



OPERATION: **KEEP THE PROMISE**

2021

DAV's Critical Policy Goals

- Ensure Veterans Who Were Exposed to Toxic Substances Receive Full and Timely Benefits, Particularly for Burn Pits, Agent Orange and other Known Exposures
- Enhance Veterans' Survivor Benefits
- Protecting Veterans in the Claims and Appeals Processes
- Ensure Equitable Benefits and Services for Women and Minority Veterans
- Improve Mental Health Services and Suicide Prevention Efforts to Reduce Veterans Suicide
- Building a Veterans Health Care System for the Future

DAV empowers veterans to lead high-quality lives with respect and dignity. It is dedicated to a single purpose: keeping our promise to America's veterans. DAV does this by ensuring that veterans and their families can access the full range of benefits available to them; fighting for the interests of America's injured heroes on Capitol Hill; providing employment resources to veterans and their families and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV, a non-profit organization with more than 1 million veteran members, was founded in 1920 and chartered by the U.S. Congress in 1932.





Ensure Veterans Who Were Exposed to Toxic Substances Receive Full and Timely Benefits, Particularly for Burn Pits, Agent Orange and other Known Exposures

When service members are subjected to toxins and environmental hazards, our sense of duty to them must be heightened. Many of the illnesses and diseases due to these toxic exposures may not be identifiable for years, even decades, after they have completed their service. These exposures can result in long-term health effects that will impact individual functioning, often resulting in industrial impairments that require physical rehabilitation and future health care. Although some notable progress has been achieved over the past two decades for veterans who suffered illness due to toxic and environmental exposures, there are still too many who have yet to receive the full recognition, health care and benefits our nation owes to them.

Burn Pits and Concession of Exposure

U.S. military operations require disposal of waste and other products, and for decades this included open burn pits. Since Operations Desert Shield/Desert Storm (1990–1991), burn pits have been utilized not only in Iraq but also in Kuwait, Oman, Qatar, United Arab Emirates, Saudi Arabia and Bahrain. Since Sept. 11, 2001, burn pits have been used throughout the operations in Afghanistan and Djibouti, as well as in Iraq after March 20, 2003. Recently, the Department of Defense also acknowledged exposures in Syria and Egypt.

Several studies indicate that veterans were exposed to airborne toxins from burned waste products, including but not limited to plastics, metal/aluminum cans, rubber, chemicals (such as paints and solvents), petroleum and lubricant products, munitions and other unexploded ordnance, wood waste, medical and human waste, and incomplete combustion byproducts. Since there is no current presumptive service connection for burn pit exposure, veterans must file claims for direct service connection for diseases and illnesses related to burn pit exposure. From June 2007 through May 2020, the Department of Veterans Affairs adjudicated 12,517 direct service connection claims for diseases related to burn pit exposure. Roughly 80% of those claims have been denied. Many of these denials are due to veterans not knowing what toxins they were exposed to, thus impeding their ability to obtain a medical opinion relating the condition to the specific toxins.

One way to overcome this is to concede burn pit exposure for veterans currently eligible to join the Department of Veterans Affairs Airborne Hazards and Open Burn Pit Registry as well as concede their exposure to the same chemicals and toxins noted in the VA's M21-1 Manual, including but not limited to (1) particulate matter, (2) polycyclic aromatic hydrocarbons (PAH), (3) volatile organic compounds, and (4) toxic organic halogenated dioxins and furans (dioxins).

A concession of burn pit exposure will not establish presumptive service connection; however, it will remove the requirement for veterans to prove their individual exposure to burn pits and the specific types of toxins emitted from such pits for disability claims based on direct service connection.

In September 2020, the National Academies of Sciences, Engineering and Medicine (NASEM) completed their report "Respiratory Health Effects of Airborne Hazards Exposures in the Southwest Asia Theater of Military Operations," which concluded that there was inadequate or insufficient evidence to determine associations needed for presumptives. However, instead of waiting for more studies and presumptive service connection, Congress can take action now and enact a concession of exposure for burn pits.

