication of services, costs, and fragmentation of care. The risk of inadequate care is a great concern for veterans with SCI/D because of the need for specialized expertise.

In addition, non-VA providers lack access to VA resources such as medical equipment and a wide array of adaptive products often created for each individual for his or her specific needs. Care should be taken to ensure that increasing privatization of VA services does not upend the VA's specialized SCI care model that provides an array of integrated services and supports research used to develop best practices for all people living with spinal cord injuries and disorders. Thank you very much for this opportunity to talk about it.

[THE PREPARED STATEMENT OF JENNY KIRATLI APPEARS IN THE APPENDIX]

The CHAIRMAN. Doctor, thank you very much for your testimony. We will now go to questioning and I recognize myself for 5 minutes.

Mr. Blake, in PVA's opinion, what is it—why is it necessary for Congress to pass H.R. 8371, the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, to continue improving services for your membership?

Mr. BLAKE. Thank you Mr. Chairman, for the question. A lot of our members rely on home care services, home-based services. The Veteran-Directed Care program is a very popular program for our members where it is available. The Elizabeth Dole Act would make those opportunities much more available. It would eliminate the 65 percent cap. It would allow our members to be at home where they want to be and receive the care that they need and not end up in simply a facility and would just improve their independence and opportunity.

I think if the bill does not get passed, then our members will continue to struggle along or we are going to end up in a situation like the lady from I AM ALS mentioned. Those are totally unacceptable circumstances. That should never happen simply because of some arbitrary cap or some limitation on home care services that are available.

The CHAIRMAN. Thank you. Ms. Sotak, can you explain why VA must ensure that accessibility and safe contracted exam facilities are available right away for veterans with ALS?

Ms. SOTAK. Sure. Thank you for the question. ALS progresses quickly, not for everybody, but for many. Some veterans have limited mobility at the time of their diagnosis. For that, we believe that contracted exam facilities must be accessible. I think we heard earlier testimony saying that is sometimes very often a challenge. We need to make sure that they get in quickly before their disease progresses more and we are able to hopefully mitigate the rapid progression of that disease.

The CHAIRMAN. Thank you. Mr. Blake, VA told the committee staff that they were operating at a 9 percent vacancy rate for the

clinic staff. I think in your testimony you said that you probably do not believe that. What do you believe it actually is?

Mr. BLAKE. Well, let me correct that. I do not believe that that is not true. We simply think it is not true. We survey the system of care every month for its bed and staffing. According to our own medical services records and our team that surveys that system, we believe that vacancy rate is closer to 30 percent, not 9 percent.

The CHAIRMAN. Do you think that the VA has the staff needed to safely care for the groups, for this group of veterans?

Mr. BLAKE. Well, I could just simply say no. That would be too easy. The answer is no.

The CHAIRMAN. Yes.

Mr. BLAKE. Clearly it is not, because the system is actually being drawn down, it is not being expanded at all.

The CHAIRMAN. Mr. Thomas, can you tell me why it is important to have competent, properly trained clinical staff when you are being treated as SCI/D veterans?

Mr. THOMAS. Thank you for that question, Mr. Chairman. I can simply say that, you know, our lives, my life, the life of our members are in their hand. We really need them to be able to diagnose us when we come in because the only thing that we know something is going on. We cannot feel, we cannot tell exactly what it is. We need to rely on these doctors and nurses to tell us what is going on and not just simply provide us with some medication to say, I will see you next time. Check back with me in a week.

The CHAIRMAN. I think you said in your opening statement that, you know, we know VA wants to provide this. We have just got to make sure that we do the oversight to make sure that it is doing it at the top level that you all deserve. We want to continue to work to do that.

With that, I am going to turn it over to Mr. Takano for his questions. Recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman. I want to start with Dr. Kiratli. Dr. Kiratli, can you expand on the training and continuing professional education that clinicians have to undergo to be able to provide appropriate care to SCI/D veterans? We just have been talking about the importance of highly trained people to take care of this SCI/D population. Can you expand on the training that is necessary?

Dr. KIRATLI. Thank you for that question. Yes, I am glad to. We have one of the clinical fellowship training programs at our facility in Palo Alto, and it is a year-long intensive program for physicians who want to have a subspecialty in spinal cord injury medicine. They become board-certified. It includes exposure to inpatient, outpatient, all sorts of additional specialty trainings that can be provided. We partner with—our program at Palo Alto is actually under Stanford University, and we partner with the community SCI/D center nearby. Most of the programs, many of the programs involve VA, but not all. When residents choose programs, often they value being able to be at a VA to gain that training, the training opportunities to work with veterans in the system for the high level of specialty training that they can get.

Mr. TAKANO. Well, thank you. Does VA cover all the costs of the ongoing training?

Dr. KIRATLI. No, not that I know of.

Mr. TAKANO. They do not. They do not cover the ongoing costs of continuing education they need to do?

Dr. KIRATLI. No, the various professionals have requirements for ongoing training. For instance, physicians have to recertify board training. We have a variety of other specialty certifications, such as wound training, high level seating training. I think there is some funds available, but not—it certainly does not cover all of it. There is a limited amount available for conference attendance.

Mr. TAKANO. It is fair to say that it takes thoughtful investment in VA's workforce in order to provide the high level of care that SCI/D veterans require and deserve. Would you say that is right?

Dr. KIRATLI. Absolutely. Well said.

Mr. TAKANO. My colleague Julia Brownley has an important bill, the Department of Veterans Affairs Continuing Professional Education (VA CPE) Modernization Act, H.R. 543. We have been stymied in advancing this bill because of its cost, estimated by the Congressional Budget Office (CBO) to be about \$3.3 billion in combined discretionary and mandatory spending over 10 years. This is addressing the cost of training SCI/D employees. However, I think this would be a very worthwhile investment. This legislation would provide stipends of up to \$2,000 per year for VA clinicians continuing professional education expenses. What would this mean for employees for VA's SCI/D system of care; It would mean a lot, would it not?

Dr. KIRATLI. That would be wonderful.

Mr. TAKANO. Well, I would like to change to Mr. Thomas. Mr. Thomas, in your testimony, you highlighted how VA's SCI/D system of care is uniquely positioned to meet VA's PVA members, your members. Why do you think it is so important to ensure that VA is able to continue to meet the needs of SCI/D veterans?

Mr. THOMAS. Thank you for that question. I believe that being able to meet the needs of all of my members, myself to be included, is that it is very important because, you know, outside in the community, as I stated in my oral statement, that, you know, the doctors do not know. They are unsure of what goes on. The specialized training that is provided for VA clinicians and everything, it is important to us to make sure, again, that we can be diagnosed correctly. They know what is going on.

A prime example is if an individual comes up with autonomic dysreflexia and the individual doctor does not know how to treat that, it can become very severe to our members and to myself as well. Having those specialized care, having a specialized care system available to us means a lot.

Mr. TAKANO. Our current investments in VA infrastructure and direct care—direct care, not Community Care—direct care for veterans with SCI/D, are they sufficient?

Mr. THOMAS. I would turn that over to our Chief Executive Officer (CEO) Blake to answer that question.

Mr. BLAKE. I will answer it like the other question. No.

Mr. TAKANO. Thank you. Well, I agree with both of you. Congress needs to make more considered effort to balance the amount of funding going out of VA to private sector providers rather than into VA in the form of investments in the direct care workforce and im-

provements in medical care facilities. Would you agree with what I just said?

Mr. BLAKE. Yes.

Mr. THOMAS. Yes.

Mr. TAKANO. Well, I am glad we agree on that premise. That is why we must continue to prioritize efforts that invest in VA. I believe investments in VA are investments in veterans, especially veterans who truly depend on the specialized care that VA can offer. We need to build on that offering and expand it, as well as other benefits.

In your testimony, you mentioned the importance of enacting legislation like the Autonomy for All Disabled Veterans Act, which would increase grants for veterans to make structural improvements to their homes and the Rural Veterans Transportation to Care Act, which would provide innovative transportation options for veterans traveling to medical appointments. I agree that these should be priorities for Congress and that we should ensure that we advance these kind of bills.

Now, I would like to go back for a moment to Dr. Kiratli. What kind of feedback do you hear from physician fellows and other providers about training they have received at VA? What do they like about practicing at VA versus in the private sector?

Dr. KIRATLI. Thank you for that question. It is an excellent question. The constant feedback we get is how the clinicians are able to practice medicine as they have been taught. They have access to the specialty services, they have access to resources, and they do not have to curtail or prioritize care based on what might be available to support it. It really allows them to practice to the fullest extent and the best interests in the health and well-being of the patient.

Mr. TAKANO. Well, thank you. I yield back. I am sorry, I went over my time.

The CHAIRMAN. Not a problem. General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Chairman Bost, for holding this hearing and giving us the opportunity to focus on the needs of our paralyzed veterans. As has been made clear through the testimony today, there are a wide range of reforms and improvements needed at VA to ensure the best possible care for these veterans. I appreciate being able to hear our witnesses' support for bills like the Elizabeth Dole Home Care Act.

My focus today will be on VA's annual health assessments for spinal cord injured and disabled, or SCI/D, veterans, as well as access to assistive devices to promote mobility and independence. As a note, when you were talking, Doctor, you talked about inactive versus active care, and I would suggest to you that things like an assistive wheelchair to stand and all that is outstanding, it enables that patient. I also believe that on the active side, things like the exoskeleton probably promotes more active care. I will leave it to the scientists to decide that.

Mr. Thomas, great to see you again, as always. Last time I think we talked was over on the Senate side. Could you please describe the benefit of these annual preventative health assessments for SCI/D veterans?

Mr. THOMAS. The benefit to having an annual exam would be that you could stay ahead of any issue that may be coming up, and the doctors are aware of the smallest thing that the individual has not come to that realization that is going on and happening with them. For me, I did not know that I was coming down with type 2 diabetes without going to this annual exam. Having doing that, it gets me to be on top of that and find a way to try and not be too diabetic, if I could say that, if that is a real way. It prevents everything. To me, medicine is preventive care anyway.

Mr. BERGMAN. Basically, what I am interpreting you to say that VA should, wherever possible, be doing more to ensure more paralyzed veterans nationwide are made aware of and then, therefore, are able to receive these assessments. I assume a simple yes would probably be——

Mr. THOMAS. You are absolutely correct, yes.

Mr. BERGMAN. Roger that. Okay. Regarding assistive devices, do you feel there are improvements that can be made to ensure paralyzed veterans are able to be assessed for and provided with devices that they are clinically eligible to receive based upon the assessment of the individual veteran?

Mr. THOMAS. I would also say yes to that. If there is any new and innovative technology that comes out, I feel that they should always be on top of that so that they can increase our mobility access.

Mr. BERGMAN. Perfect. You know, as veterans, we know what we have been subject to some interesting new technologies over the course of our careers, and let us keep it to the good ones and advance capabilities and a better life for others.

While the VA has procedures in place on paper to provide annual assessments for SCI/D veterans and provide them with assistive devices, the reality for many paralyzed veterans has shown that there is more that needs to be done. I am grateful for PVA's support of my bill, H.R. 6373, the Veterans Spinal Trauma Access to New Devices, or Veterans STAND Act, which I introduced along with Chairman Bost, Health Subcommittee Ranking Member Brownley, and Congresswoman Debbie Dingle. This bill will codify the VA's obligation to offer annual examinations for SCI/D veterans, take steps to improve outreach for those who are eligible, and ensure paralyzed veterans are able to be assessed for and provided with assistive devices.

As I said, there is still a lot of work to be done on behalf of our paralyzed veterans. I hope this committee will advance the Veterans STAND Act so we can make the progress necessary in those efforts.

With that, I yield back.

Mr. LUTTRELL. [Presiding.] Thank you, General.

Ranking Member you are recognized for closing remarks.

Mr. TAKANO. Thank you, Mr. Chairman. Well, Chairman Bost raised concerns at our budget hearing in April about significant year-to-year increases in VA's overall budget. I would love to work with the chairman to address this unsustainable trajectory, as it is pretty clear that community care is placing the biggest strain on VA's budget. The chairman and I seem to have fundamental philosophical differences about whether community care should be fund-

ed at the expense of other veterans policy priorities. H.R. 8371, the veterans package, would throw another \$1 billion at community care in the short term and at least \$3 billion if we extend temporary authorities beyond the sunset dates included in the bill. I am sorry, I just cannot in good conscience throw more good money after bad and further expand community care eligibility, especially not when VA is already proposing to transfer as much as \$10 billion from direct care and VA facility infrastructure to community care in Fiscal Year 2025.

