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JOINT HEARING ON LEGISLATIVE PRESENTATIONS FROM WWP, BVA, NASDVA, VVA, MOPH, AMVETS

JOINT HEARING

OF THE

COMMITTEE ON VETERANS' AFFAIRS

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES

AND THE

U.S. SENATE

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

FEBRUARY 26, 2020

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JOINT HEARING ON LEGISLATIVE PRESENTATIONS FROM WWP, BVA, NASDVA, VVA, MOPH, AMVETS

WEDNESDAY, FEBRUARY 26, 2020

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

The Committees met, pursuant to notice, at 2:25 p.m., in room G50, Dirksen Senate Office Building, Hon. Jerry Moran and Hon. Mark Takano, Chairmen of the Committees, presiding.

Senators present: Senators Moran, Boozman, Rounds, Tillis, and Loeffler.

Present: Representatives Takano, Lamb, Levin, Cunningham, Cisneros, Allred, Underwood, Roe, Bost, Bergman, and Roy.

OPENING STATEMENT OF HON. JERRY MORAN, CHAIRMAN, U.S. SENATOR FROM KANSAS

Chairman MORAN. Good afternoon. I am sorry for the tardiness commencing this hearing. It is a privilege to welcome all the folks at the table and all of you in this room to this joint hearing between the House and Senate Veterans' Affairs Committees.

The delay, as I think has been explained to you, was trying to determine the House voting schedule. This is the joint hearing in which Chairman Takano was to preside. We expect him here shortly, although I am uncertain as to what the House voting schedule is, so I do not know that I can say with any credibility "shortly" is the right word.

But, we, with his permission, have decided to proceed, and I am pleased, as soon as I find the gavel—oh, he has it. I call this meeting to order.

I welcome the seven organizations here to testify. I especially extend a welcome to the Kansans in the room and appreciate the work they do in my State on behalf of veterans, but I recognize no matter where you are from, it is an honor to be with people who not only served our country, but not serve others who served our country.

I will abbreviate my remarks so that we can make up, perhaps, some time, but I appreciate particularly the number of the organizations who are present here today who have been supportive of a number of legislative endeavors that I have been engaged in related to toxic exposure, the Vietnam War, Agent Orange. I also appreciate the coalition that has developed to try to deal to get Congress and the administration, the Department, to deal with these issues.

I look forward to each of your presentations today and look forward to working with you to continue to improve the benefits and services that our Nation's veterans are entitled to.

Let me now recognize—I also should say that there is a Republican retreat in which members of the Republican Senate are elsewhere. There is a Democrat retreat in which Democrat members of the Senate are elsewhere, and I think we were counting on the House members being here.

So, with that, let me now introduce our witnesses. We will begin with General Linnington. General Linnington, you are recognized for 5 minutes.

STATEMENT OF LT. GEN. MICHAEL LINNINGTON (RET.), CHIEF EXECUTIVE OFFICER, WOUNDED WARRIOR PROJECT

Lt. Gen. LINNINGTON. Thank you, Chairman Moran, and thank you to the Members of the Committee for holding this important hearing to receive the legislative priorities of organizations committed to serving veterans, their families, their caregivers, and their survivors.

Wounded Warrior Project is here today to advocate for the wounded, ill, land injured servicemembers who served on or after September 11, 2001. Our advocacy priorities today are informed and guided by responses from our Annual Warrior Survey, the largest, most statistically relevant survey of post-9/11 veterans in the country.

Our priorities are also informed by thousands of programmatic engagements delivered across the Nation. We are changing and saving live through programming focused on mental, physical, and financial health, and we are learning about those we serve in the process.

With that perspective, our legislative priorities for 2020 touch on six specific focus areas: mental health, brain health, toxic exposure, women veterans, caregivers, and finally, employment and education for wounded warriors.

Our written testimony explains in detail why addressing these issues will help your Committees deliver the biggest impact for wounded warriors, but today I will focus on three of the Wounded

Warrior project's commitments for the remainder of the 116th Congress.

First, we are committed to building a community campaign to help get health care for veterans harmed by toxic exposure during their time in service. Using the guidepost of a decades-long struggle to provide relief and care to veterans exposed to Agent Orange, Wounded Warrior Project is placing an emphasis on care first and foremost.

We have recruited others to the cause, and the Toxic Exposure in the American Military coalition is comprised of 25 organizations focused on improving treatment for servicemembers and veterans through early identification and improved research. And, Chairman, thank you for mentioning that coalition.

Forthcoming legislation backed by this coalition would create a new priority group at VA so that veterans do not need to establish service connection to receive care for toxic exposure illnesses. The bill will outline improvements to DOD and VA research and collaboration and instruct VA providers to be more considerate of toxic exposure illnesses during primary care visits. We look forward to seeking the support of Committee Members once the bill has been formally introduced.

Second, we are committed to improving the health care landscape for the fastest growing cohort of the veteran community—and that is true at Wounded Warrior Project as well—and that is our women veterans. Wounded Warrior Project has been tailoring programs to women veterans for years. We have recently initiated an advocacy campaign to better understand specifically their challenges and to find empowering solutions.

Believe it or not, we have nearly 5,000 women veterans already shared their perspectives through a recent Wounded Warrior Project survey, and I am eager to share those findings as well in a few weeks with you and your Committees.

Our Chief Program Officer, former U.S. Army veteran Jennifer Silva, will be participating in the HVAC hearing on March 11 on the mental health of women veterans, and we look forward to her testimony, as well. I will note as an aside, we have many women veterans with us today, and they met with members of your team and certainly other Members of the Committee yesterday. Thank you for that time.

I am honored to publicly state our support for the legislation proposed by Congresswoman Brownley and the Women Veterans Task Force, and we call on the Senate to follow the House's lead and pass the Deborah Sampson Act and the Veterans' Access to Child Care Act.

For the remainder of the 116th Congress, we will also be supporting efforts to deliver high-quality care for survivors of military sexual trauma and improve the military transition process for women veterans.

As a final but equally significant priority, Wounded Warrior Project continues its commitment to addressing mental health and veteran suicide by mitigating risk factors and connecting more veterans to care and support before it reaches a crisis point.

Our mental health advocacy is framed by our belief that no one organization or agency can fully meet all veterans' needs. In this context, we support the Commander John Scott Hannon Veterans Mental Health Care Improvement Act that puts particular emphasis on the proposed Community Grants Program. Through a new pilot program that leverages existing networks of support, VA can reduce barriers to care, bring more veterans into the VA system, and ultimately find a more effective way to become a part of a veteran's life before they reach a crisis point.

Wounded Warrior Project remains steadfast in our commitment to transform mental health care and support for injured veterans, their families, and their caregivers. It is through the courageous and selfless actions of those we serve that we are able to live the lives we live as Americans.

It is now our responsibility, indeed our sacred obligation, to work together to help our wounded veterans build a life worth living as well.

Thank you, Mr. Chairman, and I look forward to your questions.

[The prepared statement of Lt. Gen. Linnington follows the hearing text.]

Chairman MORAN. Thank you very much, General. I now call on Dr. Thomas Zampieri for his testimony.

STATEMENT OF THOMAS A. ZAMPIERI, Ph.D., NATIONAL PRESIDENT, BLINDED VETERANS ASSOCIATION

Mr. ZAMPIERI. A little technical problem. There we go. Whoops.

Chairman MORAN. We do want to hear you. It is true.

Mr. ZAMPIERI. Yeah.

[Laughter.]

Mr. ZAMPIERI. Thank you, Mr. Chairman, and thank the Committee for inviting us to testimony today. This is our 75th anniversary this year of the Blinded Veterans Association. It is an honor to represent all of our blind veterans across the country.

We just wanted to touch on a few issues sort of left over. The caregivers implementation, the VA system, for those that were injured and wounded in prior wars, it is obviously an oversight issue waiting for the VA to get new caregiver regulations in place for

those that were injured in previous wars. We would certainly like to have you try to move H.R. 1199 and your bill, the companion bill, S. 746, which is about accessibility, to get the VA to report back to the Committee on their funding and staffing, to improve the accessibility for blind veterans. There are still significant barriers, and that legislation really would help. And we appreciate your taking lead on that.

Third, we would ask the Members of the Committee, when they get ready to do their views and estimates to the appropriators, to include $30 million for the DOD Congressionally Directed Medical Research Program for Vision Research. It is the only area where there is Federal funding for vision trauma research within DOD. So, we are asking the Committee Members to support the $30 million.

H.R. 3504. We appreciate the bipartisan support for including veterans in the special adaptive housing eligibility criteria, and so if you could help make sure that gets across the finish line. We have been waiting since last summer for that to get completed, H.R. 3504.

I am honored here today. Dr. Renata Gomes, who is the Chief Scientist from London for the Blind Veterans of the UK, is spending the week with the Blinded Veterans Association. We are actually reaching out in London to the Minister of Veterans Affairs, the Prime Minister's office and the Minister of Defense, to get the Pentagon, the Secretary of the VA, and the UK to sign a Joint Ocular Trauma Task Force. Senator Boozman, when I met with him yesterday, said it sounded like one of the best ideas he had heard in a long time. So, we ask your support in reaching out to the Defense Secretary to encourage him to consider doing this.

There is precedence in the sense that they have had previous joint task forces before, going back to actually 2011, but this one, again, would be on ocular trauma. It would benefit as far as research, exchanging information about those servicemembers that have had TBIs and vision impairments.

The British are looking already at research in the area of PTSD, TBI, and suicides. All of this data, when we met with the Office of VA Research, they would love to be able to collaborate with them, and it really would improve care. On the battlefield, when UK and American ophthalmologists served side by side, we found inconsistencies with surgical equipment, medications, things like that. So, I am pretty excited, obviously.

Israel, Germany, Denmark, Australia, France are all interested in joining into this. I have sort of started something that I did not think I would have a year ago. So, we encourage the Members of

the Committee, and the staff, I appreciate meeting with earlier yesterday and today to discuss this.

Last thing on the agenda, real quick, is we, BVA, supports H.R. 4920, which only grandfathers existing AbilityOne programs that employ. A lot of them employ blind an disabled veterans.

I started up here in 2001. So, I guess I have been around a little while, and the unemployment rate when I walked into Washington, DC, with blind veterans was 45 percent unemployment rate for blind veterans in this country. Today the unemployment rate is 45 percent. You think of all the legislation that has come before this Committee and passed to try to help create jobs for all veterans, and we today still have the highest unemployment rate.

So, H.R. 4920, despite the false rumors and accusations, is going to help a percentage of those veterans maintain their jobs. The total VA's contracting budget, if anybody is interested in the actual facts, is $27 billion. The AbilityOne programs that would be grandfathered—no new ones would be able to apply—is $200 million. Of course, if there is some miracle here today where someone is going to come forth with proposed legislation that would fix that unemployment rate, I would love to talk with that person.

Thank you very much for inviting us to testify. I will answer any questions you have.

[The prepared statement of Mr. Zampieri follows the hearing text.]

Chairman MORAN. Thank you very much for your testimony, Doctor.

Now, the president of the National Association of State Directors of Veterans Affairs, John Hilgert.

STATEMENT OF JOHN HILGERT, PRESIDENT, NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS

Mr. HILGERT. Thank you, Chairman Moran. My name is John Hilgert. I serve as the President of the National Association of State Directors of Veterans' Affairs and the Director of the Nebraska Department of Veterans' Affairs.

NASDVA is comprised of State directors of veterans affairs of all 50 States, the District of Columbia, American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

Here with me today is John Scocos, the NASDVA Executive Director, former Secretary of the Wisconsin Department of Veterans Affairs, and Tom Palladino, the Executive Director of the Texas Veterans Commission and NASDVA Senior Vice President.

Please accept the association's written testimony for the record, and let me highlight a few items.

States and territories continue to increase their role as multi-dimensional service providers to veteran. The State Departments of Veterans Affairs promote approaches making State government effective, efficient, and customer focused. We are being asked to serve as one-stop shops to coordinate, connect, and convene teams to address veteran unemployment, economic empowerment, and whole health and wellness.

Despite constrained State budgets, States collectively contribute over $10 billion each year to our Nation's veterans and their families. NASDVA through its members of States and Territories is the single organization outside the U.S. VA that has served all of America's veterans. Given that State Departments of Veterans Affairs were asked and held accountable by our respective Governors, our boards, our commissions, we are well positioned to deliver that effective, efficient, and customer-focused service.

VA funding. Our full congressional support, we support the President's Fiscal Year 2021 VA Budget Request. We believe it is vital to meet the growing needs of veterans to fulfill the VA's mission. NASDVA is committed to working with the congressional and VA leaders to ensure scarce resources are allocated to the priorities which will meet our veterans' most pressing needs.

For example, in Nebraska, we anticipate receiving Federal funding to expand services at our Eastern Nebraska Veterans Home, in part, predicated upon the veteran population growth identified through the VA's Population Models.

Veterans' health care, benefits, and services. We support and continue the implementation of the provisions of the VA MISSION Act. NASDVA's priority for the care of our veterans are consistent with those of the VA, especially in the area of behavioral health and suicide prevention. We support an all-of-the-above approach for health care delivery. We recognize the diversity, geography, and demographic makeup of today's veterans.

Our State Veterans Homes, the State Veterans Home Program is the largest and one of the most important partnerships we have at the VA. NASDVA supports a continued commitment to the significant funding of our State Veterans Home Construction Grant Program, and we strongly support increasing the funding to at least $250 million, given the increases in demand for long-term care for veterans.

Veterans Benefits Services. Given the claims backlog and the number of claims on appeal, we recommend serious consideration for making Federal funding available to States to assist with efforts on the ground to further reduce that backlog and to maintain progress on expediting existing and new claims.

NASDVA appreciates the National Cemetery Administration's collaborative partnerships with States, Territories, and Tribal governments. We recommend the fiscal year 21 Construction Grant Program be increased to at least $60 million, comprised of $50 million for construction and $10 million specifically designated for improvements and emergent needs. This modest increase to the $45 million proposal will allow funding for some new State veteran cemeteries and upgrade projects that currently go unfunded, while allowing the NCA to respond to emergent requirements.

Transitional Assistance. Our organization strongly encourages the most effective transition program possible. We are very encouraged to changes to the program in the last few years, especially with several elements of the fiscal year National Defense Authorization Act related to transition-related issues.

Distinguished members, we are a government-to-government provider. We work with the VA to deliver services and care to those who have served in uniform. We are expanding hubs and links to local communities. With your help and support, we can ensure veterans are adequately resourced and maintain a priority. I would ask that you use us as a resource. The difficult challenges we address today are critical investments which become the foundation of our promise to serve those who have borne the battle.

Using us as a resource, we can share with you our hopes, our dreams, our visions, our frustrations, our challenges in an unvarnished direct approach to get that information and to test ideas on how they effect the veterans on the ground.

We are here for you, and we look forward to answering any questions that you might have and working as partnership together in the future.

Thank you, Senator.

[The prepared statement of Mr. Hilgert follows the hearing text.]

Chairman MORAN. Thank you so much for that offer.

Now Mr. Harvey Weiner, who is the National Commander of the Jewish War Veterans. Mr. Weiner?

STATEMENT OF HARVEY WEINER, NATIONAL COMMANDER, JEWISH WAR VETERANS

Mr. WEINER. Good afternoon, Chairman Moran. I am Harvey Weiner, a Vietnam War combat veteran, and the National Commander of the Jewish War Veterans of the USA, America's oldest, active, continuous veterans association. We will be celebrating our 125th anniversary next year. American Jews have fought in all of America's wars in a proportion greater than their proportion in the general population.

The bills that JWV supports are in the written statement I have submitted for the record, but this afternoon, I want to speak to you about something else, about courage.

Members of the armed services will risk his or her life on the battlefield to serve this great Nation and to do the job assigned. Hundreds of thousands of American soldiers have given their lives, and millions of American soldiers and their families have made other sacrifices in this regard. They had the right stuff and displayed great courage. They took enormous risk because their country called and because it was the right thing to do. Now on behalf of all veterans, past and present, and all service personnel, past and present, I am asking, each and every one, Members of this Committee and of Congress to show courage by doing your job and doing right, regardless of the political consequences, including the possibility or even the probability that you will lose your job by being voted out of office.

When you who implicitly or explicitly send us off to war and ask us to do the right thing at the risk of our lives, it is a "shanda" if you are unwilling to take that risk to do right yourself rather than what is politically expedient. "Shanda" is Yiddish for "shameful." The risk of losing your job pales in comparison to the risk we take of losing our lives.

I was reviewing the John F. Kennedy Profiles in Courage winners of the award that is the Nation's preeminent award for elected officials and public servants. For them and for you, it is the Nobel Prize, the Oscar, the Lasker, the Pulitzer.

I give you these three examples. Carl Elliott was a congressman from Alabama for eight consecutive terms from 1949 to 1965. He was a Democrat, but he authored and voted for the National Education Defense Act, which he knew would lead to his removal as a congressman in 1964. He was right, but he did what was right.

Charles Weltner, also a Democrat, was a congressman from Georgia who dropped out of his face for a third term rather than seek reelection and be bound by a party loyalty oath to support the candidacy of segregationist Lester Maddox.

Bob Inglis, who some of you may know, is a Republican and was a congressman from South Carolina. He reversed himself on the issue of climate change because he felt it was the right thing to do. He knew that it would probably mean the demise of his political career, and it did.

We who survived, who died, who were wounded, and who risked our lives in the military to do the right thing because America asked us to are asking you to do the right thing, merely at the risk of losing your jobs. Do not take funds away from the military, in-

cluding from their daycare in schools, for nonmilitary purposes, because it is politically expedient to do so.

I have a second point I would like to make and which has bothered me for 70 years. The Constitution, which you swore under oath to uphold, vests the power to declare war solely in the hands of Congress and not in the executive, who is the commander in chief. However, since World War II, Congress, as a practical matter, has ceded its constitutional responsibility to the President in the semantic guise of so-called "emergencies" or "police actions." War is too important to be in the hands of one person, and since World War II, the usurping of the war power by both Democratic and Republican presidents has led this Nation into disaster after disaster and caused the unnecessary deaths of over 100,000 of my comrades in arms, my brothers, and my sisters. An after-the-fact congressional resolution is just not enough. Take back the war power that the Framers of the Constitution in your own 1973 War Powers Resolution gave you.

When Abraham Lincoln was in Congress, he wrote the following: "The provision of the Constitution giving the war-making power to Congress was dictated, as I understand it, by the following reasons. Kings have always been involving and impoverishing their people in wars, pretending generally, if not always, that the good of the people was the object. This, our constitutional convention, understood to be the most oppressive of all kingly oppressions, and they resolved to so frame the Constitution that no one man should hold the power of bringing this oppression upon us."

As a cantankerous football coach in my neck of the woods is fond of saying, "Do your job." Risk your jobs to do the right thing because in the long run, it is not just your constituents that you must face. You must face your children, your grandchildren, your descendants in history, and also, you must face yourself and your conscience. Become a candidate for the Profiles in Courage Award.

We the veterans of America do not just ask you to do the right thing in spite of the political consequences. We really demand it, and we feel we are entitled to do so.

Thank you, and I will be glad to answer questions.

[Applause.]

[The prepared statement of Mr. Weiner follows the hearing text.]

Chairman MORAN. Mr. Weiner, thank you very much for your admonition, your demand, and perhaps reminder. I look forward to having a conversation with you on this topic when we have the chance to ask questions.

Mr. John Rowan, welcome. Good to see you, sir, again, from the Vietnam Veterans of America.

STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. ROWAN. Thank you, Mr. Chairman.

Mr. Boozman, good seeing you.

I want to take this opportunity to thank retired Senator Johnny Isakson for his service to America and our veterans. We appreciate the new Chair, but we will always remember Senator Isakson.

Chairman MORAN. I understood what you were saying.

[Laughter.]

Mr. ROWAN. We have distributed extensive written testimony outlining our legislative priorities and policy initiatives, and I would ask that they be entered into the record.

Chairman MORAN. Without objection.

Mr. ROWAN. Thank you.

Today, however, I want to focus on the most important issue that has haunted us since we left Vietnam: toxic exposures. VVA has been fighting to get acknowledgement that the hideous long-term effects of exposure to the herbicides used in Vietnam, commonly known as Agent Orange, for over 40 years. Despite the efforts of the VA bureaucracy to delay, deny until we die, we have succeeded in getting some of the health care and compensation that our Vietnam veterans deserve.

Just recently, we have joined some of our colleagues to ask President Trump to demand that the VA approve four new presumptive illnesses resulting from Agent Orange exposures.

Our work on Agent Orange led us to uncover a truly horrifying issue: the possibility of negative health effects on our children and our grandchildren due to our exposures.

The Toxic Exposure Research Act laid the groundwork for research into the health of our children and grandchildren, and we hope that we will get that done soon. While we were focused on our toxic exposures and their effects on our descendants, we could have not imagined that similar problems would arise in those who followed us in the military.

Because of our efforts on Agent Orange, we became aware of toxic exposure issues arising in the Gulf War veterans and later the post-9/11 veterans, and recently, we have become aware of the toxic exposures facing our military here at home.

The Gulf War may have been short and the number of participants relatively low, but their exposures were high due to an incredible number of issues, which I will not enumerate at this point in time, but I can give them to you, if you like.

Testing by the Department of Defense from January to April 2007 discovered 16 polycyclic aromatic hydrocarbons. I do not know what the hell they are, but it sounds really bad.

[Laughter.]

Mr. ROWAN. Fifteen volatile organic compounds as well as 17 dioxins and furans. As usual, it took the VA a long time to acknowledge that Gulf War veterans were not lying or malingering before they finally approved health care and compensation, and we are still fighting some of those issues.

Then came the post-9/11 wars. Besides being exposed to the substances noted earlier, the military decided it would be a great idea to burn their used equipment and other items in giant burn pits that have been burning for decades now. The toxic exposure from this misadventure is too numerous to mention.

While we may understand that there may be hazards related to military service in war zones, what disturbs us now is the realization that our military and their families may be subject to serious toxic exposures here at home and at bases overseas.

The toxic water identified at the Marine base in Camp Lejeune, unfortunately, was just the tip of iceberg. We now have seen story after story about polluted waters of various air bases now affecting the adjoining civilian communities.

The State of New Mexico fined the Air Force $2.5 million for polluted runoff, and chemicals have been found at McConnell Air Base in Kansas. These identical problems have arisen in bases all around the U.S. and overseas.

The Agent Orange Act of 1991 mandated that the VA engage the Institute of Medicine, now the National Academy of medicine, to convene expert panels every 2 years to review the peer-reviewed scientific literature, hold public hearings, produce findings on levels of association on health conditions related to dioxin exposure, and publish their findings in biennial updates.

This work needs to be reauthorized for at least another decade and expanded to embrace the potential effects of exposure to toxicants of veterans of all eras. This work should also include sites in CONUS (continental United States), and overseas as necessary, resulting in a new biennial report, *Veterans and Toxic Exposures*.

We are pleased to propose legislation that will establish real registries, the Toxic Wounds Registries Act of 2020, to cover deployments when troops are likely to have been exposed to toxic hazards. This would enable the epidemiological research by linking health records and veterans' military history, coding for where they were in a particular place at a particular time, enabling veterans, no matter where they live, to work together on their health. We hope that champions from both sides of the aisle in both houses will introduce and enact the Toxic Wounds Registries Act of 2020.

Toxic exposure has killed more military veterans than any of our enemies have. Several MSOs and VSOs have come together to form

the Toxic Exposures in the American Military, TEAM, to coordinate a grassroots campaign to enact this legislation. We hope that both the House and the Senate will support this effort.

Thank you.

[The prepared statement of Mr. Rowan follows the hearing text.]

HON. MARK TAKANO, CHAIRMAN,
U.S. REPRESENTATIVE FROM CALIFORNIA

Chairman TAKANO. Thank you, Mr. Rowan.

Next, we have Felix Garcia, National Commander, Military Order of the Purple Heart of the United States of America, Incorporated. You are recognized for your opening statement, sir.

STATEMENT OF FELIX GARCIA III, NATIONAL COMMANDER, MILITARY ORDER OF THE PURPLE HEART

Mr. GARCIA. Thank you, Chairman Takano, Chairman Moran, Ranking Members, Members of the Committee, and ladies and gentlemen.

As the National Commander of the Military Order of the Purple Heart and Iraq veteran, it is an honor and privilege to appear before you today representing members of the Order. I am sure that all of you are aware that the MOPH is unique among veteran service organizations in that our membership is comprised entirely of veterans who were wounded in combat and on the battlefield in the numerous wars in which the Nation has been engaged. For the wounds they suffered, they were awarded the Purple Heart Medal.

In a sense, I believe I also sit before you here today on behalf of almost 2 million servicemen and -women, Purple Heart recipients, who either gave live or spilled their blood for our Nation and the citizens while defending the freedoms that Americans are blessed to enjoy.

My oral testimony will be brief as possible with the understanding that the full written testimony will be entered in the record.

Since its organizing in 1932, the MOPH has been and continues to be the original veterans' organization for wounded warriors. We continue to serve veterans of all wars at no cost by providing tangible benefits to those veterans and their families who require our assistance.

On behalf of the Order, I would like to thank the previous Congress for passing legislation that will forever have a positive impact on the lives of our Nation's veterans and their families. In particular, I want to thank Ranking Member Roe on the eve of his retirement for his many years of dedication to protecting the rights

of American veterans and for holding the Department of Veterans Affairs accountable to the veterans it serves.

The Order thanks the Congress for passage of the Veterans' Compensation Cost-of-Living Adjustment Act of 2019, bipartisan legislation that increases the rates of VA disability compensation, dependency compensation for surviving children and spouse, and the clothing for veterans based on rising of costs of living.

MOPH also applauds and thanks Congress for passage of the Commemorative Coin Act of the National Purple Heart Hall of Honor. The Purple Heart Hall of Honor is collocated at New Windsor, New York, the site where General Washington's army camped during the Revolutionary War and where the General first awarded the Badge of Military Merit, predecessor to the Purple heart Medal. The coin will assist the Hall of Honor to continue its efforts in commemorating the sacrifices of America's military members who were killed or wounded in combat while serving our great Nation.

The order is acutely aware of the budget negotiations and the fiscal problems facing our Nation, but they should have nothing to do with caring for those who have honorably served the Nation and now require medical attention or other benefits that they have earned by their honorable military service.

I would also like to state that MOPH supports the recommendations made by the VSOs who devote their time and effort to publish the *Independent Budget*. MOPH is a proud member of both The Military Coalition and the National Military Veterans Alliance.

Our 2020 priorities. VA processing of claims is an issue in your committees, MOPH, and other VSOs have been struggling with for many years. While there has been much progress, there remains much to be done. Congress has provided increased funding to help improve the process, which enabled VA to hire more personnel and invest in information technology and other infrastructure.

While there has been progress in the area of claims processing, the veterans who may have been fighting the process for years, especially when appealing benefit denials, does not see that progress. They just know that they have been afforded, in a timely manner, the benefits that they earned by the military service.

Congress needs to continue to hold the VA accountable for its care and service to veterans in an open and transparent manner while working with Congress and the VSOs in moving forward with new initiatives.

The Order joins with the National Military and Veterans Alliance, a nonpartisan umbrella organization of 35 veteran- and military-serving organizations, to endorse the Care for the Veteran Caregiver Act of 2020.

We urge the earliest consideration by your Committees, including legislative hearings, markup, and Committee vote.

We applaud Representatives Hudson and Rice for their sponsorship of this bill and urge you and your Committee colleagues to join as cosponsors of this bill.

While the MISSION Act made crucial changes to the Caregiver program, most importantly the expansion of the program to pre-9/11 veterans), time and again our organizations and others have brought to you the continued problems with the caregiver program, specifically the lack of consistent eligibility criteria utilized by the VA in executing the program, the constant fear of the most catastrophically disabled veterans that they will lose their access to the caregiver program, and the unreasonably short transition time provided caregivers and families after an eligible veteran passes away. We urge your time and attention to this continuing issue to bring it to fruition in this congressional year.

The order is especially proud to note that during Senator Moran's first markup as Chairman of the Senate Veterans' Affairs Committee, they passed landmark legislation to improve mental health care for veterans.

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act, sponsored by Chairman Moran and Ranking Member Jon Tester, is a comprehensive and aggressive strategy to reach more veterans with the mental health care they need. As Ranking Member Tester noted and we agree, "This comprehensive approach, combining supportive services with evidence-based clinical care through the Department of Veterans Affairs, will ensure that no veteran slips through the cracks."

The bill also would hold the VA accountable for its mental health care and suicide prevention efforts by examining how the VA manages its suicide prevention resources and how the VA provides seamless care and information sharing for veterans seeking mental health care from both the VA and community providers.

It is a recognition that the invisible wounds of war that have plagued so many veterans for so long must receive equal concern and treatment.

This concludes my testimony, and I will be pleased to answer any questions. Thank you.

[The prepared statement of Mr. Garcia follows the hearing text.]

Chairman TAKANO. Thank you, Mr. Garcia, for your testimony.

Next, we have Jan Brown, the National Commander of American Veterans. You are recognized for your opening statement.

STATEMENT OF JAN BROWN, NATIONAL COMMANDER, AMERICAN VETERANS

Ms. BROWN. Chairman Moran, Chairman Takano, and Members of the Committee, thank you for the opportunity to testify on behalf of AMVETS. We are the largest congressionally chartered veterans organization that represents all of America's veterans.

This time last year, AMVETS rang the alarm. We suggested that the VA's mental health system was fundamentally broken. Simply providing additional resources would not fix what is still horribly broken.

This concern was not easy for us to voice, and it is probably not easy for Congress to stomach. You have been more than generous, investing more than $60 billion toward veterans' suicide and mental health over the past 10 years.

With that said, Congress has been lax in providing oversight in its investment. In those 10 years, we have lost more veterans to suicide than we lost in the Vietnam War.

For over a decade, Congress has supported a policy approach that is focused on three areas: more mental health providers, more space and resources, and easier access to veterans. We have lived and died by the mantra that if we build it and encourage them to come, they will.

The facts could not plaint a bleaker reality. Most veterans drop out of VA mental health services after their first visit. We insinuate that the VA mental health is world class, second to none, yet we are not asking the question: Why are veterans running for the doors? Instead, we are blaming the victim, inferring that it is the veteran's fault that they are not staying enrolled in the programs.

In 2015, the Journal of the American Medical Association, known as JAMA, stated that the evidence-based treatments veterans are receiving are generally ineffective, and new and novel treatments are needed.

In 2018, the VA conducted its first independent evaluation with regards to VA mental health. Findings indicated no clinically significant outcomes for veterans receiving general mental health care services or PTSD treatments. In layman's terms, veterans received the treatments, and they do not feel any different.

VA reported the same in their 2019 independent evaluation.

Just this month, JAMA again released a report suggesting that the go-to evidence-based treatments for VA and DOD are ineffective for as much as two-thirds of those treated. Why has Congress not held a single hearing on these reports and research?

Let me tell you why veterans are walking out the door. They do not want to live life in VA hospitals in psychotropic fogs. VA medical centers are amazing. I refer people there all the time. However,

I would not choose to go there to get mentally healthy. For myself, physical activity of some kind—yoga, tai chi, the gym, or even meditation. Our local VA clinic in Youngstown, Ohio, has offered tai chi for a couple of years now. The only cost incurred by the VA are instructor fees, as my AMVETS post provides the space free of charge. However, this class, which is conducted only twice a week, was canceled earlier this month due to budget constraints. I worry for these veterans. I have watched them gain confidence with each session and, more importantly, connect with people in a very positive way. Where do they go now?

If we had spent $9 billion this year showing veterans how to live lives worth living, our veterans would be in a lot better position. Instead, we have built a hard-to-manage mental health conglomerate with associations and unions who put their needs first.

We need to end the madness. The death toll is the only number that matters. Regardless of billions spent, our suicide numbers have not budged an inch. Why are we so scared to try something dramatically different, not in a hospital-centered system focused on symptomatology, but rather creating a substantial investment in wellness, training, and helping veterans live lives worth living, the only real anecdote to suicide?

Along these lines, we need to address the most essential clinical thing we can do for veterans: to get them to quite smoking combustible cigarettes. AMVETS has spent years promoting smoking cessation programs. Clearly, it would be best if they stopped smoking altogether or stopped using nicotine altogether, but there is ample evidence that veterans have not quit smoking.

Over the past year, AMVETS has developed an innovative nationwide program that provides participants special access to products and incentives to try alternatives such as e-cigarettes. As a result, AMVETS has significantly reduced the number of combustible cigarettes being smoked by our members.

Over Memorial Day weekend, AMVETS will hold the world's largest 1-day motorcycle event in Washington, DC, called Rolling to Remember. We expect hundreds of thousands of Americans to stand united to raise awareness that there are still more than 80,000 American military men and women missing in action and jump-starting national conversation around the veteran suicide epidemic.

Last and of importance to me, we need to do better by our women veterans. The rate at which women veterans choose to end their own lives is twice the number as women who have never served. Part of the reason involve the unhealed and untreated scars that result from sexual assault, only to be intensified by the mishandling of investigation after the assault is reported.

The investigation into Ms. Andrea Goldstein's reported sexual assault at the D.C. VA turned into a victim-blaming fiasco. The fact remains that this exact scenario happens all too often in the military and VA facilities. Imagine instead of it being Ms. Goldstein, it is your mother, your sister, your daughter who made these claims. Would you tolerate for even a moment her character being questioned? These women who are brave enough to come forward deserve the same consideration.

Thank you for the opportunity to testify, and I welcome any questions you may have.

[Applause.]

[The prepared statement of Ms. Brown follows the hearing text.]

Chairman TAKANO. Thank you, Ms. Brown, for your testimony.

Neither the Chair nor the Ranking Members have opening statements, and in the interest of time, we are going to move straight into questions.

So, I will recognize myself for 3 minutes, and I want to direct it first to the Wounded Warrior Project. You wrote in your testimony about the importance of considering brain health alongside mental health. I found it disturbing to hear our commander in chief downplay brain injuries and TBI as, quote, "not as serious," end quote, as physical injuries received in combat.

I know many in the VSO community share my sentiments about these appalling comments because we know a Traumatic Brain Injury can affect every part of a veteran's life with severe symptoms still impacting lives years later.

Accurately diagnosing and treating TBI is essential to providing veterans with quality health care and serving their mental health needs. What do you believe to be the most pressing needs for those suffering from TBI, and how can we best support those veterans and their families?

Lt. Gen. LINNINGTON. Mr. Chairman, thanks for that question.

Indeed, Traumatic Brain Injury is a significant issue among post-9/11 veterans, and it is certainly a priority area at Wounded Warrior Project. We know that since 9/11, 400,000 veterans have diagnosed and categorized TBI, and I believe the number is much greater. In fact, many of our programs that we provide, both at our Warrior Care Network facilities and in our internal programs, our independent programs, are focused on TBI.

Continued research on the effects of Traumatic Brain Injuries long term is needed. For me, it is the tsunami that is coming along with toxic exposures as excessive brain injuries—mild, moderate, severe—that over time grow into early-onset cognitive issues, dementia, ALS, other diseases that we see coming forward now as

areas that need continued research and certainly increased investment at the VA.

Wound War Project is involved in those advocacy efforts, and we certainly support the Congress' efforts and the VA's efforts on their behalf as well.

Chairman TAKANO. I do not know that I am going to be able to get an answer, because I have run out of time.

Thank you for that, by the way.

In your testimony, Mr. Rowan, VVA highlighted toxic exposure, including burn pits and Agent Orange. I want you to know that over the Thanksgiving holiday, I led a CODEL (congressional delegation) with several Members of this Committee to Germany, Kuwait, and Afghanistan to discuss how VA can serve their needs in the future.

We experienced poor air quality firsthand in Kabul and better understand what our servicemembers are living through while deployed. I want you to know that toxic exposure is one of my top priorities for the Committee, and as we work to address it, I was going to ask you what you consider to be the most important action that we can take. But I am going to run out of time, and I want to set a good example by not taking up that time. But I just want you to know that it is our top priority. We are spending a tremendous amount of staff time and actually Committee time on this topic.

I am going to cut myself off and recognize the Chairman, Mr. Moran.

Chairman MORAN. Mr. Chairman, thank you. Thank you for recognizing me. You have set a good standard, and now I have to meet that standard in the 3 minutes. I am going to try to make, perhaps, some comments and some offers to the folks here at the table.

First of all, Mr. Weiner, I thank you for your comments about political courage. None of us can ever exhibit sufficient amount of political courage. I would tell you that when this place gets discouraging or frustrating, I will put my running shoes on, and I will walk down to the Lincoln Memorial. I will walk by the—now the World War II memorial, next the Vietnam Wall, and on my return, I will see the Korean War Memorial. And in each one of those instances, I am reminded of the service of those who are memorialized in those settings. Not one of them chose to serve for Republicans or Democrats. They served for the betterment of their families, the people they know in their hometowns, for all Americans and in many instances the world. So, I appreciate you reminding us as Members of Congress, as elected officials, perhaps as Americans that have a higher calling than what we sometimes exhibit, and I am grateful for that.

Mr. WEINER. Thank you.

Chairman MORAN. You are very welcome, sir. Thank you.

One of the things you mentioned in your testimony is that the number of veterans who commit suicide a day and the recognition that a majority of those veterans are not enrolled in VA care. I would ask all of the veteran organizations, all of us and Members of Congress, what it is that we can do more to capture those who are unaware, unwilling, uninterested.

It was pleasing to me to hear in testimony yesterday that those who are participating in VA programs are faring much better in the curtailment of suicide. And so I would leave that—I may have time to have you answer that question.

My final comment—and maybe we can come back to this—is for Mr. Rowan—Mr. Rowan, you and I have known each other a while. I distinctly remember the Vietnam Veterans having a meeting in Wichita, Kansas, a national meeting, where toxic exposure was the primary topic of conversation. What captured me that day was the recognition that while no serviceman or -woman was worried about their own circumstances, they were willing to sacrifice on behalf of their country and face harm and potential death. I cannot imagine that a single soldier was thinking about their service having a consequence on their children or their grandchildren, and that was a message that was received.

We have worked to try to get things accomplished in that regard, but I would make the case to you and to others that as we look for this generational challenge and what role the VA may now need to play in caring for our children and grandchildren, even though they did not serve, please make certain that I am fully informed and engaged to try to help in that cause.

We have made some progress in the studies. You mentioned the National Institute. We have made some progress in getting records from the Department of Defense available for more veterans, but we have a long way to go in dealing with this issue.

I see that I have consumed my 34 seconds, and I would welcome that follow-up from any and all of you. And I would welcome the follow-up about what are we missing. with all the VSO organizations, all the Members of Congress who provide casework and outreach to veterans, we are still leaving a lot of veterans untouched by the Department of Veterans Affairs.

And I thank you for the opportunity to be with you here today.

Chairman TAKANO. Thank you, Chairman Moran.

Ranking Member Roe, you are recognized for 3 minutes.

