



OPERATION: **KEEP THE PROMISE**

DAV | 2022

DAV's Critical Policy Goals

- Ensure Benefits, Health Care and Justice for Veterans of All Eras Exposed to Toxic Substances
- Enhance Veterans' Survivor Benefits
- Ensure Access to Long-Term Care for Aging Veterans and Veterans with Service-Connected Disabilities
- Advance Equity in Health Services and Benefits for Women Veterans, Underserved and Minority Veteran Populations
- Improve Mental Health Services and Suicide Prevention Efforts to Reduce Veterans Suicide
- Strengthen the VA's Capacity to Deliver Timely, High-Quality Health Care

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 Benefits, Health Care and Justice for Veterans of All Eras Exposed to Toxic Substances

When service members are subjected to toxins and environmental hazards, our sense of duty to them must be heightened, as many of the illnesses and diseases due to these exposures may not be identifiable for years, even decades, after veterans have completed their service. Although notable progress has been achieved for veterans who suffered illness due to toxic and environmental exposures, too many still have yet to receive the benefits, health care and justice our nation owes to them.

Agent Orange Presumptive Diseases

The Department of Veterans Affairs (VA) has conceded that any veteran who served in Vietnam or in specific areas offshore during the Vietnam era was exposed to Agent Orange. The Agent Orange Act of 1991 officially established the presumptive diseases process in collaboration with the National Academies of Sciences, Engineering and Medicine (NASEM). In 2010, the VA added three presumptive diseases related to Agent Orange exposure, and Congress recently added three additional diseases to the list. However, the VA has failed to address other diseases linked to Agent Orange exposure.

The NASEM committee's "Veterans and Agent Orange" 2016 update reported that the conclusions of previous studies reaffirm that hypertension should be placed in the category of limited or suggestive evidence of association. Further, a 2016 VA study, "Herbicide Exposure, Vietnam Service, and Hypertension Risk in Army Chemical Corps Veterans," also found that exposure to herbicides is "significantly associated" with the risk of hypertension in members of the Army Chemical Corps.

The December 2018 NASEM report upgraded its previous findings and determined there was "sufficient evidence" of a relationship between hypertension and Agent Orange, which is the highest level of association. They further found the same "sufficient evidence" level of association for monoclonal gammopathy of undetermined significance (MGUS), which is an abnormal protein in one's blood that can progress to more serious diseases, including some forms of blood cancer. It has been more than three years since this NASEM report, and the VA has failed to add these conditions as Agent Orange presumptive diseases.

Thousands of veterans suffering from hypertension, its serious negative health impacts and complications, as well as MGUS, need access to VA health care and benefits. The VA has the authority to add these diseases as presumptive to Agent Orange exposure. Unfortunately, the VA has failed to take timely action; therefore, we call on Congress to intervene and enact legislation to add hypertension and MGUS to the list of presumptive conditions.

- ▶ **Congress must enact legislation, such as, S. 810/H.R. 1972, the Fair Care for Vietnam Veterans Act, to add hypertension and MGUS as presumptive diseases for Agent Orange exposure. Similar provisions are also included in S. 3003, the COST of War Act and H.R. 3967, the Honoring Our PACT Act.**

Burn Pits and Concession of Exposure

During Operations Desert Shield and Desert Storm (1990–1991) and since, burn pits have been utilized in not only in Iraq but also Kuwait, Oman, Qatar, United Arab Emirates, Saudi Arabia and Bahrain. Since Sept. 11, 2001, burn pits have been used throughout operations in Afghanistan and Djibouti, as well as in Iraq after March 20, 2003. Recently, the Department of Defense also acknowledged burn pit use in Syria and Egypt.

Veterans serving near burn pits were exposed to airborne toxins from burned waste products, including but not limited to plastics, metal, rubber, chemicals (such as paints and solvents), petroleum and lubricant products, munitions and other unexploded ordnance, medical and human waste, and incomplete combustion byproducts.

It is estimated that over 3.5 million veterans have been exposed to burn pits, but the VA has only adjudicated approximately 13,000 direct service connection claims for diseases related to burn pit exposure. Roughly 78% of those claims have been denied. Many of these denials were due to veterans not knowing what toxins they were exposed to, thus impeding their ability to obtain a medical opinion relating their condition to specific toxins.

One way to overcome this obstacle is to concede exposure to the toxins as recognized by VA related to burn pits, 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 a presumptive service connection; however, it will remove the requirement that veterans must prove their individual exposure to burn pits and the types of toxins emitted from burn pits for disability claims based on direct service connection.

