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STATEMENT OF
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COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairman Takano, Ranking Member Roe and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to provide testimony for the record on "Assessing the VA's Response to the COVID-19 Pandemic: 90 Days Later." DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. We are pleased to offer our views on this important issue under consideration by the Committee.

In early February, the Department of Veterans Affairs (VA) informed veterans service organizations that it was monitoring the novel coronavirus and starting initial preparations to keep veterans safe and activating procedures for disaster preparedness. By mid-March, the world had to come to grips with a global pandemic and the VA was required to make a significant shift in the delivery of health care to its more than 9 million enrolled veterans. As public health experts recommended social distancing, self-isolation and quarantine measures to help slow the spread of the COVID-19 virus, VA began informing patients via text message and social media that medical facilities and clinics would be open to provide medically necessary care to veterans impacted by the virus first and foremost. Although VA postponed elective surgeries and established strict protocols for veterans who were ill from the virus and needed to be seen, tested and treated, it quickly ramped up its telehealth capabilities and transitioned appointments for routine care through video conferencing.

In the early months of the pandemic it became clear that global supply chains were severely impacted by the rapid spread of the virus making it difficult for health care systems to get needed medical supplies and equipment. Like in the private sector, we heard complaints from VA health care providers that obtaining adequate supplies, COVID-19 test kits and personal protective equipment (PPE) was problematic. In a recent report, the Government Accountability Office (GAO-20-638T) noted that VA's antiquated inventory management system complicated issues for the Department and created additional barriers to VA getting needed equipment and supplies to protect its front-line workforce during the COVID-19 response. Given limited supplies, VA instituted measures that rationed supplies and prioritized use of PPE for providers providing direct care for veteran patients with the coronavirus but complaints from employees continued about the safety issues due to the lack of PPE for other front-line providers seeing patients. There were also reports of confusion and inconsistency related to employee telework, paid leave, testing, guidance on self-quarantine procedures and

pay issues. However, despite these challenges and personal health risks to many front-line health care workers and employees in support roles it was clear that caring for our nation's veterans remained VA's priority during this unprecedented public health crisis.

PROTECTING VETERANS IN LONG-TERM CARE FACILITIES

One critical area that VA must review and learn lessons from is the provision of long-term nursing home care to veterans during this pandemic. VA provides skilled nursing home care to veterans in its CLCs as well as through partnerships with states operating State Veterans Homes, and through contracts with community nursing homes across the country. The average daily census of veterans residing in VA's CLCs is approximately 8,500, compared to more than 20,000 in State Veterans Homes and almost 11,000 in community nursing homes. Given how devastating COVID-19 has been to older and vulnerable persons with underlying medical problems, it is crucial to examine how to best protect nursing home residents.

On March 10th, VA instituted a policy prohibiting visitors to its CLCs—with limited exceptions for compassionate care or end of life visitation—in order to help prevent the spread of COVID-19 to its nursing home residents. VA's approximately 100 CLCs are generally better prepared for infection control in part because they are co-located within VA medical facilities and have clinical staffing and equipment similar to an acute care ward in a hospital. The combination of these and other factors has so far protected veterans in VA's CLCs, with less than two dozen infected with the coronavirus at the beginning of June.

VA also pays for veterans residing in State Veterans Homes through federal matching grants and per diem payments for the care of veterans residing therein. While each state is responsible for the operation of its State Veterans Homes, VA imposes significant regulatory requirements on the Homes to meet standards of care and infection control that are equal to, and in some cases more stringent than, those which the Centers for Medicare and Medicaid Services (CMS) imposes on private nursing homes. To ensure compliance, VA conducts annual inspections of State Veterans Homes and can withhold per diem payments if VA's mandates are not fulfilled. In addition, VA contracts with hundreds of private nursing homes in communities across the country to care for veterans. These community nursing homes are overseen by and subject to regulations from CMS.

On March 13th, three days after VA announced its restricted visitation policy, CMS sent guidance to community nursing homes calling for the same restrictions on visitors. While State Veterans Homes are operated by individual states, virtually all of them also instituted the same restrictions at or around that same timeframe.

Throughout March, as the pandemic took hold and the national shortage of PPE and COVID-19 testing kits became evident, State Veterans Homes sought PPE and testing support from VA, who responded that State Veterans Homes must work through their states and FEMA. In March, Congress included a provision that became part of the CARES Act, which authorized VA to provide "medicines, personal protective equipment, medical supplies, and any other equipment, supplies, and assistance available" to State Veterans Homes, including PPE from VA's emergency cache. However, this new authority was discretionary, not mandatory.