OPENING STATEMENT OF HON. PHIL ROE, M.D., RANKING MEMBER, U.S. REPRESENTATIVE FROM TENNESSEE

Dr. ROE. Thank you, Mr. Chairman, and I apologize for being late.

I do want to give a shout-out to all of you all who came here from all across the country. We appreciate you coming, and I know it is a sacrifice. It has been a privilege for me to be on this Committee for the last, now going on, 12 years.

I grew up at Fort Campbell, Kentucky, or near there—Clarksville, Tennessee—where the 101st Airborne is. My scout master, First Sergeant Thomas E. Thayer, was killed in Vietnam in 1965. Two of my classmates died there. I served in Korea in 1973 and 1974 at Camp Bradley, Camp Casey. Many of you have been there, and it really shaped where I am right now and how I view our veterans.

I saw Sergeant Thayer's family afore. I knew that family well, and they were essentially left with nothing. As a young man, a young college student, I could not fathom that, that our country would have someone, a hero of mine, die and leave that family with nothing, and that really shaped the privilege I have had for the last 11, going on 12 years to serve with many of these members here but to serve you and right some wrongs.

I want to thank the Blinded Veterans Association for your 75th anniversary.

I want to congratulate AMVETS on your 75th anniversary. I am not far behind.

[Laughter.]

Dr. ROE. And I also want to thank the Jewish War Veterans for their 125th anniversary. I hope to make that. That would be good.

I do want to talk about a couple things, the reason I ran again. One was the electronic health record. The VA is putting an expansive—and I have gone from Seattle, Tacoma, Spokane, and made several trips. It is extremely important.

Why is that important? Because toxic exposure is not going to be the last time we had troops in harm's way that get into chemicals and so forth, and I am thinking as a physician, 50 years from now, if we had that virtual electronic health record, we would be able to go back and find out are there really, not question or guess or whatever, really find out about whether these conditions affected a certain condition in your body. I think that is hugely important, and I would challenge our group to continue to do that.

Suicide is not just a VA problem; it is a national problem. And I really appreciate you bringing it up. Another reason that I wanted to serve another term was to work on that.

When I graduated from medical school in 1970, it will be 50 years this December. We had 500,000 inpatient psychiatric beds in the United States. The population has grown 40 percent. We have less than 50,000. Our jails are now our psychiatric facilities in the United States.

It is shameful, and the VA can be a leader. I really believe that. They have the resources, and I did exactly, Ms. Brown, what you did. I was sitting at a staff meeting 1 day, and I said, "How much money did we spend on mental health in 2003?" They said, "About $2.5 billion." I said, "Well, how much are we spending today?" It was $7.5 billion. I said, "What is the suicide rate?" It is the same. I said, "So, if it is the same, we have got to quit doing what we have been doing because it makes no sense whatsoever."

I appreciate you all bringing it up, and my time has expired. I just want to thank you for allowing me to serve you. I applaud you, and Tom and so many of you, which I have become good friends. I will cherish that friendship when I leave the Congress, I appreciate what you do, and I salute you.

Chairman TAKANO. Thank you, Ranking Member Roe.

Senator Boozman, you are recognized for—actually, I am sorry. Mr. Lamb. Mr. Lamb, you are recognized for 3 minutes.

HON. CONOR LAMB,
U.S. REPRESENTATIVE FROM PENNSYLVANIA

Mr. LAMB. Thank you, Mr. Chairman.

Thank you all for joining us here today and offering us these important insights.

I want to start with General Linnington, if that is OK. The Wounded Warrior Project is a partner locally in the Western Pennsylvania area with something called PAServes, which is part of the AmericaServes network of basically hub organizations that are trying to correct the problem that Dr. Roe just spoke about, which is the persistence of this suicide and mental health epidemic that we have.

The way it works in Western Pennsylvania is this large network called PAServes basically pulls together. Every type of veteran organization, Government office like a congressional office but also the sort of broader human services networks so people who deal with homelessness and employment and addiction and mental health—so that whoever touches the veteran first is able to share that and connect that veteran with every part of the network, and it has been extremely successful in just basically filling in some of these gaps and catching the people that are not seeking treatment at the VA.

I wanted to thank Wounded Warrior Project for being one of those local partners, and I did not know, General, if you had any feedback for us on the strength of that kind of community hub model, but the Chairman recently this year advanced some legislation to try to replicate that nationwide to address this epidemic.

Lt. Gen. LINNINGTON. Congressman, thank you.

Young people join the military from communities and they return from communities. Community integration efforts, like the one you just spoke about, PAServes, and there are several other across the country that we support. Those organizations are really phenomenal at really answering the question that I think all of us struggle with is how do you get veterans out of isolation and into treatment and into other activities with other veterans that help them heal and, more importantly, transition into the same leadership roles they had in civilian life that they had when they were in the military, and really, isolation is the killer.

When veterans go back home, if they do not have organizations like PAServes and others—and the AmericaServes network to connect with them, then you cannot get access to the rest of the programs and services. That is why we are proud.

Mr. LAMB. Yeah.

Lt. Gen. LINNINGTON. We have 7,500 events a year just to connect veterans with each other and then provide them the access to the mental health, physical health, wellness, and other programs we provide, but also do it in concert with Government programs like the VA and others that help them heal.

Mr. LAMB. Well, that is a great role that you play, and I thank you for doing it.

We are, through the Chairman's legislation and this Committee as a whole, trying to find the solutions to go out and get these people, and you are really helping us with that.

Ms. Brown, I just wanted to say I was distressed to hear that example about the tai chi at your post because your congressman for that post, Tim Ryan, and I have both been working hard on trying to expand opportunities like that with VA funding.

I know last year, as a member of the Appropriations Committee, he got more money in the whole health bucket than we had had before, but obviously, it is not going far enough if there is demand for that program and it is not being met.

Go ahead, Ms. Brown.

Ms. BROWN. I was just going to say that I just recently found out that it comes out of the physical therapy budget, which I think if it was moved over to mental health, it would probably have a little better staying power.

Mr. LAMB. Yeah. We need whole health to have its own budget is the answer, and we are working on that.

Ms. BROWN. Thank you.

Mr. LAMB. Mr. Chairman, I yield back. Thank you.

Chairman TAKANO. Thank you, Mr. Lamb.

Senator Boozman, you are recognized for 3 minutes.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman, and thank all of you all for being here and all you represent.

The Committees on both sides, we hear a lot about the partisanship up here, but the Committees in the House and the Senate, I have had the privilege of serving on both of them. They really do work together very, very well.

We have gotten a lot done the last several years. We could not have gotten it done, though, without your advocacy, and so, again, thank you very much.

I want to talk about, well, first of all, myself and Senator Warner introduced the Improve Well-Being for Veterans Act, which was included in the Moran-Tester John Scott Hannon Veterans Mental Health Care Improvement Act, and what this legislation does, the part that we were trying to do, is really get at the heart of what Ms. Brown was talking about.

We insisted that we have metrics for the things that we are doing. As was pointed out by Dr. Roe and others, we are spending a ton of money, a ton of increased money, but we are not getting the results that we would like.

We were just talking. Why is the AMA—why are they doing studies? Why do not we have the information that we need in the VA? Why are not those studies already done? Why are not the metrics there? They simply are not, and so we are demanding that, again, we are going to spend the money. The money is not the problem, but we are going to insist that if we spend the money, where is it going? Are the programs effective? Are they doing the job? The ones that are, we need to double-down on. That ones that are not, we need to get rid of.

We also have the problem that most of the people, the vast majority of the people that are committing suicide, are not involved with the VA. How do we reach them? How do we get the community involved? We want to do that. We want a grant process to get those people involved, again, with programs that are working.

I would like to ask General Linnington, how do we reach those 14? Six are involved somewhere in the VA. Sometimes the programs are working; sometimes they are not. At least they are in-

volved in something. How do we reach those who are outside of the system altogether?

Lt. Gen. LINNINGTON. Senator, I think you hit the nail right on the head. Providing support to community programs that reach veterans that are not getting the care or those in rural areas, that is another tough challenge, frankly.

Senator BOOZMAN. Exactly.

Lt. Gen. LINNINGTON. How do we reach veterans that are not in the VA system or are not getting care but have communities of veterans around them?

We strongly support the Commander John Scott Hannon Veterans Mental Health Care Improvement Act and the provisions of that for providing grants program to nonprofits and community-based programs that work. Again, they have to work.

Senator BOOZMAN. Exactly.

Lt. Gen. LINNINGTON. You cannot just give money to anybody. You need the metrics behind them to show that their programming works, and we do that from our 25 hubs. We also do it through grants program to other nonprofits that extend our reach.

Just as we extend our reach, the VA can extend their reach through communities.

Senator BOOZMAN. Very good.

Well, again, my time has run out. We do appreciate you, and as always, we appreciate the auxiliaries that help you. They do all the work. We know that.

A special thanks to Tom and his organization. I have had the opportunity as an optometrist, an eye doctor. I like to be known as an eye doctor. That is a respected profession as opposed to where we are at here. But, anyway, we just thank you for all that you have done and your organization. Appreciate you.

Chairman TAKANO. I am going to recognize Mr. Bost for 3 minutes.

HON. MIKE BOST, U.S. REPRESENTATIVE FROM ILLINOIS

Mr. BOST. Thank you, Mr. Chairman.

Let me follow up on that by saying thank you to each one of you. Thank you for the time that you have served in our military, whichever branch you served in, but also for your service now.

People on the street, I do not think understand how important our VSOs are to keeping us informed and how important it is, the jobs that you do.

I had a list of questions, and we are on very short time. But I am going to go to the one that I feel like is vitally important. It took us forever to finally notice and get the Blue Water Navy taken care of, and I want to thank a lot of people on this panel that were

involved with that, whether it is the Chairman or the Ranking Member and everybody in the Senate that worked on this.

As we know, we are starting to roll that system out, and people are beginning to receive benefits, are getting calls that they should start getting their paperwork together to receive benefits. How and what input have you received already from your members? I am asking this to the whole panel or any one of you. As the progress is going along, what are you hearing from your members that for years have been showing the signs of exposure, but yet now they are finally being reached out to? Are they being reached out to fast enough? Probably not, but go ahead.

Mr. HILGERT. Yes, Senator. John Hilgert, State Director of Nebraska. I am President of NASDVA.

We anticipated and we actually started processing as soon as possible claims for the Blue Water Navy. We appreciate those veteran service officers, whether it be VSOs or State employees, that had made the claims, knowing that they were going to be denied, to build that body of knowledge up and to force that pressure to someday recognize that as a presumptive condition.

It has been happening very, very favorably. The States—and I know working with the counties—are in a great position to reach out to those veterans who have been waiting, then identifying Vietnam veterans, and to making sure that we are there for them.

Our resources are small, generally speaking, throughout the country, but I could say that it is very brisk. And we are reaching out, and it is a fairly brisk system right now. We are making those claims, Senator. Thank you.

Mr. BOST. Thank you.

Anyone else?

Mr. ROWAN. One of the concerns that we have is reaching out to the widows. It is one thing to talk to a live veteran. It is another to talk to the widow of a veteran who died many years ago from a cancer that was related to Agent Orange and had no clue they were ever eligible for anything and do not know now they are eligible now to recoup some of that money. So, we really need to figure out how we can reach out to them and try to work with groups like maybe AARP.

I mean, I hate to say it. The doctor was talking about coming up on his 75th anniversary. I am not far behind myself.

The problem is most of these widows are now in places like AARP or other senior citizen-related organizations, and we need to get them involved in doing the outreach.

Mr. BOST. Thank you.

Maybe that is a direction we can go. I appreciate that, and it is important information from you all to allow us the opportunity to see where we are falling short.

With that, Mr. Chairman, I yield back.

Chairman TAKANO. Thank you, Mr. Bost.

Mr. Cisneros, you are recognized for 3 minutes.

HON. GIL CISNEROS, U.S. REPRESENTATIVE FROM CALIFORNIA

Mr. CISNEROS. Thank you, Mr. Chairman, and I want to thank all of you for being here today and for all the work that you are doing to support our veterans throughout the country.

Ensuring servicemembers receive the most adequate care and knowledge possible when transitioning from active service to civilian life is of the utmost importance to me, and that is why I started with my colleague, General Bergman, the Military Transition Assistance Pathway Caucus, a bipartisan group of representatives dedicated to supporting and advocating on behalf of military servicemembers returning to civilian life, especially in addressing gaps in care when a servicemember transitions, including the unique barriers women servicemembers face, and honoring the service of our Nation's military retirees and their families.

So, Mr. Hilgert, I want to ask you, what unique experiences have you come across that State veterans administrations have in getting that information to our servicemembers when they are attending a TAP class, so that they know what specifically is going on in their State and how it varies from State to State? Is there a State out there that has a model that we can follow?

Mr. HILGERT. Our experience in Nebraska and the association, I think that many States do provide support for different TAP and out-processing opportunities.

One of the things that we do—and I think it is available to all the States—is the home of record, that DD–214 or the information now, is transferred to the State.

What we do in Nebraska is we have a team that when we receive that, we send a welcome home letter and, frankly, a welcome home picnic that the Governor hosts for all of our returning veterans, but we look to see who is employed, if they have a Nebraska ID, have they paid taxes. If they have not paid taxes and they have a Nebraska ID, then we have a Tiger Team that goes and does the outreach to say, "OK. What is your situation? Are you taking advantage of educational opportunities?" That would be an explanation. If they are not paying taxes, they are unemployed, "Let us get you a job." So, we have that outreach component, and we try to use, as that information comes in. I believe other States do that as well.

Mr. CISNEROS. Well, look, I applaud the efforts of Nebraska, and I hope this is something that other States can learn because I know all these different States have different benefits for each veteran when they return home. And we want to make sure that they have the knowledge when they settle in that State, what those benefits are going to be. It is important that we get our veterans that knowledge to know what are their benefits.

Mr. HILGERT. The better handoff from the Department of Defense to our State Departments of Veterans Affairs, the better that we can position ourselves to serve those returning veterans.

Mr. CISNEROS. Yeah. I could not agree more with that statement right there, and that is something that we are working on. And I am going to continue work on while I am serving in this Congress.

But thank you all again for being here, and, Mr. Chairman, I yield back.

Chairman TAKANO. Thank you, Mr. Cisneros.

General Bergman, you are recognized for 3 minutes.

HON. JACK BERGMAN, U.S. REPRESENTATIVE FROM MICHIGAN

Mr. BERGMAN. Thank you, Mr. Chairman.

As I look around the room, I see centuries of honorable service. That is everybody way in the back all the way to the front here, and I thank you for all of that because we are the land of the free because are the home of the brave. And you are the bravest, and you continue to step up. Here in Congress, we are stepping up with you.

In fact, Senator Boozman talked about the Improve Wellbeing for Veterans Act, which he introduced in the Senate. I introduced it in the House, and amended language from this bill is now included in Senate 785, which has passed the Senate Veterans' Affairs Committee last month. But it deals with veteran suicide and how do we outreach to those, 70 percent of those veterans, who are outside the VA health care system. We could pour money in that chute all day long and never reach the intended target.

I would like to hear from you, whoever wants to make a comment. What impact would you like to see these grants have for veterans specifically living in rural and remote areas? Not urban and suburban. It is kind of a different metric when it comes to the outreach, but rural and suburban. What can we as Congress do today about the urgency that we should pass legislation preventing veteran suicide, eliminating the issue? Anybody want to make a comment?

Lt. Gen. LINNINGTON. General Bergman, the intent of the bill, I think, is right on. It is finding veterans that are not getting access

to care or are not getting involved in care and get them engaged, especially veterans suffering with invisible wounds—PTSD, Traumatic Brain Injury, other injuries.

Pride is a dangerous thing. If you break your leg or if you have an injury that needs treatment immediately, you will go get treated, but for those that are suffering in silence, sometimes it takes a community-based approach that you have authored to get them engaged and involved.

Providing grant money to community programs that make a difference that can expand existing programs and create new programs, I think, is really the process that will get after the 14 out of 20. I think it is 14 out of 20 that are not engaged in the VA.

Mr. BERGMAN. It is. Thank you.

Anybody else?

Mr. Rowan?

Mr. ROWAN. Yes. Thank you, Congressman.

Our biggest concern, I think, is the fact that many of the people that we have out there try to reach out to the VA and often find they do not get a response.

Mr. BERGMAN. But let us say, again—I want to focus on the rural and remote areas——

Mr. ROWAN. Yeah. I am talking about rural.

Mr. BERGMAN [continuing]. Because it is a different scenario, if you will.

Mr. ROWAN. Yep. Yeah. First of all, we go back to Vietnam veterans. We used to have something called "trip-wire vets."

Mr. BERGMAN. Mm-hmm.

Mr. ROWAN. I was very familiar with them up in Saranac, NY, which is as rural as you can get, and we had guys living out in the woods when they came home. Unfortunately, many of them did not last very long out in those woods.

The problem is that when they try to reach out to the outpatient clinics that are out there——

Mr. BERGMAN. So, but the point is——

Mr. ROWAN [continuing]. That are in the area.

Mr. BERGMAN [continuing]. If it is not working, do we have to do something different, if what we are trying is not working?

Mr. ROWAN. No.

Mr. BERGMAN. Anyway, I can see that I am over my time, but the point is that is the idea behind the IMPROVE Act. If what we are doing is not working, let us stop doing it.

Mr. ROWAN. Right.

Mr. BERGMAN. If, for whatever reason, the outreach is such in some cases where in remote—in the woods, they did not have telephones, did they?

Mr. ROWAN. They did not have anything.

Mr. BERGMAN. Still do not.

But, anyway, Mr. Chairman, thank you for the opportunity, and I yield back.

Chairman TAKANO. Thank you, General Bergman.

Mr. Levin, you are recognized for 3 minutes.

HON. MIKE LEVIN, U.S. REPRESENTATIVE FROM CALIFORNIA

Mr. LEVIN. Thank you, Mr. Chairman, for bringing our Committees together. Thank you for all of our great veterans service organizations.

I have the opportunity to represent Marine Corps Base Camp Pendleton, so a special welcome to all of our Marines and all of our Californians who are here as well.

I have noted that much of today's testimony focused on mental health and on suicide, which I know are priorities for both of our Committees. I am Chair of the Economic Opportunity Subcommittee. I have been committed to addressing the economic factors that contribute to suicide, and in fact, strengthening economic supports is one of the Centers for Disease Control and Prevention's seven core strategies for suicide prevention.

We owe it to those who have served to ensure that they have everything they need to pursue educational opportunities, launch new careers, or start their own businesses.

That requires us to equip servicemembers for the challenges and opportunities they will face as they transition from active-duty military service to civilian life.

In May, the House passed my legislation that I did with my friend from Texas, Jodey Arrington, the Navy SEAL Chief Petty Officer Bill Mulder Transition Improvement Act, which would do just that. It would not interfere with recent changes to the TAP program. Rather, it would examine these changes and improve overall transition supports by providing the VA and DOL with employment data, extending a pilot program for off-base transition training and creating a grant program for coordinated transition assistance services.

Lieutenant General Linnington, can you speak to the importance of a smooth transition for the population you serve?

Lt. Gen. LINNINGTON. Congressman, yes, and thank you for the legislation.

We all know that if you—success as a veteran starts while you are still in uniform and still part of DOD. So, anything we can do certainly to improve the existing TAP program and provide the opportunity starting a year out as the new TAP program continues to support smooth transition from uniformed service to service on

the other side as a veteran is key. We support the legislation. Thank you for authoring it.

Certainly, the ability to start the training a year out prior to you arriving at home and trying to figure out what you are going to do is key to success for a smooth transition.

I will also tell you that for many of our veterans, economic empowerment, jobs, are a great preventative factor for mental health crises. It does not replace it, certainly, but it is a great preventative factor for suicide. If you have a job that you go to every day, you are interacting with other people in the workplace, and you have a self-worth that coincides with the worth you had when you were in uniform.

Mr. LEVIN. I appreciate that very much. I am out of time, but I thank you for your support of that legislation, and it is truly bipartisan, as is much of our work here for veterans.

We are truly grateful to all of you for being here today. I look forward to working with you for a long time to come.

Thanks again. I yield back.

Chairman TAKANO. Thank you, Mr. Levin.

Senator Tillis, you are recognized for 3 minutes.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chairman and Ranking Member Roe.

For my colleagues, we all come here. I look forward to these meetings every year to hear from you all. I want to thank you for your service. I want to talk a little bit about what more we can do.

General Linnington, you said isolation is the killer, and I agree when we are talking about veteran suicide. We have got to figure out more ways to cast a wider net.

I think one of the ways we do that is look at a simple—I think it is a simple policy change where instead of someone transitioning having to opt in to services, that they have to opt out, assume that they need the benefits, assume they need the connectivity. Just think about how many more we would be able to touch just by doing something as straightforward as that.

I also think that the Department has made a lot of headway by presuming that they are entitled to mental health benefits, regardless of the status of their discharge. I mean, if you go back and take a look at the number of people who are sadly taking their lives, they are not connected in any way to the VA. They are not connected to the community, and I want to thank you all for making that connection. But we have got to cast a wider net.

I also want to talk about the electronic health record. That is something that my office has taken a particular interest in. You all

may know that Secretary Wilkie was my MLA for 3 years before he went over to the Department of Veterans Affairs. I have got a lot of confidence in Secretary Wilkie, with his leadership and being successful with the execution of the electronic health record, but we have got to look far beyond just the baseline standard platform if we are going to do what we want to do for the veterans.

We have got to make sure that no matter where that veteran goes for health care, whether it is in a brick-and-mortar VA facility, a non-VA provider, a choice provider, that I want every aspect of that veteran's health record to be available anytime they are receiving care.

Thanks to Senator Isakson and now Senator Moran, I meet with the Department along with Ranking Member Tester about every 6 or 8 weeks to keep track of that electronic health record. Very interested in your all's input in that.

The baseline system is one thing, but it is that other technology that is going to be implemented that I think is going to be the game changer.

Then, finally, in 3 minutes, we cannot get to many questions, but I do want to tell you all that my office is wide open to sit down and meet with any of you on your suggestions, your experience, after we get the implementation up in the Northwest VISN and then we implement it across the country.

But I am also interested in your input and my capacity as the Chair of the Personnel Subcommittee on Senate Armed Services. I think we got to get smarter with TAP. We have got to get to a point where we basically have a TAP audience of one. We are looking at the unique needs and the history of that man or woman who is about to transition out of active or reserve status into veteran status, and we need to tailor things that are specific to that man or woman's need. And I think when we do that, we will reduce the isolation. We will save a lot of lives, and we will do right by the veterans that we owe a debt of gratitude.

Thank you all for being here, and make sure you know that anytime you want a meeting in my office, consider it done. It is just a matter of when you want to be there. Thank you all. God bless you, and thank you for your service.

Chairman TAKANO. Thank you, Senator Tillis.

Representative Underwood, you are recognized for 3 minutes.

HON. LAUREN UNDERWOOD, U.S. REPRESENTATIVE FROM ILLINOIS

Ms. UNDERWOOD. Thank you, Mr. Chairman, and thank you to all of our witnesses for being here today.

My questions are for Lieutenant General Linnington. I also want to recognize the work that you do and your staff has done with my office over the last year to address the unique needs of moms who served.

As we know, there is still far too much that we do not know about these moms and what they and their families need, and so my first question is about the gaps that you see in VA's benefits and services for women veterans, particularly when it comes to reproductive and maternal health care.

Lt. Gen. LINNINGTON. Congresswoman, thank you, and we have enjoyed working with your office on your legislation, Protecting Moms Who Serve Act, and really as we serve women veterans. In fact, several of them here are with me today.

Ms. UNDERWOOD. Awesome.

Lt. Gen. LINNINGTON. I know they met with you and your team yesterday. Thank you for that as well.

We know that there are still gaps in VA services for women, moms especially, maternity services and reproductive health issues. We appreciate the fact that the VA provides quality care, but there are still gaps, both at the medical centers and certainly the regional offices for women that want to get support. They are not all covered. So, we look forward to working with you in the coming months to fill those gaps and especially address the needs of women veterans with mental health concerns also, especially as that has to do with MST, reproductive health, and maternity needs.

Ms. UNDERWOOD. Thank you. Then, can you discuss how the VA's maternity care coordinators and the services that they provide benefit women veterans?

Lt. Gen. LINNINGTON. Yeah. By the way, that is a great initiative, and we appreciate them putting those programs in place, both at the medical centers and also at the regional offices.

Our veterans participate with that. It is kind of a good news/bad news. I mean, some are better than others, obviously. There are still gaps.

Ms. UNDERWOOD. Right.

Lt. Gen. LINNINGTON. I think you know that there are some vacancies in some of the providers. There are vacancies across VA that we like to see filled. We would like to see those vacancies prioritized and give access to those jobs to women veterans that are transitioning. Who better to serve those jobs than veterans that have walked in the shoes of those they will be serving?

Ms. UNDERWOOD. OK. Well, thank you again. I am really looking forward to working with you to get this legislation through the House and here over to the Senate so we can get it signed into law.

Lt. Gen. LINNINGTON. Yes, ma'am.

Ms. UNDERWOOD. Thank you all so much. I yield back.

Chairman TAKANO. Thank you, Representative Underwood.

That concludes the questioning—all right, 3 minutes, brother.

[Laughter.]

Mr. ROY. Everybody was thinking I am out.

Chairman TAKANO. OK. Mr. Roy, 3 minutes.

HON. CHIP ROY, U.S. REPRESENTATIVE FROM TEXAS

Mr. ROY. Well, first of all, I apologize for being late. Multiple hearings at the same time and votes on the floor over in the House. I appreciate you all being here.

Let me just say, personally, I just want to thank any Texans in the house and appreciate those. I am proud to represent Texas 21. We have got almost 80,000 veterans and represent Fort Sam Houston and Army Futures Command. I just appreciate everybody here who has served their country, and I appreciate the opportunity to hear from you all.

I do not want to repeat too many questions that have already been asked, and obviously, I am just walking in here a little bit. I do not know, Mr. Roe, if you have got any direction of anything that has already been covered. I can ask a little bit about budget or health care things. Is there anything that has not been covered that needs to be covered, you all?

[No response.]

Mr. ROY. No? All right. Well, look, I am just going to say thank you all for being here. I just appreciate your time, and sorry I am coming here at the tail end. I just do not want ask you to repeat things that have already been said. So, thank you all.

Chairman TAKANO. Thank you, Mr. Roy.

Well, I want to thank everyone here for their testimony. I am sorry that I had to miss much of it, but the Committee has taken your official testimony. We have it as part of our record. We were on the floor voting.

I do look forward to working with all of your organizations and your members in the future.

All members will have 5 legislative days to revise and extend their remarks and include extraneous material.

Again, thank you for your presentations. This hearing is now adjourned.

[Whereupon, at 3:48 p.m., the joint hearing was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. KEVIN CRAMER TO JAN BROWN, NATIONAL COMMANDER, AMVETS

Question 1. In your testimony you discussed how many "evidenced based" approaches to mental health care do not produce the intended results for veterans.

You stated, "Of all that, most striking, and also most concerning to us is seemingly the intent of doubling down on 'evidence-based' approaches that have been shown on at least five occasions to be failing most veterans, most of the time. How are we ever going to get a handle on this problem if we are spending more than 90% of our resources on approaches that fail most veterans, most of the time?"

In your view, how can the VA better care for veterans who may not respond to traditional mental health treatments? Why is the Department of Veterans Affairs (VA) slow to adopt new and promising treatments, such as Hyperbaric Oxygen Therapy?

Response. Thank you for the question regarding our recent testimony presented to the House and Senate Committees on Veterans' Affairs. In our testimony, we blatantly pointed out the flawed approach the Department of Veterans Affairs (V.A.) is taking to solve the mental health crisis that is facing our Nation's veterans. Multiple independent reviews have shown that V.A. mental health services are not showing promising results for most veterans most of the time. In the 2018 and 2019 Clay Hunt SAV Act assessments, V.A. reported that veterans receiving General Mental Health treatment and PTSD Specialty treatment resulted in no clinically significant outcomes as a result of their treatment. The Journal of the American Medical Association (JAMA) reported that the psychotherapy approaches considered by the Department of Veterans Affairs and Defense to be front-line treatments for military-related PTSD don't work for up to two-thirds of patients. There were two additional JAMA reports, in 2015 and 2017, whereby they highlighted the need for new and novel treatments.

AMVETS has three specific calls to action that will allow V.A. to better care for veterans who may not respond to traditional mental health treatments.

First, we call on Congress. It is Congress's duty to oversee the V.A.'s implementation of policy and their budget. For a mental health budget as large as $9 billion, Congress has not provided the appropriate oversight. AMVETS recommends that both HVAC and SVAC hold a joint hearing that includes the authors of the JAMA reports and the Clay Hunt SAV Act as well as individuals who have provided evidence for alternative models being useful in the nonprofit space. If we don't fully embrace and understand what is working well, what is not working, and what is partially working, we will be unable to start charting effective models moving forward. More voices should be at the table, particularly those that are doing great work in the community and those that are sounding the alarms in regard to our current approach.

Second, AMVETS recommends spending the totality of the proposed budget increase for V.A. mental health on a VA/DOD Mental Health Center for Innovation. This $683 million investment should not be used as additional funding for approaches that fail most veterans, most of the time, or for increasing access to those treatments. We should use this funding as an investment to incubate, test, and scale approaches that are proving to be effective. The majority of this funding should be allocated to fund alternative, novel, and non-pharmacological approaches such as Post Traumatic Growth, recreational therapy, yoga, and others that V.A. has not fully embraced, tried or tested. Portions of the funding should be allocated for providing contracts for services to non-profit community providers who have been active in serving veterans. Some of this funding should also go toward creating long term studies on the effectiveness of these approaches. We need to get out of the business of Randomized Clinical Trials (RCTs) as a holy grail of "Evidence-Based" research. The reality is that the approaches we are using are not sufficient; the research and death toll state the same.

Third, AMVETS encourages Congress to enact S. 785. While this effort does little to drastically change V.A.'s status quo of the $9.4 billion being spent on efforts that don't work up to 2/3's of the time, it is a step forward in that it would provide some funding to innovative programs in the community while also creating pilots for new approaches. With that said, if these investments do not grow significantly, we don't see them having a dramatic effect on the 6,000 veterans, and maybe more at this point, we are losing every year. A more significant portion of the Mental Health Budget needs to be spent on creating a bulwark and access to non-pharmacological, non-traditional approaches within V.A. and DOD, and within the communities in which veterans reside.

Last, with regard to Hyperbaric Oxygen Therapy, we have not seen any data of significance that would suggest this is leading to increased quality of life for veterans. What we are seeing are many veterans who are preferring non-clinical, non-pharmacological approaches to helping them live lives worth living. We need to move away from the idea that specific medical interventions or wonder drugs are going to solve this issue for us. Examples of non-medical interventions that have shown promise include Post Traumatic Growth interventions, meditation, yoga, out-

door therapy amongst others. If Hyperbaric Oxygen Therapy can be shown to increase veteran's quality of life, not simply reduce symptomology in a short RCT, AMVETS would consider supporting such an approach. However, most medical interventions rely on RCT's to show their efficacy in short durations (usually 12 weeks). What we have seen with most evidence-based approaches, and other medical interventions supported by RCT's, are short reductions in symptomology but no long-term changes in reduced symptomology or increases in veteran's quality of life.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. KYRSTEN SINEMA TO JOHN HILGERT, PRESIDENT, NATIONAL ASSOCIATION STATE DIRECTORS OF VETERANS AFFAIRS

Question 1. The State Directors of Veterans Affairs (SDVAs) provides critical services that ensure veterans can access the services and benefits they've earned. In your testimony, you highlighted the important role of the family in the veteran's experience and recovery. I agree with you and this is the reason I introduced S. 2864, the Somers Veterans Network of Support Act to implement a program that provides information to loved ones about VA programs and services so family members and friends can better support veterans. What information is most critical to share with families and loved ones so they can best support the veteran? How should SDVAs be engaged to help ensure the success of the veteran during their transition and network of support program as it is implemented?

Response. S. 2864,[1] the Somers Veterans Network of Support Act, appears to be an innovative and reasonable pilot program to increase information sharing between the Department of Veterans Affairs and designated relatives and friends of the veteran. At the State level, we share this information through various means and a myriad of partners. When called for we can use release forms in order to work with family unit and the non-veteran members in order insure access to the benefits available.

The information most critical to share with families and loved ones is dependent upon the unique needs of the individual veteran. That said, accurate claims filing and transition assistance information, is probably the most critical information set. The quality of the "input" directly correlates to the quality of the "outcome" for the veteran.

Many SDVAs are already positioned to engage to help ensure the success of the veteran during their transition and within their network of support program as it is implemented.

Question 2. Caregivers are a critical part of the veteran care team. They play a significant role in supporting the veteran and the VA healthcare system, yet. I often hear from caregivers that they feel excluded from their veterans' VA health care team and are frustrated they are left out of the conversation. As VA implements the expansion of the Caregiver Support Program under the MISSION Act, what should it do to ensure a more holistic, inclusive support program for caregivers? How can VA improve its policies and procedures to ensure that veteran caregivers are better integrated into the patient care team?

Response. The VA Caregiver Support Program under the MISSION Act expands access to the Program of Comprehensive Assistance for Family Caregivers.[2] From the State perspective, the Caregiver Support Program (CSP) has yet, as of March 2020, to be fully expanded. It is our understanding the CSP could be expanded as early as the summer of 2020.[3]

Question 3. In Arizona, we are working with state and local officials to help address challenges with recruiting landlords to accept VASH vouchers because of the challenges of cost of living, something you outlined in your testimony. Beyond your recommendation to tie vouchers to local markets, are there other best practices that you have seen to effectively recruit and retain landlords to accept these vouchers?

Response. Use the SDVAs as a resource to work with local communities and developers to recruit and retain landlords to accept these vouchers. Also, recognizing that sometimes the market moves faster than the cost of living adjustment process permits, consider engaging the cognizant State Investment Finance Authority. On occasion, a State investment finance authority can create the right incentives to recruit and retain landlords.

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[1] S. 2864, the Somers Veterans Network of Support Act. (Feb 5, 2020). Available: https://www.Congress.gov/116/bills/s2864/BILLS-116s2864rs.pdf

[2] See USDVA, Support for Caregivers. Available: https://www.caregiver.va.gov/

[3] See USDVA, Caregiver Support Program FAQ. Available: https://www.caregiver.va.gov/docs/Caregiver-Support-Program-FAQ_10172019.pdf#

Question 4. Your testimony speaks at length to the importance of providing long-term care for veterans, which includes support through State Veterans Homes, Community Living centers and VA community contract nursing homes. VA also has a Medical Foster Home program to allow more veterans who can no longer live independently to choose to live in the private homes of VA-approved caregivers. I am working with Senator Blackburn to introduce a Senate companion to this legislation that would expand this program. This is yet another option for long-term care for our veterans and could be a welcome alternative to entering into a traditional nursing home. Could you speak to the importance of providing long-term care options that provide quality care to older veterans and the importance of these programs in maintaining their dignity?

Response. Long-term care options are critical to the health and wellbeing of our veterans and their families. Each veteran is unique in their needs and industry trends suggest more "at home" or "assisted living" care may be a welcome and cost-effective alternative to traditional nursing home care. NASDVA would welcome the opportunity to work in consultation with this Committee and the USDVA in the development of any legislation which expands options for the long-term care of our veterans.

Question 5. In your testimony, you mentioned the importance of ensuring VHA has the resources to recruit and retain staff. Since Fiscal Year 2011, the VA Office of the Inspector General has listed Human Resources Management in the top 10 non-clinical occupational shortage areas across VHA. How does this shortage impact VA's ability to provide timely, quality care to veterans? Do you have suggestions for Congress to address this shortage, and other personnel challenges at the VA?

Response. NASDVA does not have visibility into the impact of any potential shortage in the Human Resources occupation at USDVA. At the State level, SDVAs tend to have constrained budgets. For example, in Nebraska, our State constitution requires a balanced budget. This financial pressure tends to lead toward an effective, efficient, and veteran focused SDVA.

Regarding other personnel challenges at the VA, NASDVA cannot ignore the fundament tenants of leadership. NASDVA recommends creating trust and shared purpose within the various teams serving our veterans. No one organization can do it all alone. Teams both inside and outside the USDVA must work together. SDVAs are a resource.

Question 6. Finally, I want to thank you for your recommendation to consider making Federal funding available to States to assist with efforts on the ground to support disability compensation claims and expedite new and existing claims. The State Service Officers play an important role in supporting veterans seeking the care and benefits they have earned, and they are a valuable resource and in high demand. What recommendations do you have regarding how such a funding structure could be made available?

Response. Block grants to meet a clearly desired and intended outcome. Metrics and measures are essential to the effective and efficient execution of national policy. However, the use of block grants provide flexibility to integrate with State funds, minimize Federal overhead and use the expertise of the several states to achieve the desired goals of the policy. Assign us the mission. Designate the objective and by providing the resources to empower several states to use their expertise, training, and ingenuity to fulfill the said objectives. The end goal should be the same. The manner in which it is achieved may differ due to the differences and unique situations encountered. The States are well positioned to be accomplish much is clearly lead and properly provisioned.

[Prepared Statements of VSOs begin on the next page.]

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WOUNDED WARRIOR PROJECT®

WOUNDED WARRIOR PROJECT

STATEMENT OF
LT. GEN. MICHAEL S. LINNINGTON (RET.)
CHIEF EXECUTIVE OFFICER

ON

WOUNDED WARRIOR PROJECT'S 2020 LEGISLATIVE PRIORITIES

FEBRUARY 26, 2020

Chairmen Moran and Takano, Ranking Members Tester and Roe, members of the Senate and House Committees on Veterans' Affairs – thank you for inviting Wounded Warrior Project (WWP) to submit the following written statement that highlights our legislative priorities for 2020. Your leadership and support over the remainder of the 116th Congress will be necessary to address the needs of veterans and those who support them, and WWP is pleased to be your partner in identifying challenges, developing solutions, and advocating for swift, sustainable, and positive impacts in the communities we serve.

Wounded Warrior Project's mission is to connect, serve, and empower our nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are meeting our mission through life-changing programming, public policy advocacy, and partnership with like-minded organizations that are helping us fill critical gaps where government services leave off. Since our founding in 2003, WWP has grown from a small, volunteer-led program to an organization with over 700 employees across the country delivering more than a dozen free programs and services that promote mental, physical, and financial health and well-being. In 2019 alone, WWP:

- Managed the delivery of over 220,000 hours of effective in-home and community-based services to severely wounded veterans and caregivers;
- Provided over 72,000 hours of clinical care to warriors through our Warrior Care Network partners and alongside Department of Veterans Affairs (VA) staff;
- Led more than 2,500 participants in our 12-week adventure-based mental health program, Project Odyssey;
- Delivered over 16,900 career counseling services to warriors, including resumé review, interview preparation, and networking opportunities;
- Placed over 14,500 emotional support calls to warriors and family members;
- Hosted over 7,500 events across the country, providing vital connection between warriors, their peers, and communities; and

- Facilitated over 800 hours of warrior-only peer support group meetings led by 149 WWP-trained volunteer warrior leaders.[1]

Opportunities like these – and many more – are currently offered to more than 138,000 warriors and 35,000 of their family support members. Since the start of the 116th Congress, more than 17,000 new warriors have registered for our programs and services, and we continue to register nearly 50 warriors each day. This evidence strongly indicates a growing demand for a 360-degree model of care and support focused on connection, independence, and mental, physical, and financial wellness.