- **Congress must enact legislation to concede burn pit exposure and remove the obstacles for veterans having to prove their individual exposure to burn pits and the types of toxins emitted, for claims based on direct service connection.**

Presumptive Diseases and Positive Scientific Association

The VA has established several toxic exposures as presumptive with conceded exposures and diseases scientifically linked to the exposure. Some established presumptive processes have statutorily required future reports to continue assessing the long-term negative health impacts. However, over the past four years, the VA has failed to add diseases that have been determined to have a positive scientific association with those known exposures, and it took action by Congress to add the three diseases of bladder cancer, hypothyroidism and Parkinsonism to the list of presumptive conditions associated with Agent Orange exposure.

In the NASEM report “Veterans and Agent Orange: Update 2014,” published in 2016, a committee of the Health and Medicine Division reaffirmed the conclusions of previous studies that hypertension should be placed in the category of limited or suggestive evidence of association, although the VA has not found hypertension to be presumptively related to service in Vietnam. The VA study “Herbicide Exposure, Vietnam Service, and Hypertension Risk in Army Chemical Corps Veterans” found that exposure to herbicides is “significantly associated” with the risk of hypertension, or high blood pressure, in members of the Army Chemical Corps.

The December 2018 NASEM updated report reviewed the VA study and affirmed there is sufficient evidence of a relationship between hypertension and monoclonal gammopathy of undetermined significance (MGUS) and Agent Orange exposure. Yet, the VA has not included hypertension and MGUS as presumptive diseases, although these conditions were scientifically associated with Agent Orange more than two years ago. Thousands of veterans suffering from hypertension, its serious negative health impacts and complications, and MGUS need access to VA preventive health care and benefits. Since the VA has failed to take timely action on hypertension and MGUS as presumptive diseases, we call on Congress to intervene and enact legislation to add these conditions to the list of recognized presumptive conditions associated with Agent Orange exposure.

- ▶ **Congress must enact legislation to include hypertension and MGUS as presumptive diseases linked to Agent Orange exposure.**

Toxic Exposures at Karshi-Khanabad (K2)

Karshi-Khanabad Air Base, known as K2, is a former Soviet air base in southeastern Uzbekistan that shares a border with northern Afghanistan. Over 15,000 U.S. service members were deployed to the U.S.-established Camp Stronghold Freedom at K2, which was used to support combat missions from 2001 to 2005. While it was a Soviet air base, K2 had contained chemical weapons, enriched uranium, and soil saturated with fuels and other solvents that formed a “black goo.” Air samples at the base found elevated levels of tetrachloroethylene as well as the residuals of chemical weapons, including cyanide, in the showers. Other health assessment tests found the base had elevated levels of volatile organic compounds and total petroleum hydrocarbons (TPH) were detected at numerous locations throughout Stronghold Freedom.

A U.S. Army study from 2015 found that veterans exposed at K2 have a 500% increased likelihood of developing cancer, to include malignant melanoma and neoplasms of the lymphatic and hematopoietic tissues.

The VA does not recognize service at K2 among its listed exposures; thus, there are no presumptives or a concession of exposure for these veterans nor are they eligible for VA health care based solely on these exposures. However, in April 2020, the VA confirmed it will study health trends among the thousands of service members exposed.

- ▶ **Congress must enact legislation to allow K2 veterans access to VA health care by amending Section 1710, Title 38, United States Code, as well as expediting all studies and research on the toxic exposures at K2.**

Presumptive Decision-Making Framework

The presumptive processes and the presumptive decision-making process are not consistent among all of the different types of exposures. This means that not all presumptive processes are the same when it comes to establishing concession of exposure, adding new diseases linked to the exposure, identifying requirements for additional studies, or the requirements for the secretary of Veterans Affairs to act on adding new diseases linked

to exposure. DAV is concerned Congress and the VA will continue to provide piecemeal legislation or regulatory provisions without addressing these much larger issues facing exposed veterans today and in the future.

