

Testimony of



Legislative Priorities
&
Policy Initiatives *for the*
118th Congress

Presented by

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Before the
House and Senate
Veterans Affairs Committees

March 1, 2023

Attachments

Good afternoon, Chairmen Tester and Bost, Ranking Members Takano and Moran, and distinguished members of your respective committees. I am pleased to appear before you today to present highlights of our legislative agenda and policy initiatives for the 118th Congress to transform support for veterans to real programs, initiatives, and benefits.

VVA is a national Vietnam Veterans Service organization chartered by the U.S. Congress as a nonprofit organization to promote the well-being of American Vietnam veterans; foster the improvement of the condition of Vietnam veterans; promote the social welfare (including educational, economic, social, physical, and cultural improvement) in the United States by encouraging the growth and development, readjustment, self-respect, self-confidence, and usefulness of Vietnam veterans and other veterans.

The themes of our advocacy reinforce what we have always stood for as an organization: First, that we tell the truth to power as best we can determine the truth, and that we, as individuals and as an organization, act openly and honestly in all our affairs. Second, we demand that our government always tell us the truth and that veterans be treated justly and with respect. Third, VVA demands accountability for the effectiveness as well as the efficiency of each government program charged with helping veterans and their families.

We stand by our motto: *Never Again will one Generation of Veterans Abandon Another.*

PRISIONE OF WAR AND MISSING IN ACTION (POW/MIA)

The Fullest Possible Accounting of America's POW/MIAs has long been VVA's solemn priority. We hold as a profound trust and obligation the responsibility to account for those American servicemembers who remain unrepatriated, missing, or otherwise unaccounted for as a result of their service to our country.

VVA's advocacy on behalf of our fellow comrades-in-arms and their families has helped change the course of history and how we, as a nation, deal with the accounting of our war missing. Today, when we send our men and women to war, they have our nation's promise to bring them home. And while those wars after Vietnam have resulted in fewer servicemembers taken into captivity and unaccounted for, there are no guarantees that this will be the case in the future.

We call on Congress to fully fund the Defense POW/MIA Accounting Agency (DPAA) with what is required to fulfill the mission. This office has the responsibility to keep our nation's promise, to investigate potential crash and burial sites, and to recover and identify remains in Southeast Asia and elsewhere around the globe. In the past three years, DPAA reports accounting for 428 U.S. servicemen; of this total, only 5 are from the Vietnam conflict.

For the 1,581 unaccounted-for American servicemembers from our long-ago war and for their survivors, the pace of recoveries is unacceptable. With the passage of time, witnesses are dying, remains are disintegrating, and the landscape is changing. Repeated delays in funding have interfered with putting recovery teams in Vietnam and Laos. DPAA has a shortage of analysts with the background and expertise to work the cases, and this, combined with inadequate funding to conduct interviews, has slowed recovery efforts.

VVA continues to press for answers regarding those Americans still listed as killed in action, body not recovered. This is the 30th year of VVA's Veterans Initiative Program, our veteran-to-veteran effort to assist Vietnam with their accounting of war dead. We continue to assist our former enemy in locating their unrecovered loved ones by providing fate-clarifying information such as maps of mass burial sites, ID cards, photos, and more.

As we continue to work veteran-to-veteran with our former enemy, we have strengthened the trust between American and Vietnamese veterans and have encouraged the continued cooperation by Vietnamese authorities with DOD search teams. To date, with the information VVA has provided, over 2,000 Vietnamese remains have been recovered from the war. We will be travelling to Vietnam in May 2023 to continue to work directly with the Vietnamese veterans.

NO CUTS TO VETERANS' BENEFITS

Less than 1 percent of the population risks everything to defend our nation and our values and everything we hold dear. You know, the 99 percent of us who don't, we owe them. We owe them big. And that's what today is all about — it's paying a debt, in my view.

Joseph Biden, President of the United States, June 7, 2022

Veterans should not be the target of situations created by Congress and the Administration, who have jointly been unable, for years if not decades, to meet the federal government's obligation to pay their debt. I joined the military to defend and uphold the Constitution of the United States -- the same oath that each of you swore as elected leaders -- and I call on each of you to protect and defend our veterans, widows, and survivors from any attempt to take away their earned benefits.

VETERANS AND MILITARY TOXIC EXPOSURES

ADDRESSING THE LEGACY OF TOXIC EXPOSURES

From Vietnam to the present-day, members of the U.S. military have been exposed to numerous toxic elements, both at home and while serving abroad, leaving many with debilitating illnesses. It is a disgrace that for years our own government hid the harmful effects of these toxic substances from people serving in these areas and then fought to deny their resulting VA claims, as well as those of their survivors and descendants.

*The Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016, P.L. 114-315, Subtitle C, Section 632, required the Secretary of Veterans Affairs to "seek to enter into an agreement with the National Academy of Medicine under which the National Academy of Medicine conducts an assessment on scientific research relating to the descendants of individuals with toxic exposure."*¹

It is evident that the VA Secretary did not follow Section 632 of the *Toxic Exposure Research Act* as identified in the law, and we are asking Ranking Member Jerry Moran (R-Kansas), the champion of this law, to hold an oversight committee hearing, with the VA Secretary as the star witness, to investigate what metrics he used that empowered him to not follow the law.

¹ Pub. L. 114-315 § 632(a)(1).

Mr. Chairman, we do not need another study but would appreciate your support in ensuring that the already agreed-upon study is conducted, and that VA reconsider their denial of any further study in the much-needed intergenerational research, in compliance with the law.

PUBLIC LAW 116-23 BLUE WATER VIETNAM ACT OF 2019

While the original law was well-intentioned and fixed a long-standing oversight regarding eligibility for claims and benefits for Blue Water Vietnam veterans by granting presumptive benefits status to those who were exposed to Agent Orange, it only covers veterans who served on vessels out to twelve nautical miles seaward from the demarcation line on the waters of Vietnam and Cambodia. This excludes veterans who served further beyond this arbitrary boundary, yet were also potentially exposed to Agent Orange, and who suffer from its effects.

VVA calls on Congress in the strongest terms to amend P.L. 116-23 to extend the nautical mile limitation sufficient to include U.S. Navy and Marine Corps Vietnam veterans who were assigned to the Vietnam Theater of Combat Operations or received the Vietnam Service Medal.

REMOVE ONE-YEAR CUTOFF DATE FOR CHLORACNE, ACUTE/SUBACUTE PERIPHERAL NEUROPATHY, AND PORPHYRIA CUTANEA TARDA

Pursuant to P.L. 116-315, GAO prepared a report published September 1, 2022, (GAO-22-105191) and recommended that the Under Secretary for Benefits “clarify the guidance in its claims processing manual to make clear that claims processors can potentially support a rationale for service connection—or request a medical opinion—for early-onset peripheral neuropathy, chloracne, or PCT without medical documentation of the condition during or within one year of service in Vietnam.” The Veterans Benefits Administration agreed and updated the M21-1 manual section V.ii.2.B.1.g. on September 27, 2022, and clarified that claims processors “must consider all relevant lay and medical evidence to establish onset of a presumptive disability during an applicable manifestation period, and when appropriate, obtain a medical opinion.”