PVA members are among the most medically vulnerable veterans VA serves, and they will suffer the most if Congress does not properly fund the VA direct care system by investing in VA's workforce and medical facility infrastructure. Now, it is up to the chairman to put the bill on the floor that can pass, and I have been very clear about my concerns. We are in agreement on about 95 percent of the provisions in H.R. 8371, including those taken from H.R. 542, the original Elizabeth Dole Home Care Act, which passed the House more than 6 months ago. However, if we want to act quickly, the Senate should pass Congresswoman Brownley's bill right now. Then we can actually spend time on the provisions that need more work and that have received very little progress, including getting updated stakeholder input and more information on the true cost of provisions that are going to have lasting impacts on VA's ability to do deliver care.

Thank you Mr. Chairman, and I yield back.

The CHAIRMAN. Thank you Mr. Takano. I would like to thank the witnesses for coming today. I would like to thank the veterans and the veterans' families that are in the audience for your service and everything that you provided for the great country that we live in. We would not be able to do our work in this committee without each and every one of you. I want to say again that many of the issues raised today will be addressed with the passage of H.R. 8371, the Dole Act.

I ask unanimous consent that all members shall have 5 legislative days in which to revise and extend their remarks and include any extraneous material. Hearing no objections, so ordered. The hearing is now adjourned.

[Whereupon, at 12:39 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESSES

Prepared Statement of Erica Scavella

Good afternoon, Chairman Bost, Ranking Member Takano, and Committee Members. Thank you for the opportunity to testify before you today to discuss SCI/D, which present unique challenges and complexities requiring specialized care and support. At VA, we are dedicated to addressing the diverse needs of Veterans with SCI/D, ensuring access to rehabilitation services; specialty benefits; and services, and assistive technologies. Joining me today is Jeffrey London, Executive Director for the Medical Disability Examination Office, with the Veterans Benefits Administration (VBA).

Overview of Care

VA's SCI/D System of Care is the largest and most comprehensive network in the U.S. dedicated to providing exceptional care for individuals with SCI/D, and it is the preferred choice for most Veterans. Its objective is to enhance the health, well-being, functionality, and quality of life for Veterans through a coordinated system of care. The system operates on a "Hub-and-Spoke" model, with 25 regional SCI/D Centers (Hubs) offering comprehensive care, while primary care services are delivered at VA medical centers (VAMC) without SCI/D Centers (Spokes) by SCI/D Patient Aligned Care Teams (PACT).

The SCI/D Centers cater to Veterans with SCI/D, as well as those with motor neuron diseases and multiple sclerosis with spinal cord involvement, offering acute/sustaining and long-term care beds. Interdisciplinary teams of highly trained SCI/D clinicians provide a full continuum of services through the SCI/D System of Care, including acute rehabilitation, medical and surgical treatment, primary and preventative care, prescribed durable medical equipment, prosthetics/rehabilitative devices, respite care, and end-of-life care.

Mental health services are provided or coordinated throughout the SCI/D System of Care as part of the overall integrated care team plan. Annual evaluations ensure ongoing assessments of Veterans' needs, including psychological, social, and vocational assessments. SCI/D-trained psychologists and social workers are embedded into the care teams and serve as excellent resources and mental health providers for enrolled Veterans. When needed, these SCI/D-trained psychologists and social workers make additional mental health referrals, which are facilitated by the SCI/D Center or PACT. Peer counseling services and programs are also offered directly at the SCI/D Center, and through Veterans Service Organizations (VSO) and community-based programs. These help Veterans adjust to new impairments, understand the rehabilitation process, develop social skills, and transition to community living. Additionally, VHA offers comprehensive pain treatment options tailored to the unique needs of SCI/D Veterans, ensuring they receive the highest quality of care and support.

Mobility Interventions and Walking Aids

The prescriptive use of mobility interventions and walking aids is individualized to the Veteran and often specific to the setting where the Veteran is seen. Evaluations typically include reviews of pathology, impairments, functional limitations, and risk factors. If deemed medically appropriate, the inclusion of mobility devices and technologies is matched based on the individual Veteran's functional goals, focusing on enhancing mobility, independence, and overall quality of life. These can include walking assistive devices, bracing supports, prostheses, orthotics, shoe modifications, functional electrical stimulation devices, powered exoskeletons, body-weight support treadmills, and virtual reality gait training.

VA has implemented rigorous quality control measures and continues to advance prosthetic technology to deliver the highest standard of care to Veterans. This approach aims to empower Veterans to live their lives to the fullest, despite the challenges their SCI/D presents. In line with this goal, the Office of Advanced Manufacturing is developing technologies to improve the efficiency and effectiveness of pros-

thetic, orthopedic, and assistive devices. The resulting 3D-printed devices can increase a Veteran's quality of life, maintain the Veteran's independence, and reduce caregiver burnout.

Long-Term Care Options

VHA recognizes that SCI/Ds are not limited to the geriatric population and that Veterans with SCI/D have complex and personalized needs. To address these needs, VA offers a comprehensive SCI/D System of Care that focuses on providing Veteran-centric care and support in the least restrictive environment possible. VA offers a range of non-institutional and home-based primary care options to eligible Veterans based on their clinical needs, regardless of age, including medical foster homes, Veteran-directed care, bowel and bladder care, SCI/D home care, home health aide care, skilled home health care, community or VA-provided adult day health care, respite care, and telehealth. Additionally, many Veterans in the SCI/D System of Care receive support through the Caregiver Support Program, which includes the General Caregiver Support Services and the Program of Comprehensive Assistance for Family Caregivers. For Veterans who require institutional care, available options include assisted living facilities, VA Community Living Centers, community nursing homes, State Veterans Homes, and VA SCI/D Long Term Care Centers.

Patient Safety Practices in Emergency Departments

VA emergency departments are required to offer a medical screening evaluation to all Veterans, including those with SCI/D, to determine if an emergency medical condition exists. This is the general expectation of emergency medical care, and our policies require a posture of continuous readiness to initially stabilize almost any medical emergency. We can then call upon community providers if there are ongoing clinical needs beyond what would typically be expected in a VA emergency care setting, ensuring integrated care for the Veteran. While there are emergent disease processes more prevalent in the SCI/D population, including sepsis and autonomic dysreflexia, the role of the emergency department in providing emergency stabilizing treatment would apply equally.

If deemed stable for discharge after an episode of emergent care, there would typically be coordination or follow up with the Veteran's primary or specialty care team to ensure appropriate care. Veterans receive specific information and education when discharged from the emergency department. This communication often involves caregivers—with the Veteran's permission—to provide them an opportunity to ask questions and gain an understanding of the necessary next steps and safety precautions in the Veteran's care journey.

All clinically active emergency department providers undergo ongoing professional practice evaluation to ensure an appropriate standard of care. This is in addition to existing quality controls within VHA to ensure high-quality care, including formal peer review and patient safety reporting. Additional specialized education is available through VA's Talent Management System and VA Library resources. Specialized training specific to SCI/D is not mandated for VHA emergency care clinical staff, as recognition and treatment of unstable emergency conditions would be a pre-existing standard across all clinical presentations.

Staff and Provider Training

Clinician training for providers, nurses, and interdisciplinary teams involved in caring for individuals with SCI/D is facilitated through various channels.¹ SCI/D Centers offer local and regional training, while the SCI/D National Program Office provides national-level training opportunities. These programs include monthly expert learning series, continuing education credits, and VA-professional community networking sessions. Additionally, annual training is provided for SCI/D PACTs located throughout the country and PACTs are also invited to annual leadership summits with SCI/D Centers. The primary objective of these training channels is to stay updated on best practices and ensure we deliver optimal care.

Addressing Transportation Concerns

VA recognizes that transportation can pose a significant barrier for Veterans with SCI/D and, as a result, VA provides various assistance options. Eligible Veterans can receive beneficiary travel (BT) benefits for regular and special mode transportation, such as ambulances and wheelchair-accessible vehicles. In 2016, Congress expanded BT eligibility to include Veterans with SCI/D, among other populations, when their travel is connected to care provided through a VA special disabilities re-

¹ Training requirements for the SCI/D System of Care are described in VHA Directive 1176(2), Spinal Cord Injuries and Disorders System of Care (Sept. 30, 2019; amended Feb 7, 2020).

habilitation program if that care is provided on an inpatient basis or during a period in which VA provides the Veteran temporary lodging at a VA facility to make the care more accessible. Additionally, VA operates the Veterans Transportation Program, offering door-to-door transportation to appointments, including wheelchair service, regardless of BT eligibility. To support Veterans in rural areas, VA oversees the Highly Rural Transportation Grant Program in 13 states, where VA provides funding to State Veterans Service Agencies or VSOs coordinating transportation in highly rural counties.

Construction and Facilities Management

VA is committed to ensuring accessibility across all aspects of its medical facilities, particularly in older facilities. This includes targeted upgrades, renovations, and integrating advanced assistive technologies to create modern, inclusive spaces that cater to the diverse needs of Veterans. VA has also pioneered the deployment of dedicated mobile units equipped with state-of-the-art equipment and resources, which serve as vital extensions of the health care network, reaching Veterans in remote or underserved areas and providing essential services and support. While not specific to SCI/D care, the Mobile Prosthetic and Orthotic Care program, supported by the VHA Innovators Network, aims to increase access to care for Veterans in rural areas. The program, already adopted in 10 VAMCs and set to roll out in 5 new areas in 2024, has improved the experience for Veterans who previously had to travel long distances for VA appointments.

VA's commitment to enhancing accessibility extends beyond physical infrastructure to a holistic approach to care. The organization has taken proactive steps to address the unique needs of women Veterans, implementing specialized facilities that ensure privacy, comfort, and tailored care. These spaces serve as safe havens for women Veterans to access the services and support they need in a compassionate and supportive environment that prioritizes their well-being and dignity.

As part of ongoing efforts to prioritize the health and safety of all Veterans, VA is also dedicated to reducing infection transmission rates within its facilities. Through rigorous infection control protocols, regular monitoring, and continuous staff training, VA is working tirelessly to create a safe and sterile environment that minimizes the risk of infections for patients, including those with SCI/D.

Overview of Benefits and Services

Spinal cord injuries are a significant cause of disability, with profound and, in many cases, devastating consequences. VBA's foremost concern is ensuring that the most catastrophically disabled Veterans receive the benefits they deserve and have earned through their military service. This includes disability compensation, employment and independent living training, and support through VA's Veteran Readiness and Employment (VR&E) program, housing benefits, and the Specially Adapted Housing Program.

Contract Examinations

As part of the disability compensation process, VBA oversees medical disability exam (MDE) contracts and related ancillary support and oversight contracts. VBA provides oversight of the exam contracts by setting metrics expectations for the Veteran experience, quality, timeliness, and production; overseeing ancillary contracts to verify examiners' credentials; and providing financial and data audits, to include invoice validation and beneficiary travel.

VBA conducts frequent in-person site visits and administrative site visits (virtual desk reviews) to ensure facilities are safe, clean, and accessible. In-person site visits allow VBA to visually inspect vendor examination locations for compliance with VA standards. In addition to in-person site visits, VBA conducts administrative site reviews (virtual desk reviews) to supplement onsite facility inspections and increase overall oversight of all locations where Veterans obtain examinations. Post-site visit reports note best practices and items that require vendor actions. All action items are tracked until completed.

In Fiscal Year (FY) 2023, VBA conducted 288 site visits and has already conducted 288 site visits in Fiscal Year 2024, with plans to complete at least another 112 site visits by the end of the fiscal year. To improve oversight, VBA also conducted a series of joint site visits with all MDE contract vendors to ensure consistency in site inspections and MDE vendor compliance.

In May 2024, the Office of Inspector General (OIG) issued a report titled "Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams." Contract facilities are required to comply with the Americans with Disabilities Act and Occupational Safety and Health Administration standards to ensure every facility where exams are performed is accessible, safe,

and clean. VBA takes Veterans' safety as its utmost priority and continues to work diligently to enhance Veteran safety and the overall Veteran experience. OIG made nine recommendations, which VBA is acting on, including updating contract requirements and standard operating procedures, and implementing improved customer feedback mechanisms. VBA is targeting to complete these actions by the end of Fiscal Year 2024.

Increasing Examination Access

VBA continues to work with MDE vendors to ensure all Veterans, including those with SCI/D, have access to VA exams by using modalities such as acceptable clinical evidence (ACE) exams and telehealth appointments that limit travel for in-person exams. MDE vendors use traveling providers, claims clinics, and per-diem or rented locations to assist Veteran populations that require additional support. Vendors have mobile units deployed throughout the country and are equipped to complete most exam types, as well as diagnostic testing. The units are accessible, with wheelchair lifts and ramps, and are fully self-contained with power supply and internet connectivity. Vendors continue to expand their mobile unit fleets and collectively have 28 operational individual units. For Veterans with SCI/D who are homebound or have transportation barriers, traveling providers, mobile units, and non-in-person examinations allow greater access. They reduce wait times without degrading the quality of the exam. In Fiscal Year 2024, through April 2024, vendors have completed over 1.9 million appointments consisting of over 200,000 (11.9 percent) ACE exams and over 160,000 (8.2 percent) telehealth appointments.

