JERRY HOTOP, NATIONAL COMMANDER, AMVETS

STATEMENT OF
COMMANDER JERRY HOTOP
AMVETS NATIONAL COMMANDER

BEFORE THE

JOINT SENATE AND HOUSE COMMITTEES ON VETERANS' AFFAIRS

CONCERNING

AMVETS LEGISLATIVE GOALS AND OBJECTIVES FOR 2011

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Chairman Murray, Chairman Miller, Ranking Member Burr, Ranking Member Filner and distinguished members of the Senate and House Veterans' Affairs Committees. I am AMVETS National Commander, Jerry Hotop. On behalf of AMVETS, the AMVETS Ladies Auxiliary, the Sons of AMVETS and all of our other subordinate organizations, I would like to extend our gratitude for being given the opportunity to share with you our 2011 legislative agenda and goals.

AMVETS feels privileged in having been a leader, since 1944, in helping to preserve the freedoms secured by America's Armed Forces. Today our organization prides itself on continuing this tradition, as well as our undaunted dedication to ensuring that every past and present member of the Armed Forces receives all of their due entitlements. These individuals, who have devoted their entire lives to upholding our values and freedoms, deserve nothing less.

AMVETS guiding principles in developing our legislative agenda lay in three documents. These documents are our annual adopted resolutions, our report developed during the 2010 AMVETS Symposium for the 21st Century Veteran and finally our compiled book of concerns of our membership and the veteran and servicemember community as a whole. My following testimony will briefly discuss each of our individual legislative goals for 2011, including Underserved Servicemembers and Veterans, Polytraumatic Brain Injuries and Prosthetics Care, the Claims Backlog and finally Transition and Veteran Entrepreneurship.

Underserved Veteran and Servicemember Populations:
Today's diverse veteran and military communities have unique and complex needs that VA and DoD have not had to face before. Women are serving in the U.S. military in record numbers and our nation is welcoming home the first generation of female combat veterans. As of early 2010 the U.S. Marine Corps and U.S. Army had began using women soldiers for a new strategy in counterinsurgency operations, or COIN. These women are now placed in small units called

"Female Engagement Teams" (FETs). The FETs are directly attached to all-male combat units and are going into the field with them. These women are providing an invaluable source of intelligence to our fighting forces through their direct interactions with Afghanistan's silent 50 percent, women and children. This is only one example of the rapidly-changing roles of women serving today in our armed forces.

Given the changing demographic of today's service members, both DoD and VA health care systems must adapt and keep pace with the changes of today's fighting forces and be ready to care for every veteran in order to effectively meet the unique needs of America's female war fighters.

While the roles and opportunities have advanced significantly for women in today's armed services, women still face significant, unique challenges during and after their service to this country. When returning home and transitioning back into civilian life women veterans are confronted with new challenges and often obstacles to care and employment. While VA has made strides in recent years, AMVETS believes they are still underprepared to provide adequate care and services to the surge of female veterans seeking VA assistance. In addition, women veterans face significant barriers when entering the civilian workforce and homeless rates among female veterans has surpassed that of their male counterparts in many parts of the country.

According the Veterans Health Administration (VHA), women veterans are the fastest growing segment of the veteran population. In 2009, the number of women veterans utilizing VA services grew by 20 percent. This historic percentage is only expected to rise as women's roles within the military grow and change. In fact, VHA projections show that women veterans will account for one in every seven VA enrollees by 2020. Furthermore, according to VA records women veterans having served in Operations Iraqi and Enduring Freedom (OIF/OEF) utilize VA services at a higher rate than other veterans, including other women veterans and male OIF/OEF veterans. Women OIF/ OEF veterans are utilizing VA health care benefits at rates VA has never seen. Of this newer women veteran population more than 85 percent are under age 40 and are of childbearing age; and nearly 60 percent are between the ages of 20-29. While VA estimates that the total number of veterans will decline by 37 percent between 2008 and 2033, the number of women veterans will increase in excess of 20 percent during the same period.

According to DoD, as of 2010 16 percent of active duty military forces are women and 18 percent of the National Guard and Reserve are women. This is in sharp contrast to 30 years ago, when women comprised only 2.5 percent of the military. Today women service members are being deployed to the same combat zones as their male counterparts; however, DoD has not been able to keep up with the needs of our ever-changing military forces. Although the number of women choosing to serve in the armed forces is continuing to rise and their options and choices of military occupational specialties, or MOS, continues to expand, women service members are less likely to serve until retirement when compared to their male counterparts.

For example, the standard issue military combat uniform issued to women service members was designed for a male's body. According to VA, there has been a steady rise in the number of long term injuries directly related to inadequately designed gear for female service members. These include, but are not limited to, back and neck problems, foot and ankle injuries and nerve damage. While female service members do not expect or ask for special treatment, AMVETS

believes it is in the best interest of our female service members and the military to equip and arm our women service members with properly designed gear. This will help ensure the health of our women service members as well as equipping all of our service members with the proper gear for peak performance and safety. It is time to stop issuing gear to female service members as though they are just "smaller men." AMVETS believes it is vital to the success and safety of our women service members to adapt and change the gear issued to them, as their roles within our fighting forces grow and change.