VVA still advocates for the removal of the requirement that the condition manifest to a degree of at least 10% within one year of discharge from service because numerous veterans may be unable to obtain lay testimony or recall events clearly themselves, given the substantial passage of time. Furthermore, the M21-1 is not fully binding law and even this favorable change may be eliminated by future administrations.

CONGRESSIONAL GAO STUDY ADDRESSING BURN PITS IN VIETNAM

Title III of the *PACT Act* -- signed into law August 10, 2022 -- expands healthcare and benefits and includes a concession of exposure to burn pits for those who served in Iraq, Afghanistan, and other key locations during the Persian Gulf War and the Global War on Terrorism in Southwest Asia. However, the *PACT Act* does not address the Vietnam-era veterans’ exposure to the effects of the daily burning of human waste in Southeast Asia.

Burning solid waste generates many pollutants, including dioxin, particulate matter, polycyclic aromatic hydrocarbons, volatile organic compounds, carbon monoxide, hexachlorobenzene, and ash. Health effects from burning waste smoke depend on several factors, including the nature of the waste being burned, duration of exposure, and proximity to the burning smoke. Vietnam

veterans who burned human waste are at greater risk for health effects. It is important for VA to acknowledge that Vietnam-era veterans were exposed to these toxins, like their fellow pre-9/11 veterans.

In addition to the visible air pollution and temporary, acute health effects like eye and throat irritation, breathing difficulties, and skin irritations, there are volatile organic compounds (VOCs) released from burning feces.² Among these VOCs, several are known to cause severe, chronic illness.

According to VA, “proper” disposal of waste during deployment is essential to prevent health problems and protect servicemembers. In certain situations, when sanitary and waste management facilities are not available, this waste may be burned in an open pit.

During the Vietnam War, hazardous-waste disposal sites--usually open-air burning of human waste and other potentially toxic materials--released harmful chemicals into the environment. VVA calls on the Government Accountability Office (GAO), through an act of Congress, to study the likelihood that exposure to these airborne hazards may have caused severe clinical irregularities, manifesting in the long-term adverse effects on the veterans’ health. Thousands of Vietnam veterans experienced daily exposure to the volatile organic compounds, such as styrene, toluene, and indole, while serving in Southeast Asia in field camps and hospital compounds. See **Attachment A**

GULF WAR VETERANS

Veterans deployed to Southwest Asia during the Gulf War in Operations Desert Shield and Desert Storm are still waiting for answers. The list of toxicants to which they were exposed include (but are not limited to):

- Oil Well fires;
- Chemical and Biological weapons, including Sarin, from the demolition of the ammunition storage depot at Khamisiyah;
- Depleted Uranium used in U.S. military tank armor and bullets;
- CARC – Chemical Agent Resistant Coating – paint on military vehicles to resist corrosion and chemical agents;
- Pesticides;
- PB – Pyridostigmine Bromide – a pre-treatment drug to protect against the nerve agent Soman; and
- Solvents, including Benzene, Cyclohexanol, Ethylene Glycol, Methylene Chloride, Methyl Ethyl Ketone, Methyl Isobutyl Ketone, Naphtha, Toluene, Tetrachloroethylene, Trichloroethylene, and Xylenes.

When those who served, who did our nation’s bidding, came home and encountered illnesses they could not explain, and subsequently went to a VA medical center; treatments often could not

² Catherine E. Garner, Stephen Smith, Ben de Lacy Costello, Paul White, Robert Spencer, Chris S. J. Probert, and Norman Ratcliffe, (2007) “Volatile Organic Compounds from Feces and their Potential for Diagnosis of Gastrointestinal Disease,” *FASEB J* 21(8), 1675-88.

mitigate their maladies or their pain. When they sought hard-earned disability compensation, most were treated as if they were trying to get over on the government, and their claims were denied.

It is important to note VA's exceedingly high denial rates of Gulf War presumptive claims (58 percent for presumptive Chronic Multi-Symptom Illness CMI and 76 percent for the broken Undiagnosed Illness UDX presumptive conditions in 38 CFR §3.317). While this does show some improvement based upon the latest data the Veterans Benefits Administration (VBA) shared with us in September 2022, it is still a high denial rate for presumptive CMI and UDX claims and perpetuates the real and ongoing misery being experienced by tens of thousands of Gulf War veterans. Therefore, until VA's presumptive Gulf War claims adjudication policies, procedures, and training all are remedied, Gulf War veterans suffering at the hands of the organization that is supposed to help them will continue.

The Agent Orange Act of 1991 mandated that VA engage the Institute of Medicine -- now the National Academy of Medicine of the National Academies of Science, Engineering, and Medicine -- to convene panels of experts every two years to audit the peer-reviewed scientific literature; hold public hearings; and produce their findings on levels of association, ranging from sufficient to none known at this time, on suspect health conditions related to exposure to dioxin. The *Act* further mandated that their findings be published in biennial updates of *Veterans and Agent Orange*. There is a real need for Congress to reauthorize the funding for this endeavor for at least another decade and to expand its scope to embrace the potential effects of past, present, and future exposures to toxicants on veterans of all eras, specifically the 1991 Persian Gulf War and the recent conflicts in Afghanistan, Iraq, and Syria.

This congressionally mandated research, paired with publication of the panel's findings, should also include the investigation of sites in the Continental United States (CONUS) known for the presence of toxic substances. This publication would follow the format of the *Veterans and Agent Orange* updates. These sites include but are hardly limited to: Fort McClellan in Alabama; Fort Chafee in Arkansas; Fort Detrick and Aberdeen Proving Ground in Maryland; Dugway Proving Ground in Utah; the Marine base at Camp Lejeune, North Carolina; the former Marine air base at El Toro, California; Fort Greely in Alaska; and Luke Air Force Base in Arizona.

Veterans deserve an acknowledgment that their health may have been compromised in the long term by service-related toxic exposure. These include the tens of thousands of servicemembers in the Gulf War exposed to the toxic plume from the demolitions of the Iraqi ammunition dump at Khamisiyah. Also included are those exposed to Per- and Poly-fluoroalkyl Substances, the "forever chemicals" in fire-fighting foam that are pervasive at overseas sites and at all Air Force bases in CONUS.

IMPLEMENTATION OF THE SERGEANT FIRST CLASS (SFC) HEATH ROBINSON HONORING OUR PROMISE TO ADDRESS COMPREHENSIVE TOXIC (PACT) Act of 2022

The *PACT Act* marks one of the greatest expansions of veteran healthcare and benefits in our generation. Thanks to the tireless work and commitment of members of this Committee, other members of Congress, and Veterans' advocates, veterans who have borne the burden of service

and have suffered from the effects of toxic exposure now have a path forward to receive the critical care and compensation they justly deserve.