- **An overall presumptive process framework needs to be established by Congress to provide consistency that must 1) improve DOD and VA data collection and record-keeping, 2) establish a concession of exposure or recognition of the toxic exposure, 3) require statutorily mandated future studies on known exposures, 4) provide a time requirement for action by the VA secretary, 5) maintain the standard of positive association versus causation, and 6) update the classifications of scientific association.**

Additional Toxic Exposures

As we have established, our service men and women are consistently exposed to harmful environments with contaminants and toxins. Veterans need congressional action to ensure the VA continues to expand known exposures, like Agent Orange in Thailand, and to study the adverse long-term health effects of other toxic exposures such as those at Fort McClellan, Alabama; water contaminated with polyfluoroalkyl substances (PFAS) found at over 600 military installations; and contaminated water at Camp Lejeune, North Carolina.





Enhance Veterans' Survivor Benefits

Dependency and Indemnity Compensation (DIC) is a monthly benefit paid to eligible survivors of veterans who die due to a service-connected condition or from a non-service-connected condition if the veteran had a totally disabling service-connected condition for a period of time, generally 10 years, before death. This benefit was intended to protect against spousal impoverishment after the death of a service-disabled veteran. To ensure that these survivor benefits continue to provide for the financial stability of the veteran's loved ones, DAV urges Congress to increase DIC rates; eliminate the arbitrary 10-year rule criteria for DIC eligibility; lower the remarriage age for retaining benefits; and remove the 10-year delimiting date for spouses, dependents and surviving spouses to utilize their Dependents Education Assistance benefit.

Increase DIC Rates

While DIC has assisted many survivors of disabled veterans, the value of the current benefit is insufficient to provide meaningful support to survivors of severely disabled veterans. A veteran who is married and receiving 100% disability compensation today would receive approximately \$3,321 a month, whereas the current DIC benefit is only \$1,357 a month.

When veterans receiving compensation die, not only do the surviving spouses have to deal with the heartache of losing their loved one, but they also have to contend with the significant loss of income—approximately \$24,000 a year. This loss of income to a survivor's budget can be devastating, especially if the spouse was also the veteran's caregiver and dependent on that compensation as the sole source of income.

The rate of compensation paid to survivors of service members who die in the line of duty or veterans who die from service-related injuries or diseases was established in 1993 and has only been minimally adjusted since that time. In contrast, monthly benefits for survivors of federal civil service retirees are calculated as a percentage of the civil service retiree's Federal Employees Retirement (FERS) or Civil Service Retirement System (CSRS) benefits, up to 55%. This difference presents an inequity for survivors of our nation's ill and injured veterans compared to survivors of federal employees.

- ▶ **Congress should enact legislation that would increase DIC rates to 55% of 100% disability compensation to provide parity with similar federal programs. We also urge Congress to index these rates for inflation.**

Eliminate the 10-Year Rule

If veterans die due to a non-service-connected condition before they have reached 10 consecutive years of being rated totally disabled, their dependents are not eligible for any DIC benefit and could potentially be left destitute—even though many of these survivors were caregivers who sacrificed their own careers and earning capacity to take care of the veteran. The DIC program would be more equitable for all survivors if they were eligible for a partial DIC benefit starting at five years of the veteran being totally disabled and increasing incrementally until reaching full entitlement at 10 years.

- ▶ **We urge Congress to enact legislation to change DIC to a graduated benefit to make survivors eligible at five years for 50% of the full benefit amount, increasing proportionally to 100% at 10 years.**

Reduce the Remarriage Age

Surviving spouses also face another unfair burden. Under the existing DIC law, surviving spouses lose their benefit if they remarry before age 55, which mirrors the criteria of the similar benefit for federal employees. However, surviving spouses of active-duty service members and veterans are more likely to be widowed at a

younger age than other professions. Therefore, on average, there is a longer wait period for surviving spouses of service members and veterans to maintain eligibility for DIC benefits than for survivors of federal employees.

- **Congress should enact legislation that reduces the remarriage age for surviving spouses to a more reasonable age or institute a new method of retaining eligibility so that surviving spouses do not have to wait an unreasonable length of time to maintain their benefits.**

Remove the Dependents Educational Assistance Delimiting Date

Spouses and surviving spouses eligible for educational benefits under the Dependents Educational Assistance program, also referred to as Chapter 35, only have a 10-year period to apply for and complete these programs of education, beginning either from the date the veteran is rated permanently and totally disabled or the date of the veteran's death. In many instances, most notably in the case of caregivers, family obligations and the need to care for the service-disabled veteran require spouses and surviving spouses to defer using these benefits for years, leaving many unable to apply or use these benefits within the required period, resulting in a loss of earned educational opportunities.