Career progression is often slower for women as they are still underrepresented within the military's senior ranks. Unfortunately, women service members with young children still face many stigmas and often feel they lack the opportunity for advancement resulting in highly qualified and talented female service members who leave the service early in their careers. Female service members most often report inadequate health care options during their service as well as instances of sexual assault and harassment as hindrances to advancement in their military careers. In fact, 22 percent of female VA patients report having been victims of military sexual trauma at some point in their career, compared to less than 2 percent of their male counterparts. The hurdles experienced by many of today's female service members not only affect them, but they threaten to affect the overall well being and readiness of today's military force.

According to the Defense Advisory Committee on Women in the Services (DACOWITS), women are less likely to be promoted into the higher echelons of the military, such as flag and staff officer rankings, and have much lower overall promotion rates compared to males. According to the RAND Corporation and Iraq and Afghanistan Veterans, the military's ban on women serving in combat may play a major factor in the opportunities available to women servicemembers for such promotions, even though today's female service members continue to actively engage the enemy in the combat zone.

Another factor affecting today's women service members is increased divorce rates. Although a recent RAND study indicated divorce rates within the military are equal to those of their civilian counterparts, the study did show disproportionate figures in the divorce rates of female service members when compared to that of male service members. The study showed that between 2005 and 2008 the average divorce rate for female service members rose 2 percent compared to only a 0.1 percent rise in divorce rates among male service members. AMVETS strongly believes further studies are needed to evaluate the stressors (multiple deployments, mental and physical health injuries, dual-military marriages and gaps in family support programs) to identify the exact causes and lack of programs or assistance leading the higher rates of divorce among the female military and veterans population.

Furthermore, women veterans and service members have been shown to have unique and more complex health needs with a higher rate of co-morbid physical health and mental health conditions (31 percent of women have such co-morbidities versus 24 percent of men). In fact, according to the VHA Plan of Care Survey for fiscal year 2007, 67 percent of sites provide primary care in a multi-site/multi-provider model (i.e., with primary care at one visit and gender-specific primary care at another visit), with only 33 percent of facilities offering care to women in a one-visit model. Furthermore these numbers proved to not have changed much, according to a 2009 OIG investigation. While most male veterans can receive the full

spectrum of primary and preventative care services in one visit, most female veterans must schedule multiple visits to receive the same gender-specific care.

As a result of our ever-changing veterans' population, AMVETS believes it is of the utmost importance VA and DoD are ready and equipped with the necessary personnel, gender appropriate facilities, one-visit models of care and equal uniformed availability and access to care as their male counterparts. While the VA system has long provided a full range of health services for male patients, many gender-specific female services were never historically been available at VA until recently. These types of care can range from gynecological care to pre- or postnatal care, infertility screening, osteoporosis treatment and menopause care. It is vital to our women veteran community that VA provide everything necessary to ensure our returning war fighters have all the necessary tools and resources in sustaining the highest quality of life and health care available.

In order to provide the promised quality of care to our women veterans and service members, VA and DoD must be able to provide the above services at all major medical facilities. It is simply inexcusable to ask our women veterans and service members to visit up to eight different facilities in order to receive the regular primary care women need. We already offer our male veterans and service members a single access point to receive all of their regular primary care. We must provide the same for our women.

Another changing demographic of today's fighting force is location. Today's military is comprised of rural and remote veterans at a percentage far exceeding other demographic groups. Given this fact, when a service member returns from combat and transitions back into civilian life, they are often returning to parts of the nation where they do not always have immediate access to VA care and services. VA must adapt to meet the needs of our nation's underserved warriors to ensure all veterans receive the care and benefits they have earned and to which they are entitled.

More than three million (or nearly half) of veterans enrolled in the VA healthcare system live in rural or remote areas. For the purposes of this outline, "rural" will encompass all veterans living in rural or remote areas. Rural Americans serve at rates higher than their proportion of the population. Though only 19 percent of the nation lives in rural areas, about 45 percent of U.S. military recruits hale from rural America. An overwhelming national misconception persists that all veterans have equal access to VA comprehensive health care and other programs provided by VA. Unfortunately, this is not true. Access to the most basic primary care is often difficult for veterans residing in rural America. Even more alarming is the fact that many veterans living in rural areas choose not to seek assistance or care from VA because they either have no means of transportation or simply do not have the time or means to travel far distances to their nearest VA Medical Center (VAMC) or Community-based Outpatient Clinic (CBOC).

Another hurdle to care for this population of veterans is the fact that many of the specialists they need to see for care are only available on certain days and most do not have provide care after 5 p.m. or on weekends, making it nearly impossible for veterans with jobs to make appointments. AMVETS believes that a veteran should not have to make the decision between that of care and missing work, which could result in lack of income to sustain their quality of life and possibly the well being of their family.

While most VAMCs and CBOCs provide excellent care to veterans, many veterans living in rural areas never have the opportunity to take advantage of this excellent care because of travel constraints, disabilities affecting mobility, age, or lack of outreach and education on the services available. Difficulties due to physical disabilities, age, or financial restraints have grown significantly over the past few years due to tough economic times, an aging veteran population and the injuries many veterans are sustaining, which directly affect cognitive ability and mobility. Moreover, the veterans' population ages 85 and older is growing and will continue to grow until 2036. Unless VA develops and implements stronger programs for our rural veteran population, today's combat veterans returning to their rural homes in need of specialized care due to war injuries—both physical and mental—will likely find access to that care extremely limited.