In August 2021, the VA announced presumptive exposure to particulate matter for those areas noted above and recognized three presumptive diseases: sinusitis, rhinitis and asthma. While the VA is investigating other diseases linked to these exposures, we urge Congress to take action now and enact a concession of exposure for burn pits to help grant veterans benefits today.

- **Congress must enact legislation, such as S. 437/H.R. 2436, the Veterans Burn Pits Exposure Recognition Act, to concede burn pit exposure and remove the requirement for veterans to prove their individual exposure to burn pits and the toxins emitted for claims based on direct service connection. Similar provisions are also included in S. 3003, the COST of War Act, and H.R. 3967, the Honoring Our PACT Act.**

Creating a New Legal Framework for Presumptives

The process for creating presumptive diseases has rarely been timely. For example, it took over 50 years for the VA to recognize mustard gas exposures and presumptive diseases for World War II veterans, more than 40 years for radiation exposures and presumptive diseases for World War II veterans, decades for Agent Orange exposure in Vietnam, and more than half a century for veterans who served in the offshore waters of Vietnam. It has also been over 20 years since veterans stationed at Karshi-Khanabad (K2) were exposed to enriched uranium and soil saturated with fuels and other solvents, and the VA still has not conceded their exposure or established presumptive diseases.

Additionally, the process for creating presumptive diseases is not consistent among different types of exposures. For example, the VA has different requirements for proof of exposure for radiogenic diseases, Persian Gulf illnesses and diseases related to Agent Orange.

DAV is concerned Congress and the VA will continue to provide piecemeal toxic exposure legislation or regulatory provisions that fail to address delays and inequities for veterans. Exposed veterans must have timely and consistent access to VA health care and benefits. DAV recommends a shift in perspective and a new process that is flexible to address any exposure and will result in a more immediate impact.

In addition, several toxic exposures and potentially associated diseases are still waiting to be studied, such as the toxic exposures from Fort McClellan, PFAS-contaminated water found at over 600 military installations, contaminated water at Camp Lejeune and the recent water contamination by the Red Hill fuel tank farm in Hawaii.

- **To ensure veterans receive their earned compensation benefits, Congress must enact a new legal framework for creating presumptions that includes timelines and triggers for (1) research and surveillance of exposures, (2) health care for exposed veterans, (3) a concession of exposure, (4) establishment of a presumptive process for each individual exposure and (5) the timely designation of presumptive diseases for each exposure.**





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 if the veteran had a totally disabling service-connected condition for 10 years before death. This benefit was intended to protect against spousal impoverishment after the loss of their veteran spouse. To ensure that these survivor benefits continue to provide for the veteran's loved ones, DAV urges Congress to increase the DIC rates, eliminate the arbitrary 10-year criteria for DIC eligibility, reduce the remarriage age, and remove the 10-year delimiting date for spouses and surviving spouses to utilize Survivors' and Dependents' Educational Assistance.

Increase DIC Rates

While DIC helps 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 rated 100% service-connected receives approximately \$3,517 a month in disability compensation, whereas the current DIC benefit is only \$1,437 a month.

When a veteran receiving compensation dies, not only does the surviving spouse have to deal with the heartache of losing their loved one, they also have to contend with the loss of approximately \$24,000 of income annually. This loss of income to a survivor's budget can be devastating, especially if the spouse was also the veteran's caregiver and reliant on that compensation as their primary income source.

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 then. 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 heroes compared to survivors of federal employees.

- **Congress should enact S. 976 or H.R. 3402, the Caring for Survivors Act, which would increase DIC rates to 55% of 100% disability compensation, provide parity with other federal programs and index these rates for inflation.**

Eliminate the 10-Year Rule

If the veteran dies due to a non-service-connected condition before the veteran has reached 10 consecutive years of being totally disabled, their dependents are not eligible for DIC benefits, even though many of these survivors were caregivers who sacrificed their own careers to take care of the veteran and could potentially be left destitute. 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 reaching full entitlement at 10 years.

- **We urge Congress to enact S. 976 or H.R. 3402, which would 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 law, a surviving spouse loses their DIC benefit if they remarry before age 55, which mirrors the criteria of similar benefits 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, the wait period to maintain eligibility for surviving spouses of service members and veterans is longer than for survivors of federal employees.