- **We urge Congress to remove the 10-year delimiting date for spouses and surviving spouses to use their Dependents Educational Assistance benefits.**





Protecting Veterans in the Claims and Appeals Processes

In recent years, Congress and the Department of Veterans Affairs have proposed and enacted many pieces of bipartisan legislation and policies advantageous to veterans and their families. However, there have been policy decisions that have negatively impacted veterans in the claims and appeals process, as well as policy proposals, which, if enacted, would reduce or eliminate existing veterans benefits, ultimately undermining the long-standing non-adversarial process between veterans service organizations (VSOs), veterans and the VA.

Ensuring Correct VA Decisions by Reestablishing Pre-Decisional Review

For over seven decades, the Veterans Benefits Administration (VBA) maintained a policy, as previously included in its M21-1 Adjudication Procedures Manual, which allowed accredited VSOs a pre-decisional review period of 48 hours for claims decisions of those veterans and claimants the VSO represented. After reviewing these decisions, VSOs were able to notify VBA of errors before a final decision was formally promulgated. The types of errors identified included incorrect effective dates of grants, incorrect evaluations and combined evaluations, and incorrect denials of benefits. If VBA agreed with recommendations, it would issue a new decision. This process benefited many veterans and claimants and, in many instances, avoided the time-consuming and often costly appeals process.

On April 15, 2020, a coalition of eight VSOs, including DAV, sent a letter calling on the president to direct the VA secretary to maintain the 48-hour VSO review policy. Despite this request, VBA officially eliminated the 48-hour pre-decisional review period.

Two recent reports from the Office of the Inspector General confirm the need for the pre-decisional review, which provides representatives the ability to work with the VA to identify and correct errors in VA decisions prior to final promulgation, acting as another layer of quality review. DAV is concerned the elimination of this important review period will delay many veterans' entitlement to earned benefits and add more unnecessary claims and appeals, which could be resolved by pre-decisional review.

- **Congress must enact legislation to reestablish the pre-decisional review for VA-accredited representatives to ensure all veterans and claimants receive quality and timely entitlement to benefits.**

Protecting Effective Dates

Effective March 24, 2015, the VA started a major change in its policy and regulations regarding use of standard forms. The VA eliminated informal claims for benefits and replaced them with an Intent to File form that acts as a placeholder, preserving the effective date for one year. The VA further requires all claims and appeals to be submitted on specific forms and will not accept any claim or appeal on the incorrect VA form.

Currently, if a veteran submits a claim or appeal on the wrong form, it may take the VA months to review and advise the veteran that the claim will not be accepted. Additionally, the VA does not consistently advise the veteran which form should have been used and does not provide the correct form to the claimant to file. Thus, when a veteran does file the correct form, they can lose months of entitlement, as the VA does not accept the claim submitted on the wrong form as a claim submission or as a placeholder for benefits, even though the exact same information may have been provided by the veteran on both forms.

This issue was complicated by the implementation of the Appeals Modernization Act (AMA). The VA will not accept any claims for previously denied issues on any form except a supplemental claim, which again can lead to a significant delay before the correct form is submitted and loss of an earlier effective date. The process is further complicated as the VA's Intent to File form cannot be associated with a supplemental claim and many claimants are not aware of what conditions were applied for in the past. Additionally, if a veteran submits an appeal directly to

the Board of Veterans' Appeals on the wrong form, again it may be months before it is discovered and the veteran may lose an earlier effective date or the appeal period may expire.

Current VA processes are firmly placing an unnecessary burden on too many veterans, which was not the intent of Congress when the AMA was enacted into law. When a veteran submits a claim and it is understood by VBA what the veteran is seeking, VBA should accept that as a date of claim, advise the veteran on the correct form, provide the correct form and adjudicate said claim. The non-adversarial nature of the VA must be restored and the effective dates and earned benefits of the men and women who served must be protected.