According to a 2006 study of the Carsey Institute, the death rate for rural soldiers is 60 percent higher than the death rate for those soldiers from cities and suburbs due to the multiple obstacles they face in their efforts to receive care as opposed to their urban counterparts. In 2009, 85 percent of all mental health shortages could be found in rural America, and VA predicts this number will continue to rise. A lack of qualified mental health professionals, shortage of psychiatric hospital beds and the negative stigma of mental illness, often result in many rural residents not receiving the care they so desperately need. Although Vet Centers provide mental health services, they are not consistently available at the local, rural level.

Currently, tinnitus, traumatic brain injury (TBI), and post traumatic stress disorder (PTSD) are the most frequent injuries sustained in recent conflicts. Such physical and psychological wounds require highly specialized care. The VHA TBI case managers, neurologist and audiologist network, as well as specially trained PTSD clinicians are vital to providing quality comprehensive care to all veterans. However, access to these services is extremely limited for rural veterans and AMVETS strongly believes immediate expansion is needed to get these vital health care services to our rural veterans' population.

According to a published 2009 VA Office of the Inspector General (VAOIG) report, waiting periods for outpatient mental health care treatment is four to eight weeks in rural areas. Unfortunately, due to lack of uniformed data tracking systems and policies, it is not known what the average wait for specialized physical specialty care is for things such as brain injuries or prosthetics and sensory aide care. To help combat these problems VA's Office of Rural Health (ORH) was established in December 2006 by § 212 of Public Law 109-461. In late 2008, Congress passed Public Law 110-387, the Veterans' Mental Health and Other Care Improvements Act of 2008. Section 107 of Public Law 110-387 directed VA to conduct a pilot program in at least three Veterans Integrated Service Networks (VISNs) to evaluate the feasibility and advisability of providing Iraq and Afghanistan veterans with a number of new services. These services include, but are not limited to, peer outreach and support services, readjustment counseling services, and other mental health services through arrangements with, among others, community mental health centers. VA's Office of Mental Health Services and ORH are in the process of fully implementing this pilot program. According to Congressional testimony from VHA, the pilot will be conducted in a number of stages evaluating:

1. The identification of rural areas that are beyond the reach of VA's mental health services for Veterans but have other mental health providers capable of providing high quality services.

2. The willingness and capability of these entities for providing outreach and treatment services for returning Veterans.

3. The feasibility of developing performance based contracts with these entities that meet the requirement of Section 107.

4. The use of services and the outcomes of care provided through these contracts.

It is important to note VA already has the authority to contract with the most appropriate provider when VA is unable to provide necessary services. In fact during FY 2008 VA expended $248 million for inpatient and outpatient services, including long term and home health care, in contracted care in rural areas. An additional $1.04 billion was expended on a "fee-for-service" basis in rural and highly rural areas for veteran health care.

Despite the creation of local access points, the greatest barrier to quality health care continues to be distance. Many young veterans from the wars in Iraq and Afghanistan suffer from severe physical and psychological disabilities long after their transition back into civilian life. These are disabilities requiring care and services long after returning to their rural hometowns. However, if readily accessible care is not available, many of these wounded warriors will chose not to receive the care needed to sustain a healthy quality of life, leading to untreated mental and physical issues. Left untreated, many of these conditions can, and often do lead to substance abuse, homelessness, divorce and/or financial problems.

To better serve today's rural veterans, AMVETS recommends annually evaluating practices that accurately identify the strengths and weaknesses that directly impact rural veterans' healthcare, access to services and resources. VA should the take the knowledge obtained from these evaluations and recommend changes or new initiatives for the identified weaknesses. The only way to ensure and sustain quality is through regular evaluations to identify and correct any weaknesses.

Due to the higher rate of physician turnover within the VA healthcare system, VA must develop new methods (to complement the current Medical Model of complete comprehensive care) in order to meet the needs of rural veterans. These methods must ensure the continuity of care and be capable of providing documentation of treatment in an electronic data exchange system to ensure accurate and readily accessible medical records.

VA's next steps must involve identifying qualifying communities, identifying local providers willing and able to participate and begin the processes of acquisition and exchanges of medical information and addressing pharmacy benefits and performance.

Another important step is the wider implementation and availability of telemental health services to rural areas. VHA Tele-mental Health is the delivery of services using virtual linkages between VHA patients and mental health providers that are separated by distance or time. AMVETS strongly supports the use of telemedical services if it stands to improve upon a veteran's access

to quality care problems in rural areas. However, for any type of telemedicine to be effective VA must ensure internet access and regular availability in rural areas, as well as the proper outreach and education to veterans and health care providers in rural areas. If developed, implemented and maintained properly, this type of care stands to have a positive effect and offer another option for care to a very large number of veterans who might otherwise not receive or forego care.

Finally, AMVETS stresses the importance that we all must be mindful of the long-term needs and costs of our returning veterans population. The wounded veterans who return today will not need care for just the next few fiscal years, they will need care for the next half century. While access for rural veterans can be daunting , VA must ensure that every possible step is being taken to ease the burdens and hurdles regarding access and quality of care to our rural veteran population. Where a veteran chooses to call home should never have an impact on the quality of and access to care and services.