In addition to increasing exam modality options, during the examination scheduling process, MDE vendors are required to include specific language in appointment notification letters regarding accessibility needs. VBA is also partnering with VA's Veterans Experience Office (VEO) to improve the scheduling process and increase Veterans' understanding of the examination process to build clarity, predictability, and flexibility to meet Veteran needs.

Customer Satisfaction and Feedback

In April 2024, VBA implemented improvements to the Customer Satisfaction survey process. A new customer service contract vendor mails survey cards to Veterans to improve process integrity. Before April 2024, MDE vendors were responsible for releasing survey cards directly to Veterans. VBA also enhanced the actual customer satisfaction survey by incorporating a VA trust question, allowing VA to gain better insights into Veterans' confidence in the contract examination process, like other Veteran Experience surveys across the VA enterprise. VA also incorporated a quick-response code onto the survey, reducing the Veterans' burden of responding by allowing them immediate access to their survey by using a smartphone or computer.

VBA takes feedback from Veterans and stakeholders seriously. As an example, based on a suggestion from Paralyzed Veterans of America, VBA made interim updates and clarified existing guidance regarding the Remaining Effective Function of the Extremities sections on the Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, Central Nervous System and Neuromuscular Diseases, and Peripheral Nerves Conditions Disability Benefits Questionnaires (DBQ). Additionally, in May 2024, VBA attended an ALS workshop in Seattle, Washington, which VHA hosted. VEO led this workshop and received a list of 29 suggested revisions to the ALS DBQ. VBA is evaluating these requests through its joint VBA-VHA DBQ Change Control Group.

VR&E

The mission of VA's VR&E program is to assist qualified Service members and Veterans with service-connected disabilities prepare for, obtain, and maintain suitable employment or maintain a life of independence. VR&E achieves this mission by providing comprehensive vocational counseling services to transitioning Service members and Veterans to ensure goals are suitable and attained.

During Fiscal Year 2023, VA provided VR&E services to 131,179 Veterans and Service members, and 17,135 Veterans successfully completed their VR&E program. During Fiscal Year 2023, VBA paid over \$1.6 billion in VR&E benefits. As of May 1, 2024, VR&E has 151,769 Veteran participants, with 90,380 enrolled in Long-Term Services, which helps program participants obtain the education and training they need to find work in a different field that better suits their current abilities and interests.

VR&E assists Veterans with SCI/D, and any other Veteran who meets the eligibility and entitlement criteria. A Vocational Rehabilitation Counselor (VRC) works with the individual to develop a plan of action that includes structured, individualized services ranging from education or necessary training to find work in a suitable

field to services that assist with living as independently as possible if returning to work is not an option at the time the plan is developed.

VR&E Independent Living Services

The VRC conducts an assessment to determine if achieving a vocational goal is currently reasonably feasible. To qualify for independent living (IL) services, the following requirements must be met:

- Service-connected disability of 20 percent or more,
- Serious employment handicap resulting in substantial part from the service-connected disability(ies),
- Inability to achieve a vocational goal,
- Limitations in activities of daily life impacting the individual's level of independence, and
- Reasonable likelihood that the gains in independence will continue after completing the program of IL services.

The VRC works with the individual to conduct a preliminary IL assessment to determine if there are any impairments in activities of daily living. Areas such as housing, emotional, spiritual, leisure, and avocational needs are discussed to ensure all aspects of the individual's needs are considered.

If the preliminary IL assessment confirms impairments in activities of daily living, the VRC must coordinate a comprehensive evaluation. A comprehensive in-home evaluation delves deeper into the preliminary assessment findings and any other areas of need, particularly potential barriers to living independently.

The VRC works with the Veteran to develop an individualized independent living plan, enabling the individual to live independently and participate in family and community life to the maximum extent possible. IL services may increase the Veteran's potential to return to work by providing services designed to lessen or accommodate the effects of the disabilities. Veterans may receive:

- Assistive technology/modifications,
- Referrals for IL skills training,
- Referrals to community-based support services,
- Case management services,
- Coordination assistance with VA and non-VA service providers, and
- Support of an avocational activity.

VA Specially Adapted Housing (SAH) Program

This year marks the 76th anniversary of the VA SAH grant program, which provides essential financial support for home adaptations, and addresses the unique accessibility needs of eligible Service members and Veterans with specific severe, service-connected disabilities, including SCI/D. The SAH program assists Service members and Veterans in constructing an adapted home, purchasing a home with adapted features, or adapting their own home. These projects, funded through this critical benefit, make Veterans' homes more accessible by removing barriers for those with qualifying disabilities. Since the program's inception in 1948, VA has administered over 52,000 SAH grants to eligible Service members and Veterans, totaling over \$2.1 billion. For Fiscal Year 2024, through May 2024, VA has approved 1,507 SAH grants totaling \$94.3 million.

With the enactment of P.L. 115–177 in June 2018, the funding and construction activities for home adaptations made necessary by VR&E rehabilitation program transitioned to VA's Loan Guaranty Service (LGY) SAH program. The VR&E and LGY SAH programs have worked together to develop the qualifying factors for the grant process, including the use of licensed contractors, permits, technical drawings, and compliance inspections. Generally, VA may provide home adaptations up to \$107,357 as part of an approved VR&E rehabilitation program for individuals who are unable to work due to service-connected disabilities or who require home adaptations to achieve a vocational goal. The amount can change, based on inflationary adjustments.

Other types of grants administered under the SAH program include the section 2101(a) grant (sometimes referred to as Specially Adapted Housing) and the section 2101(b) grant (sometimes called Special Home Adaptation). Also, the Temporary Residence Adaptation allows eligible individuals to adapt a family member's home where the Veteran or Service member is temporarily residing. The physical criteria for eligibility are defined by statute and, depending on the type of grant, include loss of use of extremities or blindness. Based on the type and level of a Veteran's

service-connected disability, Veterans may be eligible for up to \$117,014 in assistance under a section 2101(a) grant or \$23,444 under a section 2101(b) grant. These amounts represent the maximum grant amounts in Fiscal Year 2024, which change annually based on an industry cost-of-construction index.

Conclusion

Chairman Bost, Ranking Member Takano, this concludes my testimony. Thank you once again for the opportunity to update you on VA's holistic approach, encompassing innovative technologies, specialized care, and unwavering support, to ensure Veterans with SCI/D receive the highest quality of care and services possible. Our commitment to ensuring that all Veterans receive the care, support, and respect they deserve remains unwavering. My colleagues and I are prepared to answer any questions.

Prepared Statement of Steve Bracci

Chairman Bost, Ranking Member Takano, and members of the Committee, thank you for the opportunity to testify on the independent oversight conducted by the Office of Inspector General (OIG). The OIG is committed to conducting work that results in clear findings and practical recommendations to help the Veterans Benefits Administration (VBA) promptly and accurately provide veterans, their families, survivors, and caregivers with the benefits and services they have earned.

As of March 31, 2024, more than 5.8 million veterans were receiving disability compensation benefits.¹ Given the significant hardships veterans may face when the disability compensation benefit program does not work as intended, the OIG remains vigilant in its oversight of various aspects of the program. This written statement focuses on improvements that VBA can make in its oversight of the vendors providing medical exams for veterans' disability benefits claims.

When a veteran files a claim, VBA staff may request medical exams to assess the disability before deciding and rating the claim. These exams, most of which are provided by contracted medical professionals, represent a multibillion-dollar investment of taxpayer dollars by VBA since 2017. Exams are typically conducted at the medical examiner's place of business, and those facilities must be accessible, safe, and clean according to contract requirements.² The contracts also mandate that the vendors inspect all facilities where exams are conducted to ensure compliance with the Americans with Disabilities Act (ADA) and Occupational Safety and Health Administration (OSHA) standards.³

Starting in 2022, the OIG assessed concerns raised by veterans through customer satisfaction surveys that VA requires be provided to veterans after a disability exam. The OIG review focused on veterans' feedback regarding the accessibility, safety, and cleanliness of the contract exam facilities. The team inspected 135 facilities for compliance with contractual and legal requirements and reviewed key aspects of VBA's oversight of exam vendors. During the review, the OIG team identified one or more ADA and OSHA deficiencies at 114 (about 84 percent) of the exam facilities. This testimony highlights the finding and recommendations detailed in the resulting May 2024 report.⁴ The report focused on three issues related to (1) the lack of oversight over the contract exam facilities, (2) the prevalence of noncompliance with ADA and OSHA standards, and (3) the impact on veterans with mobility issues.

The numerous deficiencies at these locations created needless burdens for veterans, especially those with spinal cord injuries and disorders and those using wheelchairs. Proactive monitoring of contractors' facilities is essential to ensure compliance with laws and regulations for accommodating individuals with disabilities and maintaining an accessible, safe, and clean environment for all veterans seeking exams. VBA has made some progress on remediating these issues. However, additional monitoring is needed to ensure full compliance.

¹ VA, "VA Benefits & Health Care Utilization," <https://www.va.gov/vetdata/docs/pocketcards/pocketcard.pdf>, accessed June 3, 2024.

² Medical Disability Examination Contracts, Section 5.1 Place of Performance.

³ Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.; Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 et seq.; Medical Exam Contract, Section 8.5 Deliverable Tasks Nov 28, 2018.

⁴ VA OIG, *Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams*, May 8, 2024.

BACKGROUND

Regardless of whether a veteran is seen at a VA medical center or contract exam facility in the community, all exam facilities must comply with ADA and OSHA standards.⁵ The ADA ensures people with disabilities have the same access, opportunities, and rights as everyone else.⁶ In particular, the act mandates that publicly accessible buildings have features to help people using wheelchairs, walkers, or crutches to maneuver safely. OSHA sets and enforces standards and guidance requiring businesses to maintain clean and sanitary workplaces. It also conducts inspections to maintain safe working conditions. Notably, exit routes must be free, unobstructed, and properly labeled.⁷ They also must be reasonably straight and have smooth, solid, and substantially level walkways.

VBA created the Medical Disability Examination Office (MDEO) to oversee contract exams. VBA staff request disability exams from one of the contract exam vendors when the veteran's nearest VA medical center has reached or exceeded its maximum capacity for conducting these exams.⁸ According to MDEO, during the OIG's review period from January 1 through December 31, 2022, three contract vendors performed about 88 percent of all exams and a fourth vendor was added.⁹

THE MDEO MUST IMPROVE ITS OVERSIGHT OF CONTRACTORS' DISABILITY EXAM FACILITIES TO ENSURE ACCESSIBILITY AND SAFETY MANDATES ARE MET

The vendors' contracts require them to inspect all their facilities or subcontracted facilities for compliance with ADA and OSHA standards.¹⁰ Yet when the OIG team conducted a complete inspection of 99 facilities, and partial inspections for an additional 36, more than 80 percent of them had one or more ADA and OSHA deficiencies.¹¹ These deficiencies reflect problems related to accessibility, cleanliness, or safety, which, in a number of cases, made it difficult to accommodate some veterans who needed exams.

The deficiencies went largely undetected by VBA because MDEO did not provide sufficient oversight to assess the accuracy of vendors' self-certification of ADA and OSHA compliance. The original vendor contracts required MDEO to conduct site visits both randomly and in response to complaints at exam facilities to assess compliance. However, MDEO modified the contracts in September 2021 to state MDEO "may" conduct both random and complaint-based site visits at contract facilities at VBA's discretion. In Fiscal Year 2022 (October 1, 2022–September 30, 2023), MDEO conducted visits at 76 randomly selected sites but did not visit any sites in response to complaints. An MDEO assistant director said sites are selected based on their proximity to exam vendors' headquarters.

The OIG team's finding was supported by the following four determinations:

MDEO Depended on Vendors for Contract Facility Information

As of the report's publication, MDEO did not have independent access to a current inventory of all contract facilities used to perform disability exams, instead relying on vendors to provide this information. This reliance has limited its ability to con-

⁵MDE contracts sec. 8.5, "Deliverable Tasks," November 28, 2018; Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990); Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 et seq. (1970).

⁶The OIG's review focused on the ADA's Title III, which applies to businesses serving the public. "Introduction to the Americans with Disabilities Act" (web page), accessed November 8, 2023, <https://www.ada.gov/topics/intro-to-ada/#businesses-that-are-open-to-the-public>; Title III regulations.

⁷"United States Department of Labor, Occupational Safety and Health Administration: Maintenance, safeguards, and operational features for exit routes. standard 1910.37(a)(3)" (web page), accessed October 23, 2023, <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.37>.

