TESTIMONY ON HOUSE JOINT MEMORIAL 14

“Releasing Data on VA Patient-Centered Community Care program”

To

OREGON HOUSE COMMITTEE ON VETERANS’ SERVICES

AND EMERGENCY PREPAREDNESS

By

LTC (RET) DICK TOBIASON

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Testimony of LTC (Retired) Allan R. “Dick” Tobiason before the Oregon House Committee on Veterans’ Services and Emergency Preparedness

Chairman Lively and Distinguished Committee members.

I am Dick Tobiason, a Retired US Army Lieutenant Colonel and VA patient. I am a Service Connected disabled veteran due to an enemy hand grenade attack in Vietnam 48 years ago.

I am a member of the American Legion, Military Officers Association of America, Military Order of the Purple Heart, Veterans of Foreign Wars and Vietnam Veterans of America.

My address is 22325 White Peaks Drive, Bend, OR 97702

It is an honor to testify to you in support of House Joint Memorial 14.

I will start out with a provocative statement - no rural civilian will do what rural veterans have to do with the VA - travel long distances for timely and quality health care that is available near where they live.

Eight years ago I requested the Congress to create a rural veterans health care program now known as the VA patient-Centered Community Care program (PC3). The CEO of St. Charles Health System in Bend, Central Oregon Health Council and local governments and veterans groups supported this proposal to the Oregon delegation in Washington, DC.

The objective of the new VA Patient-Centered Community Care (PC3) program is to use local health care providers rather than distant VA facilities to reduce waiting times, eliminate wasteful driving and improve quality of care.

Example: Bend VA Community Based Outpatient Clinic (C BOC) treats about 6,500 veterans in Central Oregon and refers a like number annually to Portland VA Medical Center. About half are transported by the Disabled

American Veterans (DAV) van with daily 330 mile, 10 hour round trips for 30 minute appointments. I was a volunteer driver for 5 years. There are significant costs to buy, maintain and operate the many DAV vans across our nation. VA pays veterans for driving to distant medical centers in POVs. All of the services VA provides in Portland and Vancouver are available in Central Oregon.

As HJM 14 states, the 5 year TEMPORARY $9.8 billion PC3 program covering our nation has been in operation for about 18 months. VA awarded a 5 year $4.4 billion contract to TriWest Healthcare Alliance covering 28 states including Oregon. PC3 started as a specialty care program but was expanded to cover primary care as well.

During its December 9, 2014 Town Hall teleconference, I requested the Portland VA Regional office to tell us how much of the $4.4 billion has been allocated to Oregon, how many veterans are qualified and how many are participating, impact on waiting times, etc. I was told by the VA these were good questions and deserve answers. I submitted my questions to the VA in writing. VA advised me later that they do not report funding by State or VISN (Veterans Integrated Service Network). Oregon, Washington and Idaho are in VISN 20. VA did report the number of healthcare providers in Central Oregon enrolled in PC3 and told me that VA measures performance by its PC3 contractors and that information is not public.

To date veterans, rural healthcare providers and tax payers cannot get data to measure the effectiveness of PC3. It is still a temporary program and that should be a concern to all of us. What happens when PC3 is “finished”?

The new VA Choice Card program resulted from Congressional hearings in DC last year on the well known, wide spread VA abuses (scandals) at several VA Medical Centers. Choice began last Nov. so there has not been much time to measure effectiveness. Choice is another TEMPORARY 3 year program that would allow VA time to build more facilities and hire

more staff. Congress allocated another $10 billion to Choice plus $5 billion for VA to hire more medical staff.

The scope of Choice is about the same as PC3 - reduce waiting times, reduce travel distance, etc. VA has issued 8 million Choice cards - I have one even though I live 4 miles from the Bend CBOC. VA added Choice Card program funds to its 2 contractors managing PC3. Now there is $20 billion out there to reduce waiting times for vets by using local providers near their residence. Without data, there is now way to know if PC3 and Choice are working as intended. Many of us are skeptics about VA performance.

Getting data on Choice has been difficult. I believe VA is under a lot of pressure from Congress to make Choice work even though VA has requested to divert some of the funds to other unspecified in house VA programs which to Congress is a non starter. VA states veterans do not have a high interest in Choice as a reason for wanting to divert funding with less than 6 months into the program. Veterans are skeptical and confused by the process as evidenced by a recent IAVA (Iraq Afghanistan Veterans of America) "TheWait WeCarry" study. Notice wait is spelled W A I T not W E I G H T. Only one-third of the 1800 veterans – mostly Iraq and Afghanistan Veterans who participated in the IAVA survey found VA health care to be acceptable. Twenty eight Oregon veterans – mostly OIF/OEF participated in the IAVA survey.