VA Care and Services:
Over the last few years, the number of veterans served by VA's health care system has grown significantly, with a continued rise in enrollment expected throughout the next decade. With this rise in enrollment in mind, AMVETS believes VA must focus on proper identification and treatment of the current conflicts' signature wound, traumatic brain injury (TBI), which remains under diagnosed in today's ranks. AMVETS also believes VA must focus its attention on a rapidly expanding sector of VA services—Prosthetic and Sensory Aids Service (PSAS)—which faces potentially damaging process and funding shortfalls, if not corrected and enhanced to mirror the demand for their services.

As a direct result of recent changes in modern warfare and the major advances in battlefield medicine, service members are sustaining new and complex patterns of blast related injuries and surviving. Accordingly, DoD and VA are providing medical care to individuals with blast injuries who may have died during previous wars. Service members are increasingly deployed to areas where they are at risk for experiencing blast exposure from improvised explosive devices (IEDs), suicide bombers, land mines, mortar rounds, rocket-propelled grenades and similar weapons systems. These and other combat-related activities put our military service members at an increased risk for sustaining blast-related brain injuries.

Given the possible effects of explosions on the human body, it is not surprising that blast injuries are often "polytraumatic." According to VA, injured body systems, structures, and outcomes can include: Auditory/vestibular; eye, orbit, face; respiratory; digestive; circulatory; central nervous system; renal/urinary tract; extremity; soft tissue; mental health; and pain.

The most prevalent blast injuries soldiers are sustaining are traumatic brain injuries (TBI). It has been estimated that more than 60 percent of blast injuries result in TBI. TBI has been labeled the "signature injury" of the recent conflicts.

According to VA, a brain injury is caused by a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain. Exposure to blast events can affect the body in a number of ways; in addition, the consequences of these different injuries often interact, resulting in multiple impairments and extended recovery periods.

TBI is defined as any damage to living brain tissue caused by an external, mechanical force. It is usually characterized by a period of altered consciousness (amnesia or coma) that can be very brief (minutes) or very long (months/indefinite). Both DoD and VA measure the severity of injury using these ICD-9 codes:

• Concussion/mild TBI (mTBI)- characterized by a confused or disoriented state which lasts less than 24 hours; loss of consciousness for up to 30 minutes; memory loss lasting less than 24 hours; and structural brain imaging (MRI or CT scan) yielding normal results.

• Moderate TBI- characterized by a confused or disoriented state which lasts more than 24 hours; loss of consciousness for more than 30 minutes, but less than 24 hours; memory loss lasting greater than 24 hours but less than seven days; and structural brain imaging yielding normal or abnormal results.

• Severe TBI- characterized by a confused or disoriented state which lasts more than 24 hours; loss of consciousness for more than 24 hours; memory loss for more than seven days; and structural brain imaging yielding normal or abnormal results.

• Penetrating TBI- a head injury in which the Dura-mater, or outer layer of the brain is penetrated. Penetrating injuries can be caused by high-velocity projectiles, such as shrapnel from an IED explosion or objects of lower velocity such as knives, or bone fragments from a skull fracture that are driven into the brain.

The Defense and Veterans Brain Injury Center reports that difficulties experienced as a result of a closed brain blast injury may include a range of physical, emotional, cognitive and behavioral symptoms. Many of these symptoms are non-specific, however; that is they occur with other conditions such as depression, PTSD or combat stress. It requires an experienced clinician who is familiar with the many variables involved in blast injuries and has a full understanding of how these variables can affect recovery and ultimately impact return to everyday activities and transition into civilian life. AMVETS believes that if we are truly going to provide the best possible care for our service member and veterans having experienced TBI, VA and DoD must be equipped with the most experienced clinicians.

Concussions and TBI related to significant blast exposure are also likely to have other important co-morbid conditions present. Most people with a diagnosis of traumatic brain injuries have been involved in trauma, such as an IED explosion or automobile collision, and are also likely to have other injuries. Approximately 30 percent of people having suffered a traumatic brain injury also have injuries to the nerves of the arms and legs. Sometimes, these injuries are not discovered until the person is in rehabilitation. Several reasons exist for this. Initially, the blast-related TBI or concussion may have occurred simultaneously with other more obvious life threatening injuries. Initially, the focus of field medics and medical care providers must be on the most life threatening injuries. For example, the patient may also have combat stress or depression associated with a return from deployment; it is very challenging for the medical providers in these situations to determine what symptoms are due to the concussion and which symptoms are due to the combat stress or depression.

According to a recent Centers for Disease Control/National Institutes of Health study, about 40 percent of those hospitalized with a TBI had at least one unmet need for services one year after their injury. The most frequent unmet needs included improving memory and problem solving; managing stress and emotional upsets; anger management; and improving job skills.