Although a number of State Homes reached out to VA for this support, VA initially declined to provide PPE or support testing, citing its own limited supplies.

However, following reports of significant COVID-19 outbreaks in State Veterans Homes in Massachusetts, New Jersey and Pennsylvania, VA changed its posture toward providing assistance. By mid-April and throughout May, VA made significant outreach to State Veterans Homes to assess their situations and offer assistance, eventually offering PPE, testing and even staff to a number of Homes most severely affected by COVID-19 outbreaks. In some states, VA also offered direct support to private nursing homes caring for veterans.

In retrospect, one of the most critical lessons of the COVID-19 outbreak may be that the first lines of defense established against this particular pandemic should have been nursing homes—all nursing homes—whether operated by VA, states or privately. While VA was well positioned and acted quickly to protect veterans in its own CLCs, there may have been opportunities to provide additional support earlier to State Veterans Homes and community nursing homes that could have made a difference.

VA'S FOURTH MISSION

Section 8117 of title 38, United States Code, outlines the basic roles and responsibilities for VA's response to national emergencies. In summary, it is to maintain the readiness of its medical facilities to ensure the safety of its patients and staff; provide for the security of its medical and research facilities; use a centralized system to track pharmaceuticals, medical equipment and supplies and provide them, as necessary on a reimbursable basis, to address emergency needs of the Department of Health and Human Services; train medical residents to respond in times of national emergency; participate in the National Disaster Medical System; and provide mental health counseling to veterans, local first responders, and active duty military service members.

As the novel coronavirus pandemic reached the United States VA further outlined its responsibilities in its COVID-19 Response Plan dated March 13, 2020.[1]

- VHA will provide PPE fit-testing, medical screening, and training for ESF #85 and other federal response personnel.
- Provide VHA staff as ESF #8 liaisons to FEMA the Incident Management Assistance Teams deploying to the state emergency operations center.
- Provide VHA planners currently trained to support ESF #8 teams.
- VHA provides vaccination services to VA staff and VA beneficiaries in order to minimize stress on local communities.
- VHA furnishes available VA hospital care and medical services to individuals responding to a major disaster or emergency, including active duty members of the armed forces as well as National Guard and military Reserve members activated by state or federal authority for disaster response support.
- VHA provides ventilators, medical equipment and supplies, pharmaceuticals, and acquisition and logistical support through VA National Acquisition Center.

[1] https://www.va.gov/opa/docs/VHA_COVID_19_03232020_vF_1.pdf

- National Cemetery Administration (NCA) provides burial services for eligible veterans and dependents and advises on methods for interment during national security emergencies.
- VHA designates and deploys available medical, surgical, mental health, and other health service support assets.
- VHA provides one representative to the National Response Coordination Center (NRCC) during the operational period on a 24/7 basis.

VA's fourth mission—once also known as its contingency mission—was originally established to serve as the backup to the Department of Defense in times of war or national emergency. VA once maintained inactive beds that could be readily activated to meet the needs of the military if its own health care system became overwhelmed. As health care needs have evolved, VA has contracted its bed inventory to reflect a shift in care to outpatient and home-based settings. We understand this shift is necessary—after all, it is expensive and non-productive to maintain empty beds and space may be better used to provide outpatient care and services or meet other organizational needs, but the pendulum has now swung the opposite way. VA's March Guidelines to respond to COVID-19 suggest that VA must seek out community resources if its own bed capacity becomes overwhelmed by veterans' needs during the pandemic. VA has tested about 12,000 veterans thus far, but only about 1,400 are currently in treatment.[2] This crisis gives Congress an opportunity to re-assess VA's role in emergencies and the need for infrastructure modernization that provides adequate space to address infection control needs (including for social distancing in common areas, air flow and ventilation), in addition to maintaining some surge capacity.

It certainly seems appropriate at this time to require VA to look at maintenance of emergency equipment and supplies in a different light. VA has acknowledged the significant challenges its supply chain operations have experienced in responding to COVID-19, stating the lean "just-in-time" delivery system it has relied upon led to inventory shortfalls for VA, like many other health care systems. Shortfalls in PPE, ventilators, and other supplies and equipment have demonstrated that improvements in supply chain management are necessary.[3]

VA is modernizing its supply chain management system to integrate with the Defense Medical Logistics Standard Support System and its recent budget request supports funding for the people, resources, training and automation to make this transition, which it hopes will yield a better system for decision support and increase enterprise visibility into procurement, equipment maintenance, and inventory control. VA also stated it will maintain four Regional Readiness Centers to ensure the adequacy of the supply chain in the face of emergencies. These Centers will be responsible for responding to the needs of veterans in public health emergencies, including resurgences of COVID-19, in addition to addressing more regional disasters such as floods, hurricanes, or earthquakes. While FEMA is the designated federal manager of the supply chain for COVID-19 response, VA plays an important role in purchasing and lending logistical support to these efforts. Unfortunately, the federal government's purchasing programs did not