⁸VA Manual 21-1, "Mandatory Use of the ERRA Tool," updated May 31, 2022, sec. IV.i.2.A in *Adjudication Procedures Manual*, topic 1c.

⁹The OIG team conducted inspections at facilities from each of the four vendors. The fourth vendor was added in June 2022; however, that vendor did not complete exams until December 2022.

¹⁰The applicable 1991 and 2010 building standards (whichever is applicable to the site); Americans with Disabilities Act of 1990 (web page); <https://www.ada.gov/law-and-regs/design-standards/1991-design-standards/> and "2010 ADA Standards for Accessible Design" (web page); 29 C.F.R. Part 1910, <https://www.ada.gov/law-and-regs/design-standards/2010-stds/>, accessed April 19, 2024.

¹¹Partial inspections generally consisted of examining only facilities' exteriors. This was due to reasons such as the team finding facilities closed that had unclear operating hours or operational status, or the interior being inaccessible because exam rooms were continuously occupied, and the review team did not want to prolong veteran exam wait times.

duct site visits. Depending on vendor-provided lists that can be incomplete or weighted toward more compliant facilities affects MDEO's capability to oversee its vendors. If facilities are overlooked, compliance issues may not be found and addressed.

MDEO reported that the "vendor is responsible for developing and recruiting a provider network and therefore, a complete list of all providers they are contracted with would be considered proprietary information that they do not wish us to disclose to their competitors." The OIG contends that VA routinely receives proprietary information from contractors and that necessary controls can be instituted to limit access to those VA personnel who need the information. Particularly where oversight of veteran safety and contract exams are at issue, VA must have accurate information.

Concerningly, two of the four vendors could not provide a definitive number of facilities where their subcontractors conduct exams. One vendor reasoned that facility numbers are fluid and contract facilities are added and removed continually. Another vendor stated that when MDEO requests a list of exam facilities, the vendor provides 10 locations in the geographic area of the facilities where most veterans are likely to be seen. Another vendor reported that it would provide addresses and hours of operation for the facilities in an area upon request from MDEO.

An MDEO chief said site visits are generally within commuting distance of each vendor's headquarters. An assistant director claimed that staff plan to expand site visits throughout the country. Another assistant director also noted it was difficult to provide an exact number of contract facilities, as some examiners practice at more than one location, multiple examiners practice at the same locations, and some examiners have short-term leases. MDEO's executive director said it is working on maintaining its own list and information on contract exam facilities, so staff can conduct site visits and desk audits.¹²

Recommendation

MDEO was asked to submit a plan and documentation of progress to the OIG on implementing VBA's maintenance of an independent, updated list of contract facilities. VBA concurred with maintaining a list of facilities but stated it was unable to independently verify all of a vendor's active subcontracts.

This recommendation, and the other eight discussed below, remain open (not fully implemented) at this time. In accordance with the OIG's routine follow-up process, the first request for an update on all the recommendations is on August 9, 2024.¹³ The OIG will monitor VBA's progress on its implementation of all recommendations.

MDEO Assigned Exam Vendors the Task of Distributing Satisfaction Surveys Rating Their Own Performance

VBA contracts with a separate survey vendor to work with the four exam vendors to obtain veteran contact and appointment information to provide all veterans with a paper survey card regarding their exam experience, as well as access to other methods such as email or text.

However, the survey vendor reported it distributed the blank customer satisfaction survey forms to the exam vendors, which then mailed them to individual veterans. MDEO confirmed the practice was consistent with its guidance. Consequently, the survey vendor could not monitor how, or if, the customer satisfaction surveys were properly distributed and whether every veteran examined received one. As a result, MDEO lacks assurance it is receiving the full picture of veterans' experiences. MDEO needs the survey vendor or other distributor with no vested interest in the results to be responsible for mailing the surveys to veterans. Additionally, because the survey vendor's performance was tied to the survey response rate, MDEO cannot fairly evaluate its performance.

Per its contract, the survey vendor is expected to meet a minimum response rate of 15–20 percent. In 2022, MDEO reported that the overall response rate to the customer satisfaction survey was about 11 percent. VBA's response to this report noted that in October 2023, a new customer satisfaction survey vendor was onboarded.¹⁴

Recommendation

¹² Per MDEO, desk audits would include virtual inspections of contract exam facilities through photographs, internet images, and any available information to validate facility compliance.

¹³ At quarterly intervals commencing 90 calendar days from the report issue date, the OIG sends a follow-up status request to the action office asking for an implementation status report. The follow-up staff provides VBA 30 calendar days to respond. Nothing precludes VA from submitting information before target dates or scheduled follow up.

¹⁴ The rate equals the number of unique responses divided by the number of appointments completed.

VBA concurred with the report's second recommendation to comply with the requirements of the customer satisfaction survey contract by routing exam comment cards directly between the survey vendor and the veteran examined.

MDEO Lacked Formal Standard Operating Procedures and Training for Site Visits to Assess Safety and Accessibility Compliance

MDEO lacked formal, written, standard operating procedures outlining the responsibilities, tasks, and processes for staff conducting exam facility site visits. According to VBA's contracts with exam vendors, the standard of review for a site visit is based on ADA, the Joint Commission on Accreditation of Healthcare Organizations, OSHA, and any applicable State or local standards.¹⁵ VBA does not provide its staff with training on ADA or OSHA compliance. Staff use a checklist with a series of yes/no questions and a space for related comments. These questions are not specific enough to effectively address whether the contractual standards have been met. This was particularly true for questions regarding building and exam room accessibility for veterans using wheelchairs.

Some MDEO employees said they based their site visit checklist responses on simple visual observation, rather than addressing established criteria. When MDEO staff and managers were asked about specific ADA and OSHA requirements, several reported not knowing the specific criteria. For example, parking lots require a minimum percentage of disabled parking spaces, and there are minimum dimensions for wheelchair turning radius, wheelchair ramp slope, and doorframe widths.

Formal training plays an important role in helping staff acquire knowledge, develop skills, and improve performance, especially when employees have different roles and tasks. An MDEO assistant director stated that most training is done on the job for the practical purpose of inspecting facilities; however, MDEO is not opposed to formal training. The MDEO executive director said staff are working on a formal training program and standard operating procedures, and a dedicated team was created to be responsible for providing external training to exam vendors and MDEO staff.

Recommendations

VBA concurred with the report's third recommendation to develop and implement formal standard operating procedures for the contract exam facility site visits detailing roles, responsibilities, objectives, and monitoring. It concurred in principle with the fourth recommendation for MDEO to update the site visit checklist to include a focus on specific ADA and OSHA criteria required by exam vendor contracts. VBA also concurred in principle with recommendation 5 to complete a standardized training plan for site visit staff to include ADA and OSHA compliance.

MDEO Did Not Verify Vendor Compliance with ADA and OSHA Requirements

Exam vendors are required to self-certify annually that they meet all ADA and OSHA requirements for accessibility, safety, and cleanliness, and certify all new facilities in the quarter after they are added. The contracts allow VBA to suspend any facilities for which MDEO has identified concerns regarding health and safety. However, exam vendors generally relied on subcontractors to self-certify, and MDEO did not validate the self-certifications. One MDEO leader said exam vendors should be able to inspect every facility to ensure compliance, while another reported being unaware of any instance in which action was taken for noncompliance. Further, one of its employees confirmed that tracking individual facilities would not be possible because staff do not receive a list of each facility being self-certified; they received regional certification from the vendor. The vendor's self-certification process was not comprehensive or reliable because there was no validation, likely contributing to the unresolved ADA and OSHA facility deficiencies.

Veterans can submit complaints about contract exams through avenues such as the OIG hotline, VA regional offices, the White House hotline, veterans service officers, and MDEO. Exam vendors also submit incident reports to MDEO.¹⁶ However, MDEO was not conducting complaint-based reviews even when survey responses identified deficiencies. The OIG found that MDEO should review all sources to determine if a complaint-based site visit is warranted.

The OIG's report describes two incidents in which veterans were unable to be examined because a contract facility could not accommodate a wheelchair. In one inci-

¹⁵ The OIG did not evaluate whether exam vendors met the Joint Commission's standards for clinical operations.

¹⁶ An incident report is required in instances of physical distress, violent or threatening behavior from the veteran, or natural disaster.

dent, the veteran was injured being transferred from a wheelchair into an audio booth with inadequate space to maneuver a wheelchair.

Recommendations

VBA concurred with the sixth recommendation to conduct complaint-based contract facility inspections, and with recommendation 7 to enforce contractual requirements for vendors to conduct inspections and recertify all facilities for ADA and OSHA compliance. Although VBA requested the latter recommendation's closure, the OIG will only do so after monitoring MDEO's contract enforcement.

THE OIG FOUND ADA AND OSHA DEFICIENCIES THAT MAKE EXAM FACILITIES DIFFICULT TO ACCESS AND UNABLE TO ACCOMMODATE SOME VETERANS

Some veterans said their exams were canceled as contract facilities did not comply with ADA or OSHA requirements and could not accommodate their mobility or sensory issues. For example, accessible medical equipment should include adjustable-height exam tables and chairs, wheelchair-accessible scales, adjustable-height radiologic equipment, portable floor and overhead track lifts, and gurneys and stretchers.¹⁷ The OIG review team also found numerous facilities lacking adjustable exam tables.

Examples of survey responses from veterans highlight accessibility, safety, and cleanliness concerns at contract exam facilities:

- "Wheelchair access is too steep [sic] for handicap with wheelchair."
- "Not handicap accessible very hard getting a wheelchair in and out of the main entrance door."
- "No ramp for wheelchair."
- "The doorway entering the building has a 2–3 inch threshold that a wheelchair or scooter has to be lifted over."
- "Handicap ramp not wheelchair friendly."
- "Wasn't able to complete exam due to not being able to get into the exam booth."
- "Getting in and out of the sound booth was difficult because the wheelchair is too large for the booth. Very unsafe."
- "Office was dirty with bugs crawling on the floor."

The OIG team developed a site visit protocol that enhanced the MDEO approach by including ADA and OSHA compliance criteria to be used for 135 sites. This protocol consisted of questions related to seven areas of concern: (1) the facility location, (2) safety and protective equipment, (3) exam rooms, (4) general medical clinical equipment and supplies, (5) audiology clinical equipment and supplies, (6) ophthalmology or dental clinical equipment and supplies, and (7) protections for vulnerable veterans.

Using this protocol, the team first inspected 87 randomly selected facilities (62 complete and 25 partial inspections) that performed disability exams nationwide from January 1 through December 31, 2022.

The OIG found that

- 45 facilities had at least one accessibility deficiency,¹⁸
- 36 facilities had at least one safety deficiency,¹⁹
- eight facilities had at least one cleanliness deficiency, and²⁰
- 15 facilities had no deficiencies.²¹

The team then inspected 48 newly added facilities (37 complete and 11 partial inspections) from the four vendors chosen both randomly and based on veteran com-

¹⁷ "Access to Medical Care for Individuals with Mobility Disabilities" (web page), accessed November 13, 2023, <https://www.ada.gov/resources/medical-care-mobility/>.

¹⁸ Accessibility deficiencies included a steep ramp or curb, lack of ramps, narrow doorways, an elevated audio booth with no ramp, no adjustable exam tables, and improper door hardware.

¹⁹ Safety deficiencies included expired fire extinguishers, partially blocked exits, and tripping hazards.

²⁰ Cleanliness deficiencies included bugs in fire alarms, stained carpets, inappropriate waste disposal, and no available hand sanitation equipment in designated areas.

²¹ Facilities with no deficiencies were based on results from the 62 complete inspections only. Some facilities had more than one type of deficiency; therefore, numbers may not sum to the total number of sites.

plaints. The facilities were added between January 1 and March 31, 2023, allowing the OIG review team to ascertain whether newly added facilities complied with ADA and OSHA standards.

The team identified

- 28 facilities with at least one accessibility deficiency,
- 23 facilities with at least one safety deficiency,
- one facility with at least one cleanliness deficiency, and
- six facilities with no deficiencies.²²

Examples of ADA and OSHA Deficiencies

ADA accessibility deficiencies included issues with handicap parking, wheelchair ramps, accessible entrances, bathrooms, exam rooms, medical equipment, and audio booths. For example, the team found the entrance threshold at a facility in California was too high. Facilities in Texas, Wisconsin, and Missouri all had audio booth accessibility deficiencies, ranging from insufficient wheelchair turning radius to higher-than-allowed door thresholds or no permanent or temporary wheelchair ramp access.