- **Congress must enact legislation that reduces the remarriage age for a surviving spouse to a more reasonable age or institute a new methodology of determining eligibility.**

Remove the Dependents' Educational Assistance Delimiting Date

Spouses and surviving spouses eligible for educational benefits under Survivors' and Dependents' Educational Assistance, 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. However, in many instances, most notably in the case of caregivers, family obligations and the need to care for the veteran require spouses and surviving spouses to defer using these benefits for years, leaving many unable to apply in a timely manner, resulting in a loss of earned educational opportunities.

- **Congress must enact legislation, such as, H.R. 2167, which eliminates the time period for eligibility under Dependents Educational Assistance effective August 1, 2023. H.R. 2167 passed the House May 2021. We now need the Senate to take action.**





Ensure Access to Long-Term Care for Aging Veterans and Veterans with Service-Connected Disabilities

The Department of Veterans Affairs' program of Geriatric and Extended Care (GEC) includes a broad range of long-term supports and services. GEC's Extended Care Strategic Plan for fiscal years 2020–2024 recommends an emphasis on program development to improve overall health and improved quality of life for aging veterans. The VA's support for institutional long-term care (LTC) includes operating 131 Community Living Centers (CLCs), providing grants and per diem support to 157 State Veterans Homes (SVHs), and providing per diem support to veterans in hundreds of community nursing facilities. VA non-institutional support services include home-based and community services (HBCS) such as home-based primary care, adult day health care, respite, homemaker and health aid services, and caregiver support.

Planning and Investing to Meet Future Demand for Long-Term Care

A growing number of service-disabled veterans will require long-term care over the next two decades. While the overall veteran population is decreasing, the number of veterans in the oldest age cohorts are increasing significantly. The VA estimates that by 2039, the number of enrolled veterans 85 years of age or older will grow by almost 40%. This same group uses long-term care at three times the rate of veterans in the 65–84 age group. In addition, the number of veterans in priority group 1A (veterans with disability ratings of 70% or higher) who are at least 85 years old is expected to grow by 588%. The VA also estimates the number of women veterans in the oldest age group will more than double by 2039.

Veterans also have some unique characteristics—such as higher burdens of disability and more family dissolution than the general population—that may require more intensive care than home and community-based options can support. Accordingly, the VA projects associated costs for long-term care services and supports will double by 2037.

Currently, through its CLCs, SVHs and contracts with community nursing homes, the VA supports approximately 40,000 LTC beds in skilled nursing and domiciliary facilities. Given VA estimates for growth in the enrolled number of aging veterans, this is likely a fraction of the overall number of LTC beds veterans will require in the future.

- ▶ **The VA must develop and implement a plan that estimates the number of veterans needing institutional long-term care over the next two decades, the number of veterans the VA will support, and specific resources necessary to provide that care in both VA and non-VA facilities.**
- ▶ **The VA must establish measurable goals to address key LTC challenges, including workforce shortages, proper geographic alignment of care and meeting veterans' needs for specialty care.**
- ▶ **The VA must request, and Congress must provide, sufficient resources to maintain, renovate and modernize CLC and SVH long-term care facilities to accommodate the future institutional LTC needs of veterans, while simultaneously investing in home and community-based services to provide aging and disabled veterans a full spectrum of LTC options.**

Providing a Full Spectrum of LTC Options to Address Veterans' Unique Needs

The VA has struggled to ensure an adequate number of beds are available in its CLCs for eligible veterans while also developing home and community-based services to support seriously disabled veterans and reduce their need for institutionalized long-term care. Non-institutional services such as home-based primary care, adult day health care, and homemaker and health aid services fill critical gaps, are preferred by many aging veterans and are less expensive than institutionalized care. While the VA must continue to expand its non-institutional, home-based

services and supports, a significant number of veterans will require institutional care to remain safe. CLCs provide skilled nursing care and are able to address specialized care needs of seriously disabled veterans with traumatic brain injury and spinal cord injuries, which many nursing homes in the community are not. In addition, veterans with neurobehavioral issues or who need memory or dementia care are a challenge for all LTC facilities.

For non-institutional care to work effectively, these programs must focus on prevention and engage veterans before they have a devastating health crisis that requires more intensive care in a CLC for an extended recovery period. The VA must continue to expand existing and develop innovative new home- and community-based long-term care options for veterans, based on their needs. In particular, the VA must have sufficient resources to complete the phase 2 expansion of the Program of Comprehensive Assistance for Family Caregivers by Oct. 1, 2022, as well as implement an improved caregiver appeal system.