While passage of this legislation is an important victory for veterans, their families, and survivors, we now face the arduous work of making sure that the implementation of this new law is accomplished with congressional oversight, verifying accountability on the regulatory and statutory sides--in particular for those veterans experiencing homelessness, veterans older than 85 years-old, veterans experiencing financial hardship, and Medal of Honor and Purple Heart recipients, whose claims are to be fast-tracked by VA, as stipulated in the law. Mr. Chairman, VVA is requesting this Committee schedule an oversight hearing on the VA's progress and challenges in reaching out to these vulnerable populations, many of whom do not use the VA healthcare system.

In addition, VVA will oppose ANY attempts to cut appropriated funding from the Cost of War Toxic Exposure Funds established in accordance with Section 805 of P.L. 117-168 in the *PACT Act*. We have an obligation as veterans to ensure that Congress does not raid this program to ensure that veterans, caregivers, widows, and survivors receive the critical care and compensation they justly deserve under the law.

AGING VETERANS

The U.S. population is rapidly aging. According to the Census Bureau, the population sixty-five and older will increase by almost 70 percent by 2060. An analysis of data from the Health and Retirement Study (HRS), the National Center for Veterans Analysis & Statistics (NCVAS) reports that in 2020 almost 9 million veterans were 65 or older. After six years of being on the GAO's High-Risk List, VA "still lacks a clear and comprehensive roadmap to address VA healthcare concerns and has not demonstrated meaningful progress." VVA will work with Congress and the Administration to remove the barriers that aging veterans face regarding access to care and treatment at the VA.

Further, we must recognize that, despite comparable access and quality of care, racial and ethnic disparities persist among older veterans. The most current data highlights the need for healthcare services designed to meet the needs of culturally diverse populations. As noted by the American Psychological Association, "African American older adults experience significant health disparities, including lower life expectancies and increased risk of chronic health conditions such as hypertension, diabetes, dementia, stroke, and cancer."³ These disparities are significant. Over the age of 64, strokes occur at over twice the rate for black patients versus white patients.⁴ Additionally, black patients are more likely to face discrimination in pain management.⁵

³ Frances Adomako. "African American Older Adults and Race-Related Stress: How Aging and Health-Care Providers Can Help." *Am Psych Assn*, <https://apa.org/pi/aging/resources/african-american-stress.pdf> (last visited Nov. 4, 2022).

⁴ Brian Trimble and Lewis B. Moregenstern. "Stroke in Minorities." *Neurol Clin* 26(4), November 2008: 1177-1190.

⁵ Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver. "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites." *Proc Natl Acad Sci USA* 113(16), April 19, 2016: 1117-1190 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843438>.

African American, American Indian, and Alaska Native veteran groups have the greatest disparities compared with non-Hispanic White veterans.

We've attached a white paper to our testimony: "The Aging Veteran: Reconfiguring the Veterans Health Administration," VVA's recommendations for how to better serve your constituents who are older veterans. These constituents must be given priority when introducing legislation or other policy measures addressing their healthcare needs.

HOMELESS VETERANS

In accordance with the VA Center on Homelessness Among Veterans⁶, while the population of homeless veterans has been decreasing, the number of older homeless veterans has increased. This is important as research with older homeless individuals has shown that they are characterized by a reduced lifespan and a greater prevalence and earlier onset of geriatric conditions, such as frailty, falling, urinary incontinence, sensory and cognitive impairment, and inability to execute activities of daily living. Higher mortality rates among homeless veterans have been found across the adult life-cycle, compared to veterans without a history of homelessness. Compared to adults in the general population, homeless adults have been found to have a mortality rate that is 4.5 times higher.

They also reported in their "Bridging Housing and Healthcare For Older Homeless Veterans" Fact Sheet⁷ that homeless veterans between 56 and 82 years who are living in HUD-VASH housing have, on average, five medical diagnoses and two mental health diagnoses. The most common medical diagnosis is hypertension or high blood pressure. Substance use disorder (SUD) is the most common mental health diagnosis; 56 percent of the homeless, elderly veteran population have a SUD diagnosis. Studies also conclude that homeless veterans experience higher mortality compared with housed veterans aged 60 and over.

While there is an extreme shortage of affordable housing in the U.S. that has helped create a homelessness crisis, veterans are much more likely to experience homelessness than the average American. A multitude of factors contribute to putting veterans at an increased risk of homelessness, including Post-traumatic Stress Disorder, substance abuse, a lack of family support networks, and military jobs not easily transferable to civilian life and occupations.

Mr. Chairman, during 2022 VA permanently housed 40,401 homeless veterans, exceeding the 2022 goal by 6.3 percent.⁸ However, the success of this statistic does not tell us how well VA is reaching out to *every* homeless veteran. The homeless veteran population is diverse, and inequalities are evident among subgroups. Identifying meaningful differences within this group requires looking beyond overall population counts. Veteran homelessness risk is significantly tied to gender, race, and ethnicity. HUD's *2022 Annual Homeless Assessment Report to Congress*:

⁶ [Aging - VA Homeless Programs](#)

⁷ Lei-Nikki Bowser, MHA, Office of Health Equity and Jack Tsai, PhD, Director of Research, VA National Center on Homelessness Among Veterans, Dilan Gangopadhyay, Office of Health Equity Intern

⁸ U.S. Department of Veterans Affairs. "VA Housed More Than 40,000 Homeless Veterans in 2022," *News Release*, Office of Public Affairs, January 26, 2023. <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5854>

*Part 1*⁹ provides some demographic information. However, we are somewhat confused with the VA fuzzy math on the number of homeless veterans being housed, because the following chart states that 33,129 veterans were reported homeless in 2022 in accordance with the *2022 Annual Homeless Assessment Report to Congress*.

2022

Characteristic	All Veterans		Sheltered Veterans		Unsheltered Veterans	
	Number	Percent	Number	Percent	Number	Percent
Total Veterans	33,129	100.0 %	19,565	100.0 %	13,564	100.0 %
Gender						
Male	29,372	88.7 %	17,705	90.5 %	11,687	86.2 %
Female	3,440	10.4 %	1,784	9.1 %	1,656	12.2 %
Transgender	141	0.4 %	42	0.2 %	99	0.7 %
A Gender Not Sing. Male or Female	118	0.4 %	27	0.1 %	91	0.7 %
Questioning	38	0.1 %	7	0.0 %	31	0.2 %
Ethnicity						
Non-Hispanic/Latino	29,086	87.8 %	17,897	91.5 %	11,189	82.5 %
Hispanic/Latino	4,043	12.2 %	1,668	8.5 %	2,375	17.5 %
Race						
White	19,355	58.4 %	11,408	58.3 %	7,947	58.6 %
Black or African American	10,240	30.9 %	6,733	34.4 %	3,507	25.9 %
Multiple Races	1,679	5.1 %	698	3.6 %	981	7.2 %
Native American	1,034	3.1 %	414	2.1 %	620	4.6 %
Asian Am.	404	1.2 %	159	0.8 %	245	1.8 %
Pacific Islander	417	1.2 %	153	0.8 %	264	1.9 %

Veterans who are Black or African American comprise one-third of veterans experiencing homelessness and one quarter of unsheltered veterans. Although 58 percent of homeless veterans were white, white veterans make up 81 percent of all U.S. veterans. Transgender and gender non-conforming veterans experience a greater incidence of unsheltered homelessness. This occurrence is also seen with veterans who are multiple races: Native American, Asian, or Pacific Islander.