Examples of safety deficiencies included blocked stairways, noncompliant handrails, expired or inaccessible fire extinguishers, and blocked exit routes. No materials or equipment may be placed, either permanently or temporarily, in the exit route. Additionally, the exit route must have a smooth, solid, and substantially level walkway. At a facility in Texas, the OIG found a fire extinguisher that was stored in a cabinet under a sink, also with the last evidence of inspection being June 2017. The review team also identified eight facilities from the initial inspection of 12 states with at least one cleanliness deficiency. Some deficiencies included common area cleanliness, lack of personal protective equipment and single-use medical supplies, and lack of available hand sanitation equipment in designated areas.

EXAMS SCHEDULED AT FACILITIES WITH ADA AND OSHA DEFICIENCIES MAY CREATE DIFFICULTIES FOR VETERANS WITH MOBILITY ISSUES

MDEO told the OIG that vendors are not allowed to cancel an exam specifically because a facility was not ADA-compliant, noting that vendors would need to reschedule appointments if a room, booth, or exam table was not accessible at the time of the scheduled exam for someone who uses a wheelchair. Concerningly, one vendor could not confirm if its scheduling unit asked veterans if they needed accommodations at the time the appointment was set up.

The OIG's inspection confirmed ADA deficiencies may make it unable to accommodate veterans with mobility issues. Rescheduling these exams after veterans have needlessly gone to a facility takes time and may entail traveling long distances. Rescheduling may also delay their disability benefit claims from being processed. The OIG determined MDEO had not been holding vendors accountable to ensure exam facilities are accessible, safe, and clean for veterans attending exams.

Recommendations

VBA concurred in principle with the report's eighth recommendation to analyze all veteran complaints related to facilities received through all entities and perform complaint-based site visits or create action plans, as necessary. It also concurred with the final recommendation for MDEO to develop a plan with its vendors to determine if each veteran requires accessibility arrangements before scheduling an exam.

CONCLUSION

A critical foundation of accountability for any program is effective oversight to detect and resolve issues. This is crucial for medical exams given how critical they are to ensuring veterans receive accurate and timely disability benefits claims decisions. Additionally, the need for VBA to conduct thorough oversight is essential given the billions of taxpayer dollars paid to contractors. The OIG recognizes the challenges with doing so when most of these exams are conducted outside of VA facilities by nongovernmental personnel. As a VBA leader noted, however, while VA does not own contractor exam facilities, they represent the face of VA for veterans applying for benefits.

The deficiencies identified by the OIG persisted because MDEO's oversight was ineffective at detecting and correcting them, particularly in failing to consistently

²² Facilities with no deficiencies were based on results from the 37 complete inspections only.

conduct site visits in response to veterans' complaints. VBA and its vendors must continue to take swift corrective action to ensure veterans with spinal cord injuries and disabilities, as well as others requiring accommodations, have prompt access to suitable exams that will help determine their disability benefits. Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the subcommittee may have.

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**STATEMENT OF
ROBERT THOMAS
NATIONAL PRESIDENT AND CHAIRMAN OF THE BOARD
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
CONCERNING
"A CALL TO ACTION: MEETING THE NEEDS OF THE SPINAL CORD INJURY AND DISORDERS (SCI/D)
VETERAN COMMUNITY"
JUNE 13, 2024**

Chairman Bost, Ranking Member Takano, and members of the committee, I appreciate the opportunity to testify on behalf of Paralyzed Veterans of America (PVA) and the tens of thousands of veterans with spinal cord injuries and disorders (SCI/D) who rely heavily on the benefits and healthcare available through the Department of Veterans Affairs (VA). The VA is the care provider of choice for veterans with catastrophic disabilities. In truth, it is the only choice for veterans with SCI/D.

Since a service-connected spinal cord injury (SCI) left me paralyzed, I have spent nearly 35 years navigating the VA's health care and benefits systems. The care and benefits available through the VA not only saved my life, but have given me the ability to have a family, work, and serve my fellow veterans, most recently as PVA's National President and Chairman of the Board. I use the Louis Stokes VA Medical Center in Cleveland, Ohio. I'm fortunate that I have a VA SCI/D center less than 30 miles from my home. It gives me tremendous comfort knowing that there are medical professionals who understand my injury and can help me navigate the healthcare challenges that result from having an SCI.

I receive my medical care through VA's direct care system, except when emergencies dictate receiving care at the nearest hospital. About 10 years ago, I was in a motor vehicle accident. Following the accident, I was taken to a community hospital for immediate care. My wheelchair was in my now damaged vehicle and I was stuck on a bed, unable to get up or move. During the accident, I hit the spinner knob on my steering wheel that helps me drive my adapted vehicle. I recall the emergency room doctor asking me if I was in pain from the accident. I told

the doctor that I was paralyzed and unable to feel such pain. Rather than give me x-rays to see if I had broken ribs, I was given pain medication and released.

I knew that I needed to get to the VA as they know how to care for veterans with SCI/D. Once at the VA, I was able to get a thorough exam. Thankfully, my ribs were only bruised and not broken. I was fortunate. I know first hand why people with SCI who didn't serve tell me that they wish they could access the care and supports available through the VA.

The lives of veterans with SCI/D depend on having access to VA-provided care through VA's SCI/D system. Without this care, I don't know where I would be and many of the men and women seated behind me would say exactly the same if they were speaking with you today. That's why we become very concerned when SCI/D centers have to close beds because they don't have enough nurses to properly staff them. It's why we become concerned when our members don't have access to quality in patient mental health and substance use disorder treatment. It's why we become concerned when our medical centers aren't kept up to date with needed equipment and infrastructure enhancements. We need the care that's available through the VA for our ongoing health and independence.

Veterans Health Administration (VHA) Directive 1176 provides the staffing guidelines needed in order for SCI/D centers to properly care for veterans with SCI/D. Depending on the function level of an acute SCI/D patient, a nurse may spend an hour or more each time they enter a veteran's room doing physical transfers, repositioning, wound care, feeding assistance, bowel and bladder care, and other tasks. Nurses in other areas of work may be in and out of a patient's room in a matter of minutes. That's why it's important for SCI/D centers to have higher staffing levels than other wards. Those higher numbers are actually the minimum of what is needed to provide an excellent standard of care for veterans with catastrophic disabilities.

When we hear from medical center leaders that the staffing requirements don't have to be adhered to, we know that means SCI/D veterans will not receive the proper level of care. It also means overworked clinical providers who must fill in the staffing gaps to help ensure that veterans do not fall through the cracks and veterans with SCI/D waiting longer for assistance from nurses who are stretched to the breaking point. Despite the increased care that veterans with SCI/D require, not all SCI/D nursing staff, such as licensed practical nurses and certified nursing assistants, receive specialty pay, which often elevates turnover rates.

We need every level of VHA, including VA Central Office, the Veterans Integrated Services Networks, and the individual medical facilities, to take seriously the requirements of VHA Directive 1176. It's based on the needs of catastrophically disabled veterans and what's best for our care. We need the VA to properly deploy its resources and request the funding it actually needs to provide the level of care for paralyzed veterans outlined in this directive. If the VA system of care isn't properly funded to ensure that staffing levels meet the needs of veterans with SCI/D, then our government is defaulting on its obligation to them. It is defaulting on the promise made to care for us should we become catastrophically injured or ill in our service to this great nation. This is a disservice to those who have served and dissuades those who would serve.

It's not just acute care post-injury or diagnosis that we depend on, it's also the lifelong care that allows us to remain in our homes, to work and volunteer, and live in our communities with our families. My wife, LaShon, is not only my spouse, she is also my caregiver. Her daily support is necessary to help me get out of bed each day, to take care of my grooming needs, dress, and satisfy a number of other activities of daily living (ADL). In fact, it is only due to her support that I am able to be with you today. I can't overstress the importance of caregiver support. It's comforting knowing that there is someone available in the middle of the night if I have a health issue or need assistance. I can't imagine being at home alone without her support, comfort, and security.

I'm grateful that Congress and the VA have begun to recognize the sacrifice of family caregivers. I was approved to join VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC). I appreciate the recognition it provides to my wife for the years of support she has given to me. However, even though I am a quadriplegic, I was assigned to the lowest tier. Out of curiosity, I asked a nurse in the program what it would take for a veteran to be placed in the higher tier. Essentially, she told me they would have to be bedbound and incoherent in order for that to happen. VA's current PCAFC requirement fails to recognize that veterans who are able to have a measure of independence still may need significant caregiver assistance in completing their ADLs. Paralyzed veterans need the VA to revise its rule and fix this problem.

Although my wife provides most of my home care needs, assisting a person with an SCI/D is a 24/7, 365-day duty. I often depend on other family members who can assist me so that my wife can take care of her own healthcare and other personal needs. Some of my fellow veterans must solely depend on paid caregivers from the direct care workforce. That's why PVA is fighting so hard for passage of the Elizabeth Dole Home Care Act. This legislation would expand access to home and community-based services throughout the VA, including the Veteran Directed Care (VDC) program. VA recently expanded the program to my VA and I'm now in the process of hiring caregivers, including my sister, to assist me. This program is critical for SCI/D veterans.

Unfortunately, Andrew, a veteran with ALS, had to switch from the VDC program to the PCAFC earlier this year because expenses related to his care were expected to exceed the cap on how much the VA can spend on each veteran's home care. The VA is prohibited from spending more than 65 percent of what it would cost if a veteran was provided nursing home care. I mentioned Andrew's situation when I testified in March. Since then, we have learned that switching programs won't keep him under the cap, leaving his family to scramble as they try to figure out how to accommodate his care at home.

The Elizabeth Dole Home Care Act would fix this problem. We need Congress to pass the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (H.R. 8371), which includes this important legislation. I and my fellow paralyzed veterans have waited patiently for Congress to pass the provisions in this bill. We are tired of waiting for improved home care supports and believe that the backing of every major veterans organization should be enough to get H.R. 8371 through Congress, without further delay. Andrew can't wait anymore. His wife Lisa can't wait anymore. We can't wait anymore for Congress to do the right thing and pass this bill.

For veterans with SCI/D who need access to facility-based long-term care, the options are quite limited. I'm fortunate that my SCI/D center has a specialized long-term care facility. Most veterans are not so lucky. In fact, there are less than 200 authorized long-term care beds in the entire VA SCI/D system of care. The number of beds currently available is actually closer to 150. There are two projects currently under construction that will add long-term care beds in Dallas and San Diego. We are grateful that these major construction projects received funding, however, they will only superficially serve the need.

Community nursing homes are not always a back stop for veterans with SCI/D. Veterans who have the highest chronic care needs may have difficulty finding a facility that will accept them, especially close to home. We need VA to prioritize projects and initiatives that will result in more long-term care beds for those veterans who need the supports that facility-based care provides. These veterans can't depend on the community to provide the quality care they need.

I'm grateful for the support I receive through the VA, but my fellow veterans and I are concerned about the future of the VA's SCI/D system of care. We worry about whether or not we will have the supports and services needed to help us remain healthy throughout our lives. We cannot be served in the community the way we can

be served through the VA. That's why we need robust staffing, updated infrastructure, and access to services and supports as we age. Otherwise, we are in danger of living diminished, shortened lives. This is not what we fought for and it's not what we will settle for.

Thank you for the opportunity to provide you with my perspective on VA's SCI/D system of care. I would be happy to answer any questions.

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

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

Fiscal Year 2023

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

Fiscal Year 2022

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

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

ROBERT L. THOMAS JR.
PVA NATIONAL PRESIDENT & CHAIRMAN OF THE BOARD



PVA has changed my life by introducing me to things that I believed to be over when I became injured, such as the National Veterans Wheelchair Games, and showing me that you can still live a fulfilling life although you have sustained a catastrophic injury."

Robert Thomas grew up in Cleveland, Ohio and played football and basketball. He enlisted in the U.S. Army shortly after graduating high school in 1987. Thomas served as a power generation equipment specialist at Fort Sill, Oklahoma; Camp Humphreys, South Korea; and Fort Bragg, NC. While on active duty, in 1991, Thomas had a diving accident that severed his fifth and sixth vertebrae. He was introduced to PVA through the Cleveland VA Medical Center. PVA helped him navigate his new

life by working to obtain his earned benefits through the VA, and reintegrating him back into society through social outings with the recreational therapist.

Thomas joined PVA in 1993 as a member of the Buckeye Chapter of PVA in Ohio, and a little while later, began volunteering with the chapter. He took some time off to earn his associate degree in Information Technology, and returned to the Buckeye Chapter of PVA board in 2010. He served as the chapter's vice president from 2012-2015, and as the chapter's representative on the national Field Advisory Committee and the Resolution Committee.

Thomas was elected as President of PVA May 2023 during the organization's 77th Annual Convention, to begin a new, one-year term on July 1, 2023. He initially joined PVA leadership at the national level in 2015 as the parliamentarian, and was elected to serve on the Executive Committee in 2017. Thomas continues to serve PVA because he wants to help lead the organization well into the future. "My inspiration to serve stems from PVA's past and present leadership," Thomas says. "Being a member for 30 years and seeing how unselfishly each leader, member, employee, and volunteer gives of themselves makes me want to continue to serve an organization that does so much for veterans and the disabled community."