TBI can cause a wide range of functional changes affecting thinking, language, learning, emotions, behavior, and/or sensation. It can also cause epilepsy and increase the risk for conditions such as Alzheimer's disease, Parkinson's disease, and other brain disorders that become more prevalent with age. TBI is also the leading contributing factor to the most VA diagnosed disability, Tinnitus. Tinnitus has also been shown to be a precursor to hearing loss, as well as an aggravator of other injuries during recovery. TBI directly related to blast exposure is often a much more complex injury to treat when compared to a brain injury sustained by other causes. As such, it is challenging to differentiate blast related TBI and/or concussion from other conditions that may occur as a result of blast exposure. It is also difficult to estimate the course of recovery in these cases, as it may vary widely depending on various types of blast injury and other injury variables, such as the size of the blast, distance from the blast, etc. These issues make it difficult to assess blast related TBI and concussion in the same manner that other brain injuries are examined. A better approach may be to conduct an evaluation based on the cause of the injury; that is, screen all individual service members exposed to a blast for any symptoms which might be resulting from the effects of blast on the brain.

Failure to identify and treat TBI in a timely manner can have extremely negative effects on the service member's quality of life and contribute to numerous other hindrances. Therefore, AMVETS believes that it is of the utmost importance for VA to have all of the necessary policies, procedures and personnel in place to provide the care for all service members having sustained blast related brain injuries and the co-morbid injuries that will either immediately, or over time accompany them. AMVETS also stresses the importance having detailed long-term care models and therapies in place, as the average age of our returning wounded service member is 21-29. Social, emotional and behavioral problems often result from these brain injuries if they are misdiagnosed and untreated. Thus, it is of the utmost importance that proper identification of TBI occurs in a timely manner. Proper and timely diagnosis is a critical step in determining and providing appropriate treatment for those in need. Evidence suggests that earlier treatment is often associated with better outcomes for anyone who sustains a blast related brain injury.

Furthermore, research suggests the presence of psychiatric disorders can also interfere with the recovery from TBI and individuals who have suffered a TBI along with a psychiatric disorder are much more likely to attempt suicide than those with TBI who do not have a psychiatric disorder. Investigators have found that psychiatric morbidity, particularly PTSD and pain are particularly prevalent in OEF/OIF veterans with a history of TBI. Some medical professionals refer to the co-occurrence of TBI, pain, and PTSD as the "Polytrauma Triad."

VA has separate treatment guidelines for concussion/mTBI, pain and PTSD. Therefore, AMVETS strongly urges DoD and VA to develop and implement stronger care coordination models to ensure that from transition out of DoD, into VA and throughout a veteran's life, brain injuries are managed and treated effectively and accordingly.

AMVETS believes that it is also a vital and intricate part of a successful treatment plan to address the issues of the veteran's family or caregiver. According to VA's own reports, a significant number of caregivers, spouses and family members of persons with TBI report stress, depression, anxiety and decreased time and energy for recreational activities. Depression is often enduring. Emotional and behavioral changes in individuals with TBI are associated with caregiver distress and poor family functioning.

VA must take an approach of treating the veteran as a whole, instead of symptom by symptom to ensure the highest quality of care and life are given to America's returning war fighters.

As the face of warfare has changed during the recent conflicts, so have the injuries service members are sustaining. Injuries that may have been fatal 20 years ago are now being treated and survived through advances in field medicine. AMVETS believes that when our wounded warriors return from the battlefield they should have access to the highest quality of care possible.

The recent conflicts have given way to a surge in physical injuries such as, but not limited to, amputations, hearing and sight loss, spinal cord injuries and brain injuries; all conditions which will be treated by or provided resources from the Veterans Health Administration (VHA), more specifically VA Prosthetic and Sensory Aids Service (PSAS).

The simplest way to describe the care PSAS provides is to say if something is in a veteran (surgical), on the veteran, or for a veteran, it falls under the responsibilities of VHA's PSAS department. For example, items such as prosthetic limbs, surgically implanted devices, specialized footwear for diabetics, walking canes, eye glasses, wigs, wheelchairs, hearing aids, specially adaptive clothing, Service and Guide Dogs and thousands of other items or services needed to ensure the highest quality of care to our veteran community will be provided through PSAS.

Astoundingly, the number of veterans requiring the services and care of PSAS has risen from 25 percent to nearly 40 percent within the past five years. When compared to the total growth in the number of veterans seeking care from all of the other VHA departments, about 13 percent, PSAS has grown by more than 78 percent during the same time period. PSAS also saw a growth of 1,800 percent in the number of women veterans under their care from 2005-2009.

Due to this and the projected continued growth in the number of veterans receiving care from PSAS, AMVETS believes it is vital to the well being of our veteran community for Congress and VA to maintain the proper growth in appropriated funds for PSAS in to keep pace with the veterans requiring their services and care. Proper funding and staffing for PSAS will continue to be of the utmost importance in properly caring and providing for our wounded warriors. AMVETS believes that access to PSAS care and services should be a top priority for VA.

However, AMVETS believes there are several factors that are actually hindering a veteran's access. First, VHA has not established nor does it maintain any system of national record or corresponding request. AMVETS believes this not only negatively affects the veteran, but also poses a threat to the integrity of VA. The lack of a centralized tracking and data exchange system hinders a veteran's access to care. Due to fragmented patient records, veterans may not receive the care they need should they have to visit any VA Medical Center (VAMC) or Community-based Outpatient Clinic (CBOC) other than their home VAMC or CBOC. For example, if a veteran utilizing a wheel chair is on vacation or on travel for their job, and the wheel chair requires immediate assistance or service from PSAS, the veteran will most likely encounter bureaucratic obstacles at the nearest PSAS department as result of the missing PSAS data exchange system.