VVA recognizes the tremendous strides that have been made by VA in addressing and providing services for homeless veterans, yet this problem is a national disgrace that continues to persist. Homeless veterans require more than just a physical home. Comprehensive, individualized assessments and rehabilitation/treatment programs are necessary, utilizing the continuum-of-care concept. VVA asks Congress and the Administration to request that all agencies receiving federal funding for homeless programs report on gender, race, age, and military service on the number of veterans they house, as well as those that receive VBA and VHA benefits. This data will provide VA with the necessary resources to avoid duplication of services and to reconfigure their resources to better serve aging, homeless veterans who may not be suitable for a typical housing model.

⁹ U.S Department of Housing and Urban Development. "The 2022 Annual Homeless Assessment Report (AHAR) to Congress: Part 1: Point-In-Time Estimates of Homelessness," Office of Community Planning and Development, December 2022. <https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf>

WOMEN VETERANS

As VA continues to adapt to the reality of the increasing number of women in military service, they must continue to expand their healthcare delivery to meet the needs of female servicemembers, e.g., providing (or contracting out) prenatal care; complete reproductive healthcare, including birth control pills without co-pay; mental and physical care for victims of military sexual trauma; and understanding the unique problems faced after facial disfigurement or loss of a limb. In addition, there must be increased research into chronic conditions that affect women particularly. The median age of women using VA Healthcare is forty-eight; senior veterans are facing ageism in some prophylactic testing and care for those after age 75. To meet these relatively new challenges, VA must first call for and fund research that will illuminate treatment options; VA must also seek out and hire enough female OB-GYN specialists, whom many women veterans prefer. Gerontology is a specialty that is needed at every VA hospital. Finally, and perhaps most importantly, VA must be a safe place where women veterans can enter without fear of being victimized by sexual harassment.

VVA is proud to have been a moving force in the establishment of the VA Advisory Committee on Women Veterans and the Center for Women Veterans within VA. As issues affecting women veterans become more visible and better understood, maintaining effective, quality programs, services, and benefits require the constant oversight and attention of Congress.

VVA will work with Congress on implementation of Section V, the *Deborah Sampson Act*, of P.L. 116-315, the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvements Act of 2020*, honoring an indentured servant who disguised herself as a man and joined the Patriot Forces in the American Revolution, and subsequently became a champion for all women who served.

We also thank Congresswoman Julia Brownley (CA-D-26th) for her accomplishments on behalf of our nation's women veterans as Chairwoman of the Women Veterans Task Force, leading the charge in passing laws that support the needs of women veterans. The emphasis on more rural outreach for veterans, by this task force, has been key in helping those veterans that tend to become reclusive because of their depression.

POST TRAUMATIC STRESS DISORDER (PTSD) AMONG AMERICA'S MILITARY WOMEN VETERANS

VHA has not yet taken sufficient action to address the effects of combat-related Post Traumatic Stress Disorder (PTSD) among America's women military veterans.

The nature of the combat in Iraq and Afghanistan is putting servicemembers at an increased risk for PTSD compared to those of past wars. Servicemembers are serving multiple tours, and the intensity of the conflict is strong and constant. In addition, in these wars without fronts, combat support troops are just as likely to be affected by the same traumas as traditional combat arms personnel are. This has particularly important implications for our female soldiers, who now constitute about 16 percent of our active duty fighting force. Studies on women serving in combat zones in prior conflicts have found that women who experience sexual trauma had significantly higher rates of PTSD than women who had not experienced sexual trauma. Therefore, many of the

women serving in Iraq and Afghanistan face dual causes of PTSD. Studies conducted at the Durham, North Carolina, VAMC Comprehensive Women's Health Center have demonstrated higher rates of suicidal tendencies among women veterans suffering depression with co-morbid PTSD. The "National Veteran Suicide Prevention Annual Report," released in September 2021, reports that women veterans' suicide rates have increased proportionately more than male rates, and an increasing number of those deaths involved firearms.

Because of the number of women veterans who are now de facto combat veterans, and because of the nature of the conflicts in both Afghanistan and particularly Iraq, women veterans have entered a completely new world of need.

VVA calls on Congress to ensure that VA has both the ability and the capacity to provide gender-specific, in-patient and outpatient care and treatment for both combat- and sexual trauma-related PTSD, and that psychosocial services are fully integrated into the primary care provided to women veterans.

VETERANS BENEFITS

LOSS OF LIFE/ LOSS OF DIC BENEFITS

The death of a veteran is stressful for a surviving spouse. Making it more so are the complexities of filing for Department of Veterans Affairs survivor benefits; Congress should make the process easier, not more complicated for survivors and dependents.

This country mourned the loss of over 19,000+ men and women who served in combat due to the COVID-19 pandemic. VVA has received numerous complaints that survivors are being denied DIC benefits because their loved one's death certificate did not indicate that the veteran died of a service-connected disability due to complications from COVID-19; or that the veteran's disability was a contributing factor. This highly unsatisfactory situation indicates a dire and pressing need to educate all healthcare professionals who provide care to, or conduct autopsies on veterans, on the critical importance of registering service-connected factors in the medical records of all veterans.

Our VSOs in the field have noticed a trend in benefits for spouses and/or dependents being denied for Dependency Indemnity Compensation (DIC) because VA was attributing the veteran's death strictly to the virus.

What we really need is for VBA to follow the law as it stands under regulation 38 C.F.R. §3.312: "Contributory cause of death is inherently one not related to the principal cause. In determining whether the service-connected disability contributed to death, it must be shown that it contributed substantially or materially, it combined to cause death, or that it aided or lent assistance to the production of death." Many death certificates are not filled out adequately or even correctly, especially if the attending physician is not the veteran's regular doctor, but simply was present at death in an emergency room. When it comes to VA/DIC and service-connected burial benefits, family members need to be aware of that before the death certificate is written so they inform the doctor that a complete and accurate death certificate listing the veteran's chronic conditions, if applicable, is absolutely necessary.

In addition, VVA supports amending Section 1102 of title 38, United States Code, by adding at the end the following new subsection (c): “In the determination of benefits under this section, notwithstanding any regulation or other provision of this chapter, a death certificate relating to a deceased veteran shall not be conclusory evidence in the determination of benefits for a surviving spouse. It shall be useful primarily in the determination that the veteran is deceased and considered for granting benefits, along with but not more relevant than other medical records and information provided by the claimant. Factors such as records from the veteran’s primary medical files, and injuries or diseases the veteran may have suffered for which benefits have been awarded, or which are the subject of a pending disability award, shall be treated as compelling in any decision for benefits under this chapter.”

Mr. Chairman, these earned benefits have been out-of-reach for too many families for too long.