In addition to serving as President of PVA, Thomas currently serves as the chair of PVA's Education Foundation. He was also appointed to the VA's Family Caregiver and Survivors advisory committee. Thomas and his wife, LaShon, live in Macedonia, Ohio. Thomas enjoys reading, watching sports, and playing adaptive sports like power soccer, bowling, air guns, and scuba diving.

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STATEMENT OF CARL BLAKE
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BEFORE THE
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ON
"A CALL TO ACTION: MEETING THE NEEDS OF THE SPINAL CORD INJURY AND DISORDERS (SCI/D)
VETERAN COMMUNITY"
JUNE 13, 2024

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

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

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

VA's SCI/D SYSTEM OF CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

because of medical advancements, are now living longer. Community nursing homes often refuse to admit veterans with SCI/D because of the high number of nursing hours they require. In truth, there are very few long-term care facilities that are capable of appropriately serving veterans with SCI/D. The VA operates six such facilities; only one of which lies west of the Mississippi River.

All totaled, the department is required to maintain 198 authorized long-term care beds at SCI/D centers to include 181 operating beds. As of last month, only 153 beds were actually available. This number fluctuates depending on several variables like staffing, women residents, isolation precautions, and deaths. When averaged across the country, that equates to about 3.4 beds available per state. Many aging veterans with SCI/D need VA long-term care services but because of the department's extremely limited capacity, veterans sometimes remain in acute settings for months or years at a significant cost because other placements are simply not available. Others must reside in nursing care facilities outside of the VA that are not designed, equipped, or staffed to properly serve veterans with SCI/D. As a result, veterans staying in community nursing facilities often develop severe medical issues requiring chronic re-admittance back into an acute VA SCI/D center.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Veterans Benefits Administration Services and Benefits

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

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

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

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

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

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

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

Because of the difficulties finding contractors, many veterans are turning to VA's Home Improvements and Structural Alterations (HISA) program which is in dire need of congressional attention. HISA grants help fund improvements and changes to an eligible veteran's home. Examples of qualifying improvements include improving the entrance or exit from their homes, restoring access to the kitchen or bathroom by lowering counters and sinks, and making necessary repairs or upgrades to plumbing or electrical systems due to installation of home medical equipment.

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

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

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

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

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

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

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

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

Fiscal Year 2023

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

Fiscal Year 2022

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

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

Prepared Statement of Sonya Sotak

Chairman Bost, Ranking member Takano and members of the committee, it is my honor to be invited to testify today on behalf of I AM ALS and representing approximately 6,000 veterans living with ALS in the United States. My name is Sonya Sotak and I am the Chief Government Affairs Officer for I AM ALS. I AM ALS is a small but mighty non-profit organization for people living with ALS. Our organization is a patient-centric driven organization, and many of our activities and policy efforts are driven by and collaborated with the actual community. We were established in 2017 by Brian Wallach and his wife, Sandra, after Brian was diagnosed with ALS at the age of 37 on the same day they brought their second daughter home from the hospital. Since then, I AM ALS has been privileged to partner with many of you here today to help move significant pieces of legislation through Congress to support people with ALS. First, the ALS Disability Insurance Access Act, which passed with unanimous support in the House of Representatives in 2020; next, we worked with many of you to get the ACT for ALS passed in 2021, again, with overwhelming bipartisan support. Also, many of you on both sides of the aisle have helped the community increase funding for the ALS research program at the Department of Defense. For the last 2 years, I AM ALS and the entire community of ALS organizations have urged Congress to double this funding since the incidence of ALS among veterans is at least two times that of the general population.

We also know that the Department of Defense ALS research program is receiving more than double the amount of quality research proposals that need grant support—proposals that they cannot approve at the current funding amount—and represent strong science that otherwise might be able to address the needs of veterans with ALS. We know that the proposed Fiscal Year 2025 funding measure remains at \$40 million but we continue to urge Congress to find a way to increase resources for this program for Fiscal Year 2025 and invest in research that can address this horrible disease and help the 1 in 6 people with ALS who are veterans.

We thank each of you and all of Congress for these important accomplishments and truly appreciate the bipartisanship effort that it took to achieve each of these advancements and the willingness for everyone to work together to pass legislation improving the lives of people, including thousands of veterans living with ALS.

As I mentioned, our organization is driven by community members affected by ALS themselves, thousands of volunteers taking action. Our veterans team created by incredible veterans and caregivers for veterans living with ALS is one of our most powerful and impactful committees. These veterans with ALS and their loved ones identify barriers, create tools and toolkits, and advocate to ensure that the VA benefit and health care system is easier to navigate and provides better and more accessible services. Sadly, we know all too well that this advocacy is needed to ensure basic, supportive care for veterans with ALS. As an example, our toolkit helps veterans identify and receive existing veteran benefits once they are diagnosed with ALS. This basic guide is over 45 pages long—that is how complex the system is for our veterans at a time when they are already overwhelmed and should be focusing on maximizing life with family rather than navigating a complex, bureaucratic healthcare system. Lack of knowledge of the VA system can result in frustration and delays in service. Because ALS can progress rapidly, delays need to be avoided at all costs. Congress recognized this when you passed the ALS waiver eliminating the SSDI waiting period. Our veterans with ALS and their families deserve the same recognition when accessing benefits. We urge you to work to ensure that all the veterans not yet diagnosed will be taken care of and hopefully enter a VA system that provides stronger and better access to health care and support services than they have had while enduring ALS.

As the Chairman and committee members know, ALS is recognized as a one hundred percent service related disease. Statistics vary but we know at a minimum members of our military are two times more likely than civilians to develop ALS. This stat skyrockets to ten-times when examining post-9/11 Airforce veterans. We also have seen data that estimates approximately 5000–6000 of the 30,000 people with ALS in the United States are veterans or again, about 16 percent. I say approximately because the world of ALS lacks solid data for many reasons but one key reason is the significant delay and complexity in diagnosing ALS. The prevalence of misdiagnosis is incredibly high and many people may never receive the right diagnosis or receive their diagnosis too late for being factored into national data. We also have a national system that does not compel data collection and is based on self reporting. This is such a complex topic it's worthy of its own hearing another day up here.

Before I dive into access to home health care that is critical for our veterans with ALS I want to set the table with some critical facts.

First, I want to be sure that the committee and everyone here today knows that ALS, or Lou Gehrig's disease as it is often known, is 100 percent fatal.

Nobody survives ALS and most die within 2–5 years after being diagnosed. When people finally receive a diagnosis they are told to go home—get their affairs in order and prepare to die. So every one of our veterans that develop ALS will die from it no matter how hard they fight or how strong their valor. Every single veteran will lose their battle with ALS.

ALS is a neurodegenerative disease that affects nerve cells in the brain and spinal cord. ALS is a wicked, cruel disease that slowly paralyzes a person, taking away their capacity to be self sufficient and eventually losing their ability to breath.

ALS was determined to be a one hundred percent service connected disease by the Department of Veteran Affairs on September 23, 2008. Following that decision it has been a tough and multifaceted journey for a multitude of reasons within the VA to provide the necessary, appropriate and equitable support for Veterans with ALS. The VA issued the VHA directive 1101.07 the ALS system of care in August 2021. The intent of this directive is to ensure that all care, services and access to equipment is known to veterans and their families including the responsible parties for ensuring access. Too often while managing ALS, many of our veterans and their families have to take significant time to advocate for themselves and often it is to explain to the VA what their VA benefits actually are as a veteran with ALS.

The VA's Spinal cord injuries and disorders (SCI/D) centers are designed to provide comprehensive care for veterans with spinal cord injuries and related injuries. However, these centers often face challenges fully meeting the needs of veterans with ALS due to the multifaceted nature of ALS. Part of the challenge is the SCI/D's are set up for your typical spinal cord injury which are often a static disease while ALS is a progressive & increasingly complicated debilitating disease.

Specialized care: ALS requires specialized neurological and respiratory care that is often not fully available at SCI/D centers. For instance, expertise in managing progressive muscle weakness and continued respiratory failure is something lacking at these centers. ALS requires multidisciplinary care with a coordinated approach by a team of health care professionals from a variety of disciplines to manage the complex needs of a Veteran with ALS. The goals are to improve the quality of life, slow the disease progression and provide much needed psychological and social support. This is too often not possible and simply not how the SCI/d's are set up and they often lack the staffing capacity and training for meeting the needs of our veterans with ALS. Expertise is often lacking for managing progressive muscle weakness and repository failure at the centers.

Advanced respiratory Support : Veterans with ALS often need advanced respiratory support, including non-invasive ventilation or mechanical ventilation which is often not the focus of SCI/D centers.

Comprehensive team : As I outlined earlier, the SCI/D centers do not have all the specialists available for ALS veterans or do not have the same level of coordination and collaboration as some ALS clinics or even what is available through accessing care in a veterans home setting.

SCI/Ds often have Insufficient focus on ALS specific interventions including:

Assistive technology:

Veterans with ALS often need specific assistive technologies such as augmentative and alternative communication devices which may not be readily available or supported in the centers.

Adaptive equipment

Too often the centers focus on spinal cord injury specific equipment and not the evolving and very demanding and intricate needs of ALS veterans.

Psychological and social support gaps

The specialties counseling and training needs for managing the extensive emotional and psychological support needed by ALS veterans and their families as a result of the rapid progression and terminal nature of the disease is often found to be lacking at the centers.

Palliative and end of life care

Many of the SCI centers do not have integrated palliative care services tailored to the specific needs of ALS veterans. ALS support requires significant palliative care and end of life planning which has a unique perspective and approach for managing ALS symptoms and quality of life.

Another key challenge is the location of the 25 centers. Many of them are simply not near many of our veterans living with ALS and not easily accessible for the veterans scattered around the country managing the very debilitating disease of ALS.

I AM ALS and our veterans community believe an important component of their ALS care is being able to remain in their home. For this reason, I AM ALS fully supports the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act. While this comprehensive bill contains many important measures, I would like to focus on the pieces that are most important for veterans with ALS—The Elizabeth Dole Home Care Act contained in this comprehensive package is significant for veterans with ALS for several reasons:

Most significant for our community of veterans with ALS is that the legislation increases the expenditure cap for non-institutional care from 65 percent to 100 percent of the cost of the closest VA Community Living Center (CLC). This would allow the most vulnerable veterans and caregivers the support they need to stay in their homes, often leading to better outcomes for veteran families, especially veteran families grappling with ALS.

The removal of the cap would help families care for their 100 percent service-disabled veterans with ALS. Because of the mandated cap, families constantly have to fight with the VA to get the appropriate support in their home so their veteran can continue to enjoy being near family rather than being sent away to a facility which is often hours away from the much needed support system of family and friends. For many veterans remaining in their home with friends and family during their hardest battle managing ALS is paramount. Staying in their home with loved ones improves their quality of life but it can also help reduce medical complications.

Let me share the story of Navy veteran Garrett who served as part of the Seabees, a construction battalion with tours in Iraq and Afghanistan. Garrett's journey with ALS was challenging and started with him being forced to make the longer journey to Milwaukee because they had the VA ALS clinic even though the Iron Mountain VA was much closer to his home. As the disease progressed, and these road trips were no longer feasible Garrett had to start a Go Fund Me campaign to try and offset the additional home health care he needed that wasn't provided by the VA. Eventually, he did hit the cap. It was far more complicated—his wife was overwhelmed with managing his care alone for so many hours to prevent hitting the 65 percent cap, while also being a single parent for their three young children. Then, Garrett had to get a trach. After all this chaos, Garrett hit the cap and had to go to an institution. Garrett tried his best to maneuver the system so he could get back home with medical support from home care. Unfortunately, the current structure would not afford him that final return home and Garrett made the decision to remove his trachea and end his own life rather than spend his days alone in the center far from his family and without the daily support from friends, family and his kids. Garrett is not the only veteran that we know that chose to end their life early rather than endure being in a VA institution that failed to meet their medical needs and lacked an appreciation for the care they needed as a veteran with ALS. Even one veteran is one veteran too many to be isolated from friends and family because of the distance from their communities and family when forced to leave their homes for care because of a cap limiting their access to support in their home.

Comprehensive care for veterans with ALS. As I shared earlier—ALS is a neurodegenerative condition and as the disease progresses, veterans with ALS require extensive and specialized care. The Elizabeth Dole Home Care Act ensures that our Nation's veterans receive comprehensive home-based care tailored to their complex needs, improves their quality of life and allows them to remain in a familiar and comfortable environment with their families, friends or loved ones.