AMVETS is also concerned that PSAS still conducts all purchasing and referrals for veterans' prosthetic and sensory aide devices via hard copy. When a veteran needs anything from PSAS the VA doctor gives the written referral directly to a PSAS purchasing agent, who then contacts the supplier of the requested item. Unfortunately, if for some reason the purchasing agent is unable to make it to work or goes on vacation the referrals and requests from VA healthcare providers simply sit on their desk and cannot be fulfilled until the particular purchasing agent returns.

AMVETS strongly believes that the development and implementation of a data exchange and tracking system would eliminate this hurdle to care for veterans, further protecting veterans' health needs and the needs of PSAS in the event of a natural disaster or other emergency. AMVETS also urges VA to act swiftly on developing a data exchange system for the use of PSAS personnel to avoid a potentially large backlog where veterans would be unable to obtain the immediate resources and care provided to them by VHA PSAS.

Currently, VA has no way of tracking vital information on patients' care and purchasing orders, thus opening themselves up to potential fraud and abuse, and the inability to provide the highest quality care to the veterans they serve. The inability to provide all veterans equal access to care through centralized purchasing units, instead of the current fragmented paper copy system, also prevents PSAS from maximizing efficiencies.

Another issue AMVETS believes poses a hurdle to veterans requiring PSAS resources is the location and availability of resources to veterans living outside of major metropolitan cities. Currently, PSAS does not have the necessary prosthetic orthotic professionals needed to meet the demand for services by the veterans' community. AMVETS believes broken qualification standards for prosthetic orthotic professionals are hurting the veterans' quality and access to PSAS care. AMVETS urges PSAS to immediately develop and implement uniformed qualification standards that shall encompass all areas of orthopedic and prosthetic care.

Transition:
Seamless transition remains a critical challenge for VA as veterans return from the front lines in Iraq and Afghanistan. One of the simplest problems facing VA is ensuring veterans can get through the door to be seen at their local VA Medical Center (VAMC) or Community-based Outpatient Clinic (CBOC). When VA cannot properly adjudicate service-connected disability claims in a timely manner, veterans may be denied critical benefits and care. In addition, in this

weak economy, the veterans' unemployment rate continues to surpass the civilian rate. AMVETS believes this is unacceptable. Though educational benefits have offered significant opportunities for today's veterans, VA must modernize its procurement processes to ensure that veteran entrepreneurs are afforded the contracting opportunities to which they are entitled. Congress must also ensure that education benefits and services are readily available and equitable across the board.

One of the most significant hurdles to veterans receiving timely health care and benefits from VA is the lack of a unified health and service record between DoD and VA. As Secretaries Robert Gates and Eric Shinseki have said in the past, the day the uniform comes off, a veteran should already have a record with VA. Though both secretaries have expressed this unified health and service record as a top priority, we have seen little progress in more than two years. VA and DoD need to clear the bureaucratic hurdles contributing to the delays, which is why AMVETS calls on Congress, and the committees on armed services and veterans' affairs, in particular, to provide the oversight and guidance that DoD and VA need to make this a reality.

AMVETS also echoes the concerns voiced by Chairman Murray, Ranking Member Burr, Chairman Miller and Ranking Member Filner, calling on VA to rework the current interpretation of last summer's Family Caregiver law to reflect the intent of the bill. The longer family caregivers do not have the tools to properly care for their loved ones, the more hurdles we create for disabled veterans on the road to recovery.

Another hurdle to care is the ongoing backlog of VA benefits claims. Between 2000 and 2007 total VA benefits claims awarded have risen by 45 percent. Currently, VA estimates approximately 444,000 claims await processing and the projections for FY 2012 predict a continued rise in claims, as a direct result of the long-overdue Agent Orange presumption claims and newly published regulations on PTSD. Congress has responded to the needs of VA through additional funding for the immediate hiring of new claims processors however increased manpower alone will not eliminate the backlog or the institutional inconsistencies and shortfalls plaguing the entire compensation and pension claims system.

New programs, such as "Benefits Delivery on Discharge" and "Quick Start" have proven successful in expediting the adjudication of new claims filed for today's transitioning service members, however, much of the backlog contains older claims. We are continuing to face an outdated and inefficient appeals process built upon a fractured paper-based system that has failed to make any considerable improvements over the last century.

Throughout 2010, VA has continued to develop and implement several pilot programs intended to "break the back" of the backlog. AMVETS National Service Foundation has continued to work extensively with VA through recommendations, reviews and assistance on monitoring accuracy and timeliness, as well as providing oversight in conjunction with VA of the development and implementation of the pilot programs. The pilot programs range from automating the claims process to adjudicating fully-developed claims, as well as refining the overall business processes. These pilots have shown promise, however VA has predicted a continued increase in the backlog in the near term and beyond if the proper data exchange systems and claims processes are not updated and implemented.