REINSTATE 48-HOUR REVIEW PROCESS

For many years, prior to issuing a decision, VA regional offices would allow VSOs 48 hours to review any drafted decisions to identify errors. This was a critical program that VVA utilized to correct numerous mistakes, thereby improving the accuracy of VA decisions, lessening the burden on the appeal system, and preventing substantial heartache for the claimant. While VBA is pursuing the establishment of a system for electronic notification and has launched a Claims Accuracy Review (CAR) program, we believe it falls short of our desire to see upfront correction of errors. The CAR program is a reactive remedy to replace what was an initiative-taking system of accountability. VVA strongly advocates in favor of re-establishing this important initiative-taking program.

OVERHAUL THE BOARD OF VETERANS APPEALS (BVA) QUALITY REVIEW PROGRAM

In a collaborative effort between legal scholars and the former Chief of the BVA’s Office of Quality Assurance, the first comprehensive study was conducted to measure the effectiveness of the BVA’s Quality Review (QR) program.¹⁰ The 2019 study concluded that the BVA’s QR program “had no appreciable effect on reducing appeals or reversals.” Furthermore, “for both original and CAVC-remanded appeals, the QR program did little to stem the backlog of appeals sent back to the BVA for multiple rounds of decisions.” Most troubling, the study’s authors were able to “demonstrate that this inefficacy is likely by design, as meeting the performance measure of ‘accuracy’ was at cross-purposes with error correction.”

To VVA’s knowledge, the BVA’s Chairman of the Board has not proposed or implemented any changes to QR in response to these stark revelations. BVA issued 4,740 decisions in January and February 2020, combined, for cases in the *Veterans Appeals Modernization and Improvement Act* (abbreviated as “AMA” by VA)¹¹ system. According to information provided to VVA in a FOIA request, the BVA’s QR program reviewed only 195 decisions in the same period, or 4.1 percent.

¹⁰ Daniel E. Ho, et. Al., “Quality Review of Mass Adjudication: A Randomized Natural Experiment at the Board of Veterans Appeals, 2003–16,” *The Journal of Law, Economics, and Organization* 35, no. 2 (July 2019): 239–288, <https://doi.org/10.1093/jleo/ewz001>

¹¹ <https://www.benefits.va.gov/REPORTS/ama/>

QR identified 54 errors and assigned an accuracy rate of 72.6 percent for January, and 87.4 percent for February, well below BVA's stated goal of 95 percent, and all of this took place more than a year after AMA was implemented.¹² Notably, where a decision has multiple errors, "that case is only counted once in the number of cases with errors column," thus the true accuracy rate should be even lower. According to the Chairman's 2021 annual report, the Board's accuracy rate remains "approximately 92.06 percent for legacy decisions and approximately 87.48 percent for AMA decisions." This 2021 statement unequivocally contradicts the 2020 QR findings cited above.

Although VVA fully supports BVA's goal of issuing decisions in a timely manner, we feel it is critical that quality not fall by the wayside. Failure to improve quality causes significant waste of public funds in litigation expenses and, most importantly, impermissibly delays or denies justice to our nation's veterans and their families. Therefore, VVA urges VA first to commission a study that evaluates how best to overhaul BVA's QR system, and then to implement the proposed changes in a timely manner.

PROVIDE OVERSIGHT FOR COMPENSATION AND PENSION (C&P) CONTRACTORS

Although VA has been required by law, for decades, to provide veterans with free, competent medical examinations to support their claims for disability benefits, it has never succeeded in implementing a system to ensure compliance with CAVC standards.

Initially performed by the VHA, these exams have been outsourced to contractors such as QTC and LHI at progressively greater rates over time. VA has, as a stated goal, the full privatization of the C&P examination process within the next few years.

While these contractors have been adept at managing the scheduling aspect of the process, VVA has observed no meaningful efforts to ensure that medical professionals hired by them provide an "adequate" examination. This term has been clearly defined by the CAVC in a long series of precedential decisions, yet VVA advocates continue to see hundreds of verifiably inadequate exam reports produced each year. Invariably, these inadequate examinations are relied upon by VA adjudicators (who are prohibited from making medical determinations), resulting in the improper denial of benefits. VVA exhorts VA to implement a robust accountability system that ensures public funds are only used to procure adequate examinations for our veterans and their survivors.

VVA fully supports legislation that would provide more accountability by requiring that only healthcare professionals who are fully licensed and not barred from practice may furnish medical disability examinations under VA's pilot program. These professionals would include physicians, physician's assistants, nurse practitioners, audiologists, and psychologists.

¹² BVA provided data from August 2019 through March 30, 2020. The highest accuracy rate in this period was 87.4 percent (February 2020).

HEALTH CARE**VETERANS ADMINISTRATION (VA) ELECTRONIC HEALTH RECORD (EHR) SYSTEM**

In May 2018, VA awarded Cerner Corp. a contract to replace the 40-year-old VistA EHR system. This new Oracle Cerner Millennium system will be completely interoperable with the Department of Defense (DoD) updated Military Health System (MHS) GENESIS. VA awarded the \$16 billion contract to Cerner without considering bids from other companies. VA claimed the Millennium software would work more effectively with (MHS) GENESIS. At its core, this is the commercial EHR developed by Cerner. VA's Electronic Health Record Modernization (EHRM) program was expected to take about 10 years to complete.

The rollout has not been without controversy. One piloted Millennium EHR system at the Mann-Grandstaff VA Medical Center in Spokane, Washington, has gone down more than fifty times since it was launched in October 2020. The VA Office of Inspector General (OIG), as a result, has had to [inspect allegations](#) related to medication-management challenges and care-coordination issues. Additionally, the [OIG estimates](#) the 10-year effort, which is behind schedule, will cost as much as \$21 billion and another \$2 billion for each additional year it takes to finish. However, VA Secretary Denis McDonough believes his department will not need more taxpayer money to complete the nationwide expansion.

P.L. 117-154, *The VA Electronic Health Record Transparency Act of 2021*¹³ requires VA to report to Congress quarterly, describing all expenses, performance metrics, and outcomes of the EHRM program. The Millennium system must hit 99.9 percent uptime targets for four consecutive months before any new deployments. Reliability weaknesses discovered in Millennium by early adopters demonstrate the need for VA to improve the quality and reliability of the deployment of its EHR system. VA must comply with all recommendations of the April 25, 2022, OIG Audit, "Electronic Health Record Modernization Program Schedule Does Not Meet Quality Standards" (Project Number 21-02889-AE-0132).