Meeting that demand requires more resources than any one organization or federal agency can provide alone, which is why WWP is committed in spirit and action to partnering with others who share our vision to transform the way America's veterans are empowered, employed, and engaged in their communities. WWP's external grants program is dedicated to being a multiplying force in the community by funding innovative solutions that address the most pressing challenges veterans and their families face. WWP serves as catalyst for enduring impact through effective and deliberate partnerships across the country. We consider the community stronger when we can scale organizational impact, fill gaps in direct programming, expand networks of support, and advance collective impact through grantmaking. Since 2012, WWP has invested more than $226 million in 176 best-in class organizations. In 2019 alone, WWP granted more than $43 million dollars to 41 nonprofit organizations – many within your states and districts – addressing a myriad of needs to include homelessness, community integration, post-traumatic growth, and caregiver support.

Based on thousands of programming engagements with warriors, new and enduring partnerships with other non-profit organizations, and results from the largest, most statistically relevant survey of post-9/11 veterans in the country, WWP is uniquely positioned and informed to advocate for the needs of the community we serve. In this context, we have identified six priority issues that will guide our actions over the remainder of the 116th Congress:

1. **Mental Health & Suicide Prevention**: 83% of *2019 Annual Warrior Survey* respondents reported suffering from post-traumatic stress disorder (PTSD).
   - ***Recommendation***: Authorize VA to pursue a community grant program to aggressively connect more veterans with clinical and non-clinical services in the communities where they live and work.
   - ***Recommendation***: Enhance research capabilities related to precision medicine for PTSD and traumatic brain injury (TBI) with a goal of developing diagnostic tests and personalized therapeutics for millions of veterans who suffer the devastating effects of trauma to the brain.
   - ***Recommendation***: Explore innovations in care payment and delivery to test bundled care and value-based reimbursement models for mental health care.

[1] See Appendix 1 for more figures on WWP's programmatic impact in FY 2019.

2. **Toxic Exposure**: 70.4% of *2019 Annual Warrior Survey* respondents reported toxic exposure, and nearly 9 in 10 of these warriors reported poor or fair current health.
   - ***Recommendation***: Create a new priority group within the VA health system to deliver lifesaving treatment for toxic exposure related illnesses.
   - ***Recommendation***: Develop a platform where VA and the Department of Defense (DoD) can analyze, track, and update the Individual Longitudinal Exposure Record (ILER) and compare this data to VA records to identify "high risk" cohorts.
   - ***Recommendation***: Ensure that veterans have access to the exposure records from ILER to help with identification and treatment of toxic exposure related illnesses.
   - ***Recommendation***: Include a toxic exposure related questionnaire during VA primary care visits to track possible illnesses.

3. **Women Veterans**: 44% of female *2019 Annual Warrior Survey* respondents reported experiencing military sexual trauma (MST) in service.
   - ***Recommendation***: Support programs and services to provide compassionate, comprehensive care to MST survivors.
   - ***Recommendation***: Improve women veterans' access to care by extending hours of operation at VA facilities.
   - ***Recommendation***: Expand and make permanent VA's pilot program to provide childcare to veterans attending health care appointments as a means to reduce barriers to care for women veterans.
   - ***Recommendation***: Pass legislation to bolster programs and services that support women veterans during transition.
   - ***Recommendation***: Work to close the gap between separation from service and enrollment in VA benefits and services for all women veterans.

4. **Brain Health**: 39% of *2019 Annual Warrior Survey* respondents reported experiencing a TBI in service.
   - ***Recommendation***: Review congressional reports related to VA's expired Assisted Living for Veterans with TBI pilot program to provide qualitative recommendations on how a replacement pilot could be modified to meet the clinical and non-clinical needs of veteran patients with moderate to severe TBI.
   - ***Recommendation***: Assess current resources dedicated to the Federal Recovery Coordination Program and alignment between the program's original intent and current community needs.
   - ***Recommendation***: Pursue pathways to adequately track, document, treat, and research blast and over-pressurization injuries from service.
   - ***Recommendation***: Complete a thorough accounting of current federally funded TBI research efforts to adequately determine whether current resources are sufficient to meet future demand for care from veterans facing increased likelihood of severe neurological challenges.

5. **Caregivers**: 7.6% of *2019 Annual Warrior Survey* respondents are permanently housebound, and 56.7% of respondents indicated they need at least some assistance with activities of daily living.
   - ***Recommendation***: Support permanent (long-term) designation for caregivers of severely wounded veterans and efforts to standardize the evaluation process for caregiver program eligibility determinations.

6. **Employment and Education for Wounded Warriors**: The unemployment rate among non-Active Duty warriors completing the *2019 Annual Warrior Survey* was 11.5%.
   - ***Recommendation***: Update Chapter 31, the Vocational Rehabilitation and Education (VR&E) program, to better serve unemployed veterans with disabilities through programmatic shifts and fundamental quality changes.
   - ***Recommendation***: Increase funding for VA's education services information technology (IT) capabilities to ensure the dissemination of information, tracking of data, and general IT capabilities are in line with VA's mission.
   - ***Recommendation***: Request a federal study to understand the discrepancy between unemployment rates between disabled veterans and veterans as a whole.

The remainder of this statement will explain why each of these issues has become a priority for WWP, how our organization is addressing these issues programmatically, and what public policy initiatives we are pursuing to improve the health and well-being of the wounded, ill, and injured veterans we serve. We are confident that following these recommendations will help your committees deliver the biggest impact on the lives of our nation's wounded warriors, their families, their caregivers, and a generation of future Service members who will benefit from the lessons we have learned and actions we have and will continue to take as a community.

MENTAL HEALTH & SUICIDE PREVENTION

Veteran suicide continues to be a nationally recognized tragedy and public awareness campaigns, medical research, scientific reports, and testimonials from veterans and families have thoroughly documented the need for providing mental health services to veterans. Most military members, including those who suffer from invisible wounds, serve their country with honor and return to be productive citizens who are assets to and leaders within their communities. Others may struggle, and even those who lead healthy productive lives today have overcome significant challenges in their transition from the military.

Wounded Warrior Project's response has been guided by a philosophy that we must be willing to adapt our programs and approaches to meet the evolving needs and unique challenges facing the warriors we serve. More than 15 years into our operation, mental health continues to be a significant investment in our mission to honor and empower wounded warriors. In 2019, mental health programs were WWP's largest programmatic investment – over $63 million – for reasons grounded in data and experience.

In 2019, WWP completed the tenth administration of our *Annual Warrior Survey*[2] and received answers from nearly 36,000 warriors. Self-reported PTSD continues to rank high on the list of health problems experienced by warriors (82.8%). Delayed-onset PTSD has also been diagnosed among veterans, even years after exposure to traumatic events, and may also be a factor in the high rates of PTSD that are still being reported by warriors who may be 10 to 15 years removed from service. The percentage of warriors who reported coping with anxiety increased in 2019 (80.7% in 2019, 68.7% in 2018, and 67.9% in 2017). The percentage of warriors suffering from depression has also remained high and fairly stable (76.5% in 2019, 70.3% in 2018, and 70.1% in 2017).

Based on these responses from warriors and our experience as a program provider and partner to others in the community who are addressing veteran mental health in a variety of ways, WWP can attest to what we know and what we have learned from others. The recommendations that follow represent what we believe to be the best path to improve access to care, drive research forward, keep the community accountable, and foster collaboration among stakeholders throughout the mental health spectrum.

Recommendation: *Authorize VA to pursue a community grant program to aggressively connect more veterans with clinical and non-clinical services in the communities where they live and work.*

Wounded Warrior Project's approach to mental health care is grounded in several core and scientifically supported beliefs. We acknowledge that no one organization – and no single agency – can fully meet all veterans' needs. Empirically supported mental health treatment absolutely works when it is available and when it is pursued, but the best results will be found by embracing a public health approach focused on increasing resilience and psychological well-being and building an aggressive prevention strategy.

Section 201 of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (S. 785) captures the spirit of these beliefs. This bill recognizes that networks of support already exist, that new networks can be developed to help VA reach more veterans and enter more communities, and that VA is an indispensable partner in building and sustaining this foundation. In many ways, a new community grant program could replicate success WWP has had fostering relationships with warriors, educating and connecting them with helpful programs and services, and creating an enduring network of support.

While there is no predetermined path for warriors registering with WWP, a warrior's first engagement with our organization is often through our Alumni Program. While in the military, many Service members form bonds with one another that are as strong as family ties. WWP helps re-form those relationships by providing opportunities for warriors to connect with one another through community events and veteran support groups. This community outreach program also provides easy access to local and national resources with the help of partners like The Travis Manion Foundation, The Mission Continues, Team Red White & Blue, Team Rubicon, and over 40 other funded partner organizations. Though most events are warrior-focused, WWP also hosts a variety of family-based activities.

[2] See Appendix 2 for more information on the 10-year trends from our *Annual Warrior Survey*.

In 2019, WWP hosted over 7,500 Alumni Program events that ranged from recreational activities and sporting events to professional development opportunities and community service projects. These events are focused on engagement and connection – not simply the event or activity itself – with a goal of helping warriors develop a trusting relationship with WWP that can help resolve more challenging and personal obstacles in their rehabilitation and recovery. These engagements are often helpful independently[3], but the subsequent impact can be truly life changing.

While veterans with greater social support have more positive mental health outcomes, including lower rates of suicidal ideation, our Alumni Program ultimately connects warriors with other programs and services focused on creating a life worth living, thereby creating a protective fabric in the battle against veteran suicide. The most frequent program referral from our Alumni Program was to our Benefits Team, which assists veterans in obtaining benefits from VA and becoming more integrated into a wider network of care and support. For example, many warriors become connected to VA for the first time in this process, which contributes nearly 7 in 10 (69.6%) of WWP alumni relying on VA as their primary health care provider. Similarly, WWP mental health programs were the leading internal referral destination across all WWP programs (and the second most frequent referral from the Alumni Program), driving many towards their first engagement with our Mental Health Continuum of Support.[4] All stated, warriors may attend an engagement event to spend time with fellow veterans but may leave with newly acquired psychoeducational information, new friendships, or new awareness of helpful resources that empower them to take an additional step in their recovery.[5]

Meaningful relationships are vital to the success of warriors' transitions back into civilian life, and suicide is best combated through preventive measures such as providing mental health programs, connection opportunities, and pathways to build confidence and a sense of purpose.[6] We must be proactive when engaging warriors and showing them how their lives matter in their homes and communities.[7] WWP has relied on VA and other non-profit organizations as partners in this pursuit. Building more networks like these will help our community reach more veterans – before they reach a crisis point – and scale our impact by reaching out and connecting more veterans and families with support.

For these reasons, WWP strongly encourages members of the committee to support the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* and other initiatives that improve collaboration between VA and non-profit support networks that will connect more veterans with support services and ultimately improve mental well-being, increase resilience, and reduce veteran suicide. While WWP appreciates the need to keep VA as a coordinator of unfragmented clinical care, we believe that embracing grants to direct care

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[3] Warriors participating in Alumni Program events in 2019 reported feeling more socially connected to their peers (90% versus 72% of the average WWP warrior population) and more likely to have people in their lives they can depend on (89% versus 79% of overage warrior population).
[4] See Appendix 4 for more information on WWP's Mental Health Continuum of Support.
[5] When individuals feel connected to others, they are less isolated and as a result may come to the realization that they are not alone in their suffering or that others may have experienced similar challenges (Hall, 2014).
[6] Psychological distress (i.e., depression) has been correlated with stronger negative reactions to social interactions, which may lead to further isolation (e.g., Gotlib, Kash, et al., 2004; Mogg & Bradley, 2005).
[7] Interpersonal interactions can have a strong impact upon one's cognitions, emotions, and behaviors (Baumeister & Leary, 1995).

programs – particularly when skepticism towards VA in the veteran community is an unfortunate reality we must acknowledge – is a commitment most consistent with putting the needs of the veteran first.

Recommendation: *Enhance research capabilities related to precision medicine for PTSD and TBI with a goal of developing diagnostic tests and personalized therapeutics for millions of veterans who suffer the devastating effects of trauma to the brain.*

Every veteran who has been wounded, ill, or injured will have a unique path to recovery or adjustment to their "new normal." As their advocates in that process, WWP encourages the development of multiple effective pathways to better health and quality of life. VA provides high quality care and contributes to a growing body of research on both PTSD and TBI; however, WWP believes that a concerted effort to identify and validate brain and mental health biomarkers can unite the efforts of public and private entities and ultimately connect veterans to new and highly effective care and interventions.

Section 305 of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* would enable greater collaboration between VA and the private sector in precision medicine for two of the greatest challenges affecting post-9/11 wounded warriors. According to the *2019 Annual Warrior Survey*, 83 percent of WWP alumni have self-reported PTSD and 39 percent report sustaining a TBI in service. An internal review and assessment of these responses further suggests a high prevalence of severe and moderately severe PTSD (57 percent) that is consistent with veterans who served in Operation Enduring Freedom, Operation Iraqi Freedom, and/or Operation New Dawn and who are enrolled in the Veterans Health Administration (VHA). PTSD and TBI can have considerable impact on quality of life and daily functioning, and if left untreated, both are risk factors that may increase the likelihood of suicidal ideation, planning, and attempt.

Biomarker research has potential to lead treatment for these invisible wounds into the next generation. Just as a recent scientific report discusses a new PTSD brain imaging biomarker that may help determine an individual's response to first-line treatment[8], greater collaboration between public and private entities in this sector will help identify new diagnostic biomarkers, build predictive disease models, and develop new treatments for PTSD, TBI, and other invisible wounds such as depression, anxiety, and bipolar disorder. For these reasons, we urge you and members of your committee to support Section 305 of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2020* and other efforts to encourage research and collaboration into biomarkers for mental health and traumatic brain injury treatment.

Recommendation: *Explore innovations in care payment and delivery to test bundled care and value-based reimbursement models for mental health care.*

Section 101(i) of the *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act* (*VA MISSION Act*) (P.L. 115-182) allows VA to incorporate value-based reimbursement principles to promote the provision of high-quality care, and this permission can

[8] Amit Ekin, et al., *Using fMRI Connectivity to Define a Treatment-resistant Form of Post-traumatic Stress Disorder*, SCI. TRANSL. MED. (Apr. 3, 2019) available at https://stm.sciencemag.org/content/11/486/eaal3236.

and should be used to help encourage innovative models in physical and mental health treatment. While the health care industry has embraced bundled payment approaches to address episodes of care for hip surgery, diabetes, stroke, cancer treatment, and others, VA lags behind, and the expanded migration of this practice to mental health would allow VA to be a pioneer in an area where veterans are catastrophically suffering and would drive the wider mental health care industry towards better quality and more cost-effective outcomes.

Additionally, new innovative approaches could address the challenge that many facilities and organizations face when seeking care reimbursement through insurance. When the process is cumbersome and challenging, providers may choose to not enter the market. Inefficient care markets can lessen veteran access to critically needed resources and high-quality treatment.

Other bills to support: In addition to the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act*, WWP supports the following pieces of legislation:

- *TBI and PTSD Law Enforcement Training Act* (draft bill): This proposal would initiate the development of a federal standard of best practices and crisis intervention training tools for law enforcement and first responders to improve interactions with individuals displaying symptoms of TBI or PTSD. While not specific to veterans, many would benefit from a more informed and prepared community of first responders and law enforcement officers, many of whom are veterans.

- *National Suicide Hotline Designation Act of 2019* (S. 2661, H.R. 4194): The Federal Communications Commission (FCC) is already moving forward with plans to make 9-8-8 the nation's suicide prevention hotline. The current National Suicide Prevention Lifeline is staffed by responders who have stopped over 90 percent of suicide attempts or ideation among callers.[9] This bill would help ensure that call centers supporting the hotline are properly resourced.

TOXIC EXPOSURE

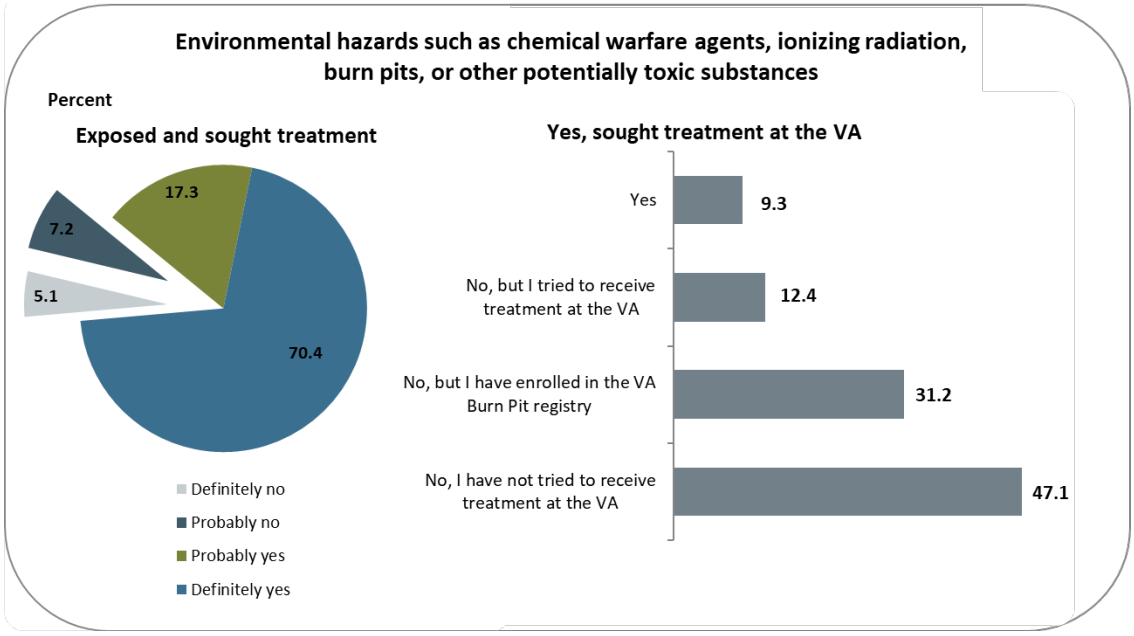
With the legacy of a decades-long campaign to deliver care and benefits to those who have or continue to suffer from Agent Orange exposure, WWP is striving to ensure that today's veterans struggling to receive health care for toxic exposure illnesses are not fighting for treatment years from now like their Vietnam counterparts. Post-9/11 generational exposure to contaminants such as burn pits, toxic fragments, or other hazards typically seen on overseas deployments are emerging as common threads among veterans who are sick, dying, or already deceased.

Results from WWP's *2019 Annual Warrior Survey* are illustrative of the issues the post-9/11 generation is facing. WWP found that a majority (70.4%) of warriors reported "certain" exposure to hazardous chemicals or substances and more than 31% are enrolled in VA's Airborne Hazards and Burn Pit Registry. Warriors who reported exposures were more likely to indicate poorer health. Additionally, 89.8 % of warriors who reported their health as "poor" or

[9] *See* SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION at https://www.samhsa.gov/suicide.

"fair" indicated "probably yes" or "definitely yes" to exposure of an environmental hazard during military service versus 81.9% of warriors who paired "very good" or "excellent" health with "probably yes" or "definitely yes" exposure of an environmental hazard during military service.

Of those who indicated exposure to environmental hazards such as chemical warfare agents, ionizing radiation, burn pits, or other potentially toxic substances during service, 9.3% stated they sought treatment at VA, 12.4% reported that they did not receive treatment at VA for toxic exposure illnesses but tried, and 31.2% indicated that they have not tried to receive treatment at VA but have enrolled in VA's Airborne Hazards and Burn Pit Registry. Although we do not clearly know why so few veterans seem to be receiving treatment at VA, our assumption is that access issues are driven by a lack of communication with veterans on this topic and the difficulty of establishing service connection for illnesses believed to be caused by toxic exposure. Whether successful in receiving VA treatment or not, it is noteworthy that nearly 22% of surveyed warriors reported seeking such treatment.



Motivated by these results and the stories and data shared by other advocates, WWP spearheaded formation of the Toxic Exposure in the American Military (TEAM) coalition to raise public awareness and investigate the harmful effects of toxic exposures in the military. To date, 22 organizations across a wide advocacy spectrum have united in their pursuit of solutions for the communities we collectively represent. Members of the TEAM coalition include AMVETS, Burn Pits 360, California Communities Against Toxics (CCAT), Cease Fire Campaign, Dixon Center for Military and Veterans Services, Enlisted Association of the National Guard of the United States (EANGUS), Hunter Seven, Iraq and Afghanistan Veterans of America (IAVA), Military Officers Association of America (MOAA), Military Veterans Advocacy, Inc., National Veterans Legal Services Program (NVLSP), Paralyzed Veterans of America (PVA), Task Force Dagger Foundation (TFD), The American Legion (TAL), The Enlisted Association (TREA), Tragedy Assistance Program for Survivors (TAPS), Veteran

Warriors, Veterans and Families for Exposure Awareness (VFEA), Veterans of Foreign Wars (VFW), Vets First, Vietnam Veterans of America (VVA), and Wounded Warrior Project (WWP). Additional organizations attend the monthly coalition meetings for broader input.

Accordingly, the TEAM coalition's efforts are focused on treating Service members and veterans before they become critically ill through early identification and better research. Using the information gathered from WWP's *Annual Warrior Survey* and lessons learned while working with the TEAM coalition, WWP has developed 2020 legislative priorities specific for toxic exposure, which are highlighted below. In addition, TEAM meetings over the past year have been convened with the express goal of developing comprehensive legislation that not only helps those affected by burn pits but also helps those affected by other toxic exposure related illnesses and builds a comprehensive structure to help those affected by toxicants not yet identified. Many of the suggestions that follow will be addressed in that bill.

Recommendation: *Create a new priority group within the VA health system to deliver lifesaving treatment for toxic exposure related illnesses.*

Generally speaking, the biggest challenge to receiving care through the Veterans Health Administration (VHA) is establishing service connection for an injury or illness. To address a rising number of terminal illness and cancers among a younger generation of warriors exposed to toxicants during service, Congress can establish a new VA priority group that offers healthcare related services to those currently ill. Connecting sick veterans to lifesaving health care should take priority over financial compensation as necessary long-term solutions are negotiated.

Currently, there are 8 VA priority groups. WWP recommends adding a new priority group placed between existing groups 6 and 7. A specific priority group for toxic exposure related illnesses would allow veterans to access VA care without a service-connected disability. This priority group will authorize veterans four toxic exposure related visits each year. During these visits, VA clinicians will be authorized to utilize any diagnostic tools needed. If a veteran is identified as having a toxic exposure related illness during one of these visits, the clinician can enroll the veteran into a new priority group 7 status which allows the veteran any treatment deemed necessary by the VA.

In addition to the establishment of a new priority group for toxic exposure related healthcare, WWP encourages VA to work with DoD to develop a "high risk" database using ILER and other evidence. This study and data collection involving VHA electronic health records, and VA's Airborne Hazards and Burn Pit Registry, should provide researchers the data needed to develop a list of illnesses that could be presumed to be related to toxic exposures and allow VA to be proactive in identifying high risk clusters in need of medical testing. Doing so would address two of WWP's primary concerns regarding toxic exposure: early identification of toxic exposure illnesses and life-saving treatment for those affected.

Recommendation: *Develop a platform where VA and DoD can analyze, track, and update ILER and compare this data to VA records to identify "high risk" cohorts.*

The difficulty in developing a "high risk" database is defining those who could be considered "high risk." WWP recommends starting with deployed Service members and veterans who have rare forms of cancer or other medical conditions that are unusual based on the prospective patient's age and background. The ILER system has potential to be used to identify at-risk clusters of individuals based off common exposures and units. Comparing these at-risk clusters with VA VHA records could help establish "high risk" groups. Once individuals are identified and treated at DoD or VA treatment centers, associated data can be fed back into the ILER system for additional tracking and research. Identifying "high risk" cohorts, compiling data on their illnesses, and administering treatment may all contribute to developing the data that could help DoD and VA become proactive in saving lives.

As discussed above, ILER is a web-based application that has been developed over the past eight years between DoD and VA that can assist in linking individuals with possible toxic exposures during military service. The system has the capacity to create a comprehensive exposure record for individual veterans by cross-referencing available DoD data. ILER links individuals with known exposure events and incidents to compile a Service member's possible exposure history.

On its current trajectory, ILER will be accessible to DoD and VA researchers, VA clinicians, and VA claims adjudicators. In theory, anyone with access to the database will have the ability to download a Service member's full ILER record in portable document format ("pdf") format. This file contains a Service member's historical exposure, a list of possible connections that exist between discovered exposures and medical symptomatology, possible diagnoses attributable to these exposures, and cross-references to other Service members from a unit that may also have been exposed. ILER is useful to researchers attempting to find and isolate specific control groups and to Service members and veterans undergoing treatment.

Recommendation: *Ensure that veterans have access to the exposure records from ILER to help with identification and treatment of toxic exposure related illnesses.*

While ILER has potential to be a lifesaving tool, it is only accessible to users at DoD and VA. Providing ILER access to Service members, veterans, and their health care providers extends the ability to identify possible exposure risk factors before or during treatment. WWP recommends that Congress direct DoD and VA to develop a portal to allow individuals to download their ILER information. Currently, a veteran seeking his or her ILER record must file a Freedom of Information Act (FOIA) request with the Defense Health Agency (DHA). This process is burdensome, unnecessary, and counterproductive when an alternative, more efficient pathway could be available. Access to personal ILER information during the diagnosis and treatment phases for exposure-related illnesses is critical and possibly lifesaving. While VA may highlight that its claim adjudicators have access to ILER, Veteran Service Organization (VSO) service officers do not have access and are limited in their ability to appropriately represent veterans.

Recommendation: *Include a toxic exposure questionnaire during primary care visits at VA facilities.*

In order to continue moving toxic exposure illness awareness towards mainstream health considerations, WWP encourages increased alignment with primary care in the VHA system. A toxic exposure questionnaire provided during VHA primary care visits can generate a dialogue between veterans and their providers about past exposure history. Increased awareness and transparency could help identify possible "high risk" veterans with toxic exposure illnesses.

Currently, during primary care exams, VA healthcare providers ask questions regarding mental health, lifestyle, and smoking to identify veterans who may need additional help or information on programs available at VA. By adding questions regarding toxic exposure to these primary care visits, we hope that the VA healthcare provider and the veteran can start to identify possible health risks to track over time and expand VA's access to data regarding veterans who need additional medical assistance. For instance, research has shown that there is a possible connection between chemicals that were inhaled by Service members while deployed and a higher risk of chronic bronchitis or chronic obstructive pulmonary disease.[10] Asking questions about toxic exposures can push the VA healthcare provider and veteran to think about other possible associations between illnesses and past service. Sometimes it can be as simple as asking, "Were you ever stationed near a burn pit?" to get both patient and provider to think more critically about toxic exposures and current medical complications.

WOMEN VETERANS

Today, women are serving our nation's military in greater numbers than ever. When all combat roles were opened to women in 2015, Active Duty Servicewomen were ushered into a modern era of opportunities to succeed, lead, and contribute to national security in new and impactful ways. Accordingly, VA anticipates a rapid increase in the population of women veterans, from the 10% they constitute today to 16% in the next twenty years.[11] WWP is seeing a similar increase in our own population; today women represent 17% of WWP Alumni, a 10% increase since 2010. Now is the time to turn our community's focus to this important group and identify where gaps in care exist to meet the unique needs of post-9/11 women veterans.

Efforts at WWP are already underway. In 2020, WWP launched our Women Veterans Initiative – a new program that will take our organization across the country, convening with women warriors to better understand the challenges they face, generate actionable solutions, and empower and enable them to reach their fullest potential. The Initiative began with distribution of a new survey to more than 20,000 female WWP Alumni to learn more about their military experiences and their challenges with mental health, economic insecurity, relationships and isolation, reproductive health, and much more.

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[10] J. Liu et al., *Burn Pit Emissions Exposure and Respiratory and Cardiovascular Conditions Among Airborne Hazards and Open Burn Pit Registry Participants*, J. OCCUP. ENVIRON. MED. (July 2016) available at https://www.ncbi.nlm.nih.gov/pubmed/27218278.

[11] NAT'L CTR. FOR VETERANS ANALYSIS AND STATISTICS, U.S. DEP'T OF VET. AFFAIRS, WOMEN VETERANS REPORT: THE PAST, PRESENT, AND FUTURE OF WOMEN VETERANS, 1 (2017).

This knowledge, coupled with feedback from our experienced staff, data collected by a decade of the *Annual Warrior Survey*, and expert advice from partners and subject matter experts, has laid the foundation for the recommendations that WWP makes to Congress.

Recommendation: *Support programs and services to provide compassionate, comprehensive care to Military Sexual Trauma (MST) survivors.*

Prevalence of sexual harassment and abuse are increasing in the military. DoD's 2018 Annual Report on Sexual Assault in the Military estimated that about 13,000 Active Duty women, or 6.2 percent of the population, experienced a sexual assault in the year prior, a statistically significant increase from the previous survey in 2016.[12] These events can have lasting and damaging effects on victims, including physical and psychological challenges that will follow them long after their military service has ended. VA found that one in four women screen positively for MST.[13] WWP's population of wounded, ill, and injured women veterans report even higher rates of MST – 44 percent per the *2019 Annual Warrior Survey*. Those who live with MST in their past have experienced the ultimate betrayal by a fellow Service member. They deserve easy access to high quality, gender-sensitive care furnished by VA.

In-Focus: WWP's Mental Health Continuum of Support. MST is complex, intense, and can be deeply devastating to those it affects, contributing to a host of mental and physical health complications, including PTSD. WWP seeks to create supportive spaces, both environmentally and emotionally, for MST survivors to interact authentically with their peers. Our programs are designed with this sensitivity in mind.

For women seeking treatment through WWP's Warrior Care Network, MST presents as one of the most frequent and complex challenges; over one-third report MST as their primary stressor. Rush University Medical Hospital's Road Home Program is Warrior Care Network's leader for MST care, hosting four MST-specific cohorts per year. Due to high demand, however, Rush has increased the number of MST-specific cohorts for 2020. When participating in a Warrior Care Network MST cohort, veterans engage in a two- or three-week intensive outpatient program using evidence-based therapies to challenge one another, evolve in their mental health journey, and heal from past traumas. The emotional ramifications of MST are extensive and can impact a survivor's ability to connect with others. Warrior Care Network's mixed-gender cohort style focuses on building strong bonds between participants, helping MST survivors to develop interpersonal skills, and restoring trust in the military community.

Another outlet available to MST survivors struggling with mental health challenges is WWP's Project Odyssey program. In FY 2019, WWP facilitated 38 female-only Project Odysseys, serving nearly 400 women. The curriculum for female-only cohorts is gender-informed, dealing with the topics and issues most important to women veterans, including MST. This 12-week, cohort-style program equips women veterans with the tools to better understand

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[12] SEXUAL ASSAULT PREVENTION AND RESPONSE OFF., U.S. DEP'T OF DEF., *ANNUAL REPORT ON SEXUAL ASSAULT IN THE MILITARY* FISCAL YEAR 2018 3 (2019).

[13] U.S. DEP'T OF VET. AFFAIRS, MILITARY SEXUAL TRAUMA FACT SHEET, https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf (last visited Feb. 18, 2020).

and identify mental health issues, tackle challenges as they arise, and integrate into their communities as more confident, healthy citizens.

When women transition out of service, the responsibilities that come with their newfound multi-hyphenate roles in their families, communities, and workplaces can be demanding, leaving them to prioritize their own health care last. It is critical that Congress and VA work to break down barriers to care for these veterans, ensuring they are afforded the care they deserve. To this end, WWP recommends that Congress:

Recommendation: *Improve women veterans' access to care by extending hours of operation at VA facilities.*

Section 201 of the House-passed *Deborah Sampson Act* (H.R. 3224) proposes to study extended hours of operation as a means to reduce barriers to care. WWP calls on Congress to pass this measure and ensure implementation as soon as possible. Doing so will improve access to lifesaving care for women veterans.

With suicide prevention rightly positioned as VHA's top clinical priority, it is imperative that Congress move to support all efforts that increase access to mental health care. The expansion of VA's operating hours is a key component of this mission. For the second year in a row, WWP's women veterans cited hours of operation as the number one barrier to mental health care via the *Annual Warrior Survey*. This is a population that is twice as likely to die by suicide than their civilian counterparts.[14] Extending the operating hours at VA facilities, including medical centers and community-based outpatient clinics, will ensure that female veterans, whose many roles and responsibilities make it difficult to access care during typical workday hours, are able to receive the care they need without sacrificing.

Recommendation: *Expand and make permanent VA's pilot program to provide childcare to veterans attending health care appointments as a means to reduce barriers to care for women veterans.*

In addition to extended hours, the provision of onsite childcare would vastly improve women warriors' ability to access healthcare. In VA's 2015 Study of Barriers for Women Veterans to VA Health Care, 42 percent of women indicated that finding childcare to attend medical appointments is "somewhat hard" or "very hard."[15] In that same study, three out of five women reported that they would find on-site childcare "very helpful."[16] Though Congress has enacted legislation extending certain childcare services through the *Caregivers and Veterans Omnibus Health Services Act of 2010* (P.L. 111-163), the authority is not yet permanent, and participating locations are still limited.[17] Since 2011, more than 10,000 children have benefitted from VA-enabled childcare, and women veterans used the services at a significantly greater rate

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[14] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, SUICIDE AMONG WOMEN VETERANS: FACTS, PREVENTION STRATEGIES, AND RESOURCES, https://www.mentalhealth.va.gov/suicide_prevention/docs/Women_Veterans_Fact_Sheet_508.pdf (last visited Feb. 18, 2020).
[15] OFF. OF WOMEN'S HEALTH SERVS., U.S. U.S. DEP'T OF VET. AFFAIRS, STUDY OF BARRIERS FOR WOMEN VETERANS TO VA HEALTH CARE (2015).
[16] *See id.*
[17] Press Release, U.S. Dep't of Vet. Affairs, *VA Launches Childcare Pilot* (July 16, 2011) (available at https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2134).

than men.[18] WWP urges the Senate to pass H.R. 840, the *Veterans' Access to Child Care Act*, which would assist veterans in securing childcare while they attend healthcare appointments.

Recommendation: *Pass legislation to bolster programs and services that support women veterans during transition.*

The point of transition from military service to civilian life is a critical one for any veteran; however, the stressors can often be compounded for women veterans, contributing to the social isolation that WWP's *2019 Annual Warrior Survey* found is more severe in women. As a smaller population, Servicewomen are less visible in the veteran community and lack the same sense of camaraderie as their male peers, while also struggling to relate to a civilian population that cannot understand their military experiences. This isolation exacerbates mental health issues, affects their ability to find meaningful employment, and discourages women from seeking benefits and services in male-dominated VA facilities.

A positive transition experience is vital to set women veterans up for success as they reintegrate into a civilian environment. Fewer than one percent of Americans serve in the Armed Forces today, and of that group, only 16 percent are women.[19] Congress and VA must provide the resources and opportunities for this under-represented group to connect with one another, share experiences and counsel, and build strong relationships as they enter into the period of transition from service. An excellent example of such an opportunity is the Women's Health Transition Training Pilot Program, which provides transition training and simplified access to VA benefits in a female-only environment. WWP urges Congress to support efforts to expand and encourage participation in this program and continue to pilot innovative solutions like it that increase utilization of VA benefits and foster social connection between transitioning women veterans.

Women veterans face unique challenges during their military transition experience and are often searching for likeminded women with whom they can bond, share, collaborate, and continue to grow even after their military service has ended. Therefore, WWP works to connect women veterans to one another through meetings and events across the country. Our WWP Alumni Program team is out in communities across the country, offering creative events and facilitating a network of women veterans. So far in FY 2020, WWP has hosted 35 women-only events.

Another way WWP brings women veterans together is through Peer Support Groups. Local Peer Support Group Leaders organize events in their communities that connect Alumni with warriors in their backyard, often enabling the organization to play a deeper role in warrior lives where we do not have a physical presence. WWP understands that veterans operate best in a unit, where each member has a key role to play in lifting and contributing to the success of their cohort. These groups provide veterans not only with the opportunity to receive support and encouragement from others with similar experiences, but also to provide that support in return. WWP has trained and provided support to 29 female Peer Support Group Leaders who are

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[18] Nikki Wentling, *House Passes Bill to Offer Free Child Care at VA Facilities Nationwide*, STARS AND STRIPES, (Feb. 8, 2019), https://www.stripes.com/news/us/house-passes-bill-to-offer-free-child-care-at-va-facilities-nationwide-1.567958.
[19] George M. Reynolds and Amanda Shendruk, *Demographics of the U.S. Military,* COUNCIL ON FOREIGN REL., Apr. 24, 2018, www.cfr.org/article/demographics-us-military.

actively working to engage the women warriors in their communities, providing an outlet for women to build authentic, indispensable relationships.

Recommendation: *Work to close the gap between separation from service and enrollment in VA benefits and services for all women veterans.*

According to a 2017 VA study, only 47 percent of female veterans used VA benefits and services, and on average, women do not connect with VHA until 2.7 years after separating from service. [20] This is an unacceptable gap in well-earned care. Congress should make efforts to better identify causes of the enrollment gap, implement policies to address these causes, and support opportunities to educate women on the health care and benefits options available to them.

The *2019 Annual Warrior Survey* found that 89 percent of female Alumni receive VBA compensation benefits, far more than the roughly 25 percent of total women veterans.[21] WWP's team of accredited, highly-skilled National Service Officers play a major role in supporting these women, working with them to navigate a complex VA system and ensure that every warrior has access to the benefits they've earned. From FY 2016 to today, roughly 15 percent of total benefits claims filed by WWP were on behalf of women veterans, a percentage in line with our organization's demographic profile. The top issues for which women veterans seek compensation are PTSD, depression, migraines, lower back pain, and OBGYN-related conditions. Not only is the compensation earned from VBA compensation for service-connected disabilities life-changing and sustaining, it's a recognition of and mark of gratitude for a woman warrior's sacrifice in defense of the nation.

BRAIN HEALTH

Conversations about "invisible wounds" of war will often group PTSD and TBI together. While these are comorbid conditions for many veterans who sustained their injuries in service, medical and scientific literature clearly illustrate that these are different disease processes that present distinguishable symptoms and challenges. Accordingly, it is imperative for the committees to consider mental health and brain health along separate – though perhaps parallel – paths and to give increased attention to the current and long-term care needs of veterans living with effects of TBI.