- **Congress and the VA must continue to ensure caregivers are adequately supported through the VA Caregiver Support Program and other resources.**
- **The VA must focus on the development of innovative programming, such as medical foster homes, and expand access to adult day health care to address veterans' unique preferences and needs.**





Advance Equity in Health Services and Benefits for Women Veterans, Underserved and Minority Veteran Populations

Health and Benefits Disparities Among Minority Veteran Populations

While the Department of Veterans Affairs health care system has evolved over time to meet the needs of its increasingly diverse patient population, gaps remain in access, usage and health outcomes among underserved veteran populations. This includes racial, ethnic, sexual orientation and gender identity groups—underscoring the need for continued focus on the causes of such disparities and implementation of practices and policies to address 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 most recent 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 high usage by 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. VA research also shows lower health care provider trust among minority veterans. Additionally, few studies are examining the variances in health outcomes among other minority groups, such as American Indian and Asian veterans.

LGBT Veterans

After the revocation of the Defense Department's "don't ask, don't tell" policy in September of 2011, the VA adopted new policies and programs to address health issues related to LGBT veterans and established the Office of Health Equity and the LGBT Health Program. In late 2021, VA announced gender identifiers would now be included in its national medical records system after a Government Accountability Office report (GAO-21-69) noted the VA lacked a standardized method of collecting such data among veterans. This will give VA providers the opportunity 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 assess the 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, including refusal of treatment, lack of provider knowledge on issues specific to sexual orientation or gender identity, and harassment.

The VA must increase 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.

Women Veterans

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, many are sent into the community for care because the VA does not have the capacity to provide all the gender-specific services they require. For too many women veterans, this can result in fragmented care and, in some cases, lead to poorer health outcomes.

➤ **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, including growing populations of women and minority veterans.**
- **Prioritize data collection and analysis to identify health trends, access issues, disparity in health outcomes and differences in patient experience among women and minority veterans.**

➤ **Congress must:**

- **Enact 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.**
- **Provide oversight of the VA programs and methods used to deliver services to underrepresented and underserved veteran populations to ensure they adequately meet their unique needs.**

Addressing Harassment Within VA Facilities

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 effectively address these issues. By the VA's own account (Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts on Delayed and Missed Care), 1 in 4 women veterans report having experienced some form of harassment or assault when trying to access care within its health facilities. Harassment is a barrier to VA care and deters many women, LGBT and other minority veterans from seeking the medical care and specialized services they need.

- **The VA must provide appropriate resources to support further development and implementation of a comprehensive plan to change its culture and create a safe, harassment-free environment that is welcoming to all veterans.**

Improving the Claims Process for Military Sexual Trauma

While military sexual trauma (MST) is not a gender-specific issue, it does disproportionately impact women veterans and LGBT veterans. Several VA Office of the Inspector General (OIG) reports released in recent years have uncovered issues with the disability claims process relating to MST. This includes a 2010 report that showed the Veterans Benefits Administration (VBA) denied female veterans at a higher rate than male veterans for post-traumatic stress disorder claims related to MST; a 2018 report that found VBA staff failure to follow department policy and procedures may have led to improper denial of veterans' MST-related claims; and a 2021 report that determined VBA noncompliance with OIG recommendations led to roughly 57% of denied claims related to MST were still not being processed correctly.

- **We urge Congress to enact H.R. 5666, the Servicemembers and Veterans Empowerment and Support Act, which would codify evidentiary standards within the MST claims process; enhance outreach to veterans concerning the claims process and available resources; mandate studies on VBA training and procedures for these unique cases; and address mental health access issues for those who have experienced sexual trauma.**





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 multiple military deployments to Afghanistan and Iraq for many service members. In fiscal year 2022, VA requested more than \$10 billion to support the comprehensive array of mental health programs through inpatient, residential, outpatient, and telehealth settings, in addition to its Vet Center program. A number of key initiatives are underway to address the mental health needs of veterans including: Suicide Prevention 2.0—efforts focused on a community-based Intervention for suicide prevention and a clinical approach focusing on broad dissemination of evidence-based psychotherapies; the NOW initiative aimed at quick deployment of interventions that have a high impact; and implementation of the recommendations from the national suicide PREVENTS initiative and comprehensive legislation enacted in last Congress to expand and improve veterans access to mental health services (Public Law 116-171 and Public Law 116-214).