VVA agrees with Senator Jerry Moran (R-Kansas), Ranking Minority member of the Senate Veterans Affairs Committee, "The potential benefits of the EHRM are tremendous, and we have to get it right."¹⁴

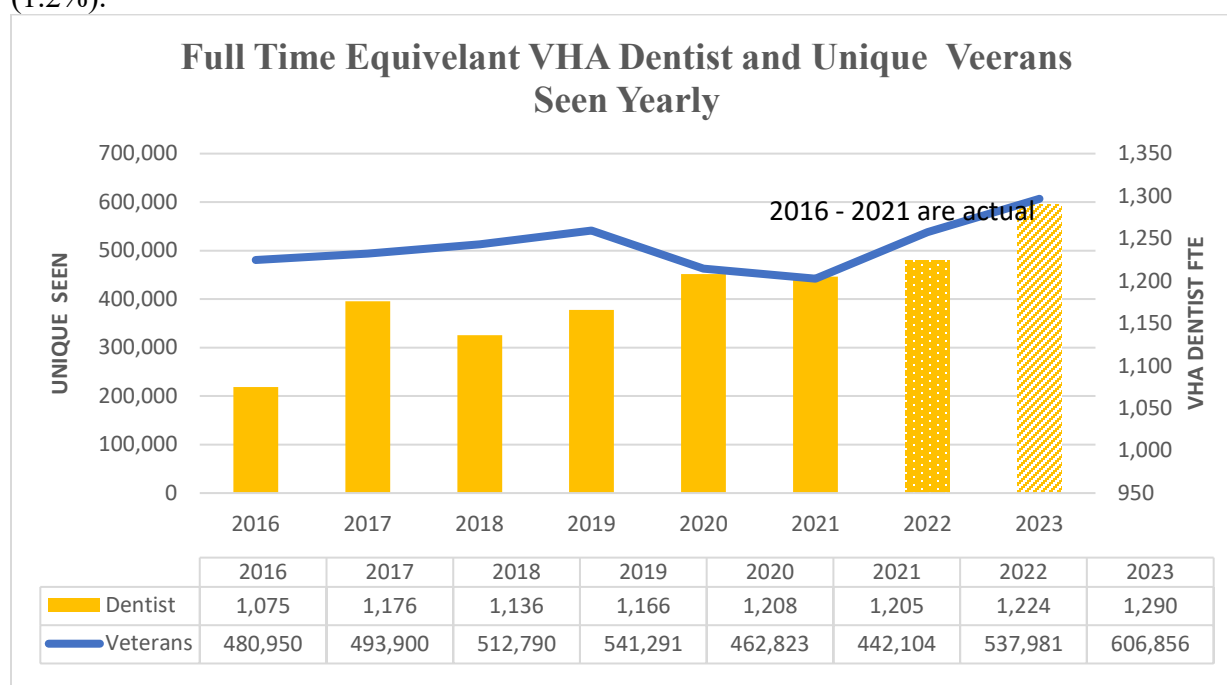
¹³ [untitled \(congress.gov\)](#) P.L. 117-154, *The VA Electronic Health Record Transparency Act of 2021*

¹⁴ Heather Landi, (2022). "VA Now Required to Report Performance, Cost of Troubled EHR System to Congress." *Fierce Healthcare, Health Tech.*, May 31, 2022. <https://www.fiercehealthcare.com/health-tech/va-now-required-report-performance-costs-troubled-ehr-system-congress>

VETERAN’S DENTAL CARE ELIGIBILITY EXPANSION

Veterans Administration provided comprehensive dental care to over 600,000 veterans in FY 2022. Although this seems like a lot, it represents only 6.5% of the 9.26 million veterans enrolled in VA healthcare. There are significant unmet oral health needs among veterans.

The 2023 budget report for VA healthcare expenditures highlights dental service cost and use among veterans. Of the 9.1 million veterans enrolled in VA healthcare, approximately 1.4 million (15%) are eligible veterans under current congressional standards to access comprehensive dental care. The number of eligible veterans is increasing an average of 7.3% per year. However, the budget goes on to report the number of VA dental staff is decreasing. The budget shows that the VHA fulltime equivalent dentist positions fell only 0.25% between 2020 and 2021, the narrative states the average annual decrease is 0.8%, led by dental hygienists (2.7%) and dental assistants (1.2%).



Full time VHA dentist and seen annually, gathered from Annual VHA Budget Submissions FY 2016-2023.

In 2021, 247 VA dental clinics saw 442,104 veterans completing 3.9 million procedures. An additional 70,000 veterans received dental care through Community Care. Although the total number of veterans receiving dental care in 2021 (512,104) seems like a lot, it represents only 36.6% of the 1.4 million eligible veterans. The VA Office of Dentistry is forecasting 767,000 veterans will receive comprehensive dental care in 2025. By 2028, about 2.26 million veterans will be eligible for comprehensive dental care.

The oral health status of a veteran may be a marker of who joins the military as well as a sign of policies governing their access to dental healthcare. Studies have shown that smoking, diabetes, depression, race/ethnicity, income, and education effects oral health. Compared to the civilian

population, veterans include a greater number of individuals at a higher risk for these negative effects on oral health.¹⁵

Poor oral health is linked to several chronic conditions including diabetes, heart disease, and stroke. The unexplained association between gum disease and these serious health conditions may not prove a cause-and-effect relationship. A 2021 study¹⁶ suggest that poor dental health might lead to cardiovascular disease, hypertension, and depression. Other studies found a bi-directional relationship between periodontal disease and diabetes.^{17, 18} The management of periodontal infection improves the metabolic status of diabetics, and glycemic control improves periodontal conditions. **See Attachment B**

These chronic conditions and poor oral health are exacerbated by living in rural America. Rural veterans are far less likely to have been seen by a dentist in the past year (42.6%), compared to rural veterans (33.2%). Oral health outcomes reflect this disparity. Twice as many rural veterans are fully edentulous (13.8%) compared to urban (7.6%).

Integrated veteran-centric healthcare yields the best outcomes for oral health and overall health. Expanding access to dental care accessed through the veteran's primary care VA facility creates the opportunity to better connect oral health to other healthcare. Rural veterans living with heart disease and diabetes have the most to gain by managing their chronic disease with oral healthcare provided by the VA.

The Dental Care Eligibility Expansion and Enhancement Act, introduced in the 117th Congress by Senator Bernie Sanders (I-VT) and colleagues, broadens eligibility to VHA dental care. Also, the bill addressed the shortage of dental healthcare staff, however, the bill was not enacted into law in the 117th Congress.

Dental healthcare is the top unmet needs for veterans and must be fully integrated as part of VHA's centric healthcare. The independent relationship between general healthcare and oral health is well established. VVA calls on Congress to reintroduce and pass the *Dental Care Eligibility Expansion and Enhancement Act* or similar bipartisan legislation in the 118 Congress.

BENEFICIARY TRAVEL/VETERANS TRANSPORTATION SERVICE (VTS)

The Veterans Transportation Service (VTS) program was established under the *Dignified Burial and Other Veterans' Benefits Improvement Act of 2012*. The purpose of this program is to assist

¹⁵ David K. Schindler, Gabriela V. Lopez Mitnik, Aida M. Solivan-Ortiz, Scott P. Irwin, Shahdokht Boroumand, and Bruce A. Dye, (2021). "Oral Health Status Among Adults With and Without Prior Active Duty Service in the U.S. Armed Forces, NHANES 2011 – 2014," *Military Medicine*, 186(186), e149-e159. <https://academic.oup.com/milmed/article/186/1-2/e149/5917414>.