- **Congress must enact legislation to protect veterans' dates of claim, time periods and earned benefits by accepting their claims regardless of the form used.**

Preserving Veterans Benefits From Erosion

Protecting Individual Unemployability Benefits. Veterans with a service-connected disability of 60% or combined disabilities at 70% or more that prevent them from obtaining and maintaining gainful employment are eligible for Total Disability Based on Individual Unemployability (TDIU). Those in receipt of TDIU stop earning Social Security credits, and many do not have entitlement to Social Security retirement benefits or any employment-based retirement or pension benefits based on their work history.

Despite the fact that many veterans in receipt of TDIU depend upon their disability compensation for basic necessities, proposals to strip these benefits appear from time to time. For example, although regulatory provisions prevent the VA from considering a veteran's age in TDIU determinations, the administration's fiscal year 2018 budget contained a proposal to eliminate eligibility for TDIU for thousands of disabled veterans when they reach the age of 62. And in 2020, a Congressional Budget Office (CBO) report included an option to end Individual Unemployability payments to disabled veterans at the full retirement age of 67, even though many such veterans do not receive Social Security or employer-based benefits.

Individual Unemployability benefits continue to be a target for cost-cutting budget proposals, despite the limited sources of income most TDIU-eligible veterans have as a result of their work history. Congress needs to protect veterans from these continuing attempts to reduce and limit TDIU benefits by codifying total disability ratings based on Individual Unemployability—TDIU into statute.

Benefits Proposed for Elimination or Reduction. In December 2020, CBO's biennial report "Options for Reducing the Deficit: 2021 to 2030" included harmful proposals that would reduce or negatively impact veterans benefits. The report provides no justification for the options, only that these proposals would result in financial savings to the government despite the negative impact they would have on seriously disabled veterans and in conflict with current statutory and regulatory provisions.

Veterans proposals included in CBO's 2020 report would:

- **Reduce all veterans' existing VA benefits by 30% on reaching full retirement age for Social Security.**
- **Eliminate compensation payments to veterans with combined evaluations of 10% or 20% disabling.**
- **Remove the tax-free status of VA compensation and pension benefits and include these benefits as taxable income.**

While CBO periodically publishes this report, thankfully most of the proposals are never acted on. However, we need to remain vigilant and Congress must ensure that existing veterans benefits are vigorously defended from reductions and eliminations, particularly for the sake of budgetary savings.

- **Congress must enact legislation to protect TDIU from reductions and limitations that will negatively impact thousands of veterans.**
- **We urge Congress to exempt veterans benefits and services from pay-go rules, since these benefits should be "paid for" by all Americans, not just veterans themselves.**





Ensure Equitable Benefits and Services for Women and Minority Veterans

While the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) has evolved over time to meet the needs of its increasingly diverse patient population, gaps remain in access, usage rates and health outcomes among women and other minority veteran populations. This includes racial, ethnic, sexual orientation and gender identity groups—underscoring the need for continued focus on the causes of such disparate rates and implementation of practices and policies to improve them.

Though the total veteran population is projected to decrease from 18.6 million in 2016 to 12.9 million in 2040, the percentage of minority veterans is expected to rise from 23% to 34% over that same period. According to the VA's 2017 Minority Veterans Report, service-disabled Black veterans had the highest rate of health care use among VA patients (77.4%), followed by disabled Hispanic veterans (71.5%). Yet, despite such large minority patient populations, the VA's own systematic review found it has not been completely successful in eliminating racial and ethnic disparities in veterans' health outcomes. Additionally, few studies examine the variances in health outcomes among other minority groups, such as American Indian and Asian veterans. VA research also shows lower health care provider trust among minority veterans, which can lead to poor health outcomes, as well as disparities in mental health care diagnoses. For example, clinicians tend to more frequently diagnose Black veterans with serious mental health conditions, such as schizophrenia, versus diagnosed mental health conditions such as bipolar disorder or depression in white veterans.