Increased Access to Mental Health Services

The VA MISSION Act of 2018 (Public Law 115-182) required VA to establish a network of non-VA providers to expand veterans' access to care in the community. While this increases veterans' access to mental health services, community providers are not always familiar with mental health issues that are common among veterans like post-traumatic stress disorder (PTSD) due to combat or military sexual trauma. Further, community providers are not required to meet VA's mental health clinical care standards or training requirements for certain evidenced-based mental health treatments. VA has developed and trained about 15,000 VA providers in evidence-based practices to address PTSD, depression and other mental health disorders. It has also jointly developed clinical practice guidelines with the Department of Defense for the management of veterans with substance use disorders, chronic pain, traumatic brain injury (TBI), PTSD and bipolar disorder, as well as those at risk of suicide.

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 TBI, PTSD and depression related to combat and/or sexual trauma. Community providers can benefit from VA's vast and collective expertise in treating these conditions and must demonstrate a commitment to delivering the same high-quality, evidence-based mental health treatments to veteran patients as VA mental health providers.

- **Congress must enact legislation that requires specific training protocols for community mental health providers to ensure they meet the same quality standards for evidenced-based treatments as VA mental health providers.**

Suicide Prevention Efforts

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 and women veterans 2.2 times more likely than non-veteran adult peers to take their lives by suicide. To address this issue, VHA established suicide prevention as its top clinical priority, coordinates a Veterans' Crisis Line which receives hundreds of thousands of calls, texts and chats annually, and has assigned at least one suicide prevention coordinator to serve at each VA medical center. With the Department's "whole of government" approach to suicide prevention we saw a 7.2% decrease in the overall suicide mortality rate among veterans reported in the 2021 National Veteran Suicide Prevention annual report (for 2019). This public health model integrates strategic planning across federal

agencies to facilitate complementary and collaborative prevention, intervention, and postvention approaches including public/private partnerships to capitalize on collective and unified suicide prevention efforts.

VA's 2021 annual report on veteran suicide prevention also noted that firearms were the method of self-harm selected most frequently by veterans who died by suicide (in 2019). Veterans used firearms in 69.2% of completed suicides compared to 47.9% of deaths by suicide in the non-veteran adult population. Rates of suicide by firearm among male veterans was 70.2% compared to male non-veteran peers at 53%, and 49.8% for female veterans compared to female non-veteran peers at 31.3%. Given these findings, counseling veterans in the safe storage of firearms is an essential and critical component of suicide prevention that must be a part of VA's comprehensive mental health/suicide prevention strategy.

In addition to VA's efforts, the White House has established a series of complementary suicide prevention goals outlined in a new national strategy, Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Approach. Both initiatives focus on improving lethal means safety through a targeted campaign to increase the safe storage of firearms and medications, and the use of safety planning interventions by providers; enhancing crisis care and facilitating care transitions in emergency settings; increasing access to and delivery of effective care through public and private partnerships and increasing interagency research coordination and data sharing.

- **Congress must provide aggressive oversight of the strategic plans to reduce military and veteran suicide and ensure VA receives sufficient resources, staffing and support to carry out and achieve its intended goals and positive mental health outcomes for our nation's veterans.**





Strengthen the VA's Capacity to Deliver Timely, High-Quality Health Care to Veterans, Particularly Veterans with Service-Connected Conditions

Over the past decade, the VA health care system has experienced unprecedented stress and undertaken historic reforms to ensure that veterans have timely access to high-quality health care. From the access crises and waiting list scandals of 2014 to the COVID-19 pandemic, there has been one consistent trend throughout: an increasing number of veterans turning to the Department of Veterans Affairs for health care. Unfortunately, the rising demand for VA care continues to outstrip capacity to provide timely and convenient care to all enrolled veterans, which is especially critical for disabled veterans who rely on the VA for most or all of their care.

In response, Congress has enacted a series of major reforms, beginning with the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146), which created the Veterans Choice Program. That legislation was intended to simplify veterans' access to community care options when the VA was unable to deliver timely or convenient care. Unfortunately, the Veterans Choice Program created as many problems as it may have solved, ultimately leading to passage of the VA MISSION Act of 2018 (Public Law 115–182), which consolidated several community care programs into a single program intended to work seamlessly with the VA health care system. Importantly, the VA MISSION Act also included provisions designed to strengthen the VA's internal capacity to deliver care, since most veterans prefer VA-provided care.