Also included in the Elizabeth Dole Home Care Act is the Veteran Directed, Home-Based Primary Care and the Homemaker Home Health Aide programs that support the care and quality of life of veterans and caregivers, especially at home and can serve as a lifeline for veterans and caregivers in need. This program, a joint offering from the VA and U.S. Department of Health and Human Services (HHS), offers veterans and caregivers greater choice and control over their care and services by allowing participants to utilize friends and family members to provide unskilled care including transportation support and other services to support the veteran in their home. Veterans and caregivers can supervise their own employees and hire additional support during the hours that are needed rather than being subject to agency hours and restrictions. In addition, this program has been especially helpful to those who struggle to find appropriate care in their homes either due to contracted agency employee absences or the general dearth of HHA providers around the country.

Support for Caregivers.

The Elizabeth Dole Act recognizes the important role of caregivers, often family members, in managing the daily needs of veterans with ALS. By providing resources, training and financial support to caregivers, the Act helps reduce the emotional and financial burdens and allows them to provide better care and support for our veterans. Being a caregiver is hard work; being a caregiver for a person with ALS is beyond daunting and incredibly exhausting.

Access to Medical Services.

The medical needs for veterans with ALS are complex and frequent including physical therapy, respiratory care and many other specialized treatments. The Elizabeth Dole Act facilitates access to these necessary treatments at home, reducing the need for hospital visits or visits to SCI/D centers that often lack the personnel and speciality training needed for minimizing the risks for people with ALS, including infections, complications and sadly, but very frequently medical professionals who simply are not familiar with ALS and unintentionally create more complications when they treat our veterans with ALS.

Quality of Life

Helps maintain a sense of independence and dignity for veterans while ensuring they receive the medical attention and daily assistance they need while remaining in a safe and comfortable home environment with advocates around them to ensure their needs are being met.

Economic benefits

Home based care is more cost effective than institutional care. By raising the cap to 100 percent and supporting veterans with ALS receiving home care the EDHCA helps manage health care costs more efficiently while allowing veterans to receive high quality personalized care.

I AM ALS is so pleased that the Elizabeth Dole Home care Act is bringing greater awareness of the challenges and needs of veterans living with ALS especially those that need more support than the current SCI centers can provide. This bipartisan legislation advocates for and demands higher quality care including respect and dignity of care in their homes with loving friends and family. This legislation will ensure that our Nation's veterans with ALS receive the respect and care they certainly deserve after their service to our country.

I would be remiss if I didn't take the honor and privilege of engaging with Chairman Bost, Ranking Member Takano and the entire committee without mentioning other key priorities for veterans with ALS that we hope you will support and guide through Congress quickly for our veterans with ALS.

As I mentioned earlier, I AM ALS supports doubling the funding for CDMRP ALS Research at the Department of Defense. Multiple studies have reported that Veterans are significantly more likely to be diagnosed with ALS than those who did not serve in the U.S. military. While the specific cause of this increased risk is unknown, the correlation between military service and ALS is well-established so we encourage a significant investment in researching this disease and finding a way to treat ALS for the thousands of veterans that will develop this horrific disease. We know that the additional research projects exist and are simply not being funded because of the lack of resources being allocated. We urge you to increase the funding to \$80 million for Fiscal Year 2025.

I AM ALS also urges Congress to pass the Justice for ALS Veterans. This bipartisan legislation would fix the unfair policy that denies benefits to the surviving spouses of veterans who died from ALS by providing the surviving spouse with the DIC kicker without meeting the 8 years of disability requirement. Unfortunately, because most people with ALS, a recognized service-connected disease, live fewer than 8 years from diagnosis, the surviving spouses of veterans with ALS have been unfairly denied this benefit. The same spouses who may have quit their jobs to take care of their loved ones who progressively lost muscle control, became paralyzed and relied heavily on their caregiver to stay alive.

Closing

I AM ALS is incredibly appreciative for all that Congress has done for the ALS community in a bipartisan, collegial manner, but the ALS community needs Congress to do even more for this 100 percent fatal disease with no real treatment options. And we need you to do more with a specific focus on our veterans with ALS. We should not allow a system of care to continue that sees more veterans like Garrett decide that ending their lives is preferred to enduring a VA institution that fails them that doesn't provide the support and medical care they need, and certainly doesn't have the staff available or trained to meet their complex medical needs despite their sacrifices and commitment to our Nation through their military service.

I AM ALS encourages the Committee and Congress to continue working together without politics and to help move important measures forward including the Elizabeth Dole Home Care Act as part of the Elizabeth Dole 21st Century Veterans healthcare and Benefits Improvement Act. Our veterans with ALS who have sacrificed for our country and selflessly served our Nation deserve to have access to home based care. They need all of you to keep working together to support them and support their families as they are in their final battle against a wicked, cruel disease.

Thank you for your time and know that the ALS community appreciates your efforts and continued work together in Congress for people with ALS, especially our veterans. For this reason we urge you to work together to get the Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act passed this year on suspension so critical services are made available for veterans with ALS.

Prepared Statement of Jenny Kiratli

Chairman Bost and Ranking Member Takano, and Members of the House Committee on Veterans' Affairs:

Thank you for inviting the American Federation of Government Employees (AFGE) to participate in today's Committee hearing, "*A Call to Action: Meeting the Needs of the Spinal Cord Injury and Disorders (SCI/D) Veteran Community.*"

I am Dr. Jenny Kiratli, and I have been a member of AFGE since 2009 and a research health scientist in the Spinal Cord Injury and Disorders (SCI/D) Center, VA Palo Alto Health Care System (VAPAHCS) since 1991. AFGE's National Veterans Affairs Council represents more than 302,000 AFGE VA employees across the Veterans' Health Administration (VHA), Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). I have more than 30 years of experience conducting research on clinical issues affecting people with SCI including musculoskeletal conditions, bone and body composition; and nutrition, activity, and exercise interventions—with a focus on extending therapies into the home to facilitate wellness. I am Director of the VA Advanced Fellowship Program in SCI Research and Associate Research Director for the SCI Medicine Clinical Fellowship Program. I am dedicated to mentoring junior investigators and fostering partnerships with veterans and other stakeholders and colleagues to conduct research that can be implemented into best practice.

The Spinal Cord Injury and Disorders (SCI/D) Center, VA Palo Alto Health Care System (VAPAHCS) is one of 25 Spinal Cord Injury and Disorders Centers located around the country. These centers offer lifelong, comprehensive, integrated, coordinated care that includes primary care, rehabilitation, emergency care, acute medical and surgical care, mental health care, and home care. The Palo Alto VA also has dietitians, respiratory therapists and orthotists & prosthetists on staff. Our services are aimed at supporting the veteran as a whole person including services that reintegrate veterans into the community and provide respite care and family education. Our facility has also pioneered telehealth services, which we launched in 2000. The expertise of the interdisciplinary care team and breadth of the services makes the VA SCI/D network the most comprehensive SCI/D care delivery system in the U.S.

The VA's system of care for SCI/D uses a hub and spokes model. The 25 SCI/D centers are the hub facilities staffed with clinicians including therapists and psychologists trained to provide specialized care to people with a spinal cord injury or disorders. These hub facilities coordinate with approximately 120 designated medical "spokes" facilities that do not have their own SCI/D center. The hub and spokes model expands the reach of the SCI/D program ensuring that veterans not located near an SCI/D center have access to comprehensive primary and specialized care tailored to the unique needs of individuals with spinal cord injuries and disorders. Primary care physicians need special training to serve SCI/D patients' specific needs. For example, primary care physicians treating the SCI/D population must be able to diagnose and treat an array of problems that may present differently in patients with spinal cord injuries such as bone breaks and infections. They must also be trained to recommend appropriate preventive care screenings and manage comorbidities common to SCI/D patients such as metabolic disease, endocrine disease, and musculoskeletal disorders. Most physicians in the SCI/D Centers pursue an additional year of focused training in SCI Medicine through fellowship programs.

Veterans comprise more than a quarter of the SCI/D population in the U.S.¹ The Palo Alto SCI/D system serves approximately 1,000 of the 18,000 veterans that receive SCI/D services across the VA system. Our center serves veterans and active-duty military personnel. While those with service-connected injuries are eligible for enhanced services, VA SCI/D centers serve veterans and active-duty military personnel with nonservice related spinal cord injuries and disorders.

Clinical research conducted at Palo Alto SCI/D center can drive improvements in care delivery that can also benefit non-veterans living with spinal cord injuries and disorders. VA Palo Alto's Spinal Cord (SCI/D) Center conducts significant clinical research aimed at developing best practices for care for veterans with SCI/D. In my role as director of clinical research, one of my current studies aims to improve the assessment of bone health of veterans living with SCI/D. Prior to this work, there has been no standardized method for measuring bone health at the knee, a common fracture site for those with SCI/D. This study will help inform evaluation of bone health for all veterans.

Adaptive gaming is another area where VA is plugging a research gap that existed for the SCI/D population. Adaptive gaming as a therapeutic tool had been studied within the stroke population, but specific research was needed on muscle activation of upper limb muscles in people with spinal cord injuries to determine whether video gaming improved upper limb motor performance, balance, coordination, and cardiovascular status. The project I led found that selected Wii games were able to elicit upper extremity muscle activation and elevated heart rates for individuals with SCI that may be used to target therapeutic outcomes.

VA further serves the general SCI/D population by pioneering modifications to existing technologies to adapt them for the SCI/D population. For example, a modification to standing wheelchairs pioneered by a team from the Minneapolis VA Health Care System allows people to move while in standing positions. Early models of standing wheelchairs allowed people to stand but not to move in the standing position. VA physicians worked with biomedical engineers to add a chain drive system to the chair that allows users to push their chairs from a standing position. The Palo Alto VA collaborates with the Minneapolis VA to research the use of this adaptation to maximize the use of the technology for the SCI/D population. All VA research is ultimately shared with non-VA SCI facilities through published research and conferences, contributing to the overall benefit of the larger, non-VA SCI/D population.

VA also plays an important role in training SCI/D professionals collaborating with academic programs to provide clinical training. VA has an advanced fellowship training in SCI medicine. More needs to be done to encourage young clinicians to enter the field. Of the 31 positions for the SCI clinical training program only usually fewer than 20 positions are filled.

We also participated in a multi-site VA study to establish, implement and test a model for vocational rehabilitation that greatly enhances opportunities for veterans with SCI/D to return to work and contribute to the workforce in meaningful ways by partnering with potential employers to understand the needs of each individual and develop jobs that meet their needs.

The VA is at the forefront of improving clinical outcomes and quality of life for veterans and all people living with spinal cord injuries and disorders. However, more can be done to strengthen the VA's SCI/D system. While the hub and spokes model greatly expands access to VA's SCI/D services, there are gaps in care, particularly for veterans in rural areas where more spoke facilities are needed.

There is a great need for increased staffing for SCI/D services. Individuals with SCI have challenging and complex health care needs requiring significant support. They live with many secondary complications that require vigilance to prevent functional decline and premature death. Individuals with SCI are two to five times more likely to die a prematurely.² SCI is also associated with higher rates of mental illness, with one in five suffering from depression, significantly higher rates of anx-

¹ Cai S, Bakerjian D, Bang H, Mahajan SM, Ota D, Kiratli J. Data acquisition process for VA and non-VA emergency department and hospital utilization by veterans with spinal cord injury and disorders in California using VA and State data. *J Spinal Cord Med*. 2022 Mar;45(2):254-261. doi: 10.1080/10790268.2020.1773028. Epub 2020 Jun 16. PMID: 32543354; PMCID: PMC8986188.

² Touchett, H., Apodaca, C., Siddiqui, S. *et al.* Current Approaches in Telehealth and Tele-rehabilitation for Spinal Cord Injury (TeleSCI). *Curr Phys Med Rehabil Rep* 10, 77-88 (2022). <https://doi.org/10.1007/s40141-022-00348-5>

iety, posttraumatic stress disorder, and death by suicide.³ Staffing requirements for SCI/D centers should be updated to reflect the higher acuity of the SCI/D population. Because of the complexity of SCI/D care, it requires specialized certification and training. The high acuity of care creates burnout and younger clinical staff often leave just when they have gained sufficient skills to perform all their duties. It is difficult to use temporary staff, such as floating nurses, to deal with short staffing in SCI/D centers because specialized training is required. As a result, SCI nurses can be moved elsewhere to deal with staffing shortages, but non-SCI nurses cannot easily fill in on SCI unit. Additional retention incentives are needed to address vacancies and turnover.