The Defense and Veterans Brain Injury Center (DVBIC) maintains a record of worldwide medical diagnoses of TBI that occurred anywhere U.S. forces are located, including the continental United States, since 2000. According to DVBIC data, there were 413,858 TBIs as of November 8, 2019. The vast majority (82.8%, or 342,747) of these were mild TBI, followed by moderate (9.8%, or 40,378), severe (1.0%, or 4,110), and penetrating (1.3%, or 5,279) injuries.[22]

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[20] NAT'L CTR. FOR VETERANS ANALYSIS AND STAT., U.S. DEP'T OF VET. AFFAIRS, U.S. VETERANS ELIGIBILITY TRENDS AND STAT., 2016, 77 (Nov. 2017) (available at www.va.gov/vetdata/docs/QuickFacts/VA_Utilization_Profile.pdf).
[21] VET. BENEFITS ADMIN., U.S. DEP'T OF VET. AFFAIRS, ANNUAL BENEFITS REPORT FISCAL YEAR 2018 77 (available at www.benefits.va.gov/REPORTS/abr/docs/2018-abr.pdf).
[22] *See* DEF. AND VETERANS BRAIN INJURY CTR., DOD NUMBERS FOR TRAUMATIC BRAIN INJURY WORLDWIDE TOTALS (2019), available at https://dvbic.dcoe.mil/sites/default/files/tbi-numbers/DVBIC_WorldwideTotal_2000-2019_Q3.pdf.

While most TBIs result in relatively mild symptoms in the immediate aftermath of an injury, long-term effects are widely varied and can include both physical and mental symptoms ranging from seizures and loss of coordination to agitation and combative behavior.

Perhaps more significantly, individual independence – and the need for long term care – is complicated by the chronic and degenerative conditions that may accompany TBI. Studies indicate that degeneration (as well as improvement) may occur as long as twenty years after the injury.[23] Unfortunately, this degeneration most often manifests as motor or cognitive deficits.[24] A growing body of research has also started to indicate increased long-term risks for Alzheimer's disease, amyotrophic lateral sclerosis (or ALS), Parkinson's disease, and early-onset dementia.[25] Further, significant complexity in treatment and recovery for TBI makes research efforts and decisions about the appropriate type, level, and frequency of treatment for each patient more difficult.[26] Lastly, irrespective of severity, VA has traditionally relied on caregivers to provide much-needed support for patients, but caregivers may not be sufficiently able to care for veterans as they age and face health declines themselves.

In summary, research in the private sector has uncovered correlations between brain injuries and early onset of long-term, debilitating illnesses that will require increasing levels of long-term therapy as well as community-based supports. In the absence of appropriate care – or even poor coordination of care that exists but is either unknown or inaccessible – TBI patients are at an increased risk for homelessness, incarceration, and institutionalization, all of which are unacceptable outcomes.[27] In the coming years, VA is likely to face increased numbers of veterans who suffer from long-term consequences of TBI (including mild TBI) and chronic traumatic encephalopathy (CTE), including significant cognitive, behavioral, and physical health challenges that cannot be resolved by caregivers alone and must be prepared to support these patients with improved access to long-term care in a variety of settings. For these reasons, WWP offers the following recommendations:

Recommendation: *Review congressional reports related to VA's expired Assisted Living for Veterans with TBI pilot program to provide qualitative recommendations on how the pilot, or a replacement pilot, could be modified to meet the clinical and non-clinical needs of veteran patients with moderate to severe TBI.*

Traditionally, VA has provided clinical services to veterans who suffer the effects of TBI; however, many veterans with TBI may benefit from treatment in an intensive rehabilitation facility to assist with skills that can create or maintain increased independence. Because these

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[23] Lindsay Wilson, et al., *The Chronic and Evolving Neurological Consequences of Traumatic Brain Injury*, THE LANCET: NEUROLOGY (Oct. 1, 2017).
[24] Helen M. Bramlett & W. Dalton Dietrich, *Long-Term Consequences of Traumatic Brain Injury: Current Status of Potential Mechanisms of Injury and Neurological Outcomes*, J. NEUROTRAUMA (Dec. 1, 2015) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4677116/.
[25] Helen M. Bramlett & W. Dalton Dietrich, *Long-Term Consequences of Traumatic Brain Injury: Current Status of Potential Mechanisms of Injury and Neurological Outcomes*, J. NEUROTRAUMA (Dec. 1, 2015) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4677116/; *Chronic Traumatic Encephalopathy*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/chronic-traumatic-encephalopathy/symptoms-causes/syc-20370921 (last visited Jan. 30, 2019); Erin Bagalman, *Health Care for Veterans: Traumatic Brain Injury*, CONG. RESEARCH SERV., 4 (Mar. 9, 2015).
[26] Joseph T. Giacino et al., *Rehabilitation Access and Outcome after Severe Traumatic Brain Injury: A TBI Model System-Sponsored Stakeholder Summit*, 9 (May 16, 2016) available at http://media-ns.mghcpd.org.s3.amazonaws.com/spauldingtbi/rehabilitation-access-and-outcome-after-severe-tbi-briefing-book.pdf.
[27] Amy Bukowski, et al., *Traumatic Brain Injury in the District: The Ignored Injury*, TBI WORK GROUP IN WASHINGTON, D.C. (July 25, 2018) available at http://www.uls-dc.org/media/1150/tbi-white-paper-final-7-25-18.pdf.

facilities are generally residential and the VA does not provide veterans with housing (with some exceptions), accessibility to such programs is limited or requires subsidized payment from other sources to cover the "housing" expense. A notable VA pilot program, the Assisted Living for Veterans with Traumatic Brain Injury (AL-TBI) Program, demonstrated a demand for these types of facilities before sunsetting in 2018.[28]

Eligible candidates typically suffered from moderate or severe TBI and benefitted from caregivers, family or otherwise, in home settings in order to escape institutionalization. Others lived in nursing homes provided by VA where those around them were much older and required different services and care. Most courses of rehabilitative treatment took place over the course of 6 to 12 months and were effective even when conducted several years after the injury occurred (although studies suggest that more immediate rehabilitative care may be favorable).[29]

Although this pilot lasted for nearly a decade, its utility in providing step-down therapies and rehabilitation has not been replicated despite ongoing need. Modest participation numbers are not reflective of the need for this type of programming and may be a false representation of actual need in consideration of the progressive nature of the TBI process. While the VA's five Polytrauma Transitional Rehabilitative Care facilities provide support for some veterans, these facilities are limited in scope, accessibility, and availability. Additionally, though directed to produce a report following the AL-TBI program, the information VA provided was limited and quantitative while lacking feedback that could help shape future programs and care within the VA system.

The AL-TBI Program was written in response to a need for "specialized residential care and rehabilitation" with the purpose of enhancing "rehabilitation, quality of life, and community integration."[30] Nothing suggests that this need for care has expired in spite of the program being allowed to terminate. Furthermore, DVBIC's *7-Year Progress Update to a 15-Year Longitudinal Study* affirms the need for this type of care by recommending that "TBI patients needing supervised environments for years beyond injury should have access to residential brain injury treatment in an age-appropriate setting and community-based extended services."[31]

The need for residential support and services remains while access to appropriate rehabilitative facilities covered by the VA is limited mostly to nursing homes where aging populations often are a poor fit for a younger person with TBI. For this reason, TBI-affected veterans and their caregivers are best served when they have the option to seek care in community-integrated rehabilitative centers where they are more likely to receive care most appropriate for TBI and also participate in therapy with similarly-injured persons whose objectives may include returning home or to participation in the community.

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[28] *See generally Polytrauma/TBI System of Care*, U.S. DEP'T OF VET. AFFAIRS (June 3, 2015), https://www.polytrauma.va.gov/about/Rehabilitation_Team.asp.
[29] Irwin M. Altman, et al., *Effectiveness of Community-Based Rehabilitation After TBI for 489 Completers Compared with those Precipitously Discharged*, PHYSICAL MED. & REHABILITATION (Nov. 2010) available at https://www.archives-pmr.org/article/S0003-9993(10)00649-0/fulltext#sec4.
[30] *Polytrauma/ TBI System of Care,* U.S. DEP'T OF VET. AFFAIRS (June 3, 2015) https://www.polytrauma.va.gov/about/AL-TBI.asp.
[31] *Report to Congress, Section 721 of the NDAA for Fiscal Year 2007 (P.L. 109-364), 7-Year Update. Longitudinal Study on Traumatic Brain Injury Incurred by Members of the Armed Forces in Operation Iraqi Freedom and Operation Enduring Freedom*, DEP'T OF DEF. (June 2017).

Recommendation: *Assess current resources dedicated to the Federal Recovery Coordination Program and alignment with original intent of the program and current community needs.*

To assist veterans and caregivers in navigating the complex environment of care available to them, the Federal Recovery Coordination Program (FRCP) was created as a joint effort between VA and DoD. The intent behind the FRCP traces back to the 2017 President's Commission on Care for America's Returning Wounded Warriors[32] recommendation for the federal government to immediately create and coordinate comprehensive recovery plans for seriously injured service members.[33] Federal Recovery Consultants (FRCs) are located at ten sites across the country or are available to provide virtual consultations across the nation. FRCs are unique in their ability to operate within both DoD and VA, working with wounded warriors throughout their recovery and eventual reintegration into the community.

FRCs were designed to liaise between a veteran's Care Management Team, composed of clinical providers, DoD Recovery Care Coordinators, service wounded warrior programs, Medical Case Managers, Non-Medical Case Managers, and any others involved in a patient's care. An FRC does not provide direct services but identifies gaps in patient needs that the Care Management Team is unable to fill and facilitates access to resources provided by State and Federal governments, non-profit organizations, medical centers, and the veteran's local community. Their holistic approach is intended to synchronize four rehabilitation factors: benefits; education, training, and employment; medical and rehabilitative care; and family support services. FRCs are available to those wounded warriors who are in a military acute care setting and require high-intensity care management. Service members with moderate to severe TBIs are likely eligible for FRC support; however, those with mild TBIs typically do not have this access, meaning veterans who experience PTSD or other neurodegenerative complications associated with repeated mild TBI would not receive the same intensive, personalized care despite the long-term consequences of their injury.

While FRCs have been a successful tool in the past, investment in the FRCP has waned as demand has declined, leaving significant gaps in case management services for veterans with complex cases. Individual Case Managers are siloed within their respective agency jurisdictions without an FRC to manage care enterprise-wide and longitudinally. As a result, patients may miss out on valuable resources due to insulated treatment planning by the Care Management Team, further obscured by the vast number of programs, services, partnerships, and benefits advertised to patients and caregivers – and which are often challenging to navigate for trained social workers not part of the FRCP. In this context, the community would likely benefit from a congressionally mandated report on the evolution of the FRCP to better align resources moving forward.

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[32] The group is often called the "Dole-Shalala Commission" in reference to its co-chairs.
[33] *See* PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS, SERVE, SUPPORT, SIMPLIFY, 5, 13-14, (July 2017), *available at* https://www.patriotoutreach.org/docs/presidents-commission-report-july-2007.pdf.

Recommendation: *Pursue pathways to adequately track, document, treat, and research blast and over-pressurization injuries from service.*

In its report to accompany the *National Defense Authorization Act of 2020* (P.L. 116-333), the Senate Armed Services Committee recognized "the novel research undertaken by U.S. Special Operations Command and the Uniformed Services University of the Health Sciences to identify and measure the effects on brain and spine health of repeated exposure to the blast and acceleration effects associated with military training and operations" and "commend[ed] and encourage[ed] continued innovative experimentation in emerging strategies and technologies for the prevention of TBI."[34] Just as DoD has been encouraged by Congress to take steps to expand blast injury research and assessment protocols and formalize documentation of blast injuries, WWP calls on Committee members to ensure DoD follows through on these initiatives and others to ensure veterans have clear service documentation of their injuries and access to the most appropriate care.

Most specifically, under Section 734 of the *National Defense Authorization Act for Fiscal Year 2018* (P.L. 115-91), DoD was ordered to conduct a longitudinal medical study on blast pressure exposure of Service members during combat and training, including those who train with any high overpressure weapon system. Annual reports on progress indicate that no data collection has begun, and congressional oversight may ensure that the study's objectives are achieved as soon as reasonably possible.

Recommendation: *Complete a thorough accounting of current federally funded TBI research efforts to adequately determine whether resources are sufficient to meet demand for future care from veterans facing increased likelihood of encountering severe neurological challenges.*

With the sunset of the AL-TBI program, VA does not offer sufficient options for care now and may be unprepared for the foreseeable wave of need that is 5 to 10 years on the horizon. The needs of veterans with severe TBI are relatively better understood and have more predictable outlooks into the future than less severe cases; however, less severe cases – as they evolve on a wide sphere – have potential to create significant stress for VA's care system if not properly anticipated.

Congress can guide VA towards correcting the current landscape and acknowledging that today's arrangements for care for veterans in their 20s, 30s, and 40s may not be sustainable as many of their caregivers approach their 70s and 80s. Research is needed to investigate the progression of mild and moderate TBI to better prepare VA for the challenge of supporting these injuries in the future. WWP believes Congress can help align and coordinate current research efforts and help create a roadmap for more investment in the future with considerations about current research exploring early onset of long-term, debilitating illnesses that will require increasing levels of long-term therapy.

[34] S. REP. NO. 116-48, at 209 (2019) (Conf. Rep.).

- Alzheimer's Disease and Dementia: Notably, one study has found 30% of patients who die due to TBI exhibit plaques that are pathological features of Alzheimer's disease.[35] Greater risk exists in patients who report having lost consciousness during their traumatic event.[36] A similar study revealed cases of moderate and severe TBI in young men may increase risk of Alzheimer's Disease and dementia later in life.[37]

- Parkinson's Disease: Evidence of a connection between neurodegenerative conditions and TBI is perhaps strongest for Parkinson's Disease (PD). In a comprehensive meta-analysis, researchers found that 19 of 22 studies reported an Odds Ratio (OR) greater than 1·0, meaning the probability of PD correlating positively to TBI is more likely than not.[38] As is consistent with other neurodegenerative diseases, the severity of the TBI increases the risk of PD.

- Amyotrophic Lateral Sclerosis (ALS): A landmark 2007 study exploring head trauma in soccer player provides statistically significant evidence linking TBI to the development of ALS. Researchers found that the OR for ALS was eleven times higher among those who had multiple head injuries within the ten years prior to diagnosis.[39]

- Post-traumatic epilepsy: In 2015, researchers at the South Texas Veterans Health Care System and the University of Texas concluded that Iraq and Afghanistan veterans who had sustained mild TBIs were 28 percent more likely to develop post-traumatic epilepsy (PTE).[40] This was a breakthrough for PTE research, which points TBI-induced neuroinflammation and intracranial hemorrhaging as primary mechanisms.

- Suicide: There is no all-encompassing explanation for suicide and no single medical cause, etiology, or treatment or prevention strategy; however, it is important to recognize that individuals with a history of TBI have been shown to have higher rates of suicide than members of the general population[41]. In a recent study conducted in Denmark, researchers demonstrated that individuals with a medical contact for TBI were nearly twice as likely to die by suicide than the general population without TBI.[42]

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[35] Thamil Mani Sivanandam et al., *Traumatic brain injury: A risk factor for Alzheimer's disease,* NEUROSCI. & BIOBEHAV. REVS. (May 2012) available at https://www.sciencedirect.com/science/article/pii/S0149763412000395.
[36] Lindsay Wilson et al., *The Chronic and Evolving Neurological Consequences of Traumatic Brain Injury,* THE LANCET (Oct. 1, 2017) available at https://www.thelancet.com/journals/laneur/article/PIIS1474-4422(17)30279-X/fulltext.
[37] B.L. Plassman et al., *Documented Head Injury in Early Adulthood and Risk of Alzheimer's Disease and Other Dementias,* AM. ACAD. OF NEUROLOGY (Oct. 24, 2000) available at https://n.neurology.org/content/55/8/1158.short.
[38] S. Jafari et al., *Head Injury and Risk of Parkinson Disease: A Systemic Review and Meta-analysis,* OFFICIAL J. MOVEMENT DISORDER SOC'Y (Aug. 22, 2013) available at https://www.ncbi.nlm.nih.gov/pubmed/23609436.
[39] Honglei Chen et al., *Head Injury and Amyotrophic Lateral Sclerosis*, AM. J. EPIDEMIOLOGY (July 19, 2007) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2239342/.
[40] M.J. Pugh et al., *The Prevalence of Epilepsy and Association with Traumatic Brain Injury in Veterans of the Afghanistan and Iraq Wars*, J. HEAD TRAUMA REHABIL. (Jan. 2015) available at https://www.ncbi.nlm.nih.gov/pubmed/24695268.
[41] G. Simpson & R. Tate, *Suicidality in People Surviving a Traumatic Brain Injury: Prevalence, Risk Factors and Implications for Clinical Management*, BRAIN INJURY (Dec. 21, 2007) available at https://www.ncbi.nlm.nih.gov/pubmed/18066936; A.W. Engberg & T.W. Teasdale, *Suicide After Traumatic Brain Injury: A Population Study*, J. OF NEUROLOGY, NEUROSURGERY, AND PSYCHIATRY (Oct. 2001) available at https://www.ncbi.nlm.nih.gov/pubmed/11561024; Nazanin H. Bahraini, et al., *Suicidal Ideation and Behaviours after Traumatic Brain Injury: A Systematic Review*, BRAIN IMPAIRMENT (May 2, 2013) available at https://www.cambridge.org/core/journals/brain-impairment/article/suicidal-ideation-and-behaviours-after-traumatic-brain-injury-a-systematic-review/686E3BEC919567BE1CC64F56B1E4B866.
[42] T. Madsen, et al., *Association Between Traumatic Brain Injury and Risk of Suicide*, J. OF THE AM. MEDICAL ASS'N (Aug. 14, 2018) available at https://www.ncbi.nlm.nih.gov/pubmed/30120477.

CAREGIVERS

As part of our mission to honor and empower wounded warriors with all ranges of disability, WWP programming and advocacy extends to the hidden heroes at their side during recovery and rehabilitation – our nation's military and veteran caregivers. As a leading voice in the passage of the *Caregivers and Veterans Omnibus Health Services Act of 2010* (P.L. 111-163), WWP is uniquely positioned to amplify the concerns of this community through data, experiences, and longstanding relationships that have evolved through our programming footprint.

Wounded Warrior Project's advocacy in the caregiver policy arena is largely informed by the community support and care coordination we provide through our Independence Program, a long-term support program available to warriors living with a moderate to severe traumatic brain injury, spinal cord injury, or other neurological condition that impacts independence. As more than 31 percent of our *2019 Annual Warrior Survey* respondents reported needing the aid and attendance of a caregiver, WWP continues to partner with specialized neurological case management teams at Neuro Community Care and Neuro Rehab Management to provide individualized services through the Independence Program. In 2019, WWP invested in over 220,000 hours of in-home and community-based services that provide case management, care coordination, cognitive rehabilitation, caregiver respite, home skills training, support to increase social engagements to decrease isolation, transportation and mobility assistance, and access to physical health and wellness training to maintain physical therapy rehabilitation gains. The goals of the program are to rely less over time on caregivers to sustain at-home living, avoid transfer to group living situations before such moves are age-appropriate, and to find greater overall comfort, peace, and quality of life. These services are provided for free and augment or complement what warriors receive from VA.

As the veteran service community awaits publication of the regulations that will govern expansion of the Program of Comprehensive Assistance for Family Caregivers (PCAFC), VA remains a critical partner. WWP's advocacy toward VA has focused on the perspective of currently eligible post-9/11 veterans and caregivers, whose unique generational needs have been documented in RAND's seminal 2014 report, *Hidden Heroes: America's Military Caregivers*. While our 2020 advocacy will focus on VA's forthcoming regulations and ensuring that the PCAFC is adequately funded and staffed, WWP can currently provide the following recommendations.

Recommendation: *Support permanent (long-term) designation for caregivers of severely wounded veterans and efforts to standardize the evaluation process for caregiver program eligibility determinations.*

Current estimates suggest that approximately 75,000 veterans will join the PCAFC once it opens to other generations – or approximately 50,000 more veterans than the program currently serves.[43] Historically, the PCAFC has had insufficient resources and staff to respond to

[43] *See* CONG. BUDGET OFF., *S. 2193 Caring for Our Veterans Act of 2017*, (Jan. 17, 2018) available at https://www.cbo.gov/system/files?file=115th-congress-2017-2018/costestimate/s2193.pdf.

all the needs of enrolled veterans. There is inconsistency in eligibility determinations, tier assignments, and revocations.

To address some of these concerns, WWP supports a permanent designation for seriously injured veterans participating in the PCAFC. For individuals classified under the new permanent designation, we recommend a non-in-home annual review to ensure payments are going to the appropriate caregiver/recipient. Further, the negative effects of the program's decentralized local-level coordination can be addressed by nationally recognized policies and standard operating procedures.

Section 2 of the *Care for the Veteran Caregiver Act* (H.R. 5701) would initiate similar processes at VA. The bill proposes that VA establish a permanent eligibility status for the most catastrophically wounded veterans using the existing criteria under the law. The bill would also standardize the evaluation process for caregiver program eligibility determinations. WWP supports this legislation and urges committee members to pass this legislation into law.

EMPLOYMENT AND EDUCATION FOR WOUNDED VETERANS

Veterans across the country are generally enjoying a labor market that values their unique experience and potential to contribute across many sectors. As of January 2020, the veteran unemployment rate was 3.5% and marking its seventeenth consecutive month below the non-veteran unemployment rate.[44] Although this historically low level of unemployment reflects a positive trend across the general veteran population, WWP's *2019 Annual Warrior Survey* data cautions that employment and debt remain areas of concern for warriors registered with our organization. As discussed in more detail below, our survey data indicates that warriors who are wounded, ill, or injured have additional challenges when faced with the military to civilian transition, especially when entering a productive long-term civilian job.

The unemployment rate among non-Active Duty warriors completing the 2019 *Annual Warrior Survey* was 11.5%. For warriors not in the labor force, the primary reasons include mental health injury (31.4%), physical injury (19.0%), retirement (18.1%), or current enrollment in school or in a training program (11.1%). While the employment struggles among this community may be attributable to the fact that 64.8% of survey respondents reported a VA disability rating of 80 percent or higher, these statistics have made employment for the severely wounded a programming and advocacy priority for WWP.

Warriors seeking employment assistance through WWP can find help through our Warriors to Work program. The Warriors to Work program assists veterans searching for jobs after military service, with an emphasis on aiding at transition. This program provides a range of services designed to meet veterans wherever they are in their job-seeking process. We assist warriors with resumé building, job placement, interview skills, and skill translators. WWP recognizes that meaningful employment is critical to a successful transition from military to civilian life. Service-connected disabilities often make finding meaningful and long-lasting

[44] U.S. BUREAU OF LABOR STAT., *Table A-5. Employment Status of the Civilian Population 18 Years and Over by Veteran Status, Period of Service, and Sex, Not Seasonally Adjusted* (Feb. 7, 2020), https://www.bls.gov/news.release/empsit.t05.htm.

employment difficult. WWP's programming is designed to fill gaps in government services and raise awareness for federal, state, and local resources that exist. Fortunately, several existing programs have an encouraging foundation that can be improved to better meet the employment aspirations of severely wounded veterans.

Recommendation: *Update Chapter 31, the Vocational Rehabilitation and Employment program, to better serve unemployed veterans with disabilities through programmatic shifts and fundamental quality changes.*

Under Chapter 31 of Title 38, the Vocational Rehabilitation and Employment (VR&E) program provides employment opportunities through job training and other employment-related services, to include education, job search services, and small business start-up funds. The program is designed to evaluate and improve a veteran's ability to achieve his or her vocational goal; provide services to qualify for suitable employment; enable a veteran to achieve maximum independence in daily living; and enable the veteran to become employed in a suitable occupation and to maintain suitable employment. WWP supports using the VR&E program as a pathway to long-term employment for disabled veterans. To ensure that this program is operating at its highest potential and capacity, the following changes to Chapter 31 should be considered.

- *Raise Awareness and Improve Clarity/Intentions for Prospecting Veterans to Better Manage Expectations before Enrollment*

The process to enroll in Chapter 31 educational benefits can vary significantly among locations where the program is offered. An ambiguous and seemingly subjective process for establishing entitlement can lead to meaningfully different outcomes for veterans who present with similar needs or requests. VA and VSOs can renew their commitment to educate veterans on the intent of the VR&E program before applying for its benefits.

Additionally, there is anecdotal evidence of applicants being told to apply to less expensive online programs, program denials without enough rationale, and little consideration for approval of graduate-level degree programs even when they meet a veteran's best interest. Vocational rehabilitation counselors (VRCs) have indicated that insufficient staffing is a lingering issue, especially in large population locations. Further, VRCs have expressed concern over monetary constraints which require them to lower the average cost of each veteran using the program. VA should be allocated the appropriate funds to achieve their mission. A common complaint we have heard from veterans is the inability to switch to another counselor if they feel their current counselor is not assisting with reaching their employment goals. These are all issues that we recommend VA address with internal policy changes or Congress address through the legislative process.

- *Increase the Chapter 31 Subsistence Allowance to Align with Chapter 33*

Wounded Warrior Project requests that VA align its subsistence allowance to those outlined in Chapter 33 of Title 38. While a subsistence allowance is often necessary to support veterans completing Chapter 31 employment goals, the universal allowance amount fails to compensate for the relative costs of urban and rural living. For example, the VR&E subsistence

allowance of approximately $900 per month does not have the same financial assistance power in Los Angeles, CA, as it does in Charleston, SC. Subsequent financial pressures can lead veterans to discontinue in the VR&E program. A 2014 Government Accountability Office report showed that 18 percent of veterans who withdrew from VR&E services cited "financial difficulties." Another 27 percent indicated "family obligations," which could be considered financial difficulties as well, depending on the situation.[45]

- *Change Vocational Rehabilitation and Employment Program Name to Align with 21st Century Terminology*

Wounded Warrior Project recommends VA change the name of Chapter 31, Vocational Rehabilitation and Employment Program. We recommend VA remove the word "Rehabilitation" and replace it with something more appropriate for the 21st century. In 1918, when the VR&E program was launched, "rehabilitation" was defined as "the restoration of someone to a useful place in society.[46] Today, that same term is defined by the same dictionary as "the action, process, or result of rehabilitating or of being rehabilitated: such as […] the process of restoring a person to a drug- or alcohol-free state [or the] process of restoring someone (such as a criminal) to a useful and constructive place in society." [47]

While the word "rehabilitation" was appropriate in 1918, it is no longer widely used in the same fashion today. At the present time, the word "rehabilitation" or "rehab" is associated with programs for those seeking assistance for substance abuse. To alleviate confusion among those not familiar with the program, including prospective employers, Congress should consider a new name that more appropriately conveys the nature of the VR&E program to civilians in 2020 and beyond.

- *Streamline Veterans Utilizing Chapter 31 into Vacant VA Positions Across the Agency*

The goal of the VR&E program is to connect veterans with long-lasting employment. There is a strong anecdotal correlation between job satisfaction and the likelihood of resigning from a job within 12 months. WWP's *2019 Annual Warrior Survey* reveals that many veterans are finding employment with federal, state, and local governments. In 2018, 31.1 percent of all new government hires were veterans.[48] While veterans are applying for these open positions in record numbers, VRCs have suggested that it can be difficult finding federal employment for participants, perhaps due to the complexity of applying and obtaining employment in the federal government.

WWP recommends a pilot program to streamline veterans who are in the VR&E program into open positions at VA. By working with VA's Office of the Chief Human Capital Officer, the VR&E program can direct veterans into healthcare-related fields with the goal of filling critically needed VA positions. In 2018, there were 45,239 open vacancies at the VA[49] and

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[45] U.S. GOV'T ACCT. OFF., VA VOCATIONAL REHABILITATION AND EMPLOYMENT: FURTHER PERFORMANCE AND WORKLOAD MANAGEMENT IMPROVEMENTS ARE NEEDED, 18 (Jan. 2014).
[46] WEBSTER'S (1913), *available at* https://www.webster-dictionary.org/definition/Rehabilitation.
[47] *Merriam-Webster.com Dictionary*, s.v. "rehabilitation," accessed Feb. 18, 2020, https://www.merriam-webster.com/dictionary/rehabilitation.
[48] OFF. OF MGMT. AND BUDG., EFFICIENT, EFFECTIVE, ACCOUNTABLE: AN AMERICAN BUDGET, ANALYTICAL PERSPECTIVES FISCAL YEAR 2019, 65, available at https://www.whitehouse.gov/wp-content/uploads/2018/02/ap_7_strengthening-fy2019.pdf.
[49] Press Release, U.S. Dep't of Vet. Affairs, *VA Releases Data on Vacancies as Required Under MISSION Act* (Aug. 31, 2018) (available at https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5104).

around 125,000 participants in the VR&E program. This seems to be a natural fit for those looking for employment.

Recommendation: *Increased funding for VA education services IT capabilities to ensure the dissemination of information, tracking of data, and general IT capabilities are in line with VA's mission.*

While some Service members transitioning out of the military decide to join the civilian workforce, others will choose school as a step towards future employment goals. Based on WWP's *2019 Annual Warrior Survey*, about 1 in 5 warriors are enrolled in school to obtain a bachelor's degree, associate degree, or certificate to help their employment opportunities. WWP recognizes that education is a strong pathway to employment and will continue to work with VA and Congress to ensure that this critical benefit is protected for future veterans.

After multiple conversations with VA regarding its IT capabilities inside its Office of Education Service, it has become clear that the current IT capacity is not sufficient long term. Because of this, WWP will advocate for additional funding to update VA's Office of Education Service IT structure. It is imperative that Congress not only give VA direction in how to expand programs to veterans but also allocate appropriate funds to ensure that the missions VA is directed to perform can be achieved with the resources it has been allocated. Currently, the office which handles the post-9/11 GI Bill is in need of additional funding to update its IT capabilities; and in order for this office to administer this benefit to future veterans with minimal operational failures, it is critical they are funded at an appropriate level.

Recommendation: *Request a federal study to understand the discrepancy between unemployment rates between disabled veterans and veterans as a whole.*

As discussed above, WWP data suggests that post-9/11 wounded warriors are not enjoying the same employment success as the veteran population at-large. To better understand the discrepancy between the unemployment rates between disabled veterans and all veterans, WWP requests a federal study to understand the barriers that disabled veterans have when attempting to obtain long term employment and the programs VA and the Department of Labor (DoL) are using to address unemployment within the disabled veteran population. This report will assist advocates like WWP in addressing unemployment among severely wounded veterans by knowing where to target legislation to fill lapses in federal assistance.

ADDITIONAL CONSIDERATIONS

While the issues above have been identified as the most critical, WWP supports three additional proposals before Congress to address the needs of post-9/11 wounded warriors. All three provide crucial benefits for our warriors to improve their quality of life.

Specially Adapted Housing

Support the *Ryan Kules Specially Adaptive Housing Improvement Act of 2019* (H.R. 3504) and the *Ryan Kules and Paul Benne Specially Adaptive Housing Improvement Act of 2019* (S. 2022)

For many of America's wounded veterans, everyday tasks can prove difficult and even dangerous due to mobility and accessibility challenges in their homes. In order to overcome these obstacles, it is important to adapt homes to accommodate the needs of disabled veterans.

The Specially Adapted Housing (SAH) program at VA provides funds to assist with the purchase or construction of an adaptive home to accommodate disabilities. While this program does provide great benefits, there are two shortcomings. First, the program often does not cover all the costs of adapting veterans' homes. Many veterans must spend tens of thousands of dollars out of pocket to make all necessary adjustments. Second, the SAH grant may only meet the needs of veterans at a particular moment in time. As younger veterans grow older, get married, or have families, their needs from their adaptive home can change dramatically. These changing needs also exist for those whose disabilities worsen over time. It is vital that adaptive housing is actually adaptable to meet the evolving needs of disabled veterans at various stages of life.

The *Ryan Kules Specially Adaptive Housing Improvement Act of 2019* passed the House floor on July 23, 2019, and we are pleased that it has been introduced in the Senate as S. 2022 by Chairman Jerry Moran. If passed into law, these bills would fully reinstate SAH benefits to eligible veterans every 10 years to accommodate moving and other normal life changes. This bill will also increase the number of times the benefit can be accessed from three up to six. Providing these benefits will significantly improve quality of life for many disabled veterans.

Dignified Air Travel
Support the *Veterans Expedited TSA Screening Safe Travel Act* (S. 1881, H.R. 3356)

Many of our nation's veterans face significant challenges surrounding airport security. At security checkpoints, veterans are frequently required to take off prosthetics, remove themselves from wheelchairs, and hand over assistive devices. Current airport security processes are overly intrusive and can make airport travel daunting, embarrassing, and even dangerous. Additionally, such requirements slow down the screening process for both veterans and other travelers, providing further safety concerns.

The *Veterans Expedited TSA Screening Safe Travel Act* would grant many severely injured and disabled veterans a more dignified experience when passing through security checkpoints. If passed, this legislation would provide TSA Pre-check free of charge to severely disabled veterans who are amputees, paralyzed, blind, or require an assistive mobility device. This is a benefit already offered to Active Duty, Reserves, and National Guard Service members at no cost; this bill seeks to provide equivalent consideration to severely disabled veterans.

The *Veterans Expedited TSA Screening Safe Travel Act* passed the Senate on September 10, 2019 and has been introduced in the House. WWP appreciates Rep. Paul Gosar's leadership in sponsoring this bill and supports its quick passage to ensure safety and dignity for our nation's veterans and comfortable and efficient travel experiences for all citizens.

Overlaps of TRICARE, Medicare, and Social Security
Support the *HEARTS and Rural Relief Act* (H.R. 3429) and introduce the *FAIR Heroes Act* (draft bill)

Many Service members who have suffered severe injury or illness are granted TRICARE eligibility for the rest of their lives. Unlike traditional military retirees, however, many severely injured medical retirees apply for Social Security Disability Insurance (SSDI) during their separation from the military. For most, this decision can restrict access to certain TRICARE plans and ultimately result in hundreds of dollars per year in costs for obligatory Medicare insurance that veterans may not want or use.

Congress has two approaches it can take to solve all or part of this ongoing problem. One option is the *HEARTS and Rural Relief Act* which would alleviate the challenges faced specifically by those severely wounded veterans who have recovered from their injuries, returned to work, and disenrolled from SSDI. This bill was introduced by Rep. Terri Sewell on June 24, 2019 and subsequently reported out of the House Committee on Ways & Means on June 26, 2019.

A more comprehensive legislative proposal to fix this confusing overlap of federal benefits is the *FAIR Heroes Act*. This bill's approach would address the problems faced by all veterans in this legal knot by creating an option to remain enrolled in a traditional, low-cost TRICARE plan if such a plan works better to address a particular veteran's health and financial needs. The bill would also apply the changes offered by the HEARTS and Rural Relief Act. *The FAIR Heroes Act* includes an educational component to help ensure that a veteran's health care insurance choice is as informed as possible. This bill was introduced by Rep. Susan Davis and Sen. Bill Nelson in the 115th Congress and is poised for reintroduction in the near future.

Wounded Warrior Project supports both legislative proposals but recognizes that the *FAIR Heroes Act* provides a more robust legislative fix. Pending reintroduction of the *FAIR Heroes Act*, WWP urges committee members to support and pass at least one of these bills to alleviate an unfair and unintended hurdle that a distinct population of wounded warriors face when hoping for comprehensive and affordable health services.

CONCLUDING REMARKS

Wounded Warrior Project thanks the Senate and House Committees on Veterans' Affairs, their distinguished members, and all who have contributed to a robust discussion of the challenges – and the successes – experienced by veterans across our great nation. Your actions to support quality mental health care and interventions; to recognize and treat the harmful effects of military toxic exposures; to meet the growing needs of women veterans; to chart a course for the near- and long-term care for TBI; to support hidden heroes; and to bolster efforts to prepare wounded warriors for meaningful post-service employment will have a particularly strong impact on the post-9/11 generation, but WWP stands by as your partner in meeting the needs of all who served – and all who support them. We are thankful for the invitation to submit this statement for record and stand ready to assist when needed on these issues and any others that may arise.

APPENDIX

Appendix 1

WOUNDED WARRIOR PROJECT | 2019 IMPACT

138,000 WARRIORS | 35,000 FAMILY MEMBERS | 49 NEW REGISTRANTS EACH DAY

Wounded Warrior Project® (WWP) is transforming the way America's veterans are empowered, employed, and engaged in our communities. Our direct service programs focused on connection, independence, and mental, physical, and financial wellness create a 360-degree model of care and support. The following statistics represent the impact of these programs on the lives of the warriors and family members we serve.

CONNECTION

VETERANS WITH GREATER SOCIAL SUPPORT HAVE MORE POSITIVE MENTAL HEALTH OUTCOMES, INCLUDING **LOWER RATES OF SUICIDAL IDEATION**

7,500 +

events held across the country, providing vital connection between warriors, their peers, and communities

RESULTING IN

90%

reporting that they feel socially connected to their peers, 18% higher than the average WWP warrior population

AND

89%

saying they have people they can depend on, 10% higher than the average WWP warrior population

800 +

warrior-only peer-to-peer support group meetings held

WOUNDED WARRIOR PROJECT

MENTAL HEALTH

2,500 +

participants in a 12-week adventure-based mental health program

72,000 +

hours of PTSD treatment provided

RESULTING IN

77%

experiencing fewer PTSD symptoms, reducing interference of mental health issues on daily life

14,500 +

emotional support calls conducted with warriors and family members

RESULTING IN

70%

improving psychological well-being, increasing overall quality of life

AND

67%

becoming more resilient, a key factor in preventing suicidal ideation

PHYSICAL HEALTH

55%

experienced a reduction in pain, reducing the interference of physical injuries on daily life

22%

reduced dosage or frequency of prescription medication

55%

improved physical well-being, associated with lower health care costs and fewer doctor visits

59%

improved psychological well-being, contributing to their mental health recovery

INDEPENDENCE

220,000 +

hours of in-home and local care provided to the most severely injured warriors, helping them reach and maintain a level of autonomy that would not otherwise be possible

FINANCIAL WELLNESS

93%

approval rate for benefits issues filed

RESULTING IN

$131 MILLION

economic impact for warriors

WARRIORS WORKING FOR AN EMPLOYER THAT HAS AN AFFINITY GROUP OR MENTORSHIP PROGRAM FOR VETERANS ARE **MORE THAN TWICE AS LIKELY TO BE TOTALLY SATISFIED WITH THEIR EMPLOYMENT**

16,900 +

career counseling services provided, including resume review, interview prep, and networking opportunities

1,900 +

warriors and family members achieved meaningful employment with veteran-friendly employers

$51,610

average full-time salary (10% higher than the U.S. average)

Appendix 2

WOUNDED WARRIOR PROJECT®

★ 2019 ★

ANNUAL WARRIOR SURVEY

10-YEAR TRENDS

Since 2010, Wounded Warrior Project® has conducted the Annual Warrior Survey to identify the greatest challenges faced by the warriors we serve. Over the last decade, it's allowed us to track changes in these challenges and respond to the evolving needs of warriors with innovative programs and services, as well as advocacy for legislation that makes a real difference.