Due to administrative and contracting challenges, implementation of key parts of the VA MISSION Act—including establishment of Veteran Care Networks (VCNs) by the new third-party administrators (TPAs)—were delayed by more than a year to 2020. The onset of the COVID-19 pandemic that year further complicated the rollout of new VCNs and altered veterans' use of both VA and community care. The need to mitigate the spread of COVID-19 also led to a massive acceleration in the use of telehealth and other virtual modalities, which, if properly used, could continue to expand access to VA health care in the future. In the two and a half years since the VA MISSION Act became effective, neither the VA nor TPAs have been able to adequately meet the access standards established by regulation for the VA or by contract for TPAs. Furthermore, despite clear and unambiguous statutory language in the law, the VA has yet to require non-VA community providers to meet the same access and quality standards that VA providers must meet.

- **The VA must maintain sufficient internal capacity to provide timely care in order to remain the primary provider and coordinator of care for all enrolled veterans.**
- **Congress and the VA must ensure that non-VA community care providers meet the same access, quality, training and certification requirements as VA providers so that veterans receive timely, high-quality care regardless of where they receive it.**
- **The VA must carefully study the efficacy and effectiveness of virtual health care to determine its optimal use to ensure the best health outcomes for veterans.**

Health Care Infrastructure

The VA MISSION Act also established an Asset and Infrastructure Review (AIR) process to modernize, realign and rebuild VA health care facilities to meet veterans' demand for care over the next two decades. The VA has conducted market assessments to determine demand, capacity and non-VA options for delivering care in each of its regional health care markets. However, VA market assessments were completed before and during the COVID-19 pandemic, raising questions about the reliability of the data used to project the VA's future needs. Following the release of AIR recommendations for every health care facility, an independent commission, appointed by the president and

confirmed by the Senate, will review and may revise those recommendations before sending them to the president next year. If the president approves the commission's recommendations, Congress will vote whether to approve or reject the entire set of VA facility recommendations in early 2023.

- ▶ **The VA must provide full transparency to all of the data and information related to its market assessments and must ensure that veterans and veterans service organization stakeholders have full access to the AIR commission process.**

IT and Electronic Health Record Modernization

The VA's ongoing transition to a new electronic health record (EHR) hit some stumbling blocks in 2021, as reports of problems surfaced during the first rollout of the new system in Washington state. Following a months long strategic review last year, the VA released a revised national rollout plan that would still meet the original 10-year modernization timeline while addressing implementation problems. The success of this new EHR system is critical to the future of the entire VA health care system, including truly seamless scheduling and clinical care coordination.

- ▶ **Congress must aggressively oversee the implementation of the new VA EHR system to ensure patient safety and health care outcomes remain the primary focus.**

VA Fourth Mission for National Emergencies

As demonstrated during the COVID-19 pandemic, the VA plays a significant role in responding to national health emergencies, which is just one aspect of its Fourth Mission. The VA is also the backup health care system for the Department of Defense and has additional federal responsibilities during national emergencies. Since the country has no comparable federal or private health care systems, it is imperative that the VA maintain adequate capacity to fulfill this critical mission.

- ▶ **The VA must maintain sufficient health care capacity to meet its Fourth Mission functions during national emergencies while also ensuring that veterans continue to have uninterrupted and timely access to VA health care.**





BY THE NUMBERS



More than 1 million veteran members are organized into over 1,200 local chapters and 52 departments, including Puerto Rico.



More than 12 million claims for benefits 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 \$25 billion in earned benefits in 2021.



In 2021, over 500,000 hours were donated by volunteers in VA hospitals and clinics.



In spite of the pandemic, DAV Transportation Network volunteers provided more than 163,000 no-cost rides for ill and injured veterans to VA medical facilities in 2021.



With a value of nearly \$85 million, DAV has donated a total of 3,618 vehicles to the VA since 1987 for transporting veterans to appointments.



In 2022, DAV acquired Patriot Boot Camp, which provides entrepreneurs in the veteran and military-connected community with the resources and education they need to become business founders and employers. The program's 1,000 alumni have raised more than \$150 million in venture capital and employ more than 1,900 individuals.



Since 2014, DAV has co-hosted 781 traditional and virtual job fairs, connecting nearly 259,000 active-duty, Guard and Reserve members, veterans and their spouses with employment, resulting in more than 158,000 job offers.



During 2021, DAV donated over \$1.3 million to nearly 2,200 veterans affected by natural disasters, including hurricanes, tornados, floods and fires. In addition, roughly 550 comfort and hygiene supply kits were also provided.



From April 2020 to April 2021, over \$2.1 million in COVID-19 unemployment relief was distributed to disabled veterans in need.