TESTIMONY ON SENATE JOINT MEMORIAL 11

Releasing to rural veterans healthcare

To

OREGON SENATE COMMITTEE ON VETERANS

AND EMERGENCY PREPAREDNESS

By

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Chairman Boquist 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 the Chairman of Bend Heroes Foundation, 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.

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It is an honor to testify to you in support of Senate Joint Memorial 11. Last week I testified to your counterpart Committee in the House on HJM 14 which relates directly to SJM 11.

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.

I would like to summarize 2 new VA programs aimed at allowing veterans to use non VA providers near their homes rather than drive long distances to VA medical care facilities.

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.

PATIENT-CENTERED COMMUNITY CARE (PC3):

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 (CBOC) treats about 7,500 veterans in Central Oregon and refers a like number annually to Portland VA Medical Center for care not available at the Bend VA Clinic. 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. A lot of time is wasted by veterans during these trips and often they must return for continued treatment. 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 and many other rural areas.

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 in PC3, the impact on waiting times, how many providers are enrolled, etc. I was told by the VA these were good questions and deserve answers. I submitted my questions to the VA in writing.

To date we 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"?

VA CHOICE CARD PROGRAM:

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 medical staff. Congress allocated $10 billion to Choice plus another $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 8.5 million Choice cards - I have one. 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 no way to

know if PC3 and Choice are working as intended. Many of us including the Congress are skeptics about VA performance.

I believe VA is under a lot of pressure from Congress to make Choice work even though the President's budget would divert some of the Choice funds to other unspecified in house VA programs. This is a non starter with the House and Senate Veterans Affairs Committees. 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. I have asked Senator RonWyden and Representative Greg Walden to not allow VA to divert funds.

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 <u>one-third</u> 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.

A fellow Vietnam Veteran from Bend is 100% disabled and suffers from PTSD. He was issued a Choice card. Let's call him Joe. Joe was at the Portland VA Medical Center two days last week being treated for skin cancers and neurological issues. The VA told Joe he could not be treated under Choice in Bend where there are many exceptional specialists who can treat him because VA can treat him within the 30 day criteria and he lives within 40 miles of the Bend VA Clinic. The Bend VA clinic does not provide the services Joe requires.

But because VA Choice rules stipulate 40 miles from any VA facility rather than a facility which provides the specialty care, Joe had to spend 2 days in Portland plus travel time. After his visit to Portland VA, the VA told him he can have dermatology treatments in Bend where he lives.

The VA Choice program has 2 major restrictions: 40 mile distance from the nearest VA facility and 30 day waiting time. Some veterans believe they both apply. Only 1element, not both has to be met. Another criteria includes geography, lakes, etc. Presently VA applies the 40 mile criteria as the "crow flies" rather than the actual driving distance. Also, the "nearest" VA facility is inappropriate as it should be the nearest VA facility providing the care veterans require. On March 24 VA indicated it will seek a change in the statute to remedy those 2 impediments. We understand the 40 mile change will double the number of veterans eligible non VA care. Having heard the veterans complaints, the Oregon delegation in Washington sent

letters to the VA Secretary requesting the 40 mile criteria be revised from as the “crow flies” to actual driving distance. That simple common sense change is a big victory for veterans.

Veterans often give up when calling the busy VA Choice phone number. Sometimes they are told by VA that the 30 days are business days not calendar days. Like Joe, 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 (1,000) of veterans receiving healthcare through Choice. If VA can report Choice statistics, why can it not report PC3 performance as envisioned in HJM 14? Answer: get Congress involved. I am pleased that SJM 11 includes a role for the Oregon delegation in Washington.

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.

I believe VA and Congress imposed restrictive criteria to accommodate a $10 billion limitation. Without the 40 mile and 30 day restrictions the cost of Choice would be $50 billion according to Congress. But, at an average of about $5 billion per year spent on PC3 and Choice, that is a small fraction (5%) of the $73 billion annual VA healthcare budget and smaller than the percentage of rural to total veterans noted in SJM 11.