Following the repeal of "Don't Ask, Don't Tell" in 2011, the VA adopted new policies and programs to address health issues related to LGBT veterans and established the VHA's Office of Health Equity and the LGBT Health Program. However, a Government Accountability Office report (GAO-21-69) notes the VA still lacks a standardized method of collecting sexual orientation and self-identified gender identity data among veterans. As such, VA health officials may miss opportunities to properly screen, identify and address specific health disparities within this population or provide the comprehensive care necessary to address them. For example, VA researchers found that LGBT veterans may experience higher rates of depression and more frequent thoughts of suicide, but without data collection on sexual orientation or self-identified gender identity (89% of veterans' records lack such information) providers can't properly analyze these findings and overall health of these veterans. Studies have also shown many LGBT veterans are hesitant to disclose their gender identity with VA health care providers for fear of bias and mistreatment. For example, some LGBT veterans report instances of discrimination within the VA, to include refusal of treatment, lack of provider knowledge on issues specific to sexual orientation or gender identity, and harassment.

The VA must redouble its efforts to diversify its staff to better reflect the veteran patient population it serves. Peer support specialists could help to create a more welcoming and personalized health care experience for new patients and veterans struggling with mental health challenges. These specialists can help veterans navigate the system and promote engagement in treatment and recovery. Peer support specialists have often overcome similar challenges and should represent subpopulations within medical centers' patient demographics, including Black, Hispanic, women, sexual minorities or others who may need a more personalized and culturally sensitive approach to seeking recovery.

Studies show women who have served often do not identify as veterans, which makes it critical for the VA to engage them in an effective manner to ensure they are aware about their earned benefits and health care services. Of the women veterans who use the VA health care system, 60% have a service-connected disability rating of 50% or higher. These veterans often have complex medical needs and are best served by the VA's comprehensive whole health model of care that includes specialized programs and supportive social services. However, because women

make up just a fraction (500,000) of the VA's 7 million patient population, they are often sent into the community for care because the VA is not able to provide the gender-specific services they require. For women veterans, this can result in fragmented care and, in some cases, lead to poorer health outcomes.

While stranger or sexual harassment is not specific to any one group of veterans, it continues to be a notable problem within the VA. Despite considerable pressure over the past several years to eliminate sexual assault and harassment at VA facilities as well as numerous campaigns to achieve that end, the VA still struggles with employing a comprehensive, leadership-driven and departmentwide strategy to truly address the issue. By the VA's own account, 1 in 4 women veterans report having experienced some form of harassment or assault when trying to access care within its health facilities. This behavior is a barrier to VA care and deters many women and other minority veterans from seeking the medical care and specialized services they need.

- ▶ **The VA must take action to ensure all enrolled veterans have equitable access to health care and services and improve health outcomes across its patient population, to include growing women and minority veteran populations. To achieve these goals, DAV calls on the VA to:**
 - **Prioritize data collection and analysis to identify health trends, access issues, disparity in health outcomes and differences in patient experience among women and minority veteran populations.**
 - **Review the programs and methods used to deliver services to underrepresented and underserved veteran populations to ensure they are adequately meeting their unique needs.**
 - **Investigate cultural differences that create barriers for veteran subpopulations and develop ways to improve outreach to minority, at-risk and underserved groups.**
 - **Develop a comprehensive plan to change VA culture and create a safe, harassment-free environment that is welcoming to all veterans.**
- ▶ **Congress should introduce legislation for new VA peer support programs and integrative health treatment options that better reflect the demographics of its medical centers and needs of women veterans and racial, ethnic and sexual minority veteran populations.**





Improve Mental Health Services and Suicide Prevention Efforts to Reduce Veterans Suicide

Veterans' need for mental health care and readjustment services has grown substantially in the last two decades in the wake of continued deployments to Afghanistan and Iraq and an increasing number of veterans seeking Department of Veterans Affairs health care. In fiscal year 2019, the VA Veterans Health Administration (VHA) provided mental health care services to 1.76 million veterans (about 29% of the VA's enrolled patients). For FY 2022, the VA requested more than \$10 billion to support its mental health programs, which includes care in inpatient, residential, outpatient and telehealth settings in addition to its community-based Vet Centers. In recent years, the VA has developed supportive programs to address interpersonal violence, anger management, parenting and relationship counseling, and eating disorders in addition to its programming for readjustment counseling, substance use disorders, serious mental illness, homelessness and post-traumatic stress disorder.