¹⁶ Harriet Larvin, Jing Kang, Veshal R. Aggarwal, Sue Pavitt, and Janhua Wu (2021). "Multimorbid Disease Trajectories for People with Periodontitis." *Journal of Clinical Periodontology* 48(12), 1587 – 1596.

¹⁷ Sharayu Dhande, Mariam Khan, Sangeeta Muglikar, Sagar Chaudhari, Sheetal Ajit Jangale, and Ajit Govind Jangale. (2022). Diabetes and Periodontal Disease: The Reciprocal Relationship." *Journal of General Dentistry* 2022 3(2), retrieved from https://www.academia.edu/75967463/Diabetes_and_Periodontal_Disease_The_Reciprocal_Relationship

¹⁸ Carlos Arana Molina, Luna Florencio Ojenda, Maia Sevillano Jimenez, Cristobal Morales Portillo, Isabel Serrano Olmedo, Shomas Martin Hernandez, and Gerardo Gomez Moreno. (2016). "Diabetes and Periodontal Diseases: An Established Two-Way Relationship." *Journal of Diabetes Mellitus* 6, 209 – 229. <http://dx.doi.org/10.4236/jdm.2016.64024>

visually impaired, elderly, and immobilized veterans' populations, as well as those living in remote or rural areas, in accessing transportation to and from VA medical facilities or authorized non-VA healthcare appointments. VVA is genuinely concerned that this program is not meeting the needs of these disabled veterans who access this program through their local VA medical centers. In February 2013, the VA Office of Inspector General identified issues with inadequate management and oversight. VHA has identified the program as susceptible to significant improper payments and has estimated \$71 million in improper payments for fiscal year 2012.¹⁹

Under this program, VA facilities may hire drivers and purchase vehicles for veteran transportation. There is also a transportation network that has been established through cooperation with the Office of Rural Health and external organizations, e.g., various VSOs, federal, state, and local transportation agencies, etc.²⁰

Prior to fiscal year 2022, VHA included the VTP under "VHA Membership Services," preventing review of VTP-specific budgeting, i.e., based on publicly available VHA annual budgets, spending on VTS cannot be determined. Actual discretionary obligations for VHA Membership Services in FY18 totaled \$163,659,000²¹, and \$215,097,000 in FY19.²² In its 2022 budget, VA reorganized its reporting to match reorganization of VHA by subordinating Member Services (and thus, VTP) under Operations spending; VA did not provide a FY20 actual discretionary obligation total.²³ This makes it difficult to determine precisely how much funding is being allocated and how it is being distributed to VHA facilities to support VTS.

We call for Congress to hold an oversight hearing without delay on the serious shortcomings of this program, as witnessed by my staff and myself first-hand.

COMMUNITY HEALTH WORKERS

In 2005, local leaders in New York City developed the Washington Heights/Inwood Network for Asthma Program to address the burden of asthma in their community. Bilingual community health workers based in community organizations and the local hospital provided culturally appropriate education and support to families who needed help managing asthma. After 12 months, hospitalizations and emergency department visits decreased by more than 50 percent, and caregiver confidence in controlling the child's asthma increased to 100 percent. Key to the program's success was the commitment and involvement of community partners.²⁴

The VA healthcare system has a community health worker model, the Individualized Management for Patient-Centered Targets (IMPACT). This is a standardized, scalable, and evidence-based model of care initiated at the Corporal Michael J. Crescenz VA Medical Center (CMCVA) in

¹⁹ VA Health Care: Additional Steps Needed to Strengthen Beneficiary Travel Program Management and Oversight GAO-13-632

²⁰ Roscoe Butler and Michael Yaskowiak, [Understanding VA's Veterans Transportation Program](#), PVA (Dec. 2021), 11.

²¹ FY 2019 VA Budget, Vol. II Medical Programs, and Information Technology.

²² FY 2021 VA Budget, Vol. II Medical Programs, and Information Technology.

²³ FY 2022 VA Budget, Vol. II Medical Programs and Information Technology.

²⁴ Patricia J. Peretz, Luz Adriana Matiz, Sally Findley, Maria Lizardo, David Evans, and Mary McCord, "Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative." *American Journal of Public Health*, 102(8) (August 2012): 1443-1446.

Philadelphia.^{25,26} A multi-site trial including the CMCVA demonstrated a two-fold increase in patient satisfaction and a 65 percent reduction in hospital days. *Veterans' Perspectives* reported that IMPaCT would be launched in two more VA facilities in the spring of 2019. Judith A. Long, MD, Co-Director of VA's Health Services Research & Development's (HSRD) Center for Health Equity Research & Promotion (CHERP) stated: "It only takes six months to get an IMPaCT program – capable of serving 2,000 patients a year – up and running within a VA Medical Center." She went on to say, "[T]he cost of the program is \$1,200 per patient, including salaries, supplies, and training. There is a 2:1 return within the fiscal year for the investment. Most importantly, vulnerable veterans receive care and have much better health."

VVA supports the integration of Community Health Workers in the VHA model for care and treatment plan across the VA 22 VISN network to aid the overworked and understaffed VISN medical professionals, especially in rural areas where aging veterans have fewer physician practices, hospitals, and other health-delivery resources.

RURAL VETERANS

A disproportionate share of veterans lives in rural or remote areas of the country. According to the National Center for Veterans Analysis and Statistics and the U.S Department of Veterans Affairs, Office of Rural Health (VA-ORH), of the twenty million veterans in the U.S., 4.7 million live in rural America. Fifty-eight percent, or 2.7 million of these rural veterans are enrolled in the VA health care system. Of those rural, VA-enrolled veterans, 55 percent are 65 years and older, and 56 percent are affected by a service-related condition.

These statistics are particularly important because veterans living in rural areas may have difficulty accessing health services for reasons shared by other rural residents. Some rural veterans also face poverty, suicide, homelessness, and substance-use disorder, some or all related to their service, which can exacerbate their health issues. In most cases, the majority of veterans are unaware of the benefits, services, and facilities available to them through VA, and it may be even more difficult for rural veterans and their caregivers to access healthcare and other services, due to rural delivery challenges.

Congress established the Veterans Health Administration (VHA) Office of Rural Health (ORH) in 2006 (38 USC §7308) to conduct, coordinate, promote, and disseminate research on issues that affect the nearly five million veterans who reside in rural communities. The mandate also requires ORH to develop, refine, and promulgate policies, best practices, lessons learned, and innovative and successful programs.