Compensation claims development and adjudication is complex and time consuming. When VA inadequately trains employees, traditionally they have failed to recognize claims that are sufficiently prepared and continue to develop claims that are ready to be rated. When VA notifies a claimant that s/he can submit a private medical opinion, they do not explain which elements will make the private opinion adequate. There are cases that could be rated because the existing evidence is sufficient, but because of current "Duty to Assist" requirements, VA must ask the veteran for additional evidence to support the claim. The current accountability mechanism, the Systematic Technical Accuracy Review (STAR) program, allows for too small a sample to determine the accuracy of the claims process of a Regional Office (RO). STAR has also made it possible for new claims processors to have "single signature" authority. This system of oversight has caused claims to be remanded, contributing significantly to the backlog. The employee work-credit system is an ineffective measure of productivity. It measures productivity quantitatively, allowing for credit regardless of quality of the claim. Finally, the number and complexity of cases generated by the conflicts in Iraq and Afghanistan indicate that staffing levels may still be too low.

From the new successful pilot programs, BDD and Quick Start, VA has managed its case load of current disability claims generated from the front lines in Iraq and Afghanistan. However, several unintended inequities in Quick Start have come to light which AMVETS believes must be addressed. First, Quick Start participants may not seek counsel from an accredited claims service officer until 60 after the claim in filed. Next, Quick Start participants only have 60 days to appeal a decision they believe may be incorrect, compared to the 6 months veterans may appeal by filing a standard claim.

This combination of issues within the VA claims process has reduced the productivity and efficiency of the VBA, directly resulting in veterans who do not receive their disability payment in a timely manner.

First, VA must develop a 21st-century electronic document management system. It must be capable of transferring paper documents in a secure data-based system that can be accessed, searched and updated throughout the process. Along with this IT development, Congress must amend Title 38 U.S.C. to reduce processing and appeal times and workload. Reforming the Duty to Assist and appeal notification will significantly reduce processing time and work hours. VA must undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence. In addition, to complement recent improvements in its training programs, VA should require mandatory and comprehensive testing of the claims process and appellate staff. To the extent that VA fails to provide adequate training and testing, Congress should require mandatory and comprehensive testing and under which VA will hold trainees accountable. VA must evaluate the Appeals Management Center (AMC) to determine its necessity. AMC needs to be either dissolved with remands returning to the original rating team or require AMC to provide quarterly feedback to the ROs to ensure that similar mistakes do not persist. VA must also evaluate STAR to ensure that single signature authority and a low quantity of random claim audits do not adversely affect the claims process.

Second, VA must continue to monitor the effectiveness of its ongoing pilot programs and administer any necessary changes at VA Regional Offices from coast to coast. AMVETS leaders acknowledge the significance of these pilots and the potential impact on the backlog.

Finally, veterans who choose to use the Quick Start program must have equal access to representation through accredited veterans' service officers from day one. Quick Start participants also should have an equal window to properly appeal any decision made by Veterans Benefits Administration, like their non-Quick Start counterparts.

Education, Entrepreneurship and Employment:
The Department of Defense estimates an average of 160,000 service members transition out of their respective branch and return to civilian life annually. Not since the end of World War II has America seen such large numbers of troops returning from multiple war fronts. Just like WWII veterans, veterans of operations Iraqi and Enduring Freedom (OIF/OEF) have access to higher learning or training programs thanks to the Post 9/11 G.I. Bill, which was modeled with the same foundations and fundamentals as the G.I. Bill of Rights after.

Today, many Americans have opened their hearts and often pocket books in welcoming home OEF/OIF veterans. However, unlike the post-WWII generation, we have failed in the establishment of solid transition and employment programs. As of mid-2010 the rate of unemployment (regardless of disability status) among OIF/OEF veterans continued to hover around 21-28 percent. Compared to the unemployment rates of the post-WWII veterans, which averaged 4 percent, this daunting figure clearly illustrates the immediate need for federal and private sector assistance, programs and resources. What vital piece of the transition process have we as a nation failed to provide to our war fighters?

Unemployment and homelessness are plaguing our entire veterans' community; particularly our OIF/OEF veteran community as VA and Pentagon data has recently shown. In the years immediately following WWII, America witnessed an immense saturation of public propaganda, outreach, and news coverage calling for all citizens to do their due diligence in aiding veterans as they reintegrated back into civilian society. Entire outreach programs focused purely on connecting employers with service members and making sure every veteran had a place to stay. Many war widows, churches, and everyday citizens opened up their homes to returning war fighters that had no place to go. The nation pulled together, both at the federal and local levels, and often went without to guarantee that their troops had everything they needed in and out of the combat zone. What the government could not provide, the private sector willingly did.

During these difficult economic times, veterans have been hit disproportionately hard by unemployment. Veterans have already proven their competence and leadership ability on the battlefield. It is the duty of AMVETS and our nation's leaders to ensure that veterans have every opportunity to succeed in a competitive job market.

Viable career placement will take a concerted effort on the part of the federal government to lead the way in ensuring equity in opportunity for today's veterans. Veteran owned and Service Disabled Veteran Owned Small Businesses (VOSBs and SDVOSBs) play a critical role in providing services to the federal government, but the system in its current form does not serve the best interests of today's veteran entrepreneurs.

As we move through the 21st century, during a time of war, the VOSB and SDVOSB population continues to rise at a rate not seen since the end of WWII. As America's war-fighters transition back into civilian life, many are choosing to pursue lives as entrepreneurs. Given the almost 30-percent influx of VOSBs and SDVOSBs it is vital that the Center for Veterans Enterprise, Small Business Administration (SBA), Department of Labor, and Office of Federal Contract Compliance Programs (OFCCP) be ready to meet the growing demand for their services. However, until VA, DoD and these agencies start excising the authorities granted to them in oversight, our veteran population will continue to be negatively affected and continue to lose employment in these hard economic times.