Wounded Warrior Project's Annual Warrior Survey continues to be the largest, most statistically relevant survey of injured post-9/11 veterans. With 35,908 respondents, the 2019 Annual Warrior Survey boasts the highest number of participants in its ten-year history.

NUMBER OF WARRIORS WHO PARTICIPATED IN THE SURVEY:

2010	2014	2019
1,121	21,120	35,908

DEMOGRAPHIC PROFILE

MALE | FEMALE

UP 10% SINCE 2010

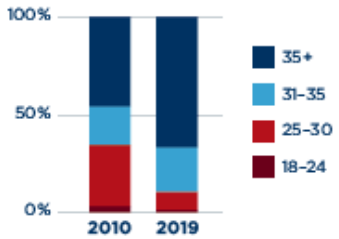
	2010	2014	2019
MALE	93%	86%	83%
FEMALE	7%	14%	17%

AVERAGE AGE IS

★ 42 ★

WAS 36 IN 2010

AS WARRIORS AGE, THEIR NEEDS WILL CONTINUE TO EVOLVE — MAKING RESOURCES LIKE THE ANNUAL WARRIOR SURVEY CRITICAL TO UNDERSTANDING HOW TO BEST SERVE THEM.



★ 7% ★

ARE ACTIVE DUTY

WAS 20% IN 2014*

*Question was not asked in 2010

MENTAL HEALTH & MENTAL HEALTH CARE

★ 83% ★

OF WARRIORS **SUFFER FROM PTSD, A 7% INCREASE FROM 2010 (76%).**

10

WHILE MENTAL HEALTH ISSUES CONTINUE TO ARISE AT AN ALARMING RATE, **ACCESS TO MENTAL HEALTH CARE HAS MADE LITTLE IMPROVEMENT IN THE PAST 10 YEARS.**

★ 32% ★

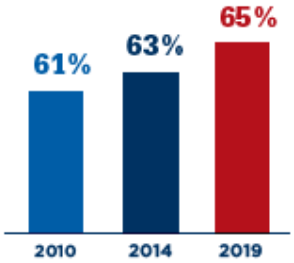
HAD DIFFICULTY GETTING MENTAL HEALTH CARE, PUT OFF GETTING SUCH CARE, OR DID NOT GET THE CARE THEY NEEDED — A MINIMAL IMPROVEMENT FROM 34% IN 2010.

THE BARRIERS THAT HAVE REMAINED A TOP CONCERN FOR WARRIORS OVER THE PAST 10 YEARS INCLUDE:

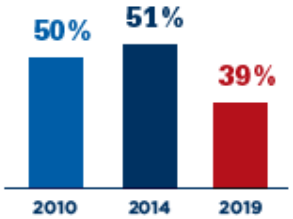
1. **INCONSISTENT TREATMENT** DUE TO CANCELED APPOINTMENTS, HAVING TO SWITCH PROVIDERS, ETC.
2. **UNCOMFORTABLE WITH EXISTING RESOURCES** WITHIN THE DOD OR VA
3. **FELT THEY WOULD BE CONSIDERED WEAK** FOR SEEKING MENTAL HEALTH TREATMENT

Despite a noticeable culture shift, the stigma associated with mental health remains a barrier to care among warriors. **Nearly 1 in 5 fear being seen as weak for seeking treatment (21% in 2010).**

ABOUT 2/3 OF WARRIORS CITE VA MEDICAL CENTERS AS A TOP RESOURCE FOR ADDRESSING MENTAL HEALTH CONCERNS — A STEADY INCREASE SINCE 2010.



WARRIORS ARE RELYING LESS ON PRESCRIPTION MEDICATION TO COPE WITH MENTAL HEALTH ISSUES. 39% CITED IT AS A TOP RESOURCE IN 2019, COMPARED TO 50% IN 2010.



PHYSICAL HEALTH & HEALTHCARE

★ **65%** ★

HAVE A DISABILITY RATING OF **80% OR HIGHER — A NOTABLE INCREASE FROM 48% IN 2010**

★ **52%** ★

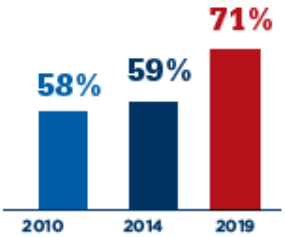
OF WARRIORS ARE **OBESE (BMI SCORES OF 30+), SOARING 12% SINCE 2010.**

THE PERCENTAGE OF WARRIORS WHO HAVE HEALTH CARE COVERAGE THROUGH THE VA

HAS INCREASED BY

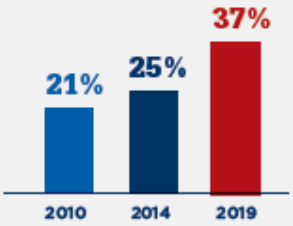
★ **12%** ★

IN JUST THE PAST FIVE YEARS.

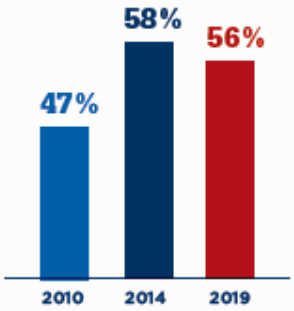


EDUCATION, EMPLOYMENT, & FINANCES

WARRIORS WHO HAVE A BACHELOR'S DEGREE OR HIGHER:



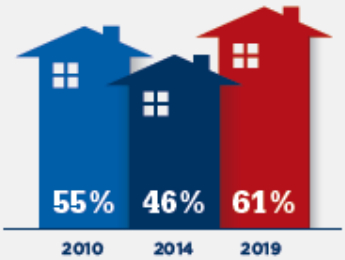
WARRIORS EMPLOYED FULL- OR PART-TIME:



WARRIORS ARE FEELING BETTER ABOUT THEIR FINANCES, **30% STATING THAT THEIR FINANCIAL STATUS IS BETTER THAN IT WAS A YEAR AGO – AN IMPROVEMENT FROM 22% IN 2010, AND 23% IN 2014.**

HOMEOWNERSHIP

HOMEOWNERSHIP AMONG WARRIORS **REACHED A 10-YEAR HIGH IN 2019.**



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Appendix 3

★ 2019 ★ ANNUAL WARRIOR SURVEY

WOUNDED WARRIOR PROJECT®

For the last decade, the **Wounded Warrior Project® Annual Warrior Survey** has given injured post-9/11 veterans a voice — a platform to be heard by individuals and organizations who can initiate change.

In 2019, 35,908 warriors participated, making it the largest, most statistically relevant survey of its kind — providing an extensive 360° view of the warriors WWP serves. The data allows us to track and treat the most pressing needs of warriors, guiding our programmatic, research, and advocacy efforts.

★ DOWNLOAD THE FULL REPORT and additional materials at AnnualWarriorSurvey.com/2019

DEMOGRAPHICS

83% MALE

17% FEMALE

AVERAGE AGE IS ★ **42** ★

★ **7%** ★ ARE ACTIVE DUTY

HEALTH

★ **91%** ★ EXPERIENCED **MORE THAN THREE** SERVICE-RELATED INJURIES OR HEALTH PROBLEMS.

★ **44%** ★ OF FEMALE WARRIORS EXPERIENCED **MILITARY SEXUAL TRAUMA (MST).**

★ **70%** ★ OF WARRIORS REPORTED EXPOSURE TO TOXIC SUBSTANCES OR HAZARDOUS CHEMICALS DURING THEIR MILITARY SERVICE.

★ **HOWEVER, ONLY 9%** ★ **SAID THEY HAD RECEIVED TREATMENT FOR THEIR EXPOSURE AT THE VA.**

EMPLOYMENT

WARRIORS CONTINUE TO OVERCOME UNIQUE CHALLENGES IN THE WORKFORCE BUT FACE **AN UNEMPLOYMENT RATE 3X HIGHER** THAN THE U.S. NATIONAL UNEMPLOYMENT RATE.

UNEMPLOYMENT RATE

11.5% WWP WARRIORS

3.5% ALL VETERANS

3.5% U.S. NATIONAL RATE

WARRIORS CITE THE FOLLOWING AS BARRIERS TO EMPLOYMENT:

1. MENTAL HEALTH ISSUES
2. DIFFICULTY BEING AROUND OTHERS
3. NOT QUALIFIED — LACK OF EDUCATION

MENTAL HEALTH

PTSD	ANXIETY	DEPRESSION
83%	81%	77%

★ 33% ★

REPORTED HAVING THOUGHTS RELATED TO SUICIDE IN THE PAST TWO WEEKS

MENTAL HEALTH ISSUES CONTINUE TO GROW AT AN ALARMING RATE, WHILE **NEARLY 1/3 OF WARRIORS ARE STILL STRUGGLING TO GET THE MENTAL HEALTH CARE THEY NEED.**

VA USAGE

★ 90% ★

ARE RECEIVING COMPENSATION BENEFITS FROM THE DEPARTMENT OF VETERANS AFFAIRS (VA).

★ 65% ★

HAVE A DISABILITY RATING OF **80% OR HIGHER — MORE THAN ONE-THIRD HAVE RATINGS OF 100%.**

71% OF WARRIORS RECEIVE SOME HEALTH CARE COVERAGE THROUGH THE VA

70%

OF THEM CHOOSE THE VA AS THEIR PRIMARY PROVIDER

TOP THREE REASONS:

- CAN GET CARE FOR A SERVICE-CONNECTED DISABILITY
- THEY FEEL ENTITLED TO IT
- PRESCRIPTION BENEFITS

TOP THREE REASONS:

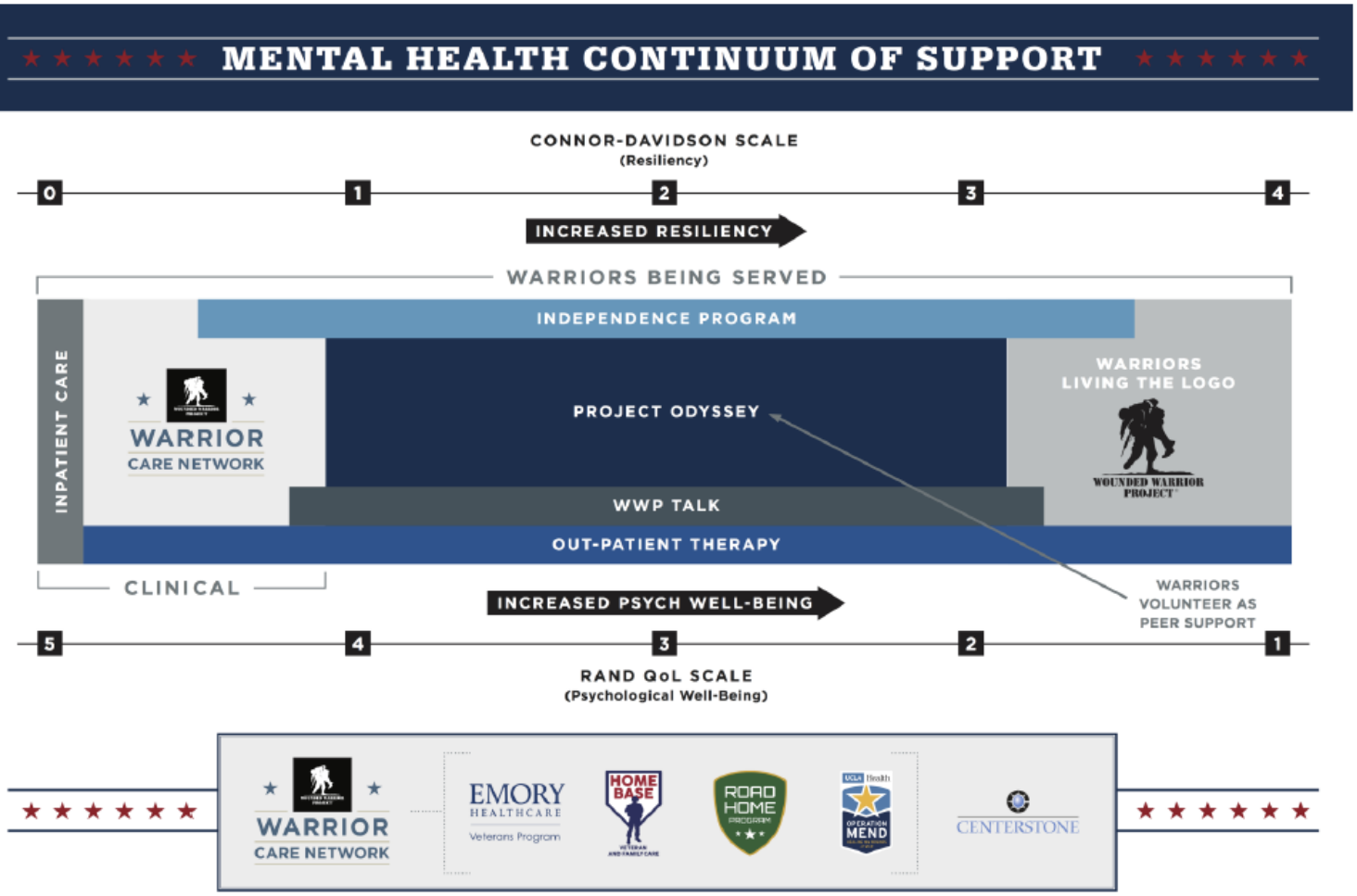
- BAD PRIOR EXPERIENCE AT THE VA
- DON'T THINK THE VA HEALTH CARE WOULD BE AS GOOD AS THAT AVAILABLE ELSEWHERE
- VA CARE IS DIFFICULT TO ACCESS

30%

OF THEM CHOOSE A PRIMARY PROVIDER *OTHER THAN* THE VA

Appendix 4

Wounded Warrior Project Mental Health Continuum of Support



Wounded Warrior Project Mental Health Continuum of Support

Wounded Warrior Project's (WWP) comprehensive approach to mental health care is focused on improving the levels of resilience and psychological well-being of warriors and their families. The Mental Health Continuum of Support is comprised of a series of programs, both internal to WWP and in collaboration with external partners and resources, intended to assist warriors and their families along their journey to recovery. The Mental Health Continuum of Support provides diverse programming and services in order to better meet their needs. All programs are at no cost to the warrior or their families.

The programs within the continuum are designed to complement one another to foster momentum in the healing process. Through the implementation of the Connor Davidson Resiliency and the VR12 Rand Quality of Life scales, WWP measures outcomes of services and provides the most effective programming based on the needs of warriors and their families.

Inpatient Care

Inpatient care is the highest level of care offered on the continuum and is intended to meet the most urgent needs of warriors by providing immediate stabilization. Inpatient services are reserved for those who are actively suicidal, had recent suicide attempts, require drug or alcohol detox, or other similarly acute needs. WWP contracts with a number of vetted skilled facilities across the country. These warriors have usually exhausted all other resources for care and are in severe psychological distress.

Warrior Care Network

Warrior Care Network (WCN) is a collaborative program between WWP and four Academic Medical Centers (AMC) - Emory University, Massachusetts General Hospital, Rush University, and UCLA. Each AMC provides a 2-3 week long post-traumatic stress (PTS) centric intensive outpatient program (IOP) as well as regional outpatient (OP) services. The IOP is structured around a cohort model with clinicians who specialize in the care of veterans. WCN is designed for warriors who are not in acute levels of psychological distress but still have significant impairment due to PTS and/or other mental health conditions.

Project Odyssey

Project Odyssey (PO) is a 90 day program which includes a multi-day event led by WWP teammates specially trained in adventure based counseling and experiential learning. The strong mental health component fully integrated into PO is what separates it from other adventure based programs. There are male only, female only, and couples POs at multiple sites across the country designed around a cohort model leveraging the peer to peer support. During the event portion, participants are challenged through a variety of activities such as rock climbing, kayaking, high ropes courses, and the like, while continuously engaged in psycho-education. PO not only improves mental and emotional well-being, but provides additional tools to help with PTSD, combat stress, and other invisible wounds of war. Participants engaged with PO are further along in their recovery journey and relatively stable but are still in need of mental health support. Following the PO event, participants are engaged by WWP teammates, either telephonically or via the web, for 90 days to strengthen the skills learned during the PO, set growth goals, and receive support on goal achievement.

WWP Talk

WWP Talk is an internal program where WWP teammates, specially trained in active listening, reach out telephonically to warriors, family members and/or caregivers on a routinely scheduled weekly basis for 6-9 months. Participants are provided an empathic ear without fear of judgment and are provided assistance in establishing and achieving SMART goals. WWP Talk is often used simultaneously while participants are engaged in other programs and services throughout the Mental Health Continuum of Support.

Outpatient therapy

Traditional outpatient therapy is a resource available to warriors and families throughout the continuum. WWP engages with an external partner to provide individual, family, or couples therapy delivered by a military culturally competent therapist in the participant's local community. WWP refers warriors and family members to various external partners who have created a national network of therapists. WWP funds 12 sessions with the possibility to extend those sessions if clinically appropriate.

Independence Program

The Independence Program is a long-term support program available to warriors living with a moderate to severe traumatic brain injury, spinal cord injury, or other neurological condition that impacts independence. WWP has a partnership with specialized neurological case management teams at Neuro Community Care and Neuro Rehab Management to provide individualized services. These teams focus on increasing access to community services, empowering warriors to achieve goals of living a more independent life, and continuing rehabilitation through alternative therapies.

Living the Logo

Living the Logo is WWP's ultimate goal for all warriors - the WWP logo is much more than a trademark, it is a symbol of empowerment. Living the Logo refers to a warrior that was once being carried who has become empowered through the healing and recovery process and can now carry another warrior along their journey of recovery. As resiliency and psychological well-being reach the highest levels in the continuum, warriors become community ambassadors and engage as peer mentors and leaders.

TESTIMONY
PRESENTED BY

Thomas A. Zampieri, Ph.D.
BVA NATIONAL PRESIDENT

BEFORE A JOINT SESSION OF THE HOUSE AND SENATE COMMITTEES ON VETERANS AFFAIRS

February 26, 2020

INTRODUCTION

Chairman Moran, Chairman Takano, Ranking Member Tester, Ranking Member Roe, and distinguished Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) – and its membership – we appreciate this opportunity to present our legislative priorities for 2020. As the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our nation's blinded veterans – and their families – BVA would like to highlight that "National Blind Veterans Day" occurs March 28, 2020 and marks the 75th anniversary of our organizations founding by World War II blinded army servicemembers at Old Avon Farms Convalescent Center in Connecticut.

It is our hope that this second session of the 116th Congress will proactively address the following critically important issues:

I. Ensure that the Department of Veterans Affairs (VA) implements caregiver benefits for catastrophically disabled veterans of *"ALL"* war eras – mandating that eligibility criteria be inclusive of caregivers for blinded veterans;
II. Enact H.R. 3504 modernizing VA's Specially Adapted Housing (SAH) grant program – mandating eligibility criteria be inclusive of legally blind veterans;
III. Enact H.R. 1199 mandating VA's compliance with website accessibility as required by Section 508 of the Rehabilitation Act (29 United States Code §794d), as amended by the Workforce Investment Act of 1998 (Public Law 105-220);
IV. Enact H.R. 4589 making permanent the authority of VA's Secretary to award grants for the transportation of highly rural veterans to medical care;
V. We support and urge swift Senate passage of H.R. 4920 continuing VA contracting with AbilityOne® programs that employ blinded and visually impaired veterans;
VI. We support adequate funding of Veterans Health Administration (VHA) Blind Rehabilitation Services (BRS);
VII. We support improving programs and services for women veterans;
VIII. We support Fiscal Year 2021 (FY21) appropriations of $30 million for the Department of Defense (DoD) Congressionally Directed Medical Research Program (CDMRP) Vision Research Program (VRP) strengthening the *"ONLY"* research program focused on prevention and treatment of combat-related ocular trauma and Traumatic Brain Injury (TBI) visual dysfunction;
IX. We call upon Congress, VA, and DoD to request that the Assistant Secretary of Defense for Health Affairs (ASDHA) – working with our United Kingdom (UK) Defence Medical colleagues, Universities, and non-profit associations – to sign a five-year agreement establishing a Joint International Ocular Trauma Task Force;
X. We urge Congress to mandate DoD Defense Health Agency (DHA) compliance with Section 703 of the National Defense Authorization Act (Public Law 114-328) for (FY17) requesting the designation of four ocular trauma centers.

I. EXTENSION OF VA BENEFITS TO CAREGIVERS OF VETERANS FOR ALL WAR ERAS

Caregivers are the most important component of rehabilitation and maintenance for veterans with catastrophic injuries. While the Department of Veterans Affairs (VA) provides essential health care services to severely disabled veterans, for many it is caregivers who provide the day-to-day services and

support needed to sustain their well-being. The welfare of caregivers has a direct impact on the quality of care veterans receive and the quality of life they can sustain. Title 1 of Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, required VA to create a caregiver-support program for those veterans catastrophically injured as a result of their service. Currently, some 19,000 Post-9/11 era veterans access these services. In the years to come, as the VA MISSION Act provisions are enacted, an estimated 90,000 veterans are likely to begin utilizing these services.[1]

The task before VA is monumental. The Caregiver Support Program must correct current flaws while preparing to meet and serve a larger, older population of veterans that – in addition to their service-connected disabilities – have age-related conditions as well.[2] One of the factors that most commonly leads people over the age of 65 to seek admission into nursing homes is blindness. Such admissions are sought based on a false assumption that nursing homes are the only place where blind persons can obtain the support and assistance they need. However, there is ample evidence to indicate that paying for nursing home care is neither cost-effective for VA, nor in the best interest of most veterans. Rather, many such veterans can and should age in place, supported by one or more caregivers. VA support for these caregivers would require a fraction of the cost of nursing home care. The Blinded Veterans Association (BVA) concurs with the discussion and recommendations on this issue contained in the Independent Budget Veterans Service Organizations (IBVSO) for 2019.

Further, we caution members of Congress and VA officials to ensure that the measures in Public Law 161-163, which purport to expand benefits to caregivers of veterans who served in conflicts prior to 9/11, do not inadvertently deny some veterans access to this more cost-effective and quality-of-life enhancing alternative. By utilizing eligibility determination tools that result in inaccurate characterization of the catastrophic impact vision loss has on a veteran's life, these measures deny caregivers much needed benefits. As VA begins the phasing-in of these benefits to veterans of all eras, we urge members of the House and Senate Veterans' Affairs Committees to ensure that VA's implementing regulations do not define eligibility in a manner that measures need based exclusively on a veteran's ability to perform activities of daily living (ADL) involving non-sensory physical tasks, such as feeding and grooming oneself.

After a comprehensive review in 2017 and the issuance of Veterans Health Administration (VHA) Directive 1152(1), "Caregiver Support Program," the Independent Budget Veterans Service Organizations (IBVSOs) believe VHA has made consistent improvements, but BVA rejects any assessments based on ADL criteria alone, as they do not provide adequate means to measure the impact of "sensory disabilities."[3] Any VHA policy made to expand benefits for caregivers must be implemented in a manner that recognizes that "catastrophic disabilities" substantially affect a range of life activities – including neuro-sensory and cognitive functions – and fairly evaluates eligibility based on the severity of the disability and a veteran's demonstrated need for caregiver support.

II. MODERNIZING VA SPECIALLY ADAPTED HOUSING GRANT ELIGIBILITY FOR BLINDED VETERANS

The Blinded Veterans Association (BVA) thanks Congresswoman Luria – and the House Veterans Affairs Committee (HVAC) – for passing H.R. 3504, the "Ryan Kules Specially Adaptive Housing Improvement

[1] http://www.independentbudget.org/pdf/funding.pdf pg. 6
[2] http://www.independentbudget.org/116-congress/ pg. 26
[3] Ibid, IBVSO Caregivers pg. 37

Act," bipartisan legislation that would expand the pool of veterans eligible to receive Department of Veterans Affairs (VA) administered Specially Adaptive Housing (SAH) grants to include blinded veterans. Current eligibility requirements mandate that a blinded veteran also suffer from the loss, or loss of use, of an additional extremity.

Section 202 of Public Law 112-154 also provides that, in addition to those veterans currently eligible for SAH under 38 United States Code § 2101(a) (see 38 Code of Federal Regulations § 3.809), veterans who served on or after September 11, 2001, and who incurred a permanent – but not necessarily total – disability "due to the loss or loss of use of one or more lower extremities – which so affects the functions of balance or propulsion as to preclude ambulating without the aid of braces, crutches, canes, or a wheelchair" are eligible for the SAH benefit. Legal blindness, by itself, was not included as a qualifying disability under the existing language. This limitation precludes blinded veterans from adapting their homes with features capable of mitigating vision loss and restoring lost independence. Modern technologies are available that would enable blinded veterans to perform many of the tasks associated with independent living. Unfortunately, these technologies are expensive, and therefore, often beyond the reach of many blinded veterans. We urge swift passage of H.R. 3504 by the Senate.

III. MANDATING VA COMPLIANCE WITH EFFECTIVE COMMUNICATION REQUIREMENTS

The Blinded Veterans Association (BVA) thanks Congresswoman Luria – and the House Veterans Affairs Committee (HVAC) – for passing H.R. 1199, the "VA Website Accessibility Act of 2019," bipartisan legislation that would direct the Department of Veterans Affairs (VA) to report to Congress regarding the accessibility of VA websites (including attached files and web-based applications) to individuals with disabilities. The report would identify websites, files, and applications that are not accessible to such individuals and include the VA's plan to make each of them accessible.

VA currently faces a myriad of challenges on multiple fronts, and many issues compete for the attention of its leaders. Not the least of these concern the capacity of VA's Information Technology (IT) infrastructure to meet the demands resulting from ever-changing expectations regarding communications between federal government agencies and those who utilize their programs and services. Federal agencies are now expected to make ever-increasing amounts of information accessible through a rapidly growing number of media and devices, and VA has struggled to keep up with these demands. One area in which VA has struggled the most is the area of compliance with accessibility guidelines for the design and dissemination of electronic information.

A 2012 Department of Justice (DOJ) report indicated that although Section 508 was enacted in 1998, agencies across the federal government continue to fall short when it comes to the implementation and management of compliance with this provision, and regrettably, VA is no exception. Despite this report and several years of ongoing dialogue between VA's senior IT officers and BVA's national leadership, numerous websites and information technologies utilized by VA remain out of compliance with the most basic accessibility guidelines. In addition, VA has repeatedly compounded this problem by introducing new technologies that are not compliant and, in some cases, allowing upgrades that remove accessibility features that were once in place.

Guidelines and best practices for digital accessibility have existed for decades. The Website Content Accessibility Guidelines (WCAG), developed by the Worldwide Web Consortium, have been accepted as

the industry standard by both the private sector and the federal government for years. It is therefore time that government agencies comply as the federal courts have ruled.

In 2013, the Office of General Counsel (OGC) advised VA that by failing to send correspondence to claimants who were known to be blind – in formats they could read – VA was in violation of its statutory obligation to "send proper notice." The OGC went on to point out that in cases where such improper notice was given, the claim must remain open until such time as the appropriate notice was given. It was noted that this includes claims where decisions have been rendered denying the claim. The OGC stated that in such cases notice of denial was improperly given and was therefore invalid, thus subjecting VA to possible litigation for retroactive benefits. If VA fails to serve proper notice in such cases, the amount of any retroactive benefits due to an applicant may continue to compound.

Under current Veterans Benefits Administration (VBA) regulations, notice by telephone is only provided to blinded veterans who have service-connected disabilities and who have previously received a rating of 70 percent or higher. Therefore, veterans who have visual impairments rated at less than 70 percent, whether the underlying disability is service-connected or not, do not qualify to receive phone calls to alert them of actions taken on their claims, let alone notices of those actions that are sent in a format the veteran can read, such as large print.

An ongoing concern involves VA's Training, Responsibility, Involvement, and Preparations of Claims (TRIP) portal. Several years ago, prior to its deployment, BVA made repeated requests to VA staff asking for assurance that the portal be accessible, enabling blind Veteran Service Officers (VSOs) access to the training. The portal was released by VBA in 2018 – and to date – remains inaccessible to individuals requiring adaptive screen reader technologies. As is all too often the case, this situation could have been avoided if the site's developers had followed industry-standard accessibility guidelines. Now, barriers to access via screen readers that were inadvertently built into the website's design cannot be readily removed without requiring a major and expensive overhaul of the entire design.

Another challenge for blinded veterans in rural regions involves VA's reliance on telehealth initiatives for the provision of mental health services. Unfortunately, much of this technology remains inaccessible to the blind, and more than a third (36 percent) of rural veterans lack access to the Internet at home, which further constrains VA's ability to meet their needs. Thus, the web-based technologies routinely used to monitor and educate so many veterans cannot be accessed by this cohort. [4]

We recommend that Congress require VA to create an Information Accessibility Officer position in every Veterans Integrated Service Network (VISN) and VBA Regional Office. These Information Accessibility Officers would serve as liaisons to VA's 508 Compliance Office. They would also be responsible for ensuring that every disabled veteran have access – and the necessary knowledge – to use VHA and VBA documents and websites. They would also educate veterans on how to navigate VA websites and notify VA of any barriers that may limit veterans' access to information.

In addition to the countless DOJ and VA Office of Inspector General (OIG) warnings, the recent Supreme Court decision rendered October 7, 2019 should serve as a VA wakeup call. The Court declined to hear an appeal by Domino's Pizza seeking to overturn an order from the Ninth Circuit requiring the company

[4] Ibid, VSO Independent Budget pg. 71

to make their website accessible to people who have disabilities. The case was initiated by a blind individual who could not use Domino's website to place an order using his screen-reading software. The federal court ruled in his favor, stating that just as the Americans with Disabilities Act (ADA) requires businesses to ensure that people with disabilities have access to their buildings, goods, and services, businesses must also ensure that they can use their websites.

We believe these challenges will continue until the issue of accessible communications becomes a top IT system priority for VA's entire senior leadership. Failure to do so could result in our joining with various other stakeholders in finally filing a federal lawsuit forcing VA compliance. We believe that by directing the VA Secretary – via implementation and strong Congressional oversight of H.R. 1199 – would provide the impetus for VA's commitment to the addressing of these issues.

The following VA 508 compliance issues remain as outstanding BVA concerns:

- Continued reliance on inaccessible kiosks at VA Medical Centers (VAMCs), the use of which are required to check in for scheduled appointments. A recent Request for Information (RFI) issued by VA failed to notify prospective vendors of 508 requirements and, when asked by vendors for clarification prior to issuance of a formal Request for Proposals (RFP), VA officials appeared to lack understanding.
- Inaccessible Telehealth tools, namely the "Health Buddy" home monitoring station.
- VBA web pages containing e-Benefits information that are inaccessible to blinded veterans who use screen readers.
- The continuing accessibility barriers faced by VA employees with visual disabilities who are forced to use legacy systems that are largely incompatible with adaptive software in order to do their jobs.
- Inadequate staffing by VA to ensure its capacity to address internal and external accessibility issues.
- Lack of an enforcement mechanism or other means of addressing compliance issues so that if equipment, hardware, software, or a website are found to be noncompliant with accessibility standards, someone follows through and addresses the issues that are identified and thereby resolves the issue.
- Recent statements by CERNER representatives announcing waiver requests in advance of VA's new Electronic Health Record (EHR) system deployment.

IV. OVERCOMING TRANSPORTATION BARRIERS FOR BLINDED RURAL VETERANS

Barriers remain a persistent problem for blinded veterans who live in rural areas and have either no or very limited options for getting to and from medical appointments. Blinded veterans cannot drive themselves and for many, finding someone to drive them presents a major and frequent barrier to keeping their medical appointments. The Veterans Travel Program (VTP) provides transportation to medical appointments at Department of Veterans Affairs (VA) Medical Centers (VAMCs) for veterans with disabilities. VTP policies must ensure that blindness is included as a medical justification for VA to authorize the use of various modes of transportation so that veterans who are blind can get to local VAMCs and receive health care services.

VA currently operates 21 VAMCs – and an additional 350 Community Based Outpatient Clinics (CBOCs) – located in rural areas. Regrettably, access to health care for rural blinded veterans remains a major problem, particularly as these veterans age, become more disabled, or lose their family caregivers. Transportation has become one of the most pressing issues for blinded rural veterans. Beneficiary travel funds reimburse eligible veterans for part of their travel expenses, but the reimbursement depends upon the veteran finding an able and available driver and vehicle.

The Blinded Veterans Association (BVA) supports H.R. 4589 and S. 2966 amending Title 38 of the United States Code, making permanent the authority of VA's Secretary to award grants for the transportation of highly rural veterans to medical care. Presently, only 90 VAMCs support the Veterans Transportation Services (VTS) due to uncertainty regarding yearly extension of the program. Making the VTS program permanent would allow local VA facilities to hire drivers and purchase vehicles to transport veterans as needed. It would also extend a grant that allows Veterans Service Organizations (VSOs) and State Veterans Service Agencies new approaches to providing transportation and/or travel assistance.

V. PROTECTING ABILITYONE® EMPLOYMENT FOR BLINDED VETERANS

Each year, the AbilityOne® Program provides employment opportunities for more than 45,000 people who are blind or severely disabled, including more than 3,000 wounded, ill, or injured disabled veterans. The Blinded Veterans Association (BVA) knows of no targeted efforts by Service-Disabled Veteran-Owned Small Businesses (SDVOSBs) that actively recruit blinded veterans into their workforce or provide the training and adaptive technology equipment necessary to employ blinded veterans that occurs within AbilityOne® agencies.

National Veterans Benefits Administration (VBA) data continues to demonstrate that veterans with higher ratings of catastrophic disabilities experience unemployment rates of 45 percent or greater. In the year 2017, an estimated 27.0 percent (plus or minus 0.72 percentage points) of non-institutionalized persons age 21 to 64 years with a visual disability in the United States were living below the poverty level. In other words, 1.3 million out of 3.7 million non-institutionalized persons aged 21 to 64 years with a visual disability in the United States were living below the poverty level in 2017. [5]

BVA points to the Veteran Service Organizations Independent Budget (VSOIB) evidence on employment challenges for veterans with the highest disability ratings as being even greater. Veterans who have a disability rating of less than 30 percent were about 40 percent more likely to be engaged in the workforce than veterans with a 60 percent or higher disability rating. Only about four in every 10 veterans with a 60 percent or higher disability rating participated in the labor force in 2017. This growing labor force participation disparity exists for Post-9/11 veterans who have served on active duty since September 2001. Bureau of Labor Statistics (BLS) data showed that Post-9/11 veterans without a disability were 12 percent more likely to be in the labor force than Post-9/11 veterans with disabilities.

We recognize the "Veterans First Contracting Program" (established by the Veterans Benefits, Health Care, and Information Technology Act of 2006) and the AbilityOne® Program (established through the JWOD Act, which serves people who are blind or have significant disabilities) serve different, but complementary missions. Both programs are important to creating employment for two populations while meeting their respective objectives. Congress has repeatedly affirmed its long-standing support of

[5] http://www.disabilitystatistics.org/reports/acs.cfm?statistic=2

the AbilityOne® Program. Continuing the existing contracts from the Department of Veterans Affairs (VA) to AbilityOne® programs ensures employment opportunities for our blinded and disabled veterans, which are critical to increasing their economic independence.

BVA supports and urges swift Senate passage of H.R 4920, strong bipartisan legislation continuing VA contracting with AbilityOne® programs that employ blinded and visually impaired veterans. This legislation would simply amend Title 38 of the United States Code providing for an exception to certain small business contracting requirements applicable to VA's procurement of certain goods and services covered under the AbilityOne® Program. In short, this legislation would ensure that one of our nation's most socio-economically disadvantaged populations of veterans isn't further harmed.

VI. FUNDING VHA BLIND REHABILITATION SERVICE (BRS)

As of August 6, 2018, 42,583 veterans were on permanent Visual Impairment Service Team (VIST) Coordinator case management lists. Veterans' Health Administration (VHA) research studies estimate that there are 131,580 legally blinded veterans in the United States population. Epidemiological projections indicate that there are another 1.5 million low-vision veterans in the United States with visual acuity of 20/70 or worse.

The Department of Veterans Affairs (VA) currently operates 13 residential Blind Rehabilitation Centers (BRCs) across the country. These BRC's provide the ideal environment in which to maximize the rehabilitation of our nation's blinded veterans. Unfortunately, Veterans Integrated Service Network (VISN) and Veterans Affairs Medical Center (VAMC) directors at some sites housing BRC's are failing to replace BRC staff who retire or transfer to other facilities, claiming limited funding to support maintenance of staffing at previous levels. As a result, some BRCs now lack the staffing to help blinded veterans acquire the essential adaptive skills they need to overcome the many social and physical challenges of blindness. Without intervention, we fear that the number of BRCs in this position will grow.

The Blinded Veterans Association (BVA) requests that Congress provide oversight into how funds allocated to VA Blind Rehabilitation Services (BRS) are being used. VHA and VISNs should be required to explain how funds are allocated within and among BRC's. These centers need directed funding to bring staffing levels up to required levels. Directors should not be allowed to divert funds designated by the Veterans Equitable Resource Allocation (VERA) System for these rehabilitation admissions from the blind centers to other general medical operations. BVA is concerned that community care funding contracted under the auspices of the VA MISSION Act will take funds away from these VA rehabilitation centers. There should be no bed closings or hiring freezes on critical blind center staff positions because facilities also need to offer veterans more community care options. We point out that VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of the "Veterans' Health Care Reform Act of 1996" (Public Law 104-262).

We call on Congress to conduct oversight ensuring that VA is meeting capacity requirements within the recognized systems of specialized care in accordance with Public Law 104-262 and the "Continuing appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2017," (Public Law 114-223). Despite repeated warnings about these capacity problems, Congress has conducted minimal oversight on VA's ability to deliver specialized health care services.

BVA requests that if VA does contract with private agencies to provide rehabilitation training to blinded veterans, VA should ensure that the private agencies with which it contracts have a demonstrated capacity to meet the peer reviewed quality outcome measurements that are a standard part of VHA BRS. We further recommend that VA require private agencies with which it contracts to be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Impaired (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, VA should require those agencies to provide veterans with instructors who are certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

No agency should be used to train newly blinded combat veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, mental health care counseling, and joint peer reviewed vision research. BVA also supports the FY19 Independent Budget Veterans Service Organizations (IBVSO) recommendation mandating that competency standards for non-VA community providers be equivalent to standards expected of VA providers, and that non-VA providers meet continuing education requirements to fill gaps in knowledge about veteran specific conditions and military culture.[6]

Private agencies for the blind lack the necessary full specialized nursing, physical therapy, pain management, audiology, speech pathology, pharmacy, and radiology support services that are available at VA BRCs because they are located adjacent to VAMCs. Also, most private agencies are outpatient centers located in major cities, making access for blinded veterans from rural areas difficult, if not impossible. In many rural states there are no private inpatient blind training centers at all. Therefore, the availability of an adequately funded and staffed VA BRC is the only option. These veterans should not be forced to utilize alternative facilities when VHA BRS has the capacity to ensure that they have access to a program at a facility that is adequately staffed and funded.