Compared to their civilian counterparts, veterans have a higher burden of trauma exposure and post-deployment readjustment challenges that place them at higher risk for mental health conditions. Veterans are also at an elevated risk of suicide—with male veterans 1.5 times more and women veterans 2.2 times more likely to commit suicide—than nonveteran adult peers. Veterans from recent deployments who enroll for VA care are more likely to seek mental health and substance use disorder services and use them more often than veterans from earlier conflicts. Still, even after VHA established suicide prevention as its top clinical priority; expanded access to care; and developed mental health programs, clinical guidelines and research initiatives, the rate of suicides among veterans has remained relatively constant.

The VA MISSION Act of 2018 (Public Law 115-182) required the VA to establish a Veterans Community Care Network (VCCN) of providers and expanded veterans' access to care in the community. While this increases veterans' access to mental health services, VCCN providers are not required to meet the same mental health clinical care standards or training requirements for evidenced-based mental health treatments as VA mental health care providers. The VA has developed and trained about 15,000 VA providers in evidence-based practices to address post-traumatic stress (PTS) and depression. It has also, with the military, developed clinical practice guidelines for addressing veterans at risk of suicide, substance use disorders, use of opioids in management of chronic pain, traumatic brain injury (TBI), PTSD and bipolar disorder.

DAV believes that mandating training in evidence-based treatments will ensure community partners develop core competencies for addressing veterans' unique mental health care needs—specifically for conditions frequently associated with military service such as PTS and depression (related to combat and/or sexual trauma) and TBI. Community partners can benefit from the VA's vast and collective expertise in treating these conditions and demonstrate a commitment to delivering high-quality, evidence-based mental health treatments to veteran patients.

The VA's integration of primary and behavioral health care serves as a model for the health care industry. The VA requires at least one suicide prevention coordinator to serve in each VA medical center and its Veterans Crisis Line receives hundreds of thousands of calls, texts and chats annually. The VA also developed guidance for its emergency departments—known as Safety Planning for Emergency Department, or SPED—to ensure that veterans who present in mental health crisis receive safety planning prior to discharge and receive follow-up contact after discharge to encourage them to seek outpatient treatment associated with their suicidal ideation. As a targeted effort to reduce veteran suicide, we want to be sure that this policy has been implemented with fidelity throughout VHA. All VA emergency room clinicians and VCCN providers should adopt this best practice, which is associated with a significant reduction in suicidal behavior and increased engagement in outpatient behavioral health care after discharge, to ensure at-risk veterans receive appropriate and timely follow-up care.

In its efforts to reduce veteran suicide, the VA has also initiated a safe storage of lethal means initiative to improve providers' skills for counseling at-risk veterans about safe storage practices for prescription medication and firearms. According to the VA's 2019 annual report on veteran suicide, firearms were the method of self-harm selected most frequently by veterans who died from suicide in 2017. Veterans used firearms in 69.4% of completed suicides compared to 48.1% of deaths by suicide in the nonveteran adult population. Rates of suicide by firearm among male veterans was 70.7%, compared to male nonveterans at 53.5%. The rate was 43.2% for female veterans, compared to female nonveterans at 31.3%. Given these findings, counseling veterans on the safe storage of firearms and other lethal means is a critical component of suicide prevention that should be a part of any comprehensive public health strategy.

- **Congress should require mandatory suicide prevention training for all VA clinical staff and its community care partners to ensure veterans in mental health crisis receive proper screening, crisis interventions (for lethal means safety and substance use disorders) and mental health treatment.**
- **The VA should require that protocols included in the VA's SPED program are mandatory for every veteran in mental health crisis who seeks emergency or urgent care services from the VA or a VCCN provider.**
- **The VA must consistently update, disseminate and train staff and community partners on established mental health clinical practice guidelines and evidence-based treatments for commonly experienced conditions among veterans, including PTSD (related to combat and/or military sexual trauma), substance use disorders, depression, anxiety, TBI and suicidal ideation.**





Building a Veterans Health Care System for the Future

Over the past decade, the Department of Veterans Affairs health care system has faced significant challenges and undergone historic reforms to improve veterans' access to timely and high-quality health care. The VA MISSION Act of 2018 was designed to improve veterans' access to medical care by expanding the VA's internal capacity and creating a system of high-performing community provider networks to work seamlessly with the VA health care system.