The federal government has long utilized billions of dollars of buying power through contracting. This system was designed to maximize the procurement opportunities for small businesses. More specifically, it is to use funds to offer SDVOSBs and VOSBs a greater presence and success rate in the federal procurement process. The Veterans Benefit Act of 2003 established the program, permitting contracting officers to award set-aside and sole-source contracts to any small business concern owned and controlled by one or more service-disabled veterans. Executive Order 13360 also aides SDVOSBs by requiring procurement officials and prime contractors incorporate opportunities for employment to SDVOSB as smaller or subcontractors working with the larger primes. As of December 2009 the statutorily-mandated prime and subcontracting goal for SDVOSB participation is three percent of all federal contracting dollars, although VA set a self imposed goal of seven percent. Alarmingly, according to SBA, in 2007 the federal government, including VA, could only account for less than one percent of the funds appropriated for SDVOSB awards having actually been used in awards to SDVOSBs.

At present, vendors desiring to do business with the Federal Government must register in the Central Contractor Registration (CCR) database, and those who indicate they are veterans or service-disabled veterans, self-certify their status without verification. P.L. 109-461, required VA to establish a Vendor Information Page (VIP) database to accurately identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. This database was originally designed to act as a reliable, centralized database enabling all federal agencies a single source in the identification of possible SDVOSB and VOSB for consideration during their procurement processes. However, businesses claiming SDVOSB or VOSB status annually self-report through the VETS-100 forms. Under current policy, no proof of compliance is required, nor do random compliancy audits occur, to ensure the validity of the VETS-100.

AMVETS has many serious concerns with regard to the current state of VA acquisition controls, policies and procedures, specifically regarding VOSB and SDVOSBs. Even more disconcerting is the fact that VA has allowed their entire acquisitions program to deteriorate to such levels. The individuals VA has vowed to protect are now the ones most negatively affected by the lack of uniformed processes, proper training of contracting officers, no data exchange system, and overall lack of accountability. As AMVETS has testified to several times in the last year, we find it unacceptable that VA's decentralized system of acquisition function and contract procurement is resulting in inconsistent applications of the policies and initiatives, thus resulting in loss of employment opportunities for veteran-owned businesses in these challenging economic times.

VA's difficulties in many areas of contract administration illustrate VA's challenge in monitoring performance of previously awarded contracts, as well as several initial or pre-award practices.

AMVETS continues to believe that educational opportunities remain a critical stepping point for veterans seeking viable careers following their time in the military. Though the Post-9/11 G.I. Bill has proven to be a successful tool in providing educational opportunities, inequities remain in the system

AMVETS applauds the recent passage of the G.I. Bill improvement bill late last year, offering expanded educational opportunities for more of our nation's heroes, but AMVETS has concerns about the controversial provision included in the bill effectively ending break payments for veterans relying on Post-9/11 G.I. Bill living stipends. Before the bill passed, AMVETS and our partners in the veterans community called on Congress to leave living stipends intact. We hope the new Congress will move quickly to remedy this potentially dangerous situation which could create financial hardships for more than 450,000 veterans utilizing these critical benefits.

Since the passage of the Post-9/11 G.I. Bill, AMVETS and our partners Supportive Education for the Returning Veteran (SERV) have been the lone voice on Capitol Hill advocating for federal grants to establish student-veteran "centers of excellence" on college campuses. In 2010, 16 federal grants were commissioned for colleges across the country. AMVETS will monitor each of these campuses to ensure success and demonstrate to Congress the value of comprehensive student-veteran services. The first step was ensuring veterans had educational opportunities. The next step is ensuring they graduate.

Finally, AMVETS believes we must address the issue of homelessness among veterans more vigorously. While we applaud the actions VA has taken thus far and the Secretary's promise to eliminate homelessness within five years, AMVETS still believe there is much work to be done. AMVETS believes this should start with stronger outreach programs in all areas of the country. AMVETS also believes that if we are to achieve the Secretary's promise of eliminating homelessness among all veterans VA needs to have more dedicated resources, staff and facilities outside of VAMCs. Furthermore, AMVETS strongly believes the development and implementation of a mobile outreach staff and centers to serve our nation's rural and remote areas would also lend to achieving the five year goal. These brave men and women, who have so selflessly served this nation deserve better than sleeping on the streets and wondering where their next meal is going to come from. AMVETS calls upon this congress, VA and the private sector work together and to step up all efforts in eliminating homelessness among the entire veteran population. They have served for us and it is now time for us to work together and serve them.

In closing, while AMVETS applauds VA for their continued and tireless efforts in improving the lives of all veterans and their families, we believe we still have a long way to go in order to truly meet the needs of all veterans. AMVETS will continue to be a voice for all veterans and service members to our nation's leaders and law makers. We will continue to ensure that every entitlement earned by your service to our nation is provided and that you receive nothing than the best quality of health care and access to all of the services and resources VA and DoD have to provide.

Chairman Murray, Chairman Miller and distinguished members of the committees I thank you for allowing me to share AMVETS 2011 Legislative Priorities. I stand ready to answer any questions you may have for me.