VII. ADDRESSING ISSUES FACING WOMEN VETERANS

The Blinded Veterans Association (BVA) looks forward to working with the Department of Veterans Affairs (VA) and members of Congress to improve programs and services for women veterans. It is our hope that some of the concerns that women veterans face, which were highlighted during hearings held by Congress, will be acted upon sooner rather than later. For instance, there is a continuing need for gender-specific health care services at VA Medical Centers (VAMCs) across the country. We urge Congress to give VA the resources it needs to address these issues in a timely and comprehensive manner.

Although it is not exclusively a women's issue, Military Sexual Trauma (MST) is an issue that commonly affects women servicemembers and veterans. It is also one that has been swept under the rug for too long. We urge members of Congress to continue their vigilant monitoring of VA's handling of MST claims to ensure that they are handled with sensitivity and fairness, as well as promptness. We also support passage of H.R. 1092, the bipartisan "Servicemember and Veterans' Empowerment and Support Act of 2019," which expands the definition of MST to ensure that servicemembers and veterans who experience sexual harassment can access VA counseling and benefits. It also codifies a lower burden of proof so that more survivors are eligible for trauma and mental health care related to MST, even if they didn't feel comfortable reporting the event to their chain of command while in service.

[6] http://www.independentbudget.org/116-congress/ pg. 15

BVA fully supports the FY20 Independent Budget Veterans Service Organizations (IBVSO) section on women veterans calling for advance appropriations of $540 million designated for gender-specific health care for women veterans. In addition to this amount, we recommend Congress direct $75.8 million in increased funding to hire an additional 200 new physicians as designated women's health providers; train 700 designated women's health providers (conduct mini residencies—including a specific women's health mini residency training program on-site for rural communities); hire 800 additional employees, to include: nurses, women veteran program managers, care coordinators (for preventative screening services such as pap smears, mammography, maternity care ,and other gender-specific services), clerks, and other support staff, to account for attrition in staff serving on women veteran's clinical teams and continued growth and demand for services; and hire and provide specialized training for 100 women veteran peer support specialists for placement in primary care clinics and mental health care teams to assist with more complex patients and suicide prevention efforts in high-risk patients. Finally, additional resources are needed to fund expansion of successful and ongoing pilot programs, including women-only therapeutic nature retreats and child care pilots.[7]

VIII. BVA URGES CONGRESS TO FUND THE FY21 DoD VISION RESEARCH PROGRAM (VRP) AT $30 MILLION

The Vision Research Program (VRP) was established by Congress in FY09 to fund impactful military-relevant vision research that has the potential to significantly improve the health care and well-being of servicemembers, veterans, their family members and caregivers, and the American public. The VRP's program area aligns with the Sensory Systems task area of the Clinical and Rehabilitative Medicine Research Program, a core research program of the Defense Health Agency (DHA).

Eye injury and visual dysfunction resulting from battlefield trauma affects many servicemembers and veterans. Surveillance data from the Department of Defense (DoD) indicates that eye injury accounts for approximately 14.9 percent of all injuries from battlefield trauma sustained during the wars in Afghanistan and Iraq, resulting in more than 182,000 ambulatory patients and 4,000 hospitalizations between 2000 and 2011. In addition, Traumatic Brain Injury (TBI), which affects more than 413,898 servicemembers between 2000 and 2019, can have significant impact on vision – even when there is no injury to the eye.

Research sponsored by the Department of Veterans Affairs (VA) showed that as many as 75 percent of servicemembers who had suffered a TBI had visual dysfunction. The VA Office of Public Health has reported that for the period October 2001 through June 30, 2015, the total number of Operation Enduring Freedom (OEF) / Operation Iraqi Freedom (OIF) / Operation New Dawn (OND) veterans enrolled in VA with visual conditions was 211,350; including 21,513 retinal and choroid hemorrhage injuries (including retinal detachment); 5,293 optic nerve pathway disorders; 12,717 corneal conditions; and 27,880 with traumatic cataracts.[8] VA continues to see increased enrollment of this generation with various eye and vision disorders resulting from complications of frequent blast-related injuries.

VA data also revealed a rising number of total Post-9/11 veterans with TBI visually impaired "ICD-10 Codes" enrolled in the Veterans Health Administration (VHA) system. In FY13 there were 39,908

[7] http://www.independentbudget.org/pdf/FY22IB pg. 7

[8] VHA Office of Public Health OIF/OEF/OND Veterans Medical Encounters for Disorders Eye and Vision, FY 2002 to June 30, 2015 Enrollment Code data report.

enrollees identifying with symptoms of visual disturbances, and by FY15 those numbers increased to 66,968. Based on recent data (2000-2017) compiled by the TBI Defense Veterans Brain Injury Center (DVBIC), the reported incidence of TBI without eye injury but clinical visual impairment is estimated to be 76,900.

A January 2019 Military Medicine journal article, based on a 2018 study by the Alliance for Eye and Vision Research that used prior published data during 2000-2017, has estimated that deployment-related eye injuries and blindness have cost the U.S. $41.5 billion in that timeframe, with $40.2 billion of that cost reflecting present value of a lifetime of long-term benefits, lost wages, and family care.

On April 3, 2019, former DHA Director Vice Adm. Raquel Bono testified before the House Subcommittee on Defense (HACD), stressing the need for "specific research programs supporting efforts in combat casualty care, Traumatic Brain Injury, psychological health, extremity injuries, burns, vision, hearing and other medical challenges that are militarily relevant and support the warfighter. This budget request proposes increased funding for battlefield injury research and establishes a permanent baseline for our mission-essential research."

Of note, the Congressionally Directed Medical Research Program (CDMRP) appropriations that fund this critical extramural vision research into deployment-related vision trauma is not currently conducted by VA, elsewhere within DoD – including the Joint DoD/VA Vision Center of Excellence (VCE), or the National Eye Institute (NEI) within the National Institutes of Health (NIH). Additionally, DoD continues to identify gaps in its ability to treat various ocular blast injuries. Thus, this funding is critical to meeting those challenges.

In its history, the VRP has funded two types of awards: hypothesis-generating, which investigates the mechanisms of corneal and retinal protection, corneal healing, and visual dysfunction resulting from TBI; and translational/clinical research, which facilitates development of diagnostics, treatments and therapies–especially designed for rapid battlefield application. Research funded by the VRP has produced:

- 15 patents, patent applications, or provisional patents.
- 8 clinical trials funded by VRP and/or based on results of VRP-funded projects.
- 163 peer-reviewed publications in highly respected scientific journals.

VRP funding has also supported the development of:

- A portable, handheld device to analyze the pupil's reaction to light, enabling rapid diagnosis of TBI-related visual dysfunction.
- An "ocular patch," which is a nanotechnology-derived reversible glue that seals lacerations and perforations of the eye on the battlefield, protecting it while a soldier is transported to a more robust medical facility where trained ocular surgeons can properly suture the globe.
- A validated computational model of the human eye globe to investigate injury mechanisms of a primary blast wave from an Improvised Explosive Device (IED), which has accounted for 70 percent of the blast injuries in Iraq and Afghanistan. The model determines the stresses on and deformations to the eye globe and surrounding supporting structures to enable DoD to develop more effective eye protection strategies.

- A vision enhancement system that uses modern mobile computing and wireless technology, coupled with novel computer vision (that is, object recognition programs) and human-computer interfacing strategies, to assist visually impaired veterans undergoing vision rehabilitation to navigate, find objects of interest, and interact with people.

The Blinded Veterans Association (BVA) believes the priority in DoD research is to "Save Life, Limb, and Eyesight," which has been the motto of military medicine for decades. Therefore, along with other Veterans Service Organizations (VSOs) and Military Service Organizations (MSOs), we respectfully request that your support of the DoD/VRP Peer Reviewed Medical Research Program for extramural translational battlefield vision research be funded in the amount of $30 million for FY21.

IX. ESTABLISHING A JOINT INTERNATIONAL OCULAR TRAUMA TASK FORCE

In 2017, Assistant Secretary of Defense for Health Affairs McCaffery signed a Joint United States (US) - United Kingdom (UK) Task Force Charter establishing an international partnership to advance interoperability between the allied military medical services. This reaffirmed the partners' commitment to mutually advancing medical care in defense of global interests by sharing information and developing opportunities for combined training and collaborative research. The Blinded Veterans Association (BVA) subsequently met with senior UK Defence medical officials in London – and the British Embassy – who expressed a keen desire to officially establish a dedicated Joint Ocular Trauma Task Force to advance combat ocular trauma care and research under this partnership. The US response, however, has thus far, been noncommittal. BVA requests that Members of Congress express their staunch support for this strategic initiative between allies in order to preserve sight.

Ocular casualties account for approximately 14.9 percent of combat casualties, with a higher incidence during increased combat activity. Moreover, the Department of Veterans Affairs (VA) reports that upwards of 70 percent of Traumatic Brain Injury (TBI) patients suffer from visual symptoms. The legendary British-American military cooperation developed over a century of shared battlefield experience has led to a unique level of interoperability and familiarity. This extends to ocular casualty care, beginning with early battlefield treatment guidance provided by the UK in World War I – and blind rehabilitation programs at St. Dunstan's – for US casualties. This level of cooperation continues today but largely through individual, unofficial efforts. For example, several key publications reflect joint authorship; prior research symposia included joint participants; and, during a 2019 six-month partnership, a UK-US ophthalmology team delivered ocular trauma care in Afghanistan, offering one of the most active clinical specialties. Nevertheless, ocular care is routinely overlooked at official Department of Defense (DoD) / Defense Health Agency (DHA) policy levels. For example, neither the 2011-2014 Joint Task Force on Wounded, Ill, and Injured Servicemembers nor the 2012 Dismounted Complex Blast Injury Task Force reports mention military ocular trauma care or research, much to our disappointment. Similarly, the current Task Force Partnership Agreement neglects ocular trauma – despite the critical importance of sight to combat effectiveness and personal welfare – and the increasing incidence of eye injuries in the past 100 years of warfare.

The 2019 John S. McCain National Defense Appropriations Act (NDAA), Public Law 115-232, requires DoD to provide a Strategic Medical Research Plan that describes its medical research focus areas and medical research projects; details coordination processes across defense medical research and development (R&D) to ensure alignment with mission, promote synergy, address gaps, and minimize

duplication. Public Law 115-232 also outlines efforts to coordinate with other departments and agencies of the federal government. DoD's response was sent to Congressional committees on April 8, 2019.

In summary, the report identifies the need for agility and responsiveness across all levels and types of medical care, requires an R&D strategy that is nimble, responsive, and attuned to emerging needs of the warfighter. The report is nested within national strategic guidance and capitalizes on opportunities in science and medical technology. It also requires partnerships at home and abroad. This strategy offers a common framework to ensure that DoD continues to discover, develop, and deliver the medical capabilities required today – and in the future. It provides the basis on which to optimize infrastructure, coordination, and information exchange among the Services and defense agencies across DoD, Federal Interagency, and the civilian sector to continue to be responsive to both contemporary medical readiness requirements and future needs of the warfighter. While the Strategic Plan does not specifically mention ocular issues, the US Army Medical Research and Materiel Command (USAMRMC) maintains an ocular health research portfolio, the goal of which is to "improve the health and readiness of military personnel affected by ocular injuries and vision dysfunction by identifying clinical needs and addressing them through directed joint medical research." Specific topics of interest include:

- Validated models to inform deployment treatment of blast ocular injury and TBI vision system injuries.
- Prolonged field-care and critical-care capabilities.
- Portable diagnostic tools.
- Decision aids for unit-level, MEDEVAC en-route, and MTF care.
- Deployable ocular trauma medical treatment packages.
- Research vision prosthetics and vision restoration devices.
- Regenerative medical techniques.

Most of these goals are germane to international military forces and would benefit from combat experience and cooperative research with our British allies and colleagues. A specific goal of the Joint Ocular Trauma Task Force will be reporting on these initiatives at the Schepens 7th Military Vision Symposium "Future Military Conflicts and Civilian Mass Casualties Events." The symposium, which will bring together international ocular trauma experts and vision researchers, is scheduled for March 5-6, 2021 in Boston.

A Joint Ocular Trauma Task Force should be officially established now, with specific objectives to collaboratively identify opportunities for enhancing interoperability between the US and UK in ocular combat casualty care. The Task Force would improve the prevention, diagnosis, mitigation, treatment, and rehabilitation and reintegration of ocular injuries and TBI-associated vision loss. It would also enhance vision research exchange. This initiative also seeks to improve civilian ocular trauma care through migration of military lessons learned, particularly regarding issues facing first responders and non-ophthalmic providers in civilian disasters or acts of terrorism, resulting in improved emergency medical services and vision trauma outcomes.

We call upon Congress, VA, and DoD to request that the Assistant Secretary of Defense for Health Affairs (ASDHA) and Secretary of Veterans Affairs – working with their UK Defence Medical colleagues – sign an agreement to establish this Joint Ocular Trauma Task Force for five years.

X. MANDATING THE DESIGNATION OF FOUR OCULAR TRAUMA CENTERS

The FY17 National Defense Appropriations Act (NDAA) was enacted and Section 703 authorized the Secretary of Defense (SECDEF) to "…designate a medical center as a regional center of excellence for unique and highly specialized health care services…" Although ocular injuries clearly meet that definition, no ocular injury Military Treatment Facilities (MTFs) were ever identified by the Defense Health Agency (DHA) as designated specialized care centers to provide for improved eye injury care. The current result is that there are no Department of Defense (DoD) requirements for eye injuries to be referred to specialty treatment centers for evaluation, treatment, care coordination, vision research, or rehabilitation for our military wounded personnel.

Designating four ocular trauma centers should have been accomplished more than two years ago as mandated – with strengthening clinical coordination between DoD and the Veterans Health Administration (VHA). These ocular trauma centers should be mandated to develop bidirectional, longitudinal vision joint clinical injury registries with up-to-date information on the diagnosis, treatment, and follow-up evaluations for wounded personnel.

Ocular injuries are characterized by complex poly-trauma wherein multiple delicate eye structures are injured and remain at long-term risk. These injuries are best treated by a coordinated team of highly trained ocular subspecialists and require close follow-up, particularly when they accompany other systemic polytraumas. The Blinded Veterans Association (BVA) calls upon Congress to require the SECDEF to designate four ocular trauma centers.

CONCLUSION

Once again, Chairman Moran, Chairman Takano, Ranking Member Tester, Ranking Member Roe, and all Members, thank you for the opportunity to present BVA's legislative priorities before you today.

BVA SUPPORTED LEGISLATION

H.R. 100 "Veteran Overmedication and Suicide Prevention Act of 2019"
A bill to direct the Secretary of Veterans Affairs to conduct an independent review of the deaths of covered veterans by suicide during the last five years, and for other purposes.
Rep. Vern Buchanan (FL-16-R)

S. 2991 "Veteran Overmedication and Suicide Prevention Act of 2019"
A bill to direct the Secretary of Veterans Affairs to conduct an independent review of the deaths of covered veterans by suicide during the last five years, and for other purposes.
Sen. Dan Sullivan (AK-R)

H.R. 4920 "Department of Veterans Affairs Contracting Preference Consistency Act"
A bill to amend title 38, United States Code, to provide for an exception to certain small business contracting requirements applicable to the Department of Veterans Affairs' procurement of certain goods and services covered under the AbilityOne® program, and for other purposes.
Rep. Mark Takano (CA-41-D)

H.R. 4524 “Rural Veterans Travel Enhancement Act of 2019”
A bill to amend title 38, United States Code, to make permanent the authority of the Secretary of Veterans Affairs to transport individuals to and from facilities of the Department of Veterans Affairs in connection with rehabilitation, counseling, examination, treatment, and care, and for other purposes.
Rep. Rick Larsen (WA-2-D)

S. 450 “Veterans Improved Access and Care Act of 2019”
A bill to require the Secretary of Veterans Affairs to carry out a pilot program to expedite the onboarding process for new medical providers of the Department of Veterans Affairs, to reduce the duration of the hiring process for such medical providers, and for other purposes.
Sen. Cory Gardner (CO-R)

S. 746 “Department of Veterans Affairs Website Accessibility Act of 2019”
A bill to require the Secretary of Veterans Affairs to conduct a study on the accessibility of websites of the Department of Veterans Affairs to individuals with disabilities, and for other purposes.
Sen. Robert P. Casey Jr. (PA-D)

S. 785 “Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019”
A bill to improve mental health care provided by the Department of Veterans Affairs, and for other purposes.
Sen. Jon Tester (MT-D)

S. 850 “Highly Rural Veteran Transportation Program Extension Act”
A bill to extend the authorization of appropriations to the Department of Veterans Affairs for purposes of awarding grants to veteran service organizations for the transportation of highly rural veterans.
Sen. Dan Sullivan (AK-R)

S. 1154 “Department of Veterans Affairs Electronic Health Record Advisory Committee Act”
A bill to amend title 38, United States Code, to establish an advisory committee on the implementation by the Department of Veterans Affairs of an electronic health record.
Sen. Jon Tester (MT-D)

S. 1648 “Supporting Veteran Caregivers Act of 2019”
A bill to reinstate and compensate family caregivers who were improperly removed from the family caregiver program of the Department of Veterans Affairs, or whose benefits were reduced, and to ensure that all veteran caregivers receive the support and assistance for which they are eligible in a fair and consistent manner, and for other purposes.
Sen. Robert P. Casey Jr. (PA-D)

H.R. 1749 “PFC Joseph P. Dwyer Peer Support Program Act”
A bill to authorize the Secretary of Veterans Affairs to make grants to state and local entities to carry out peer-to-peer mental health programs.
Rep. Lee M. Zeldin (NY-1-R)

S. 1835 “21st Century Assistive Technology Act”
A bill to reauthorize the Assistive Technology Act of 1998, and for other purposes.
Sen. Robert P. Casey Jr. (PA-D)

S. 2022 “Paul Benne Specially Adaptive Housing Improvement Act of 2019”
A bill to amend title 38, United States Code, to provide for improvements to the specially adapted housing program of the Department of Veterans Affairs, and for other purposes.
Sen. Jerry Moran (KS-R)

H.R. 3504 “Ryan Kules Specially Adaptive Housing Improvement Act of 2019”
A bill to amend title 38, United States Code, to provide for improvements to the specially adapted housing program and educational assistance programs of the Department of Veterans Affairs, and for other purposes.
Rep. Gus M. Bilirakis (FL-12-R)

H.R. 3640 “Housing Access for Blind Veterans Act”
A bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to assist blind veterans who have not lost use of a leg in acquiring specially adapted housing, and for other purposes.
Rep. Elaine G. Luria (VA-2-D)

H.R. 3636 “Caring For Our Women Veterans Act”
A bill to require the Secretary of Veterans Affairs to submit to Congress certain reports relating to the health care and treatment provided by the Department of Veterans Affairs to women veterans, and for other purposes.
Rep. Lauren Underwood (IL-14-D)

H.R. 4451 “S.O.S. Veterans Caregivers Act”
A bill to amend title 38, United States Code, to clarify that caregivers for veterans with serious illnesses are eligible for assistance and support services provided by the Secretary of Veterans Affairs, and for other purposes.
Rep. Raul Ruiz (CA-36-D)

S. 1881 “VETS Safe Travel Act”
A bill to provide PreCheck to certain severely injured or disabled veterans, and for other purposes.
Sen. Todd Young (IN-R)

H.R. 2620 “Faster Treatments and Cures for Eye Diseases Act”
A bill to advance treatment and cures for blindness and other retinal conditions and to promote competitiveness in the United States through a pilot program to increase funding for translational research, and for other purposes.
Rep. Sanford D. Bishop Jr. (GA-2-D)

H.R. 4589 “No Title”
To make permanent the authority of the Secretary of Veterans Affairs to make grants for the transportation of highly rural veterans to medical care.
Rep. TJ Cox (CA-21-D)

H.R. 3356 “VETS Safe Travel Act”
A bill to provide PreCheck to certain severely injured or disabled veterans, and for other purposes.
Rep. Paul A. Gosar (AZ-4-R)

S. 191 “Burn Pits Accountability Act”
A bill to direct the Secretary of Defense to include in periodic health assessments, separation history and physical examinations, and other assessments an evaluation of whether a member of the Armed Forces has been exposed to open burn pits or toxic airborne chemicals, and for other purposes.
Sen. Amy Klobuchar (D-MN)

H.R. 663 “Burn Pits Accountability Act”
A bill to direct the Secretary of Defense to include in periodic health assessments, separation history and physical examinations, and other assessments an evaluation of whether a member of the Armed Forces has been exposed to open burn pits or toxic airborne chemicals, and for other purposes.
Rep. Tulsi Gabbard (D-HI-02)

H.R. 1199 “VA Website Accessibility Act of 2019”
A bill to direct the Secretary of Veterans Affairs to conduct a study regarding the accessibility of websites of the Department of Veterans Affairs to individuals with disabilities.
Rep. Elaine G. Luria (D-VA-02)

S. 669 “The Air Carrier Access Amendments Act of 2019”
To protect the rights of passengers with disabilities in air transportation, and for other purposes.
Sen. Tammy Baldwin (D-WI)

NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS

Joint Hearing of the House and Senate Veterans' Affairs Committees

February 26, 2020
Presented by
John Hilgert

President, National Association State Directors of Veterans Affairs
Director, Nebraska Department of Veterans' Affairs

INTRODUCTION

Chairman Moran, Chairman Takano, Ranking Member Tester, Ranking Member Roe and distinguished members of the committees on Veterans Affairs, my name is John Hilgert, and I serve as the President of the National Association of State Directors of Veterans Affairs (NASDVA) and as the Director of the Nebraska Department of Veterans' Affairs.

NASDVA is comprised of the State Directors of Veterans Affairs for all fifty States, the District of Columbia, and five territories: American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands. Here with me today are – John Scocos, NASDVA Executive Director, and former Secretary of the Wisconsin Department of Veterans Affairs, and Tom Palladino, Executive Director, Texas Veterans Commission and NASDVA Senior Vice President.

States and Territories continue to increase their role as multidimensional service providers to Veterans. The State Departments of Veterans Affairs (SDVAs) promote "whole-of-state" approaches making State government efficient, effective, and customer focused. Second only to the U.S. Department of Veterans Affairs (VA) in providing services, SDVAs are service providers, service coordinators, connectors, and conveners creating an expanding hub at the intersection of local communities and the federal government. Our mission includes advocating for all our nation's Veterans, their family members, and survivors, to access earned federal and state benefits. The State Departments of Veteran Affairs (SDVAs) advocate for Veterans' access to VA Healthcare (including mental health); filing disability claims and appeals on behalf of Veterans; administering and operating State Veterans Homes and Veteran Cemeteries; connecting women, minority, LGBTQ and rural Veterans to needed services; and acting as the State Approving Agency for GI Bill use. Beyond these core missions, the role of SDVAs continues to grow. State Departments of Veterans Affairs are being asked to serve as "one stop shops" to coordinate, connect, and convene teams to address veteran employment, economic empowerment, and whole health and wellness. To be successful, States will need to tighten the linkages with the USDVA,

their fellow State agencies, and their local communities.

Examples of these linkages in action include SDVA support for the establishment and operation of Veteran Treatment Courts; support for local community efforts to end and prevent Veteran Homelessness; the awarding of grants to local governments and non-profit organizations that provide assistance to Veterans; and assist service members with transition and employment services. SDVAs often serve in helping Veterans in ways that may not fit into any established program. To this end, SDVAs are well positioned and often have the capacity to assist the VA in the development and deployment of new programs and initiatives. Despite constrained State budgets, States collectively contribute over $10 billion each year in service to our nation's Veterans and their families. NASDVA, through its Member States and Territories, is the single organization outside of the VA that serves all of America's nearly 20 million Veterans.[1]

Given that SDVAs are tasked and held accountable by our respective Governors, State Boards or Commissions, we are well positioned to deliver efficient, effective, and veteran focused services. SDVAs are responsible for addressing the needs of our Veterans irrespective of age, gender, era of service, military branch or circumstance of service. State Directors and their staffs are confronted with unique situations in caring for all Veterans and their families on a daily basis and coordinated at the local level. However, SDVAs cannot do this important work alone.

USDVA – NASDVA PARTNERSHIP

The formal partnership between USDVA and NASDVA continues to yield positive results for our Veterans across the nation. Since NASDVA's incorporation in 1946, there has been a long-standing government-to-government cooperative relationship. This relationship was formalized through a Memorandum of Agreement (MOA) between USDVA and NASDVA originally signed

[1] Veteran population estimate, as of September 30, 2018 (VetPop 2016) 19,508,946. See FY 2018 GDX available: https://www.va.gov/vetdata/Expenditures.asp

in 2012 and updated on February 25, 2019 between VA Secretary Robert Wilkie and NASDVA President Lourdes E. Alvarado-Ramos. The MOA established the "Abraham Lincoln Pillars of Excellence" award to recognize best practices from NASDVA members that developed effective programs. For 2020, the seventh year of program awards, the VA Secretary presented seven awards to the following states: Alaska, Maine, Michigan, Minnesota, New Mexico, New York, and Wisconsin. These States demonstrated best practices to address: Customer Experience with VA Benefits and Services, Eliminating the Claims and Appeals Backlog, Eliminating Veteran Homelessness, Suicide Awareness and Prevention, and Innovative State Programs (to include Tribal Programs). For 2021, NASDVA intends to focus on and recognize excellence in effective programs to address: Customer Experience with VA Benefits and Services, Eliminating the Claims and Appeals Backlog, Eliminating Veteran Homelessness, Suicide Awareness and Prevention, and Innovative State Programs (to include Tribal Programs).

VA FUNDING

Congress' work to improve overall funding for healthcare, claims and appeals processing, cemetery operations, and homeless Veterans' programs is vital to meet the needs of a new generation of Veterans who require extensive medical and behavioral care and transition to our communities. While there is significant focus on our returning service members, we must continue the critical work of serving all Veterans, especially the large cohort of aging Veterans. Full Congressional support of the President's FY 2021 VA budget request is vital to meet the growing needs of Veterans to fulfill the VA's mission. NASDVA is committed to working with Congressional and VA leaders to ensure scarce resources are allocated to priorities that will meet our Veterans' most pressing needs in an efficient, effective, and veteran focused manner. As the VA continues its transformation journey, NASDVA supports a continuation of new initiatives, relentless vigilance in ensuring effective and efficient program execution, and a continued focus to

deploy resources where Veterans can best be served.

U.S. CENSUS AND VETERAN STATISTICS

Understanding the market is critical to effective and efficient service delivery. Census data drives the predictive models that assist both VA and SDVAs to better serve our veterans. For example, in Nebraska, the State I know best, we have received State funding to expand services at our Eastern Nebraska Veterans Home in part to the predicted growth of the veteran population in Sarpy County identified in the VA's population models. States leverage these models and data to make informed budget decisions. For States with constitutionally mandated balanced budgets, timely, accurate, and predictive information is vital for providing efficient and effective service. NASDVA urges Congress and VA to continue to work with the US Census to obtain military service information and demographic data.

VETERANS HEALTHCARE BENEFITS AND SERVICES

NASDVA supports the continued implementation of the provisions of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (The MISSION Act). Given the demographic and geographic diversity of U.S. States and Territories, NASDVA recommends authorization and funding based on a veteran-centric approach. The Veterans Health Administration (VHA) is a comprehensive healthcare system that provides, the full spectrum of care for our Nation's Veterans; in many cases, care that is provided nowhere else. VA also conducts extensive research and training that benefits our country writ large. Future plans for Veterans' healthcare must allow VA management flexibility, perhaps at the regional Health Care System level, that emphasizes an integrated (VA and Non-VA) and flexible care model. A proper mix of simplified care delivery should be based on Veterans' needs, location, accessibility, and availability of services. Decisions for care within VA or in the community should be determined

by the Veteran and his/her provider.

State Directors, represented by NASDVA, fully support efforts to increase Veterans' access to VA Healthcare. This includes the continued involvement of SDVAs with VA Medical Centers (VAMCs) to collaborate in enrolling Veterans and eligible family members in the VA healthcare system. This collaboration also continues to address expansion of Vet Centers, the deployment of mobile health clinics, and maximizing the use of tele-health services. We commend VA's efforts to address behavioral health, rural Veterans, Military Sexual Trauma and women Veterans' health issues.

NASDVA's priorities for the care of our Veterans are consistent with those of the VA, especially in the area of behavioral health and suicide prevention. While the VA has made commendable progress on suicide prevention, there is still much work to be done given that the rate of suicide is 2 times higher for veterans than it is for non-veterans according to a 2019 GAO report.[2] Additionally, as noted in the VA's 2019 Veteran Suicide Prevention Annual Report "after adjusting for age, the 2017 rate of suicide among women Veterans was 2.2 times the rate among non-Veteran women."[3] It is critical that SDVAs work with the VA healthcare system to address this high priority clinical issue. NASDVA proposes the creation of "outreach grants" from the USDVA to SDVAs. These grants could potentially address shortfalls and needed improvements in suicide prevention and awareness outreach.[4] Arguably, states are in a better position and closer to vulnerable veterans that need help. The VA and other government health care networks must serve as the core for providing health care services. External networks and preferred providers should be expanded to provide care where VA services are not available. In short, NASDVA supports an "all of the above" strategy for health care delivery which recognizes the diversity, geography, and

[2] GAO-19-66. VA Suicide Prevention Media Outreach. Available: https://www.gao.gov/assets/700/695485.pdf
[3] 2019 National Veteran Suicide Prevention Annual Report, Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs. Available: https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf
[4] GAO-19-66. VA Suicide Prevention Media Outreach. Available: https://www.gao.gov/assets/700/695485.pdf

demographic makeup of today's Veterans.

It is imperative that VA, specifically VHA, receives the funding required to care for Veterans who are enrolled today. While the number of Veterans is decreasing, the complexity of their care is increasing. VHA must have the resources necessary to recruit and retain doctors, nurses, and other professional staff. A policy of wholesale privatization or contracting outside a Veteran-centric environment, may diminish VA experience. Recognizing that under some circumstances it is certainly necessary and appropriate for Veterans to receive care at facilities and providers outside VA, reimbursements for service/care must be prompt and meet industry standards. Slow payments discourage providers to participate in providing care to our Veterans.

Telehealth services are mission critical to the service delivery of VA healthcare and NASDVA applauds the VA as a world leader in this practice. Telehealth is particularly critical to rural Veterans in States like Kansas, Montana, Texas, and Nebraska when just in time access to mental health services is not available or when they have to travel long distances to see a provider. SDVAs can play an important role in connecting rural Veterans to telehealth. Through federal funding, SDVAs can provide outreach and connect our most vulnerable Veterans to life saving programs. This outreach effort will help close the gap in access to mental health care in rural, American Indian/Alaska Native and other underserved minority communities.

To meet the demands of the 21st century Veteran, we are also prepared to assist VA as they develop and deploy the Electronic Health Record (EHR). This complex, multibillion dollar modernization program is essential for the care of Veterans in the future. This time, failure is not an option and the States are positioned to advocate, promote and provide VA with timely feedback for the success of this mission.

STATE VETERANS HOMES

The State Veterans Home (SVH) Program is the largest and one of the most important partnerships between SDVAs and VA. SVHs provide over 51% of total VA long-term care and is a cost-efficient partnership between federal and State governments. SVHs are the largest provider of long-term care to America's Veterans, providing a vital service to elderly and severely disabled Veterans with skilled nursing, domiciliary, and adult-day health care services. There are 158 operational SVHs in 50 States and the Commonwealth of Puerto Rico.

NASDVA and the National Association of State Veteran Homes (NASVH) have actively advocated for the principle that Veterans in our homes are entitled to the same level of support from VA as Veterans placed in Community Living Centers and VA community contract nursing homes. Both national associations have been engaged with Congress to demonstrate program needs and needed levels of funding support. We maintain that the benefit is to the Veteran, regardless of where he or she chooses to receive their care. To ensure State homes can continue to operate and provide high quality care, the Provider Agreement provision to care for the most vulnerable and compromised Veterans (70% or above service connected) must be maintained and strengthened in future legislation. Furthermore, care must be taken to ensure Veterans are able to utilize VA for services and specialty care not traditionally part of nursing home operations.

NASDVA also has concerns about behavioral health and the future incidence of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and other conditions in the aging Veteran population. While there are war-related traumas that lead to PTSD in younger OEF/OIF Veterans, aging Veterans are exposed to various catastrophic events and traumas of late-life that can lead to the onset of PTSD or may trigger reactivation of pre-existing PTSD. Reactivation of PTSD has been seen more frequently in recent years among World War II, Korean and Vietnam War Veterans and has been difficult to manage. VA has limited care for Veterans with a propensity for combative or violent behavior and the community expects VA or State Veterans

Homes to serve this population. NASDVA and NASVH recommend a new Grant Per Diem scale that would reflect the staffing intensity required for psychiatric beds and medication management. SVHs and VA Community Living Centers are unable to serve care intensive psychiatric patients; therefore, VA can't turn over hospital psychiatric beds because of a lack of community psychiatric step-down capacity. This level of care is critically needed in our States.

NASDVA and NASVH support a continued commitment to the significant funding of the State Veterans Home Construction Grand Program as demonstrated last year. It is important to the veterans we serve to keep the existing backlog of projects in the State Extended Care Facilities Construction Grant Program at a manageable level to assure life safety upgrades and new construction. In its FY 2021 budget proposal, VA is requesting $90 million for Grants for State Extended Care Facilities.[5] NASDVA strongly supports increasing funding to at least $135 million.

Both VA and our State Veterans Homes (SVH) are experiencing healthcare provider shortages. These shortages are projected to continue for the next 15 years as the baby boomer generation ages. It is imperative that VA continues its recruitment and retention efforts in order to have the quality and quantity of providers to care for eligible Veterans.

Regarding implementation of the Electronic Health Record, our State Veterans Homes with 30,000 beds across the nation, should have access to the system. In the past, select facilities have had read only access. Full access, as planned for community clinics and providers will allow facility health care providers to seamlessly coordinate the care of our Veterans.

NASDVA continues to recommend that VA, in consultation with NASVH, begins an evaluation process to implement an Assisted Living level of care or enhanced domiciliary grant program. Currently there are only two levels of care: Domiciliary or independent living for Veterans unable to thrive in the community and Skilled Nursing care. The Domiciliary rate does

[5] Department of Veterans Affairs, Budget In Brief, 2021. Available: https://www.va.gov/budget/docs/summary/fy2021VAbudgetInBrief.pdf

not cover the cost of caring for this higher level of care. NASDVA (and NASVH) will be asking VA to collaborate on this critical effort and ensure that Veterans have options, especially when unable to age at home. Finally, NASDVA, in consultation with NASVH, supports H.R. 4138, the "State Veterans Home Inspection Simplification Act." While this Act has been referred to the Committee on Ways and Means Subcommittee on Health, this Committee should carefully consider the positive impacts of efficient, effective, and customer focused government.

VETERANS BENEFITS SERVICES

State Directors continue to take on a greater role in the effort to manage and administer claims processing. Regardless of whether the State uses State employees, nationally chartered Veterans Service Organizations (VSO) and/or County Veterans Service Officers (CVSO), collectively, we have the capacity and capability to assist the Veterans Benefit Administration (VBA).

NASDVA applauds VA's efforts to overhaul its disability claims process administered by the Veteran Benefit Administration (VBA) and although we are optimistic, NASDVA remains concerned that there is a backlog and emphasizes that resources and focus must be kept on adjudicating claims in a timely manner. In December 2013, VA testified before the Senate Committee on Veterans Affairs that it had made significant progress in executing their benefits transformation plan, and had significantly reduced the backlog from a peak of 611,073 in March 2013.[6] While the backlog is currently much smaller at 69,933 (as of December 2019) one should also recognize the number of claims on appeal. VA should continue to focus resources on continuing to reduce the backlog while working with SDVAs. Recognizing that there is a wide range in the resources available in individual States, NASDVA recommends serious consideration

[6] Veterans Benefits Administration Reports, Claims Backlog. Available: https://www.benefits.va.gov/reports/mmwr_va_claims_backlog.asp

to making federal funding available to States to assist with efforts "on the ground" to further reduce the backlog and maintain progress on expediting existing and new claims.

Additionally, the VBA should review its metrics and incentives. In theory, State Service Officers have 48 hours to review claims for accuracy and potentially prevent a need for an appeal. In practice, the VBA is "pushing" claims through in less than 48 hours in order to improve "the flow." While it is admirable for the VBA to be timely, an accurate claim that alleviates a need for an appeal is arguably better than a claim rushed in error. VBA can and should ensure that its management of claims processing is veteran-centric. NASDVA advocates reforming the VA administrative appeals process to streamline VBA appeal procedures and decisions and allow for seamless transition to and enable decisions in the Board of Veterans Appeals (BVA). By placing significant focus on the process within VBA (Regional Offices) prior to appeals being sent to BVA, due diligence and due process (in favor of the Veteran) can be maintained while creating an environment where appeals requiring VBA or BVA adjudication can be decided on the merits of the original claim; in a timely manner. In addition, while transforming to a streamlined appeals process which is more efficient and less costly for taxpayers, VA will need (and NASDVA supports) a short-term funding increase to be able to resolve the inventory of appeals that are pending in the current system. As the "front line" providers of Veterans' claims service and representation, NASDVA is ideally positioned to work with VBA and BVA to assist in reforming and transforming the appeals process.

A success story of government-to-government collaboration between VA and NASDVA is the work that led to the modernization of the Claims Appeals Process. A multistate team joined VA, Veterans Service Organizations (VSOs) and Congressional staffs to develop a product that will change a system that was failing our Veterans. NASDVA commends Congress for passing legislation leading to appeals modernization, which reduces backlog and creates a more informed Veterans experience.

State Approving Agencies (SAA) function in nearly all States to monitor and approve educational institutions for receipt of Veterans' education benefits. SAAs assess and approve educational institutions and training programs for GI Bill education benefits. Twenty-six SAAs are in State Departments of Veteran Affairs. As a part of this effort, NASDVA works closely with the National Association of State Approving Agencies (NASAA). In 2006, the SAAs secured a mandatory funding model to ensure their programs would have sufficient funding each year. With the important passage of the Post-9/11 GI Bill, the SAAs' mission expanded with more compliance requirements but no additional resources. Without adequate resources, SAAs report that it is harder to sufficiently monitor and assess all academic programs under their charge. Under the current (and proposed) VA model, the requirements placed on SAAs have increased while, in most cases, funding has decreased. Additionally, the funding source for the program is increasingly unstable. NASDVA requests a revision of the SAA Total Requirement and Allocation Model.