Veterans often give up when calling the busy VA Choice phone number. There are instances of veterans being sent hundreds of miles from their homes for VA treatment under the Choice program rather than treatment where they live. To be fair, Portland VA has replied to my questions on the number of veterans enrolled and receiving healthcare through Choice.

There are reports that Veterans will have to pay for local Non-VA medical care and wait for the VA to reimburse them often long afterwards. Credit ratings can be negatively impacted. VA and Congress are still negotiating the 40 mile driving distance criteria and VA diversion of Choice funds to undefined in house VA programs. In fact the Senate Veterans Affair

Committee will hold hearings on the 40 mile criteria next week. I have asked Senator Wyden and Representative Walden to not allow VA to divert funds.

Two days ago on March 24 VA announced the 40 mile criteria will change from “as the crow flies” to actual driving distance. This revision will make thousands of more veterans eligible for Choice Card. That is a small victory for veterans and Congress.

To us veterans, the VA seems to be finding ways to degrade Choice by narrow interpretations of the 40 mile distance criteria and building an empire rather than serving veterans where they live.

PC3 and Choice are new but TEMPORARY programs with fine goals. They represent a new way of doing business as we requested 8 years ago. VA is experiencing problems in implementation and telling veterans, healthcare providers and the public about performance. In fact the U.S. House of Representatives Veterans Affairs Committee recently created the “VA Honesty Project”; the goal of VA Honesty Project is simple: “*to highlight the Department of Veterans Affairs’ lack of transparency with the press and the public about its operations and activities*”. On January 26 I submitted the following statement on PC3 implementation to the House VA Honesty Project:

“Portland VAMC/Regional Office will not inform the public how many veterans are being treated under its new PC3 program. Nor will Portland VA disclose how much of the $4.4 billion, 5 year contract with Tri West Healthcare Alliance covering 28 states is allocated to its service area. VA did respond to how many local providers have been enrolled in PC3 by Tri West. I submitted 5 related questions to Portland VAMC.”

I have not had a reply from the House Veterans Affairs Committee.

It is time to hold VA accountable for the expenditure of public funds and measure effectiveness of PC 3 and Choice by requiring performance measurement and periodic public reporting. There should be a third party involved to monitor program implementation and effectiveness. The 2

programs should be consolidated into one. If PC3 and Choice can be made to work as intended, they should become permanent.

Perhaps the new VA Advisory Committee formed 2 weeks ago will evaluate VA performance using objective measures as envisioned in HJM 14.

I would like to thank Rep. Knute Buehler for initiating HJM 14 with support from Senator Knopp and Representative Whisnant. Ten years ago Dr. Buehler replaced my knee that was damaged in combat in Vietnam. That surgery was eligible under Medicare. That is a blessing for us older veterans but not available to veterans not qualified for Medicare. This kind of surgery is a must for VA to contract out. You may have the read the recent report of a veteran's horrible experience with VA leg surgery that ended up with amputation when non-VA surgeons discovered botched VA surgery.

Daily reports of VA failures are all we have for information on VA's performance. Performance measurement and reporting will force VA to disclose to the public how it is meeting or not meeting its goals.

Quite frankly, VA should be planning to consolidate PC3 and Choice and continue them beyond their temporary lives. Also, building more VA facilities is another waste as proven by the huge cost overrun of the new VA Hospital in Denver: original cost of $328 million now approaching $1.73 billion – 5 times the original cost meaning fewer veterans will be served.

VA should really expand its contacting out, become expert at auditing its health care providers and make prompt payments to providers and veterans.

As the issues in HJM 14 should be of national concern, we can only hope HJM 14 will be treated seriously by VA and Congress.

I respectfully urge the Committee to expand its resolution to include the "Choice Card" program (line 31) and add the Oregon delegation in Washington, DC to the recipients of HJM 14. Perhaps they can follow up with VA on its implementation.

Thank you Chair Lively and Committee members for providing this opportunity to testify on HJM 14. I plan to also testify on SJM 11 on March 31 as SJM 11 also relates to rural veterans healthcare.

I would be pleased to respond to questions the Committee may have.

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