The Mission Act increased access to non-VA facilities. Research suggests that use of VA and non-VA care has the potential to cause unintended duplication of services, costs and fragmentation of care.⁴ But the potential for inadequate care is a greater concern for veterans with SCI/D. The VA's SCI/D model provides uniquely comprehensive and integrated services delivered by highly knowledgeable teams of specialists that do not exist in the private sector. In addition, non-VA providers lack access to VA resources such as medical equipment and a wide array of adaptive products, often created for each individual veteran to meet his or her specific needs. Further, non-specialists often do not recognize serious disorders (e.g., a bone fracture) because of an absence of the normal symptoms. Care should be taken to ensure that increasing privatization of VA services does not upend the VA's specialized SCI/D care model that provides veterans living with spinal cord injury and disorders an array of integrated services and provides research used to develop best practices for all people living with spinal cord injuries and disorders.

³Touchett, H., Apodaca, C., Siddiqui, S. *et al.* Current Approaches in Telehealth and Tele-rehabilitation for Spinal Cord Injury (TeleSCI). *Curr Phys Med Rehabil Rep* **10**, 77–88 (2022). <https://doi.org/10.1007/s40141-022-00348-5>

⁴Hatch MN, Etingen B, Raad J, Siddiqui S, Stroupe KT, Smith BM. Dual utilization of Medicare and VA outpatient care among Veterans with spinal cord injuries and disorders. *J Spinal Cord Med*. 2023 Sep;46(5):716–724. doi: 10.1080/10790268.2022.2027321. Epub 2022 Feb 2. PMID: 35108176; PMCID: PMC10446768.

STATEMENTS FOR THE RECORD

Prepared Statement of MitoSense, Inc.

Statement for the Record by Dr. Catherine Baucom, Chief Medical Officer, MitoSense Inc. & Director, Elliott Mitochondria Research Center

Submitted to the House Committee on Veterans' Affairs

Hearing: "A Call to Action: Meeting the Needs of the Spinal Cord Injury and Disorders Veteran Community"

Date: June 13, 2024

Honorable Members of the House Committee on Veterans' Affairs,

It is with a deep sense of responsibility and urgency that I, Dr. Catherine Baucom, on behalf of MitoSense Inc. and the Elliott Mitochondria Research Center, address this esteemed committee. As we convene to discuss "A Call to Action: Meeting the Needs of the Spinal Cord Injury and Disorders Veteran Community," I wish to underscore the critical intersection of advanced mitochondrial science and the profound impact it can have on our veterans suffering from spinal cord injuries and disorders (SCI/D).

The challenges faced by veterans with SCI/D are multifaceted, encompassing not only physical and neurological impairments but also metabolic disturbances that significantly impair quality of life. At MitoSense Inc., our mission to innovate at the forefront of mitochondrial function offers promising implications for therapeutic strategies aimed at this brave population.

Mitochondria, often described as the powerhouses of the cell, play a crucial role in energy production and cellular health. Research has increasingly shown that mitochondrial dysfunction is a key contributor to the pathology of spinal cord injuries. Our ongoing studies and developments at the Elliott Mitochondria Research Center emphasize not only understanding this critical relationship but also harnessing this

knowledge to develop interventions that can restore mitochondrial function using Mitochondrial Organelle Transplantation (MOT™), thereby improving motor and sensory outcomes for individuals with neurodegeneration.

Our commitment to advancing care for our veterans is further solidified through our collaborative efforts with the James A. Haley Veterans' Hospital and the Walter Reed Army Institute of Research (WRAIR). We are proud to be part of a Cooperative Research and Development Agreement (CRADA) that focuses on pioneering research into novel prehospital treatments for traumatic brain injuries, which share underlying pathophysiological mechanisms with spinal cord injuries.

Additionally, we are engaged in a CRADA with the James A. Haley Veterans' Hospital to explore innovative treatments for Amyotrophic Lateral Sclerosis (ALS), further underscoring our dedication to addressing a spectrum of neurodegenerative conditions affecting our veterans. These partnerships not only accelerate our research but also ensure that the findings and technologies we develop are directly informed by and tailored to the needs of veterans.

The potential for mitochondrial-targeted therapies includes:

1. Enhancing cellular energy production to support damaged nerve cells,
2. Reducing oxidative stress to limit further cellular injury, and
3. Promoting the inherent regenerative capacities of neural tissues.

Our current initiatives involve developing and testing novel therapies that can be administered safely and effectively, aiming to significantly enhance the lives of those living with neurodegeneration. The implications of this research extend beyond basic science, offering hope for tangible, improved patient outcomes.

Given the unique challenges and the severe impact on quality of life associated with spinal cord injuries and disorders, it is imperative that

we direct adequate resources and attention to accelerating research and clinical trials in this field. Enhanced funding and support can enable more rapid advancements in mitochondrial therapies, potentially revolutionizing treatment paradigms for our veterans.

As this committee seeks to galvanize efforts to support our veterans with SCI/D, I advocate for increased investment in mitochondrial research. A commitment to this area of science is a commitment to uncovering new, impactful therapies that could vastly improve the lives of thousands of veterans across the nation.

Thank you for the opportunity to submit this statement. We at MitoSense Inc. and the Elliott Mitochondria Research Center are committed to continuing our research and clinical efforts to serve our veterans and advance the field of mitochondrial medicine.

Respectfully,

Catherine Baucom MD, PhD
Chief Medical Officer, MitoSense Inc.
Director, Elliott Mitochondria Research Center

Prepared Statement of Christopher and Dana Reeve Foundation



June 20, 2024

The Honorable Mike Bost
Chair
House Committee on Veterans' Affairs
364 Cannon House Office Building
Washington, D.C. 20003

STATEMENT FOR THE RECORD

Hearing: *"A Call to Action: Meeting the Needs of the Spinal Cord Injury and Disorders (SCI/D) Veteran Community"*

Dear Chairman Bost, Ranking Member Takano, and members of the committee:

On behalf of the Christopher & Dana Reeve Foundation and the 1 in 50 individuals living with paralysis in the United States, we would like to thank you for holding the hearing, *"A Call to Action: Meeting the Needs of the Spinal Cord Injury and Disorders (SCI/D) Veteran Community"*. Through the Paralysis Resource Center (PRC), the Reeve Foundation is proud to help current service members and veterans who are living with spinal cord injury and related disorders.

For over 20 years, the Reeve Foundation has operated the Paralysis Resource Center (PRC), through a cooperative grant, competing in a rigorous, competitive application process every five years. The PRC is supported by federal appropriations to the Administration for Community Living (ACL), within the Department of Health and Human Services (HHS). [The PRC](#) is a free, comprehensive, national source of informational support for people with paralysis and their caregivers. The primary goals are to foster independence, promote health, and improve quality of life. The PRC has assisted over 125,000 individuals and families, including 5,773 veterans and military service members.

Military and Veterans Program

One of our most critical PRC programs is the Military and Veterans Program (MVP). The MVP program provides specialized resources to help individuals navigate military and civilian benefits as they reintegrate into their communities. The program provides personalized information tailored to each person's needs by an Information Specialist, considering factors such as branch of service, type of injury, and home state. MVP also helps with rehabilitation information and referrals. Due to staffing shortages at VA (Veteran Affairs) SCI/D hospitals¹, there is an increasing need to refer service members and veterans to other facilities. Our Information Specialists work with state and county Departments of Veterans Affairs to help navigate referrals to Model SCI (Spinal Cord Injury) Centers and CARF-designated SCI/D rehabilitation centers.

Support for Caregivers

The role of a caregiver is one of the most important forms of support for people living with spinal cord injury and paralysis. Caregivers help with all daily activities, ranging from eating, bathing,

¹ OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023 August



coordinating transportation to assisting with medical needs such as medication and wound care. Direct care workers such as home health aides, nursing assistants and personal care attendants (PCAs) are essential workers who are in extreme demand, due to staffing shortages². The Reeve Foundation supports the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (H.R.8371), which includes provisions aimed at addressing these barriers to receiving the support and care that services members and their families need.

Investing in SCI/D Research

The Reeve Foundation was founded in 1982 by families determined to find a cure for paralysis. At the time, it was not only an act of hope, but defiance: the idea that spinal cord injuries could be treated was inconceivable. Over the next four decades, we have invested more than \$140 million in groundbreaking research that has helped pave the way for progress. As 21st-century technology and cumulative scientific gains converge, we are on the cusp of a new era in spinal cord injury research. Continued congressional funding for VA SCI/D research contributes to these advancements and benefits the larger SCI/D community. We also advocate for increased federal funding for paralysis research sponsored by the National Institutes of Health (NIH) and the Department of Defense (DOD) through the Congressionally Directed Medical Research Programs (CDMRP).

Once again, thank you for your efforts to increase the support for veterans who live with spinal cord injury and paralysis. The Reeve Foundation advocates for funding that supports access to quality medical services for our nation's service members that live with SCI/D and those that care for them, and continued investments in groundbreaking spinal cord injury research initiatives.

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

Administration for Community Living (ACL), Paralysis Resource Center (PRC)

- FY' 21: July 2021-June 2022 \$8,700,000
- FY' 22: July 2022-June 2023 \$8,700,000
- One-time funding to expand Public Health Workforce COVID-19 \$160,000 Awarded 3/31/2022
- Supplemental Award September 2022 \$747,037
- FY'23: July 2023-July 2024 \$10,447,000

² OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023 August

Prepared Statement of Neuralink

June 27, 2024

The Honorable Mike Bost
Chair
House Committee on Veterans' Affairs
364 Cannon House Office Building
Washington, DC 20003

**Re: Neuralink Statement for the Record for House Committee on Veterans' Affairs
Hearing: "A Call to Action: Meeting the Needs of the Spinal Cord Injury and Disorders
(SCI/D) Veteran Community"**

Dear Chairman Bost, Ranking Member Takano, and members of the committee:

On behalf of Neuralink, I am honored to submit this statement for the record in connection with the House Committee on Veterans' Affairs hearing: "A Call to Action: Meeting the Needs of the Spinal Cord Injury and Disorders (SCI/D) Veteran Community." We commend the Committee for its dedication to improving the lives of veterans living with spinal cord injuries and disorders.

Challenges Faced by Veterans with SCI/D

Veterans with SCI/D face significant obstacles in their daily lives, including compromised mobility, chronic pain, and a host of secondary health issues, adversely impacting their independence and quality of life. Despite the progress made in medical science and rehabilitative care, existing interventions fall short of fully addressing these multifaceted challenges. It is crucial that we explore and invest in innovative technologies that offer new possibilities for restoring autonomy to our nation's veterans.

Neuralink's Role and Mission

Neuralink's mission is to restore autonomy to those with unmet medical needs. We aim to do this by developing brain-computer interface (BCI) technology that enables a direct interface between the brain and external devices. The first indication we are addressing with BCI technology is the restoration of digital autonomy to people living with tetraplegia due to spinal cord injury or amyotrophic lateral sclerosis (ALS).

Neuralink's intracortical BCI implant – the Link – is designed to record, process, and wirelessly transmit neural activity to external devices, such as a computer. The neural data is then translated into actions, such as movements of a cursor on a computer screen.

Earlier this year, our first clinical trial participant, Noland Arbaugh, received his Link. Since then, Noland has used the Link to control his laptop using his mind: browsing the internet, playing chess, and livestreaming to audiences worldwide. He has also pushed the boundaries of BCI performance, repeatedly setting new world records for BCI cursor control.

“[The Link] has helped me **reconnect with the world**, my friends, and my family. It’s given me the ability to **do things on my own again** without needing my family at all hours of the day and night.”

– Noland Arbaugh

Enabling the control and use of a laptop represents an important but early step towards our mission. We are currently seeking approval to explore how the Link can offer people with tetraplegia greater autonomy by interfacing with smart home devices, wheelchairs, and prosthetic limbs.

Neuralink’s mission is aligned with the objectives of this Committee: to enhance the autonomy, mobility, and quality of life of our nation’s veterans with SCI/D. We are committed to conducting rigorous clinical trials to ensure the safety and efficacy of our technology and dedicated to delivering our transformative BCI technology to those in need, including our veterans, as urgently as possible.

Commitment to Collaboration

Neuralink is committed to developing our technology in collaboration with the Food and Drug Administration (FDA), our clinical partners, and patient advocacy groups. Public-private partnerships can play a crucial role in accelerating progress and increasing access to treatments. Neuralink welcomes the opportunity to partner with the Department of Veterans Affairs (VA) to ensure our technology is developed with the specific needs of veterans with SCI/D in mind.

Conclusion

Neuralink’s BCI technology has the potential to profoundly improve the lives of veterans with SCI/D. We appreciate the opportunity to share our vision with this Committee. If you have any questions or we can provide any assistance to the Committee, please do not hesitate to contact me. Thank you for your leadership and dedication to this critical issue.

Sincerely,



Dongjin (DJ) Seo
President & COO
Neuralink Corp.