BURIAL AND MEMORIAL BENEFITS

NASDVA appreciates the National Cemetery Administration's (NCA) collaborative partnership with States, Territories and Tribal governments. The Veterans Cemetery Grants Program (VCGP) complements NCA's 141 national cemeteries and is an integral part of NCA's ability to provide burial services for Veterans and their eligible family members. State, Territory and Tribal cemeteries expand burial access and support the NCA number one goal of "increasing access to a burial option in a National or State Veterans cemetery" and by FY 2021 provide burial services to 95% of all Veterans within in a 75-mile radius of their home. There are currently 115 VCGP cemeteries located in 48 States, Guam, Saipan, the Commonwealth of Puerto Rico and thirteen (13) operational tribal cemeteries. In fact, these cemeteries provided over 39,000 interments in FY 2019, which is approximately 22% of the total interments by both NCA and VCGP cemeteries.

We recommend the FY 2021 construction grant program budget be increased to at least $60M comprised of $50M for construction and $10M specifically designated for improvements and emergent needs in State and Tribal cemeteries. This modest increase to the $45M budget proposal would allow funding of some new State cemeteries and upgrade projects that currently go unfunded while also allowing NCA to respond to emergent requirements.

NASDVA fully supports the NCA goal of ensuring that State and Tribal Veterans cemeteries are maintained through a Compliance Review Program to the same standard of excellence applied to the national cemeteries. This aligns a review process for VA grant-funded State and Tribal Veterans' cemeteries to achieve National Shrine Standards. As NCA pilots the feasibility of weekend interments, the budget impact cannot be an unfunded mandate for neither VA nor the States. The operational cost for State Veterans Cemeteries depends on the plot allowance for Veterans. There is no plot allowance for the interment of family members. NASDVA recommends that Congress appropriates funds to increase the plot allowance. This would assist the States to maintain parity with National Cemeteries.

Finally, NASDVA supports the passage of S.2096 which would authorize the VA to fund the travel cost for State and Tribal Cemetery personnel to attend training at the NCA training center in St. Louis. We hope the House will take action on this measure and appreciate the Senate's approval on December 19, 2019.

WOMEN VETERANS

Women now comprise nearly 20% of the Armed Forces and assume roles in nearly all military occupational specialties.[7] The elimination of the combat exclusion rule by the Department of Defense in 2016 means that women will fill 100% of occupational specialties soon. There are

[7] Office of the Under Secretary of Defense, Personnel and Readiness. Population Representation in the Military Services: Fiscal Year 2017 Summary Report. Published in 2018. Accessed Jan 2, 2020. http://www.cna.org/research/pop-rep

several areas NASDVA believes VA can work on to close gaps in service, ensure continuity of care, and address the needs of women Veterans.

Veterans are impacted by the provider shortage for the delivery of gender and transgender specific healthcare. In addition, we understand the VA priorities include addressing needs of victims of Military Sexual Trauma (MST) to include those who served in the National Guard and Reserve. Due to an increasing volume of Veterans with MST, compatible care and provider alternatives need to be deliberately extended to all those Veterans who might otherwise be dissuaded from seeking treatment at the VA. As well, work must continue on the reconciliation of MST claims for PTSD recommended in the U.S. Department of Veterans Affairs Office of Inspector General Report #17-05248-241, dated 21 August, 2018.[8] Of note, one of the "factors leading to the improper processing and denial of MST-related claims" was the implementation of the National Work Queue resulting in a "lack of specialization" for claims requiring special handling.[9]

Additional gender specific healthcare includes infertility care. NASDVA advocates progressive support for veterans with infertility issues caused by illness or injury while serving in a military capacity. VHA must also ensure that Women Veterans have access to and receive in a timely manner, high quality, gender specific and individualized prosthetic care that will allow them to improve their quality of life.

With the relatively recent VA investment of state-of-the art women's clinics across the country, there still exists a disproportionate and non-standard availability to access gender- specific healthcare relative to the population of women Veterans. The decision-making and planning for new clinics or renovation of existing clinics must be data driven to ensure Veterans receive care commensurate with the population. As noted early, the need for census data is critical for this type

[8] U.S. Department of Veterans Affairs, Office of the Inspector General. "Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma." August 21, 2018. Available: https://www.va.gov/oig/pubs/VAOIG-17-05248-241.pdf
[9] Ibid, page 3.

of effort.

The largest emerging population of homeless Veterans is women. Recent efforts across the country to end and prevent Veteran homelessness are commendable and deserve recognition. We know the true numbers of this emerging population are underrepresented due to prescribed models of addressing homelessness. For example, a victim of domestic violence fleeing an abuser and living with a friend is not considered homeless. NASDVA recommends, and will work with VA and HUD to allow flexibility in their definition of homelessness and revitalize transitional housing models to better serve women Veterans especially those with children.

NASDVA continues to advocate for passage of HR 95, the Homeless Veterans Families Act, which was passed in the House in October and received and referred to the Senate. Currently, the VA does not have the authority to provide the reimbursement for the costs of services for minor children of homeless Veterans. This issue disproportionally impacts women Veterans as women bear the primary responsibility of child raising. A GAO report found that this inequity led to financial disincentive for housing providers and in turn, limits housing for veterans with young children. HR 95 would eliminate this issue by allowing VA to reimburse providers for 50 percent of the costs of housing minor dependents of homeless Veterans when the Veterans receives services from the grant recipient.

Homeless Veterans consistently identify childcare as a top unmet need. The cost is a common barrier for many as they try to seek employment and healthcare. As noted earlier, women Veterans are more likely to commit suicide than non-veterans.[10] NASDVA recommends that VA develop a mechanism between VHA and VBA to identify at risk veterans at the time a claim is initiated or when a service is requested through the VBA. In short, any seams between VBA and VHA need to be mitigated to identify veterans at risk of committing suicide. NASDVA

[10] 2019 National Veteran Suicide Prevention Annual Report, Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs. Available: https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

recommends that more efforts through the VA Experience Office be made to support the community efforts to prevent suicide. Data indicates that 70% of the Veterans who take their own lives do not engage with the VA. The community must be supported to take on this monumental task of suicide prevention.

MINORITY VETERANS

Veterans in Island Territories have had significant issues with services due to their isolation. For example, during hurricane catastrophes in Puerto Rico and the Virgin Islands, the VA was one of the only available providers yet category 7 and category 8 veterans were not accepted and thus did not have any viable options for their urgent medical needs. NASDVA recommends provisions in VA healthcare to allow care to all veterans in VA facilities during catastrophic events.

Native American Veterans are underserved on their reservations. Veteran Service Organizations (VSO) and SDVA do not have the capacity to provide services consistently and until recently, could not accredit Tribal Veterans Representatives (TVR). We commend VA for the recent rule changes that allow SDVSs to accredit TVRs and/or allow for Tribes to seek their own accreditation. This will ensure TVRs serve their nations within their cultural beliefs and sovereignty and promote self-sufficiency.

HOMELESSNESS AMONG VETERANS

NASDVA commends VA's effort and continued emphasis on ending homelessness among Veterans. States will continue to develop and support outreach programs that assist VA in this high priority effort, particularly in further identifying those Veterans that are homeless and programs to prevent homelessness. As partners with VA at the nexus of local communities, we are focusing on addressing the multiple causes of Veterans' homelessness e.g. medical issues (mental

and physical), legal issues, limited job skills, and work history. We appreciate the continued funding for specialized homeless programs such as Homeless Providers Grant and Per Diem, Health Care for Homeless Veterans, Domiciliary Care for Homeless Veterans, and Compensated Work Therapy. It is vital to continue VA's partnership with community organizations to provide transitional housing and the VA/HUD partnership with public housing authorities to provide permanent housing for Veterans and their families.

We know that many stages of homelessness exist and likewise we know that many factors contribute to our nation's homelessness among Veterans. Contributing factors are alcohol and drug abuse, mental health issues, PTSD, lack of employment, and involvement with the justice system. To eliminate chronic homelessness, we must address the many root causes by providing the necessary mental health and drug treatment programs in conjunction with job skills training and employment. These collective programs must be adequately staffed and fully funded in the current and future budget. Another revolving door that appears to increase the rolls of homelessness among Veterans is the overburdened courts and corrections system.

NASDVA commends VA and HUD for their collaboration in increasing the number of VASH vouchers. Unfortunately, in large cities with high costs of living, the voucher value is insufficient to allow the veteran to secure adequate housing. Some cities need cost of living adjustments to ensure the VASH voucher will actually cover most of the cost of affordable housing. NASDVA recommends that vouchers are tied to local markets to ensure they can support a veteran with secure permanent housing.

The VA Veterans Justice Outreach (VJO) Program is a prevention-focused component of VA's Homeless Programs Office (HPO), whose mission is to end homelessness among Veterans. Since the program was founded in 2009, VJO Specialists at every VA medical center have provided outreach and linkage to VA and/or community services for justice-involved Veterans in various settings, including jails and courts. VJO Specialists are essential team members in

Veterans Treatment Courts (VTC) and other Veteran-focused courts, as they connect Veteran defendants with needed VA services and provide valuable information on their progress in treatment. NASDVA supports increased USDVA funding for more Veteran Justice Outreach Coordinators to increase this valuable service.

VETERANS TREATMENT COURTS

States continue to recognize the increase in justice-involved Veterans, especially in the time shortly after discharge, and continue to work with leaders at the State level to create environments (through legislation and other means) that encourage the creation and support of Veterans Treatment Courts (VTC). After discharge, many Veterans suffer from severe mental and emotional problems that result in behaviors that are disruptive and often criminal in nature.

It is important that we all remain committed to seeking innovative ways to help justice involved Veterans become the productive Veterans that they were meant to be. Support for Bureau of Justice Assistance (BJA) and National Drug Court Institute (NDCI) orientation and training programs for jurisdictions interested in establishing VTCs is important to that effort. The States respectfully request support for increased funding to the BJA, so more jurisdictions can participate. Additionally, increased funding for multi-year grants to aid jurisdictions in the establishment and sustainment of VTCs is needed. Problem solving courts such as Veterans Treatment Courts can make life altering and society improving transitions as a form of direct help for Veterans.

TRANSITION ASSISTANCE PROGRAM (TAP)

Our organization strongly encourages the most effective transition program possible, to ensure success when a military member leaves military service and returns to civilian life. This is a tremendously important and sometimes stressful time for service members and their families. Service-members are required to attend the Transition Assistance Program (TAP) at their military

installation prior to separation or retirement. TAP is a mandated workshop across all services and all components and primarily delivered by the Department of Defense, Department of Labor and Veterans Affairs, and focuses on benefits, employment and education.

We are very encouraged by changes to the program over the last few years and especially with several elements of the recently passed 2020 National Defense Authorization Act to address transition-related issues, such as updates to the DD Form 214, Certificate of Release or Discharge from Active Duty; the creation of a standard record of service for members of the reserve components; the creation of an online application for the Transition Assistance Program; and the provision for the DoD to connect retiring or separating members from the Armed Forces with community-based organizations and state veterans agencies. We have long advocated for this connection since states are in a unique position to provide separating members with timely, tailored and relevant information to allow them to make the best-informed decisions that they can. We look forward to working with the Department of Defense to implement this provision.

JOBS FOR VETERANS STATE GRANT (JVSG) MANAGEMENT BY DOL-VETS

SDVAs have clearly witnessed how viable employment is essential to a successful transition from uniformed military service to civilian life. To assist in this transition, the U.S. Department of Labor-Veterans Employment and Training Services (DOL-VETS) manages the Jobs for Veterans State Grant Program. However, the flexibility of the States to serve the employment needs of Veterans is greatly restricted in many cases by DOL-VETS. States should determine the agency that can best administer, control and fund this critical program. In some states it could be the employment agency, in other states it could be the SDVA or other entity. Ultimately, individual States' Chief Executives (Governors) should have authority to determine what organizational structure may best serve the employment needs of that State's Veterans and the workforce needs of the State.

We commend the continued emphasis on hiring Veterans for federal employment. We are encouraged by the provisions of the National Defense Authorization Act for Fiscal Year 2020 to promote awareness of the provisions and benefits under the Uniformed Services Employment and Re- Employment Rights Act (USERRA), improve the Transition Assistance Program, and connect members retiring or separating from the military with community-based organizations such as SDVAs.

SUPPORTING VETERAN FAMILIES

Veteran families are an important part of the Veteran experience and recovery. NASDVA recognizes the role of families in the Veteran life cycle. The VA, States and Congress, must recognize that the family unit serves and all programs and legislation must consider these unsung heroes. While the VA's Congressional authorization is to serve Veterans, more must be done to include their families and ensure their emotional and physical wellness. VA spends billions of dollars to provide care to the Veteran. If the family is not well, the probability for the Veteran to reach his/her highest level of functioning will be compromised resulting in the waste of precious resources.

CONCLUSION

Chairman Moran, Chairman Takano, Ranking Member Tester, Ranking Member Roe, and distinguished members of the committees on Veterans Affairs, we respect the important work that you have done and continue to do to improve Veteran services and benefits. I emphasize again, that we are government to government partners with VA in the delivery of services and care to those who have served in uniform. SDVAs serve as an expanding hub and link to local communities. Our presence today illustrates your recognition of NASDVA's contribution and value in serving our nation's Veterans and their families. With your help and continued support,

we can ensure our Veterans and their needs are adequately resourced and remain a priority. The difficult challenges we address today are critical investments, which become the foundation of our promise to serve those who have borne the battle and for their families, and survivors.

Thank you for including NASDVA in this very important hearing.

Statement of
Jewish War Veterans of the USA
2020 Legislative Priorities
Before the Joint Senate and House
Veterans Affairs Committees

February 26, 2020

Presented by

Harvey Weiner
National Commander, JWV

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INTRODUCTION

Chairman Moran and Chairman Takano, and distinguished Members of the House and Senate Committees on Veterans' Affairs, my fellow veterans and friends, I am Harvey Weiner, the National Commander of the Jewish War Veterans of the U.S.A. (JWV). JWV was established in 1896 and was congressionally chartered August 21, 1984.

JWV advocates for all veterans regardless of their religion. We provide counseling and assistance to veterans encountering problems dealing with the Department of Veterans Affairs (VA), and other entities with which our members work.

JWV has been helping veterans and preserving the legacy of American Jewish military service for over 124 years. We represent veterans from all conflicts.

Volunteering at VA facilities, hosting educational programs, supporting patriotic organizations like Scouts of America, and advocating on behalf of all veterans lead the efforts our members make to serve the American veteran and our country.

The following veteran issues are the most relevant and concerning to our members. Earlier this month, we brought these important issues to Capitol Hill, in member-led meetings with individual members of Congress and the Senate. JWV urges the Senate and House Committees to address our concerns for all veterans. JWV strongly supports:

- No privatization of the VA
- Suicide prevention
- End veteran homelessness
- Agent Orange presumptives
- Membership defined more broadly.

Mr. Chairman, on March 15, we at JWV will celebrate our 124th birthday. For these 124 years, JWV has advocated for a strong national defense and fair recognition and compensation for veterans. The Jewish War Veterans of the USA represents a proud tradition of patriotism and military service to the United States.

COURAGE

Chairman Moran and Chairman Takano, Ranking Members Tester and Roe, I am Harvey Weiner, a Vietnam War combat veteran and the National Commander of the Jewish War Veterans of the USA, America's oldest active continuous veterans' association. We will be celebrating our 125th anniversary next year. American Jews have fought in all of America's wars in a proportion greater than their proportion in the general population.

I want to speak to you this afternoon about courage. Members of the armed services will risk his or her life on the battlefield to serve this great nation and to do the job assigned. Hundreds of thousands of American soldiers have given their lives and millions of American soldiers and their families have made other sacrifices in this regard. They had the right stuff and displayed great courage. They took enormous risks because their country called and because it was the right thing to do.

On behalf of all veterans, past and present, and all service personnel, past and present, I am asking each and every one of you to show courage by doing your job and by doing right, regardless of the political consequences, including the possibility, or even the probability, that you will lose your job by being voted out of office. When you, who, implicitly or explicitly, sent us off to war and asked us to do the right thing at the risk of our lives, it is a shanda if you are unwilling to take that risk to do right yourselves, rather then what is politically expedient. Shanda is Yiddish for "shameful." The risk of losing your job pales in comparison to the risk we take of losing our lives.

I was reviewing the John F. Kennedy Profiles in Courage winners of the award that is the nation's preeminent award for elected officials and public servants. For them and for you, it is the Nobel Prize, the Oscar, the Lasker, the Pulitzer. I give you these examples.

Carl Elliott was a Congressman from Alabama for eight consecutive terms from 1949 to 1965. He was a Democrat, but he authored and voted for National Education Defense Act, which he knew would lead to his removal as a Congressman in 1964. He was right, but he did what was right.

Charles Weltner, also a Democrat, was a Congressman from Georgia who dropped out of his race for a third term rather than seek reelection and be bound by a party loyalty oath to support the candidacy of segregationist Lester Maddox.

Bob Inglis, whom many of you know, is a Republican and was a Congressman from South Carolina. He reversed himself on the issue of climate change because he felt it was the right thing to do. He knew that it would probably mean the demise of his political career and it did.

We, who died, who were wounded, who survived, or who risked our lives in the military to do the right thing because America asked us to, are asking you to do the right thing, merely at risk of losing your jobs. Do not take funds away from the military, including from their daycare and schools, to build a border wall, because it is politically expedient for you to do so.

In addition, the Constitution, which you swore under oath to uphold, vests the power to declare war solely in the hands of Congress and not in the President, who is solely the Commander in Chief. However, since World War II, Congress, as a practical matter, has ceded its Constitutional responsibility to the President in the semantic guise of so-called "emergencies" and "police actions." War is too important to be in the hands of one person, and since World War II, the usurping of the war power by both Democratic and Republican presidents has led this nation into disaster after disaster and caused the unnecessary deaths of over a hundred thousand of my comrades-in-arms, my brothers and my sisters. An after-the-fact toothless Congressional resolution is not enough. Take back the war power that the framers of the Constitution and your own 1973 War Powers Resolution gave you.

When Abraham Lincoln was in the Congress, he wrote the following:

> "The provision of the Constitution giving the war-making power to Congress, was dictated, as I understand it, by the following reasons. Kings had always been involving and impoverishing their people in wars, pretending generally, if not always, that the good of the people was the object. This our convention understood to be the most oppressive of all Kingly oppressions; and they resolved to so frame the Constitution that no one man should hold the power of bringing this oppression upon us."

As a cantankerous football coach in my neck of the woods is fond of saying, "Do your job!" Risk your jobs to do the right thing!

In the long run, it is not just your constituents that you must face. You must face your children, your grandchildren, your descendants, and history. Also, you must face yourself and your conscience. Become a candidate for the Profiles in Courage award.

We, the veterans of America, do not just ask you to do the right thing despite the political consequences. We demand it, and we are entitled to do so.

Thank you.

NO GOVERNMENT FUNDING

For the record, the Jewish War Veterans of the USA, Inc., does not receive any grants or contracts from the federal government. This is as it should be.

THE MILITARY COALITION (TMC)

JWV continues to be a proud member and active participant of The Military Coalition (TMC). Past National Commander Norman Rosenshein, JWV's National Chairman, serves on the Board of Directors.

JWV requests that the Senate and House Committees on Veterans' Affairs do everything possible to fulfill the legislative priorities of The Military Coalition.

NO PRIVATIZATION OF THE VA

JWV is strongly opposed to the healthcare of veterans being privatized. Privatizing VA healthcare would mean worse healthcare for veterans.

The VA system is designed specifically to meet the needs of veterans. That means amputees, paralyzed veterans, blinded veterans, the traumatic brain injured, blinded veterans, and PTSD sufferers see medical personnel in the VA who specialize in these types of combat related injuries and who have the knowledge to deal with them. Privatizing the VA, i.e., changing the VA and giving every veteran a healthcare card, would result in the loss of access to these invaluable specialists.

The traumatized veteran needs medical personnel who are experienced working with these specific types of problems.

Also, those who work in VA healthcare have a special affinity for veterans and seem to give an extra effort on their behalf. Moreover, veterans who are patients tend to wear caps to indicate their military service, and tend to bond with each other, which helps make the VA health facility a friendlier place.

The Jewish War Veterans of the USA asks the members of this joint committee to firmly resist any, and all efforts of those who want to privatize the VA.

The Jewish War Veterans of the USA asks the members of this joint committee to firmly resist any, and all efforts of those who want to privatize the VA.

SUICIDE PREVENTION

There has NOT been a significant decrease in the number of suicides
among veterans. Although there has been and continues to be a growing awareness of this issue, the Department of Veterans' Affairs continues to report approximately 20 veteran suicides per day. This is unacceptable.

There continues to be a need for more mental health professionals directly involved in the identification of at-risk veterans and active duty personnel. Suicide-prevention projects and research into the causation of self-destructive behaviors needs to be fully funded.

The Jewish War Veterans of the United States of America urges Congress to pass H.R. 3495, the ***Improve Well-Being for Veterans Act*** proposed by House Veterans' Affairs Committee Chairman Mark Takano. This bill will allow the VA to responsibly partner with community organizations already serving veterans.

Additionally, this bill would protect VA's expertise in providing clinical care and begin to reach the 60 percent of veterans not using VA healthcare. Services covered by this grant program include, educating families on suicide risks and prevention, peer support, everyday support, and safety planning.

HOMELESS VETERANS

The U.S. Department of Housing and Urban Development (HUD) estimates that approximately 40,000 veterans are homeless on any given night. There are many reasons veterans become homeless. These include the basic lack of affordable housing, income, lack of access to necessary health-care, the effects of PTSD and substance abuse, all of which are compounded by a lack of family and social support networks.

To help address these issues, The Jewish War Veterans of the United States of America urges Congress to pass H.R. 2223, the ***Helping Homeless Veterans Act of 2019***.

This bill would make permanent several programs that provide transitional housing, employment assistance, and supportive services

It provides for $50 million for each fiscal year after 2020 for homeless veterans' reintegration programs.

It provides $380 million for each fiscal year after 2019 in financial assistance for very low-income veteran families in permanent housing.

AGENT ORANGE PRESUMPTIVES

As an Agent Orange survivor, this issue is one that is close to my heart. Agent Orange, an herbicide used to clear trees and plants during the Vietnam War, likely causes several illnesses. These are referred to as Agent Orange presumptive diseases.

Cancers believed caused by contact with Agent Orange include:

- Chronic B-cell leukemia**:** A type of cancer that affects your white blood cells (cells in your body's immune system that help to fight off illnesses and infections). I contracted two of these cancers a decade before it was recognized by the VA as presumptive.
- Hodgkin's disease**:** A type of cancer that causes your lymph nodes, liver, and spleen to get bigger and your red blood cells to decrease (called anemia)
- Multiple myeloma**:** A type of cancer that affects your plasma cells (white blood cells made in your bone marrow that help to fight infection)
- Non-Hodgkin's lymphoma**:** A group of cancers that affect the lymph glands and other lymphatic tissue (a part of your immune system that helps to fight infection and illness)
- Prostate cancer**:** Cancer of the prostate (the gland in men that helps to make semen)
- Respiratory cancers (including lung cancer): Cancers of the organs involved in breathing (including the lungs, larynx, trachea, and bronchus)
- Soft tissue sarcomas (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma): Different types of cancers in body tissues such as muscle, fat, blood and lymph vessels, and connective tissues

Other illnesses believed caused by contact with Agent Orange include:

- AL amyloidosis**:** A rare illness that happens when an abnormal protein (called amyloid) builds up in your body's tissues, nerves, or organs (like your heart, kidneys, or liver) and causes damage over time
- Chloracne (or other types of acneiform disease like it): A skin condition that happens soon after contact with chemicals and looks like acne often seen in teenagers. Under our rating regulations, it must be at least 10% disabling within 1 year of contact with herbicides.

- Diabetes mellitus type 2**:** An illness that happens when your body is unable to properly use insulin (a hormone that turns blood glucose, or sugar, into energy), leading to high blood sugar levels
- Ischemic heart disease**:** A type of heart disease that happens when your heart doesn't get enough blood (and the oxygen the blood carries). It often causes chest pain or discomfort.
- Parkinson's disease**:** An illness of the nervous system (the network of nerves and fibers that send messages between your brain and spinal cord and other areas of your body) that affects your muscles and movement—and gets worse over time
- Peripheral neuropathy, early onset**:** An illness of the nervous system that causes numbness, tingling, and weakness. Under our rating regulations, it must be at least 10% disabling within 1 year of contact with herbicides.
- Porphyria cutanea tarda**:** A rare illness that can make your liver stop working the way it should and can cause your skin to thin and blister when you're out in the sun. Under VA's rating regulations, it must be at least 10% disabling within 1 year of contact with herbicides.

Jewish War Veterans of the U.S.A. thanks these committees for establishing these presumtives and helping Vietnam Veterans receive the care they need.

BURN PITS

Burn pits are defined as open-air pits used to burn war chemicals, paint, medical and human waste, metal/aluminum cans, munitions and other unexploded ordnance, petroleum and lubricant products, plastics, rubber, wood, and discarded food. As of March 2019, there are currently 9 burn pits in existence.

Various peer review studies suggest a strong association between burn pit proximity and respiratory illness. Burn pits not only exposed the men and women who operated them but also, the troops located near them. These men and women are now suffering the ill effects of the burn pits on their health. The Departments of Defense and Veterans Affairs maintain that any ill effects from exposure to burn pits is temporary and will pass once the military member is removed from the area.

However, these denials have a familiar ring to them in the minds of the Vietnam

veterans and their issues with the military's denial of any ill effects of Agent Orange and other herbicides.

Military.com reports that 12,000 claims were filed with the VA about burn pits, but so far only 2,500 of the claims were accepted. The VA "has emphasized the need for clear scientific links between war zone exposure and illnesses later in life before making large-scale benefits decisions."

JWV strongly urges these committees and the Department of the VA to accomplish for burn bit casualties as they have for Agent Orange casualties.

JWV urges Congress to:

- Pass H.R. 663 and S. 191, the Burn Pit Registry Act. These bills would require the Department of Defense (DOD) to evaluate all members of the Armed Forces to determine if they served in a location where an open burn pit was used to dispose of waste or if they were exposed to toxic airborne chemicals. The evaluations must be included in periodic health assessments, physical exams conducted immediately prior to separation from active duty, and deployment assessments
- Require, at independent universities and non-governmental organizations, to research the long-range effects of exposure at burn pits;
- Add conditions shown to have a link to burn pits and airborne toxic exposures to VA's Presumptive List.
- Ensure that all VBA claims professionals are informed and knowledgeable about all rules and regulations for accepting a burn pit or airborne toxic chemical-related claims.
- Create a disability classification for servicemembers and veterans impacted by burn pits and other toxic airborne exposures.

MEMBERSHIP DEFINED

In July 2019, the Legion Act, S.504, became a law. Congress expanded the current eligibility period to cover Dec. 7, 1941, to the present, and includes the current war campaigns. This allowed the American Legion to extend the privilege of membership "to all military personnel who served on active military duty during all of the unrecognized war eras involving active United States military personnel."

As the Jewish War Veterans is also a veteran service organization chartered by Congress, we are petitioning lawmakers to sponsor a similar piece of legislation to allow JWV to define the scope of its membership in a similar manner.

POW/MIA

For many years JWV has consistently sought the return of all POW's, the fullest possible accounting for the missing, and repatriation of all recoverable remains. At every National Executive meeting, JWV displays the POW/MIA flag in front of the dais to show our continued support.

JWV asks the Congress to provide the necessary personnel and funding to continue to make every effort to bring closure to the families of the missing. The number of still missing and otherwise unaccounted for servicemembers from the Vietnam War is 1,424. The total accounted for since the end of the Vietnam War in 1975 is 1059.

The Jewish War Veterans of the United States of America urges Congress to provide adequate funding to support the greatest possible accounting of missing service members and the repatriation of all recoverable remains. JWV remains a strong advocate for the return of all those missing in action and prisoners of war. JWV is pleased to see the reparation of those missing in Vietnam, as well as those from the Korean War and even from WWII. It's important that as many families as possible have closure.

CONCLUSION

Chairman Moran and Chairman Takano, our great nation must care for its veterans.

Early in January, more than 3,000 military personnel were quickly and unexpectedly dispatched to the Middle East, a very dangerous area. These troops are in addition to the tens of thousands that are already there. These military personnel are now potentially in harm's way, as growing tensions with hostile actors, such as Iran and Isis could precipitate a military conflict. In fact, rockets from Iran have caused Traumatic Brain Injury (TBI) and or concussions to 109 of our military personnel. These injuries were severe enough that a significant number of these personnel had to be evacuated both to Landstuhl Army Medical Center in Germany and to medical facilities in the United States.

Soldiers do not return from war the same as when they went to war. Some will have physical injuries, from a slight wound to the horrific loss of limbs. Some will have invisible wounds, such as PTSD, psychological trauma, TBIs, and/or the effects of herbicides and chemical exposure. Some soldiers come home suffering trauma which can lead to homelessness, an empty life, and/or suicide when the veteran has hit bottom.

Every soldier will become a veteran and your support, your legislation, and your interest in them is needed to take care of their needs now, and throughout their lifetime.

JWV looks to the House and Senate Committees on Veterans Affairs to ensure that the needs of these veterans are met. JWV believes that veterans' benefits are earned through service and sacrifices in defense of the nation and are not "entitlement" or "social welfare" programs. Our country must, therefore, pay the costs involved.

We thank you for the opportunity to present our priorities to you today.

Testimony

of

Legislative Priorities
&
Policy Initiatives
for the
116th Congress

Presented by

John Rowan
National President

Before the
House and Senate
Veterans' Affairs Committees

February 26, 2020

Good afternoon, Chairmen Moran and Takano, Ranking Members Tester and Dr. Roe, and distinguished members of your respective committees. I first want to acknowledge you, Senator Moran, on your elevation to the chairmanship of your critically important committee. And, on behalf of our members and their families, I want to thank each member of both committees for all that you do to transform support for veterans to real programs, initiatives, and benefits. This gives real meaning to what it means to be "veteran-friendly."

I am pleased to appear before you today to present highlights of the legislative agenda and policy initiatives of Vietnam Veterans of America for the second session of the 116th Congress. As you know, although VVA is the only Vietnam veterans service organization chartered by Congress, we advocate on behalf of veterans of all eras, those who served before us and those who have served most recently in the Persian Gulf War in 1991, and the Post-9/11 wars in Afghanistan and Iraq, and in Syria, the Philippines, in Africa and elsewhere.

As you are aware, ***THE FULLEST POSSIBLE ACCOUNTING*** of America's POW/MIAs has long been our solemn priority. VVA continues to press for answers regarding those Americans still listed as killed in action, body not recovered, in the Southeast Asia theatre of operations. We must insist that Congress fund the Defense POW/MIA Accounting Agency (DPAA) what it requires to investigate potential crash and burial sites, and to recover and identify remains. And as we pursue our Veterans Initiative, which has been building bridges between American and Vietnamese veterans, this effort has encouraged continued cooperation by Vietnamese authorities with DOD search teams.

For several years, VVA's foremost legislative objective was enacting a statute that would foster the peer-reviewed research necessary to determine if a veteran's exposure to certain toxic agents might be responsible for certain birth defects, cancers, and/or learning disabilities that have afflicted far too many of our children and grandchildren. And toxic exposures, not only to Agent Orange, remain our prime concern.

AGENT ORANGE / TOXIC EXPOSURES

Public Law 114-315 Subtitle C, the Toxic Exposure Research Act. In one of its final acts, the 114th Congress passed a "minibus" that incorporated much of the intent of a bill VVA had promoted for eight long years. This bicameral, bipartisan legislation was introduced and co-sponsored in the Senate by your new Chairman, Jerry Moran (R-KS), and Dick Blumenthal (D-CT), both of whom were real champions; and in the House by Dan Benishek (R-MI), who really pushed the bill forward, and Michael Honda (D-CA). This bill laid the groundwork for research into the health of our children and even our grandchildren, which we believe is impacted by our exposures during military service. We fear the epigenetic impact of our exposures on those we love the most.

By "our" we refer to not only those of us who served in Southeast Asia, but to ***veterans of all eras***, including vets who served in CONUS, because, as you surely know, numerous current and former military bases in the continental United States are now categorized as toxic waste sites – some are even designated as Superfund sites – polluted by long-lasting chemical, biological, and/or radiological waste. This is the detritus of research projects and experiments, from the development and production of arms and ordnance to programs on the potential use of hallucinogens against an enemy. It is our hope that this legislation will ensure that our most recent veterans will not have to wait 50 years for answers, inasmuch as many of them were exposed to a smorgasbord of toxic substances in the burn pits in Southwest Asia.

We do want to thank you for having enacted this vital legislation, and we will continue to monitor the compliance of the Department of Veterans Affairs in complying with and implementing it.

Now that it has been determined that it is in fact feasible to conduct follow-up epidemiological studies on the "descendants" of veterans who were exposed to toxic substances while in uniform, the VA has, under the law, the next move. But thus far, they haven't moved with any sense of urgency. Rather than establishing the commission called for in the law, the Secretary has only recently pulled together a sort of ad hoc committee from various government departments. To say we're less than thrilled would be an understatement. So, it's time for you in Congress to exercise the oversight for which you have statutory responsibility. Call the VA Secretary to appear at a hearing. Ask him to explain, under oath, why his department has been lollygagging, and what he will do to get them back on track to execute the provisions of the act.

And let us be clear: since Vietnam, our military, yet again, to protect the men and women in uniform from the harmful effects of the toxicants to which they were exposed by ***the uncontrolled burning in burn pits***, some nearly as large as 20 acres, in Iraq and Afghanistan of a mélange of junked and jettisoned objects – medical and human waste, amputated body parts, animal carcasses, chemicals, paint, metal/aluminum cans, munitions and other unexploded ordnance, batteries, petroleum and lubricant products, plastics, tires, rubber, wood, discarded food – with jet fuel (JP-8) used as the accelerant. Just had to have the burn pits, commanders stressed, as the wars went on and on.

When they served, veterans deployed to Southwest Asia during the Gulf War in Operations Desert Shield and Desert Storm were likely exposed to a variety of environmental and chemical hazards that carried potential health risks. These included:

- Vaccinations for Anthrax and Botulinum Toxoid
- Oil Well fires

- Chemical and Biological weapons, including Sarin, from the demolition of the ammunition storage depot at Khamisiyah;
- Depleted Uranium used in U.S. military tank armor and bullets
- CARC – Chemical Agent Resistant Coating – paint on military vehicles to resist corrosion and chemical agents;
- Pesticides;
- PB – Pyridostigmine Bromide – a pre-treatment drug to protect against the nerve agent soman; and
- Solvents, including Benzene, Cyclohexanol, Ethylene Glycol, Methylene Chloride, Methyl Ethyl Ketone, Methyl Isobutyl Ketone, Naphtha, Toluene, Tetrachloroethylene, Trichloroethylene, and Xylenes.

Department of Defense performed air sampling at Joint Base Balad in Iraq from January through April 2007. Among the 16 PAHs (Polycyclic Aromatic Hydrocarbons) detected there were Anthracene, Benzo(a)pyrene, Chrysene, Dibenz(a,h)anthracene, Fluorene, Naphthalene, and Pyrene.

The 15 VOCs (Volatile Organic Compounds) also detected included Acetone, Benzene, Carbon Disulfide, Chloromethane, Ethylbenzene, Hexane, Pentane, Propylene, Styrene, and Toluene.

And detected as well, albeit in low doses, were 17 dioxins and furans, including 2,3,7,8 TCDD. It's as if the military hadn't learned a thing from the national agony over Agent Orange.

And when those who served, who did our nation's bidding, came home and encountered illnesses they couldn't explain, and went to a VA medical center, treatments often could not mitigate their maladies or their pain; and when they sought disability compensation, most were treated as if they were trying to get over on the government, as the VA more often than not put up roadblocks to veterans suffering with illnesses. It was déjà vu all over again. This is wrong.

VETERANS and TOXIC EXPOSURES

The Agent Orange Act of 1991 mandated that the VA engage the Institute of Medicine, now the National Academy of Medicine of the National Academies of Science, Engineering, and Medicine, to convene panels of experts every two years to review the peer-reviewed scientific literature, hold public hearings, produce their findings on levels of association, ranging from sufficient to none known at this time, on suspect health conditions related to exposure to dioxin, and publish their findings in biennial updates of ***Veterans and Agent Orange***.

There is a real need for Congress not only to re-authorize the funding for this endeavor for at least another decade, but to expand its scope to embrace ***the potential effects of exposures to toxicants on veterans of all eras***, specifically the 1991 Persian Gulf War and the recent conflicts in Afghanistan and Iraq and Syria.

Such research and the publication of the panel's findings also should include sites in CONUS known for the presence of toxic substances. These sites include, but are hardly limited to, Fort McClellan in Alabama; Fort Chafee in Arkansas; Fort Detrick and Aberdeen Proving Ground in Maryland; Dugway Proving Ground in Utah; the Marine base at Camp Lejeune, North Carolina; the former Marine air base at El Toro, California; and let's not forget Fort Greely up in Alaska.

The Secretary of Veterans Affairs must be required, as the law stipulates, to enter into an agreement with a reputable research entity such as the National Academy of Medicine that would empanel distinguished scientists, researchers, clinicians, and academics in the fields of toxicology, environmental hazards, and chemical, biological, and radiological exposures, to research the literature, hold public hearings, discuss and debate their findings, and produce biennial updates of ***Veterans and Toxic Exposures***. This publication would succeed, and follow the format of the *Veterans and Agent Orange Updates*.

Toxic exposures can be, and often are, as deleterious if not deadly to health as piercing wounds from bullets and bombs. Many veterans, like the tens of thousands in the Gulf War exposed to the toxic plume from the demolitions of the Iraqi ammunition dump at Khamisiyah and the CIA's detonation of at least five other sites that remain classified, and the hundreds of thousands of veterans who have seen service in Iraq and Afghanistan and lived or worked next to those insidious burn pits that pockmarked their bases in the desert, warrant an acknowledgment that their health may have been compromised in the long term.

TOXIC WOUNDS REGISTRIES ACT OF 2020

This leads us to argue for legislation that will ***establish real registries*** to cover deployments during which troops were likely to have ingested airborne toxic hazards. The VA's Hepatitis C Registry can serve as the template for subsequent and future registries; their Agent Orange Registry, though, is little more than a mailing list. If the VA were to take registries seriously, if they perceived their value and potential to inform and enlighten rather than function as little more than a bureaucratic exercise just to say they're doing something, their registries might actually be useful.

A valuable, useful registry would enable epidemiological research by linking, or knitting together, in Electronic Health Records a veteran's military history, coding for where they were in a particular place at a particular time. So, if a veteran in Plano, Texas, comes down with a

malady that they feel evolved from a particular exposure, and their battle buddy living in Topeka, Kansas, is afflicted with the very same condition, VA techs can go to the appropriate registry to check others they served with who are now living their lives in Glastonbury, Connecticut, and Livonia, Michigan. Actually, the VA could have, and we believe should have, been doing this with VistA, which has three blank fields that can accommodate hundreds of word-number combinations. For the record, we must insist that you in Congress insist that this capability must be built into the VA's futuristic IT system being created by Cerner.