If the $19.8 billion PC3 and Choice programs were pro rated to the 8.5 million Choice card holders, VA would be budgeting about $2,300 per veteran over several years. Oregon’s 330,000 veterans represent about 1.5% of the nation’s 22.5 million living veterans. That would translate into 120,000 Oregon Choice card holders and $300 million of the $19.8 billion might be allocated to Oregon but VA will not tell us the funding. VA should know the dollar value its TriWest contractor is spending and the number of eligible and served PC3 and Choice veterans and non VA providers in VISN 20 (Oregon, Washington, Idaho). Without that information we have no means of knowing the size of the problem to be fixed and how well VA is progressing toward its goals. I have submitted a FOIA request for the data.

PC3 and Choice are new but TEMPORARY programs with fine goals as

SJM 11 envisions. It is interesting that PC3 uses driving time criteria while Choice uses distance. They represent a new way of doing business as we requested 8 years ago. VA is experiencing huge problems in implementation – growing pains and telling veterans, healthcare providers and the public about the programs and its 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. If VA cannot do the job, there should be a third party 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 will raise expectations from veterans and non VA providers that could be dashed if these programs die at the end of their temporary lives. They should become permanent.

VA Secretary McDonald is dispatching teams to investigate the low veterans enrollment in Choice and waiting times.

Perhaps the new VA Advisory Committee formed 3 weeks ago will evaluate VA performance using objective measures as envisioned in HJM 14.

I strongly recommend some of the features in HJM 14 be integrated with SJM 11 and one Oregon Joint Memorial be issued. I have taken the liberty to enumerate them:

Whereas the Department of Veterans Affairs (VA) has implemented two new but temporary nationwide programs funded at $19.8 billion aimed at

improving veterans access to healthcare by using local Non - VA providers than distant VA treatment: Patient-Centered Community Care (PC3) and Choice Card; and

Whereas Veterans are experiencing great difficulty in accessing PC3 and Choice because of the lack of information, inconsistent VA interpretation of the rules and confusion caused by VA's narrow definitions of driving distance and the VA facility criteria in Choice: and

Whereas the VA is not providing veterans, healthcare providers and tax payers cost and performance data on PC3 and Choice implementation that would allow judging performance against program goals (veterans and Non VA provider enrollments, referrals to Non VA providers, waiting times, quality, funding; and

Whereas local non VA providers are experiencing difficulty in enrolling in PC3; and

Whereas PC3 and Choice have the potential to achieve significant improvements in timeliness and quality of healthcare for rural and other qualified veterans: and

Whereas the VA and Congress should establish a goal of consolidating PC3 and Choice into a permanent program: and

Whereas the Congress should not allow the VA to divert any funds from PC3 and Choice programs for in house VA programs;

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.

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 now on VA's performance. Performance measurement and public reporting will force VA to disclose to the public how it is meeting or not meeting its goals.

Attached are last week's articles published by the Bend Bulletin on local veterans unsatisfactory experiences with Choice. Similar issues were reported by the Union Bulletin in Walla Walla. The former deals with the Portland VA Medical Center while the latter relates to the VA Medical Center in Walla Walla, WA where some Oregon veterans are treated.

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. How many more veterans could have been treated by this $1 billion+ massive overrun and with no end in sight! Congress will be holding a hearing on the Denver hospital cost overrun.

Twenty thousand veterans in Louisiana may lose their non-VA health services due to late payments by VA.

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 SJM 11 and HJM 14 should be of national concern, we can only hope they will be treated seriously by the VA, Congress and the President.

As Representative John Huffman, a member of the House Veterans Affairs Committee commented while I was testifying last week, Medicare patients would not want to drive to distant Medicare facilities as veterans are required to do to VA facilities. If they can be made to work, PC3 and Choice would provide rural veterans with the same access to local primary and specialty care as Medicare patients. Some treatments are unique to veterans and should continue under VA.

I respectfully urge this Committee to expand its resolution to include the PC3 and Choice Card programs as they are the only games in town now. We need to do all we can to make them work while there is high level of new funding and serious concerns from Veterans, Congress and the Oregon Legislature.

Finally, as a member of the VFW, I should make the Committee aware of the February 27, 2015 VFW Initial Report: "Veterans Choice Program". The report's Executive Summary was introduced at the HJM 14 hearing last week. The report is an excellent document detailing the status of Choice

and 6 recommendations to improve its implementation. I request it be made part of the SJM 11 record.

Thank you Chairman Boquist and Committee members for providing this opportunity to testify on SJM 11.

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

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