However, the slow transition from the former Veterans Choice Program provider networks to the new Veterans Community Care Network (VCCN) was only recently completed and it is not yet clear how this change will affect veterans' health care usage patterns. The quality of care provided to veteran patients by VCCN providers must be routinely monitored and evaluated, and the VA must ensure that these providers meet the same training, certification and quality standards required of VA providers. The VA must also take into account how its significant expansion of telehealth services, due to the COVID-19 pandemic, will impact health care delivery in the VA and other private health care systems in the future.

The MISSION Act also established an Asset and Infrastructure Review (AIR) process to modernize, realign and rebuild the VA's health care facilities. The success of the AIR process will depend on the degree to which the VA works in true partnership with veterans and veterans service organization (VSO) stakeholders, which has not yet occurred. As a result of challenges implementing the MISSION Act, as well as the yearlong disruption from the COVID-19 pandemic, the VA is behind schedule completing systemwide market assessments required by the AIR process that are critical to ensuring the VA has comprehensive and accurate data about veterans' health care options, needs and preferences.

The VA is also currently engaged in a 10-year, \$16 billion modernization of its electronic health record system to improve interoperability with other federal and private medical systems. The VA's track record of IT failures calls for continuous and aggressive oversight by Congress. In addition, the VA must implement a modernized scheduling system and an easy-to-use interface designed to meet its veteran patients' needs and preferences.

All of these critical transformations take place as health threats posed by the COVID-19 public health crisis continue. The VA must also review its Fourth Mission requirements during national emergencies so that they are properly aligned and consistent with the VA's primary missions, without negatively impacting the VA's ability to provide safe and uninterrupted care to veterans during future pandemics or national emergencies.

- **The VA MISSION Act must be faithfully implemented as intended. The VA must fully engage with veterans and VSO stakeholders to ensure veterans' preferences are paramount while planning local VCCNs and implementing the AIR process.**
- **Non-VA community care providers must be required to meet the same training, certification and quality standards as VA health care providers so that veterans receive the highest quality of care regardless of where they receive it.**
- **Congress should amend the MISSION Act to extend the AIR timeline by at least one year and ensure that lessons learned from the COVID-19 pandemic are fully incorporated into the VA's long-term infrastructure planning.**
- **Congress must aggressively oversee the VA's transition to a new electronic health record system, which must include a modernized scheduling system and user-friendly interface for veterans.**
- **Congress and the VA must ensure that the VA's Fourth Mission functions are appropriate to respond to future pandemics and national emergencies while ensuring that veterans always have uninterrupted and timely access to VA health care.**





BY THE NUMBERS



More than 1 million veteran members are organized into nearly 1,300 local chapters and 52 departments, including Puerto Rico.



More than 11.8 million claims have been submitted by DAV since the organization was chartered by Congress in 1932.



More than 1.1 million veterans trust DAV with their power of attorney to represent them for benefits claims and have received more than \$23 billion in earned benefits in 2020.



In 2020, over 1 million hours were donated by volunteers in VA hospitals and clinics.



In spite of the pandemic, volunteer drivers in DAV's Transportation Network provided more than 243,000 no-cost rides for ill and injured veterans to VA medical facilities in 2020.



With a value of nearly \$89 million, 3,797 vehicles have been donated to the VA since 1987 for transporting veterans to appointments.



Since 2014, DAV has co-hosted 699 traditional and virtual job fairs, connecting nearly 240,000 active-duty, Guard and Reserve members, veterans and their spouses with employment, resulting in more than 151,000 job offers.



In 2020, nearly \$2 million in COVID-19 unemployment relief was distributed nationwide to nearly 8,000 veterans in need.