Therefore, we now are seeking "champions" from both sides of the aisle and in both houses of Congress to introduce, and enact, the ***Toxic Wounds Registries Act of 2020***. This legislation would direct the Secretary of Veterans Affairs to ***establish a master registry*** that would incorporate *real* registries that are not just mailing lists for:

- Exposure to Agent Orange during and in the aftermath of the Vietnam War;
- Exposure to toxicants relating to deployment during the 1991 Persian Gulf War;
- Exposure to toxicants from a deployment during Operations Enduring Freedom, Iraqi Freedom and New Dawn, and the Global War on Terror;
- Exposure to toxicants during a deployment to Bosnia, Somalia, or the Philippines; and
- Exposure to toxicants while stationed at a military installation contaminated by toxic substances overseas and/or here in CONUS.

This legislation would authorize the VA Secretary to enter into an agreement with the National Academy of Medicine to review published, peer-reviewed scientific research, and suggest future research on ***the health effects of the toxic exposures*** identified in those registries; and it would require those conclusions to inform the Secretary's selection of research to be conducted and/or funded by the VA.

It also would establish ***a presumption of service connection*** for the purpose of veterans' disability and survivor benefits, for any illness that the Secretary determines warrants such presumption because of a positive association with exposure to a toxicant noted in the master registry; and becomes manifest, within a time period determined by the Secretary, in a veteran who experienced such exposure while serving on active duty in the Armed Forces.

It is our intention to work with the champions we've identified to introduce this legislation, and to work with ***TEAM***, the coalition of VSOs and MSOs that have affiliated to form ***Toxic Exposures in the American Military***, to coordinate a grassroots campaign to enact such legislation.

"HAVE YOU EVER SERVED*?* - In this same vein, there is limitless potential for the ***Electronic Health Record*** to be of significant assistance to clinicians in private practice – especially those who participate in the VA's Community Care Program – as well as those who are employed in a VA healthcare facility. Obviously, a patient at a VAMC or CBOC has seen

service in uniform. Still, a clinician should pose a series of questions: . . . When and where did you serve? . . . What was your Military Occupational Specialty? . . . Were you ever in combat? . . . Were you ever wounded? . . . Were you ever exposed to blood or other bodily fluids in combat or in the wake of combat? . . .

The answers to these questions can, and should, lead a savvy clinician to understand a potentially crucial aspect of a patient's medical history, which should suggest that the clinician ought to look to certain health conditions that might not be readily apparent. With some 70 percent of all medical students in this country receiving at least some of their training at a VAMC or CBOC, they are a captive audience who can learn an awful lot about veterans who might be among those they will treat in private practice, simply by asking, ***Have you ever served in the Armed Forces of the United States?***

DECISION TIME - The Agent Orange Act of 1991 specifies the timeline the VA Secretary is to follow after having received the latest *Veterans and Agent Orange Update*. This has patently *not* been followed after National Academy of Medicine panels found a positive association between exposure to dioxin and a quartet of health conditions: bladder cancer, hypothyroidism, hypertension, and Parkinson's-like symptoms. This president's first VA Secretary publicly stated that he intended to add three of the four to the roster of service-connected presumptive; he was rebuffed by the Office of Management and Budget (which means the White House). The current VA Secretary, after having deferred making a decision for a year and a half, now wants to wait until the end of calendar 2020, coincidentally after the next quadrennial election, when a pair of studies are slated to be completed, analyzed, and published. This is, to VVA and to thousands upon thousands of our fellow veterans, yet another delaying tactic, a smokescreen, an excuse for non-action. It's now time for you in Congress to put your collective foot down: further delays should not be acceptable; further delays must not be an option.

We can understand the rationale for denying hypertension: it is one of the most common afflictions of advancing age. But we don't really comprehend the reasons why a decision on the other three maladies must be deferred till the end of 2020, till two in-progress VA epidemiological studies are analyzed and, the VA hopes, peer-reviewed. From what we've been told, we doubt their conclusions will make much, if any, difference. Again, for too many Vietnam vets, it's the same old refrain: ***Delay, Deny, Until We Die.***

FOR a 4th VA ADMINISTRATION

THE VETERANS ECONOMIC OPPORTUNITIES ADMINISTRATION

The VA must embrace a corporate culture that measures its vocational rehabilitation programs and educational initiatives as to whether and how much they assist veterans obtain and sustain gainful employment at a living wage. To achieve this worthy goal, the VA should institute "one-

stop shopping" by creating a fourth entity: ***the Veterans Economic Opportunities Administration***, to be headed by an Under Secretary nominated by the President and confirmed by the Senate.

This is logical and will be cost-effective. It will eliminate duplicative programs; it will increase cooperation among and between its various divisions: The VEOA would house under one roof the Vocational Rehabilitation Service and the Veterans Education Service; and grant functional control, if not the outright transfer, of VETS, the Veterans Employment and Training Service, from the Department of Labor, as well as newly federalized DVOP (Disabled Veterans Outreach Program) and LVER (Local Veterans Employment Representative) positions, which currently reside in state departments of labor. It will promote Veterans' Preference; it will facilitate veterans' entrepreneurship.

SERVING VETERANS WITH LONG-TERM PTSD

It should come as a surprise to no one the VA employs too few mental health clinicians. This is true for myriad reasons, not the least of which are the hiring hoops clinicians must negotiate, which can take six, eight, ten months or longer before they can be officially employed by the VA. Yet in a short-sighted attempt to satisfy the needs of the moment, the VA is leaving in the lurch too many vets afflicted with chronic, long-term PTSD.

Out in Kansas City, some 50-70 of these men and women would meet at the VAMC once a week for an hour, facilitated by a VA mental health professional. Until a little over a year ago, these therapeutic sessions were a staple of their weekly lives. Now, it seems, the mental health service at the medical center can no longer spare a clinician for a single hour. *Why don't y'all go to a coffee shop to talk?* Is the best the leadership at the VAMC can offer. And this situation is not unique to Kansas City. The same is true in West L, here in the District of Columbia, and, we are told, at virtually every VAMC.

Luckily for the group, Dr. Tom Hall, who heads VVA's PTSD and Substance Abuse Committee, stepped in to fill the breach. He thought this would only be for a few weeks; it's now fourteen months and counting. This experience in Kansas City is not an outlier, an exception to the rule; it seems that the VA's understaffed mental health corps cannot afford to have one qualified clinician oversee a gaggle of PTSD-afflicted veterans discussing their issues for one hour each week. The question is: Will you in Congress use your standing to support these veterans? They come together to stay alive. The VA is not addressing, let alone fixing, a situation its bureaucrats created.

TARGETING VETERANS BEFORE THE ELECTIONS

VVA's Chief Investigator and Associate Director for Policy and Government Affairs Kris Goldsmith exposed, in a thorough, well-researched report two years in the making, how foreign trolls continue to target veterans, by creating accounts meant to look like they produced by real

veterans and VSOs like VVA. They use these to engage in financial scams that play off veterans' patriotism and love. They spread real "fake news" to damn one candidate or other in an insidious attempt to influence veterans' preferences in the upcoming elections. (If you have not yet read this expose', go to vva.org/trollreport; at the very least, read the executive summary.)

Chairman Takano held a hearing based on these revelations. In December, we wrote to the President to bring these issues to his attention and to request a significant government response to both educate veterans and the public as well as to seek out and punish the bad actors that target troops and veterans online. That letter, to date, has yet to receive a response. So it is up to you in Congress, and to all of us in the VSO community, to alert veterans and our families about ***this insidious, ongoing threat to our democracy***. We believe, too, that it is the responsibility of Congress to toughen penalties for any foreign individual or entity that creates or promotes such untruthful content – up to and including imposing sanctions against countries that allow cyber-criminals to freely operate within their borders.

GUARDING AGAINST PRIVATIZATION

During the last administration, the Department of Veterans Affairs was the "whipping boy" for politicos eager to compromise the President. The hasty solution to a hyped-up VA scandal was to give eligible veterans "choice" in choosing their healthcare provider if they could not get an appointment with a VA clinician within 30 days or if they had to travel more than 40 miles to a VA healthcare facility. The choice program was expensive, necessitating hefty infusions of funding from Congress to pay private care.

Under the MISSION Act, the VA, bowing to the entreaties of proponents of privatization, established regulations that loosened eligibility for travel time and distance, making several million more veterans eligible for non-VA care. The regs are specious, e.g., a veteran is now eligible if it takes more than 20 minutes to travel to a primary care clinician, or more than an hour to get to a specialist at a VA medical facility. We have argued time and again that what has been established will prove to be economically unsustainable; we can imagine potential scenarios in which VA healthcare services are cut back or simply cut so that private clinicians and hospitals can get paid. Hence, we urge Congress to exercise strict oversight of VA's management of its responsibilities under MISSION, and to consider the implications for undermining VA facilities at the altar of increasing eligibility for non-VA care and preserving "choice." What actually is needed is to restore the infrastructure and the organizational capacity of the VA, not to undo the VA by outsourcing care.

NUMBERS GAMES with HOMELESS VETERANS

Homeless veterans in large cities and small towns alike universally offend our sense of justice for those men and women too many of their fellow citizens ignore except for calling them fallen "heroes" on Veterans Day. Because it had been oft-stated that one of the key goals of the VA has been to end veteran homelessness (a promise that, realistically, never could be kept), this has

given rise to placing as many as possible in apartments, if only for the short-term. As long as the VA is able to provide a continuum of care, the key to which is a plenitude of well-staffed and –funded transitional services, this policy is sensible. The statistics looked good; the VA can rightly claim its policies are helping. The reality, however, that must be acknowledged is that there are some homeless vets who will not come in from the cold. Despite their circumstances, they still are deserving of our respect and gratitude, twin attributes that the VA might better promote via a sensitive outreach campaign.

THE NEEDS of WOMEN VETERANS

The VA needs to continue adapting to the new reality that, with the increasing number of women in military service, they will be faced with healthcare issues they had not been faced with before, e.g., providing (or contracting out) prenatal care, counseling victims of military sexual trauma, understanding the unique problems faced after facial disfigurement or loss of a limb. To meet these relatively new challenges, the VA must call for and fund research that will illuminate treatment options; the VA must also seek out and hire enough female OB-GYN specialists, whom many women veterans prefer.

ADDRESSING VETERAN SUICIDE

Two out of three veteran suicides are over 55 years of age. Fourteen of 20 do not get care at a VA healthcare facility. Ranking Member Dr. Roe was quoted as having said that more and more millions of dollars are being expended in an attempt to make an impact on the number of veterans who die by their own hand, yet the numbers don't seem to lessen. Mountains of studies, funded by millions of VA and DoD dollars, seemed only to develop recommendations revolving around the need to learn why veterans commit suicide . . . by funding yet more studies.

The whys may be unique for each individual who attempts to take their life, but they are no mystery: Demons borne of the horrors of war, horrors they have experienced. Return from a war zone to a society that does not know, or understand, what they went through too often leads to drinking and/or drugging to ease the pain. Add to this fiscal uncertainties, failed relationships, the loss of hope . . .

Permitting vets to seek help from non-VA practitioners may help some. This will be costly, and its effectiveness difficult to gauge. The answers may lie in community. Increased reliance on "battle buddies" may be viable for recent veterans but not necessarily for those who served in Vietnam a half-century ago. We want to help the VA create a culture that proactively seeks out lonely, homeless, family-less, disaffected veterans and brings them in from the cold.

Also, let the experts at the VA, clinicians who have been dealing with veterans every day, do what they do best. As Dr. C. Edward Coffey, Affiliate Professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, a leading expert on achieving system-wide culture change within a health system in order to reduce suicide deaths, recently testified before

the House Veterans Affairs Committee regarding a promising initiative to disrupt suicide attempts: He states;

> "In conjunction with our National Center for Patient Safety, we developed the Mental Health Environment of Care Checklist. This tool is used by interdisciplinary inspection teams to assess the environment for hazards and determine actions that need to be taken to protect our veterans. The rate of suicide prior to the implementation of the checklist was 4.2 deaths per 100,000 admissions. It is now less than 1 per 100,000 admissions."

What Congress might do is enact a law that will make mandatory the insertion of this single question on every death certificate: ***Did the decedent ever serve in the Armed Forces of the United States?*** This will enable researchers to do a more thorough medical post mortem of anyone determined to have committed suicide. This should provide some answers that should add to our understanding of the whys and wherefores of a real American tragedy.

Vietnam Veterans of America greatly appreciates the efforts of both committees to improve the lives of veterans, our families, and our survivors and your bipartisan support of seeking justice for our Blue Water Vietnam Veterans and the repeal of the "widow's tax," a financial penalty affecting military survivors across the country. We appreciate the opportunity to testify today, and to submit our extended remarks for the record. We look to work in concert with Congress, as partners, to make inroads into many of the issues and problems you have heard about this afternoon and over the past several weeks. And we will do our best to reply to any questions or concerns you might care to put to us.

Thank you.

THE

MILITARY ORDER OF THE PURPLE HEART OF THE U.S.A., INC.

THE ONLY CONGRESSIONALLY CHARTERED VETERANS ORGANIZATION

EXCLUSIVELY FOR COMBAT-WOUNDED VETERANS

ANNUAL TESTIMONY
FELIX GARCIA III, NATIONAL COMMANDER

BEFORE A JOINT HEARING OF THE SENATE AND HOUSE COMMITTEES ON VETERANS AFFAIRS

FEBRUARY 26, 2020

FELIX GARCIA III, NATIONAL COMMANDER

2020 ANNUAL TESTIMONY

BEFORE A JOINT HEARING OF THE

SENATE AND HOUSE COMMITTEES ON VETERANS AFFAIRS
FEBRUARY 26, 2020

Chairman Moran, Chairman Takano, Ranking members Senator Tester and Representative Roe, members of the committees, and ladies and gentlemen.

As the National Commander of the Military Order of the Purple Heart (MOPH), it is an honor and privilege to appear before you today, representing members of the Order. I am sure that all of you are aware that the MOPH is unique among Veteran Service Organizations (VSOs) in that our membership is comprised entirely of veterans who were wounded in combat on the battlefield in the numerous wars in which this nation has been engaged. For the wounds they suffered they were awarded the Purple Heart Medal.

In a sense, I believe I also sit before you here today on behalf of the almost 2 million servicemen and women, Purple Heart recipients all, who either gave their lives or spilled their blood for our nation and its citizens while defending the freedoms that all Americans are blessed to enjoy.

My oral testimony will be as brief as possible with the understanding that the full written testimony will be entered into the record.

Since it's organizing in 1932, the MOPH has been and continues to be, the original Veterans' Organization for wounded warriors. We continue to serve veterans of all wars, at no cost, by providing tangible benefits to those veterans and their families who require our assistance.

On behalf of the MOPH, I would like to thank the previous Congress for passing legislation that will forever have a positive impact on the lives of our nation's veterans and their families. In particular, I want to thank Ranking Member Roe on the eve of his retirement for his many years of dedication to protecting the rights of America's Veterans, and for holding the Department of Veterans Affairs accountable to the Veterans it serves.

The MOPH thanks the Congress for passage of the Veterans' Compensation Cost-of-Living Adjustment Act of 2019, bipartisan legislation that increases the rates of VA disability compensation, dependency compensation for surviving children and spouses, and the clothing allowance for veterans based on rising costs of living.

MOPH also applauds and thanks to Congress for passage of the Commemorative Coin Act for the National Purple Heart Hall of Honor. The PH Hall of Honor is collocated at the New Windsor, New York Cantonment Site where General Washington's army camped during the revolutionary war and where the General first awarded the Badge of Military Merit, predecessor to the Purple

Heart Medal. This coin will assist the Hall of Honor to continue its efforts in commemorating the sacrifices of America's military members who were killed or wounded in combat while serving our great nation.

MOPH is acutely aware of the budget negotiations and the fiscal problems facing our nation but they should have nothing to do with caring for those who have honorably served this nation and now require medical attention or other benefits that they have earned by their honorable military service.

I would also like to state that MOPH supports the recommendations made by the VSOs who devote their time and effort to publish the Independent Budget. MOPH is a proud member of both The Military Coalition (TMC) and the National Military Veterans Alliance (NMVA).

<u>MOPH 2020 PRIORITIES:</u>

VA processing of claims is an issue that your Committees, MOPH and other VSOs have been struggling with for many years. While there has been much progress there remains much to be done. Congress has provided increased funding to help improve the process, which enabled VA to hire more personnel and invest in information technology and other infrastructure.

While there has been progress in the area of claims processing, the veteran who may have been fighting the process for years, especially when appealing benefit denials, does not see that

progress. They just know that they have not been afforded, in a timely manner, the benefits that they earned by their military service.

The Congress needs to continue to hold the VA accountable for its care and service to Veterans in an open and transparent manner while working with the Congress and the VSOs in moving forward with new initiatives.

The MOPH joins with The National Military & Veterans Alliance, a nonpartisan umbrella organization of 35 veteran and military serving organizations, to endorse *The Care for the Veteran Caregiver Act of 2020*. We urge the earliest consideration by your Committees, including legislative hearings, mark-up, and Committee vote. We applaud Representatives Hudson and Rice for their sponsorship of this bill, and urge you and your Committee colleagues to join as cosponsors of this bill.

While the MISSION Act made crucial changes to the Caregiver program (most importantly the expansion of the program to pre-9/11 veterans), time and again our organizations and others have brought to you the continued problems with the Caregiver program. Specifically, the lack of consistent eligibility criteria utilized by the VA in executing the program, the constant fear of the most catastrophically disabled veterans that they will lose their access to the Caregiver program, and the unreasonably short transition time provided Caregivers and families after an eligible veteran passes away. We urge your time and attention to this continuing issue to bring it to fruition in this Congressional year.

MOPH is especially proud to note that during Senator Moran's first markup as chairman of the Senate Veterans' Affairs Committee, they passed landmark legislation to improve mental health care for veterans. The *Commander John Scott Hannon Veterans Mental Health Care Improvement Act*, sponsored by Chairman Moran and Ranking Member Jon Tester (D-Mont.), is a comprehensive and aggressive strategy to reach more veterans with the mental health care they need.

As Ranking Member Tester noted and we agree, "This comprehensive approach—combining supportive services with evidence based clinical care through the Department of Veterans Affairs— will ensure that no veteran slips through the cracks."

This bill also would hold the VA accountable for its mental health care and suicide prevention efforts by examining how the VA manages its suicide prevention resources and how the VA provides seamless care and information sharing for veterans seeking mental health care from both the VA and community providers. It is a recognition that the invisible wounds of war that have plagued so many veterans for so long must receive equal concern and treatment.

This concludes my testimony and I will be pleased to answer any questions.

Thank you,

Felix Garcia III

MOPH National Commander

Annual Legislative Presentation
Jan Brown
National Commander
AMVETS

Before a Joint Hearing of the
House and Senate Committees on Veterans' Affairs
February 26, 2020

"We continue to maintain that the best investments Congress can make are those that encourage and assist servicemembers and veterans to live happy and healthy lives such as the G.I. Bill and investments in training servicemembers how to be mentally healthy." –Jan Brown

Chairman Moran, Chairman Takano, and honorable members of the House and Senate Committees on Veterans' Affairs, I appreciate the opportunity to present you with the 2020 legislative priorities and policy recommendations of AMVETS. For more than 75 years, our organization has been a leading voice in veterans' advocacy work. As the largest veteran non-profit to represent all of our Nation's veterans, this annual address allows AMVETS to assist Congress in making policy decisions that serve the best interests of veterans across the Nation.

We are thankful for all of your team's efforts and time over the first year of this Congress. AMVETS has made increased investments in our efforts on Capitol Hill because we believe there are many troubling outcomes that the veteran community is facing. As you know, there is much work to be done in a presidential election year.

As such, we are worried that, unfortunately, the veteran space has become overly politicized, particularly on the House Veterans Affairs Committee. Veterans have long enjoyed a tradition and respect of decorum that both parties and the individuals assigned to lead these committees abide by. We hope that all of the leaders on these committees can make necessary adjustments and thereby significant progress on the many issues we will discuss.

We continue to maintain that the best investments Congress can make are those that encourage and assist service members and veterans in living happy and healthy lives such as the G.I. Bill and investments in training servicemembers how to be mentally healthy. Too often, we are finding ourselves focused on emergent needs. The problem with this approach is generally expensive programs with poor long-term outcomes.

AMVET pursues those issues that are most negatively affecting our veterans or that stand to provide the most significant positive benefit to them.

As such, we have three pressing issues we are advocating for in the remainder of this Congress: addressing our mental healthcare crisis and suicide epidemic, addressing the critical needs of women veterans, and providing timely access to high-quality healthcare.

AMVETS Encourages Congress to make a Significant Investment in Alternative Approaches to Mental Health

If the entire 2019 mental health care budget was $100, the House Veterans Affairs Committee spent the first year of Congress arguing over a quarter. Meanwhile, AMVETS sees no reason or any new significant change in efforts that would lead us to believe we did not lose another 6,000 veterans in 2019. Victory laps were taken for hearings and roundtables. Poorly thought out legislation was marked up before having any hearings that included the VSO and non-profit community. Any voices that are not supportive of

the status quo have generally been shut out of the conversation or not considered for finding a path forward. Union needs were prioritized over coming up with new solutions amidst a crisis. Draft legislation was not shared with VSO's for consideration. Key staff bullied other staff on the committee, and the list goes on.

Of all that, most striking, and also most concerning to us is seemingly the intent of doubling down on "evidence-based" approaches that have been shown on at least five occasions to be failing most veterans, most of the time.

How are we ever going to get a handle on this problem if we are spending more than 90% of our resources on approaches that fail most veterans, most of the time?

This approach not only seems to be poor politics, but it will also certainly result in more lives lost.

The Evidence on Evidence-Based Approaches

AMVETS has been astonished that significant research has been released without any consideration by Congress to review the research or ask those who are in charge of these research efforts to testify before Congress. The most glaring examples of this are the two outcomes assessments ordered by Congress.

As a result of the Clay Hunt SAV Act, Congress required V.A. to provide an outside assessment of V.A. Mental Health programs. The first report was due to Congress in October of 2018[1] and the second was due in October of 2019.[2]

In both assessments, V.A. reported that veterans receiving General Mental Health treatment, and PTSD Specialty treatment resulted in no clinically significant outcomes as a result of their treatment.

Just this month, The Journal of the American Medical Association (JAMA) reported that the psychotherapy approaches considered by the Departments of Veterans Affairs and Defense to be front-line treatments for military-related PTSD don't work for up to two-thirds of patients.[3] JAMA reported similar findings in 2015 and 2017[4], whereby they highlighted the need for new and novel treatments.

The bottom-line, our approach for veterans mental health is failing, or as Dr. Edward Coffey recently testified, “what does it mean to be the best in an incredibly mediocre system.” Congress continues to ignore the most critical fact in the room: where we are

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[1] 2018 Annual Report: VA Mental Health Program and Suicide Prevention Services Independent Evaluation.

[2] 2019 Annual Report: VA Mental Health Program and Suicide Prevention Services Independent Evaluation.

[3] Steenkamp, Maria M., et al. “First-Line Psychotherapies for Military-Related PTSD.” *Jama*, vol. 323, no. 7, 2020, p. 656., doi:10.1001/jama.2019.20825.

[4] SteenkampMM,LitzBT,HogeCW,MarmarCR. Psychotherapy for military-related PTSD: a review of randomized clinical trials. *JAMA*. 2015;314(5): 489-500. doi:10.1001/jama.2015.8370

spending the vast majority of resources fails most veterans, most of the time. Most efforts by the White House, the V.A., and Congress continue to focus on creating more "access." Access, or more significant funnels, to treatments that do not work, will not, and have not, achieved the outcomes we need: helping veterans live mentally healthy lives that are worth living.

Recommended Actions Related to Mental Health

AMVETS recommends spending the totality of the proposed budget increase for V.A. Mental Health on a VA/DOD Mental Health Center for Innovation. This $683 million investment should be used not as additional funding for approaches that fail most veterans, most of the time, or for increasing access to those treatments. We should use this funding as an investment to incubate, test, and scale approaches that are proving to be effective. The majority of this funding should be allocated to fund alternative, novel, and non-pharmacological approaches such as Post Traumatic Growth, recreational therapy, yoga, and others that V.A. has not fully embraced, tried or tested. Portions of the funding should be allocated for providing contracts for services to non-profit community providers who have been active in serving veterans. Some of this funding should also go toward creating long term studies on the effectiveness of these approaches. We need to get out of the business of Randomized Clinical Trials (RCTs) as a holy grail of "Evidence-Based" research.[5] The reality is that the approaches we are using are not sufficient; the research and death toll state the same.

The bottom line, we need to stop doing the same actions, and expecting fewer deaths, it did not work when the budget was 2.4 billion dollars, and it will not work when it is well over ten billion dollars. We need to start making significant investments in an approach that gets us out of our flawed and ineffective model.

AMVETS recommends that both HVAC and SVAC hold a joint hearing that includes the authors of the JAMA reports, and the Clay Hunt SAV Act; as well as individuals who have provided evidence for alternative models being useful in the non-profit space. If we don't fully embrace and understand what is working well, what is not working, and what is kind of working, we will be unable to start charting effective models moving forward. More voices should be at the table, particularly those that are doing great work in the community, and those that are sounding the alarms in regards to our current approach.

The Department of Defense should be at the table. In most discussions, including at the President's PREVENTS task force and throughout 2019's congressional hearings and roundtables, the Department of Defense has been a significant and noticeable non-participant. AMVETS believes a Servicemembers time in service, and their transition is likely the most critical component missing as we work to help service members and

[5] Shedler, Jonathan. "Selling Bad Therapy to Trauma Victims." *Psychology Today*, Sussex Publishers, 19 Nov. 2017, www.psychologytoday.com/blog/psychologically-minded/201711/selling-bad-therapy-trauma-victims.

veterans alike to create a real antidote to suicide: a life worth living. Having DOD involved in all of these solutions is the most pro-active way we can get ahead of this issue. For many of our veterans, their downward spiral starts at their transition from the military. At that moment, when they leave behind their band of brothers and sisters, lose their mission and purpose, they will often find themselves isolated. This is a critical final touchpoint, one in which crucial training and resources can be provided before their geographic dispersion.

We recommend that Congress require higher levels of budget accountability for V.A. mental health. We continue to write blank checks for V.A. concerning the effectiveness of their programs over the long term. This year, some members of Congress devalued alternative approaches to mental health and flouted the V.A. as best in class. These same members, and their staffs, took no time to do any oversight of the programs they have negated. They have generally relied on RAND studies that, in their research, assume "evidence-based" approaches to be effective, and simply compare V.A. and non-VA evidence-based approaches. In contrast, JAMA and V.A.'s Clay Hunt Reports review the effectiveness of the dominant approaches used at V.A. and DOD and come to the conclusion they are not generally clinically effective at all. Proponents of more of the same also rely on Randomized Clinical Trials, as the proof for the effectiveness of "Evidence-Based" treatments.

The reality is there is very little being tracked at V.A. with regards to the treatments V.A. patients are receiving and their effectiveness over significant periods. There is even less data when you consider the combination of treatments veterans receive over time. For instance, many veterans receive psychotropics in combination with Cognitive Behavioral Therapy. If this proves to be ineffective, they will be referred to inpatient treatment. Along this entire continuum, little is measured evaluating the effectiveness at 6 months, 18 months, 10 years. Very little is known about these treatments long term impact on veterans, and it is time we hold V.A. more accountable for long-term impacts and stop allowing 12-week RCT's to be held up as the holy grails of treatment modalities.
Further, all modalities should also start to incorporate quality of life measures. How are these treatments leading to veterans living higher quality of lives, if at all? Again, this is all data V.A. does not track and should, if we are going to get a handle on this situation, spend this budget effectively, and most importantly, help veterans live high quality mentally healthy lives.

AMVETS strongly discourages using the following statement: “16 of 20 veterans who have died by suicide have not been to the V.A." The statement is highly misleading, and it denigrates what is possibly the most critical question we should be asking: "How many of the veterans who have commit suicide have EVER been to the V.A.?" The importance of the question highlights the fact that at some point, many of these veterans have been to the V.A. and that we may have failed them somewhere within that continuum. We need to stop blaming the victim by suggesting a different result may have occurred had they been to a V.A. recently. The facts point to V.A. Mental Health as generally ineffective for too many veterans who have very few alternatives. The more important questions we need to start asking are: at what point did we lose this veteran’s confidence in V.A. and

why?; what programs, treatments, and pharmaceuticals did these veterans receive at V.A. before their suicide?; and how do we deliver high impact treatments that are effective over time?

Lastly, AMVETS encourages Congress to enact S. 785. While this effort does little to drastically change V.A.'s status quo of the $9.4 billion being spent on efforts that don't work up to 2/3's of the time, it is a step forward in that it would provide some funding to innovative programs in the community while also creating pilots for new approaches. With that said, if these investments do not grow significantly, we don't see them having a dramatic effect on the 6,000 veterans, and maybe more at this point, we are losing every year. A more significant portion of the Mental Health Budget needs to be spent on creating a bulwark and access to non-pharmacological, non-traditional approaches within V.A. and DOD, and within the communities in which veterans reside.

Closing the Gap for our Women Veterans and Servicemembers

Addressing mental health issues that are specific to women is a top priority for AMVETS. The rate at which women choose to end their own lives is 180 percent higher than members of the same gender who never served. Male veterans, meanwhile, are 140 percent more likely to commit suicide than their peers who have only known civilian life.

Let AMVETS be clear. There are many improvements to be made at V.A. to make women veterans feel welcomed and safe. This is a top-down effort, and at no time should we be questioning victims about their experiences at the V.A. AMVETS is appalled to learn of continued lapses at V.A. with regards to its policies in handling such incidents. Adequate, timely, and practical training needs to be provided to all employees with regards to creating safe environments for all veterans. And when claims of harassment are made, there should be clear guidelines that are followed in those incidents for attending to those victims. V.A. personnel and V.A. leadership should be held accountable for those policies. Blaming victims or insinuating character issues would be unacceptable if it were your mother, sister, or daughter; thus, it is equally unacceptable when they are someone else's loved one.

AMVETS is supportive of the *Servicemembers and Veterans Empowerment and Support Act of 2019*, introduced in the House as H.R. 1092 and in the Senate as S. 374. This legislation expands health care and benefits from the V.A. for military sexual trauma. Section 101 of this legislation adds technological abuse as an assault that the V.A. is required to provide counseling and appropriate care for. Technological abuse may include unwanted, repeated phone calls, text messages, or social media posts.

Upon passage of this bill, if a veteran claims that a covered mental health condition was caused by military sexual trauma during active service and the opinion of a mental health professional is consistent with that claim, the V.A. will accept this claim as sufficient proof of service-connection even if there is no official record of such incurrence in the service.

H.R. 1092 and S. 374 will allow members of the reserve components of the Armed Forces, including members of the National Guard, to be able to access all V.A. health care

facilities to receive counseling and treatment relating to military sexual trauma and not just Vet Centers.

There are specific sections of S. 785 *John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* that address mental health disparities specific to women veterans. We support language that will require an assessment of the capacity of peer specialists of the V.A. who are women. This assessment will be required on the geographical distribution of peer specialists of the V.A. who are women, the geographical distribution of women veterans, the number and proportion of women peer specialists who specialize in peer counseling on mental health or suicide prevention, and the number and proportion of women peer specialists who specialize in peer counseling on non-mental health-related matters. Based on this assessment, the V.A. will then submit a plan to hire additional qualified peer specialists who are women.

AMVETS has also endorsed H.R. 4281 *Access to Contraception Expansion for Veterans Act* and H.R. 5045 *Veteran Employment and Child Care Access Act of 2019*. This legislation allows Women Veterans to have autonomy and feel empowered to decide what's best for them. With the benefits of contraception beyond the pregnancy, Women Veterans should have peace of mind knowing the lack of contraception won't be an added stressor.

AMVETS supports H.R. 4281, which gives women veterans the option to receive a 12-month supply of oral contraceptive pills at the V.A. Providing women service members with more than the current 6-month standard supply allows them to have greater control over how their bodies regulate. This may further maximize performance while on deployment or in circumstances where women's health services are not readily available during unexpectedly prolonged assignments.

AMVETS also urges the passage of H.R. 5045, which requires the Secretary of Veterans Affairs to provide childcare assistance to a veteran who is receiving training or vocational rehabilitation on a full-time basis. The VA currently provides a wide gamut of supportive services for veterans undergoing vocational rehabilitation, such as training costs, tuition and fees, books, supplies, equipment, tutoring, and special services. A lack of childcare options has been a long-standing barrier for too many veterans who would otherwise benefit from this additional support to fully participate in vocational rehabilitation.

Timely High-Quality Access to Healthcare

The VA has pledged to serve our veterans' healthcare needs, but the means of accessing this care is different for every veteran. There are an estimated 4.7 million rural and highly rural veterans who face a unique combination of factors that create disparities in healthcare not found in urban areas, such as inadequate access to care, limited availability of skilled care providers and additional stigma in seeking mental healthcare. There is also the continued challenge of the politicization of V.A. healthcare. AMVETS realizes that the best healthcare option for veterans will provide a reliable, well run, and

fully staffed V.A. first! As a support mechanism, V.A. will utilize private care when it makes sense to provide ease of care to veterans, as is often the case for veterans in rural areas.

As such, AMVETS fully supports H.R. 4154, the Leave No Veteran Behind Act, which requires V.A. to reach out to veterans who have not utilized V.A. care for an extended period. Even though these veterans are out of sight, they should not be out of mind. Proactively encouraging veterans to receive overdue, baseline, comprehensive physical exams, comprehensive eye examinations, and mental health check-ins can go a long way in reducing long-term higher cost treatments and reducing veterans isolation.

AMVETS also supports language in S. 785 that will make telehealth available to more veterans living in rural areas.

The Largest and Least Discussed Threat to the Veteran Community: The Combustible Cigarette

Despite a great deal of effort and resources put forth by the government, AMVETS, and many other organizations, far too many veterans and their family members still choose to participate in one of the most unhealthy, legal actions one can take: smoking combustible cigarettes. The U.S. Centers for Disease Control and Prevention and V.A. estimate that nearly one in three veterans use tobacco. Anecdotally, we see an even higher rate, of about 40 percent, in our posts.

In testimony last year, my predecessor spoke of AMVETS' deep concern and AMVETS' new efforts to address the number-one cause of preventable deaths in the United States.

Veterans smoke at much higher rates than most non-veterans. It is easy to trace the disproportionate number of smokers in the veterans' population back to military service. The majority of our members served in uniform when our military still issued cigarettes in military rations. Many tell us the stress inherent to military service made it virtually impossible not to at least try smoking at some point on a deployment, after a firefight, or to fend off hunger pangs during downtime in the field.

AMVETS has spent years promoting smoking cessation programs in partnership with the V.A. Clearly, it would be best if veterans refrained entirely from using nicotine. But there is ample evidence that there is still a lack of interest in quitting among far too many. Encouraging and helping veterans to quit their nicotine use will remain a long-term goal. But we now are thinking and acting outside the box to aid veterans in finding alternative means to obtain nicotine.

Over the past year, AMVETS has developed an innovative, a first-of-its-kind nationwide program that brings to our members special access to products and incentives to try alternatives such as e-cigarettes.

This AMVETS program is voluntary, solely for veterans and their spouses who already smoke, and are at least 21 years of age. We have made available to our members' support and e-cigarette alternatives at reduced costs.

AMVETS hopes this program will help in the national effort to reduce secondhand smoke. After decades of progress in the United States, efforts to reduce exposure to secondhand smoke among non-smokers recently stalled, according to the CDC. Being that veterans organizations' posts are private clubs, many state and local codes allow these gathering centers to be the last places in town in which smoking is legal indoors. The secondhand smoke is affecting non-smokers, their spouses, and even the posts' viability as non-smoking veterans find smoky rooms unwelcoming. The importance of having welcoming, inclusive places for veterans to share one another's comradery cannot be overstated.

As we've discussed the program with our posts' leaders, we found most "smoking posts" unwilling to go "smoke-free" out of fear they would lose many current members. But the desire to do so is real. We hope that as more veterans go through our program, more posts will stop allowing smoking indoors.

Interest in bringing the program to their posts has been very high, with more posts requesting inclusion than we had the capacity for in the first year. It is clear that our members want and need alternatives, such as this program.

Over the first year of this program, AMVETS has significantly reduced the number of combustible cigarettes being smoked by our members and in our posts.

The program was brought to 35 of our posts in eight states in 2019, with members joining from about a dozen other posts remotely. AMVETS' goal beginning the program was to enroll 200 members. We exceeded that with 371 members enrolling. 189 were women, and 182 were men. That ratio is notable, given that women make up only about 12 percent of our membership.

Most participants self-identified as "long-term heavy smokers." The average participant started smoking when they were 18 years old, had been smoking for an average of 37 years and was smoking at least a pack a day (20 cigarettes) when they began the program.

We found that switching from cigarettes to an e-cigarette is not easy and is not for everyone. While program participation does not guarantee a full transition from combustible cigarettes, it is a good indicator of program interest and value. Each participant in the 90-day program was asked to voluntarily complete a survey every 30 days. 60 percent of those who enrolled completed the first survey. 43 percent completed the 60-day survey. And 36 percent completed the 90-day survey.

Numerous participants provided additional feedback, many describing fully transitioning from smoking a pack or more a day for decades. 92 percent of those who completed the program said they would recommend it to others.

AMVETS continues to closely monitor the U.S. Food and Drug Administration's important work on formalizing regulations concerning vaping products. This AMVETS program has only involved legal, commercially available, factory packaged devices, and liquids.

We encourage other veterans organizations and the V.A. to look at our innovative program. The desire and need for new approaches are strong among veterans and their spouses to address the on-going use of combustible cigarettes at significantly higher rates than non-veterans.

In response to the program's success and growing demand, we are continuing through 2020. Our goals for 2020 are to make our program available to more of our members. We aim to continue reducing the number of combustible cigarettes used by our members and in our posts, making our posts more welcoming, inclusive environments. And we hope the program’s success generates new, meaningful dialogue among other veterans advocates and V.A. to find new approaches and solutions.

Conclusion

Chairmen Moran and Takano, and members of the Committees, I would like to thank you once again for the opportunity to present the issues that impact AMVETS' membership, active duty service members, as well as all American veterans. As the V.A. continues to evolve in a manner that can improve access to benefits and healthcare, it will be imperative to remember the impact that any changes to those systems on millions of individuals who defended our country. We cannot stress enough the need to preserve and strengthen the V.A. as a whole, across all administrations, to ensure the agency can deliver on President Lincoln's sacred promise now and in the future.

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