[2] Senate Veterans Affairs Committee, Statement of Richard Stone, Executive in Charge of VHA, June 3, 2020.
[3] Senate Veterans Affairs Committee, Statement of RICHARD A. STONE, M.D., EXECUTIVE IN CHARGE, VA, June 9, 2020. P. 1

envision a global disruption in the supply chain, which led to the shortfalls VA and others health systems experienced. While VA now has about 30 days of supplies on hand, its goal is to have 6 months of supplies available in the future.

VA'S ROLE AS PRIMARY PROVIDER OF VETERANS HEALTH CARE

Throughout this crisis, DAV believes that the nation's need for a veterans' health care system have never been so clear. In recent years, VA has sought to shift more and more of its care to the community. DAV has supported many of these changes with the caveat that such care should be coordinated and managed by VA, and that the quality and timely access to such care is at least as good as VA can provide. But as VA's own statement to the Senate suggests, VA has remained an integral care provider throughout the pandemic, while many community care providers closed or greatly reduced access to their users. While its community partners reduced services, VA ramped up its capabilities by hiring an additional 10,000 providers, and scaling telehealth platforms to rapidly manage an exponentially larger caseload. Within a two-month period, VA video connect visits increased from 10,500 to 104,387.[4] These are tremendous accomplishments that demonstrate VA's ability to continue to perform its mission to care for veterans even in times of a national emergency and illustrate the need to continue a robust government program into the future. If not for VA, many veterans would likely have lacked any medical care access during the pandemic.

In recent national disasters, such as hurricanes, and emergencies such as 9/11, VA has also been there as an additional asset to FEMA and other national disaster relief providers to ensure that mental health counseling needs are served and to offer logistical support.

As the VA begins a phased reopening of facilities and clinics in the weeks ahead, we continue to hear complaints from employees that in certain locations there are still shortages of basic supplies, such as hand sanitizer, masks, gowns and other essential items to control the spread of the virus and for the safe treatment of patients. VA recently testified that it was adequately stocked with supplies and had 30 days worth of N95 masks and other PPE. This seems to be a modest supply at best and raises concerns about preparedness for future emergencies as we enter into hurricane season and hear warnings from health experts that we should expect and be prepared for the normal flu season on top of a likely resurgence of the virus and increased COVID-19 infection rates this fall and winter.

DAV was pleased that Congress quickly and approved $19.6 billion for VA in the Coronavirus Aid, Relief, and Economic Security—CARES Act to address this historic public health crisis allowing VA to expeditiously hire 10,000 additional staff, secure needed medical supplies and COVID-19 test kits and carry out its fourth mission of providing medical support for vulnerable populations and communities that were hard hit by the virus.

These additional resources provided to VA in the CARES Act should be used to ensure its medical care system is fully prepared for meeting the health care needs of veterans and providing support to the community throughout the pandemic. Dr. Richard Stone, Executive in Charge of the Veterans Health Administration testified on June 9, before the Senate Veterans'

[4] Senate Veterans Affairs Committee, Statement of Richard Stone, Executive in Charge of VHA, June 3, 2020.

Affairs Committee that VA was working diligently to gather needed supplies and prepare for a possible second wave of the virus, adding the goal is to secure, at a minimum, a sixty-day supply of PPE but that a six-month supply would be needed to be fully prepared for a potential resurgence of the coronavirus this fall. He also noted the significant cost for meeting demand for PPE which has increased from $10 million per month to $100 million per month. VA must find a way to ensure there is sufficient PPE for all front-line providers and other medical equipment necessary to fight COVID-19 despite the lack of a national strategy for ensuring adequate production and distribution of such supplies.

Equally important is access to universal COVID-19 testing for veterans and VA employees and the ability to trace and notify patients and staff of exposure to a COVID-positive person. During the June 9 hearing, VA acknowledged that despite the department's intent to have tests available for the entire workforce, it still lacked enough testing supplies to provide screening for all employees that wanted to be tested. The ability to test will be essential to keep infection rates low among veteran patients and VA health care staff—and especially important as VA begins it phased reopening of medical facilities to identify and control outbreaks.

Mr. Chairman, again thank you for holding this hearing today. This concludes my statement and I am pleased to answer any questions you may have.