²⁵ "Making an IMPaCT in our Communities: Community Health Workers Improve Health for High-Risk Veterans" *Veterans Perspectives* February 2019. https://www.hsrdr.research.va.gov/publications/vets_perspectives/0219-Community-Health-Workers-Improve-Healthcare-for-High-Risk-Veterans.cfm#1

²⁶ Shreya Kangovi, Nandita Mitra, Lindsey Norton, Rory Harte, Xinyi Zhao, Tamala Carter, David Grande, and Judith A. Long, "Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities." *JAMA Internal Medicine* 178(12) (December 1, 2018): 1635-1643. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6469661/pdf/nihms-1017510.pdf>

To best meet our obligations to these veterans, Congress must: Expand access to accessible, culturally sensitive primary care, behavioral health, specialty care, and other support services; improve coordination and co-management of veterans between VA and community-based service systems; increase availability of community-based care services; expand the use of technology and transportation programs to increase access and outreach; and VA must continue the expansion of the VHA Veterans Rural Health Resource Centers.²⁷

THE PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS (PCAFC)

PCAFC provides a wide range of benefits, including monthly stipends, reimbursement for travel costs, medical coverage, training, counseling, and respite care for caregivers of veterans who were severely injured during military service. However, since implementation, the program has been plagued by chaos and mismanagement.

The program has been allocated for FY2023 a discretionary budget of \$1.9 billion dollars; a budget trusted to be allocated to support the health and wellness by providing stipend payments and support services to help empower families' caregivers.

Earning trust continues to be a hallmark issue in the Caregiver Support Program. These concerns regarding trust and transparency have sparked lawmakers to hold numerous hearings with VA officials, VSOs, and stakeholders regarding the inequitable practices continuing to plague the Program. Inequitable practices have led to unjust denials, discharges, and downgrades of countless participants and applicants since 2016. Most recently, VA determined that 90 percent of legacy participants were slated to be discharged from the Program after reassessment. This was due to the VA decision to finalize regulations for the Program expansion in 2020, that consequently tightened eligibility in a manner not intended by Congress. Congress had counseled VA to not make any regulatory changes that might prevent access to the PCAFC.

Vietnam veterans are now eligible to enroll in the PCAFC, however due to VA lack of transparency, equity, and most importantly, accountability, the questions that VVA asks this committee that will make the biggest impact for PCAFC applicants and participants are: What actionable steps will Congress take to align the PCAFC with the intent of Congress? What solution has Congress addressed with VA that will accomplish the goal of expanding vs. restricting access to the PCAFC? The US Court of Appeals for the Federal Circuit Court struck down VA's definition of "need for supervision, protection, or instruction" because of a lawsuit against the VA Secretary. This action invalidated the reassessment that would have removed 90 percent of participants from the program. However, these inaccurate assessments remain in the individual veterans' medical record. Therefore, what will this committee do to ensure that VA retracts this invalid imaging assessment from their record?

²⁷ Veterans Rural Health Resource Centers (VRHRCs) are Office of Rural Health (ORH) field-based satellite offices that serve as hubs of rural health care research, innovation, and dissemination. Congressional mandate 38 USC § 7308 located in Iowa City, Iowa; Salt Lake City, Utah; White River Junction, Vermont; Gainesville, Florida; and Portland, Oregon VA medical centers.

We ask this committee to help foster policies that support equity among applicants and participants of color who were found to be discharged at greater rates compared to white veterans from the PCAFC in 22 percent of the VISN networks, in accordance with a study published by the *American Journal of Managed Care*, entitled “Predictors of Discharge from the VA Caregivers Support Program.”²⁸

VVA looks forward to working with Congress and the Administration to remove the regulatory final rule 70 percent service-connection requirement issued on July 31, 2020; discontinue assessment of catastrophically injured participants; implement standardized practices across the VHA; and, most importantly, ensure transparency on data collection for veterans accepted or denied by race, gender, and nature of military service.

MEDICAL CARE FOSTER HOME

VVA is grateful that Congress included language in the FY2023 Omnibus package P.L. 117-328, authorizing a pilot program for the VHA to explore an alternative to nursing-home care for our aging veterans by establishing a pilot program for veterans who require nursing-home care, but prefer a non-institutional setting.

This program, launched in 2008, is currently available in forty-three states with a little over seven hundred caregivers housing about 1,000 veterans nationally, and is a program within the VHA Geriatric Office and Extended Care.

These Medical Care Foster Homes allow veterans to live in private homes in their communities at no cost to them. VVA will work with Congress and the Administration on implementation of this provision in the law, as we believe that this program will enhance the lives and dignity of our aging veterans.

VHA VETERANS DIRECTED CARE PROGRAM

VHA implemented the Veterans Directed Care Program in accordance with the *Mission Act* (P.L. 115-182) in the VHA VISN network care. The Veteran Directed Care Program is part of the VHA’s Medical Benefits Package and is a collaboration between the Veterans VHA and the Community Living (ACL) Aging and Disability Network Agencies (ADNAs).

Veterans of any age are eligible, who want to live in their own home and meet the clinical need of Veteran Directed Care (VDC). The VAMC assigns a monthly budget, based on the veteran’s needs and functional limitations. Additionally, they help plan the veteran’s goals/needs/services, and most importantly, the provider is a visible and trusted organization in the veteran’s community. This is an affordable alternative to institutional care, not currently available at all VA Medical Centers. Without outreach and expansion, most veterans or caregivers would not be knowledgeable about this healthcare benefit.

²⁸ [Predictors of Discharge from the VA Caregiver Support Program \(ajmc.com\)](https://ajmc.com)

Courtney Harold Van Houtven¹, Valerie A Smith, Theodore S Z Berkowitz, Katherine E M Miller, Megan Shepherd-Banigan, Jennifer Henius, Margaret Kabat

VDC is an excellent program that provides veterans with choice and control over their long-term care services. VVA fully supports the expansion of VDC programs at every VA Medical Center.

VETERANS WITH LONG-TERM PTSD

It should come as no surprise that VA employs far too few mental health clinicians. This is true for myriad reasons, not the least of which are the hiring hoops clinicians must negotiate, which can take six, eight, ten months, or even longer before they can be officially employed by VA. As a result, in a shortsighted attempt to satisfy the needs of the moment, VA is leaving in the lurch too many vets afflicted with chronic, long-term PTSD. Indeed, VA is not addressing, let alone fixing, a situation its own bureaucrats have created. The question is: Will you in Congress use your standing to support these veterans? VA is currently still operating with critical shortages of staff that have, unfortunately, been exacerbated by a chronic and acute shortage of vitally needed mental health clinicians across the United States. If we are going to make progress on reducing the number of suicides among veterans of every age, the first step is to fill long vacant positions and to return to full staffing as quickly as possible.

VVA is also advocating for continuing care groups led by a clinician to be reinstated by VA to support either those veterans who are considering treatment for PTSD or related mental health issues, or those who need some help in maintaining the gains made after having gone through evidenced-based treatment. We are also asking VA to help those veterans who may have received a less than honorable discharge due to symptoms of PTSD, to begin the process of having their discharge considered for upgrade.

VVA continues to support the provisions of the *Sergeant Ketchum Rural Veterans Mental Health Act*, which became Public Law 117-21 in June of 2021. This bill requires VA to establish and maintain three new centers of the Rural Access Network for Growth Enhancement (RANGE) Program, which serves veterans in rural areas who are experiencing mental illness. While this change does not necessarily increase the overall number of clinicians, it does increase access for vulnerable veterans.

VETERAN SUICIDE

According to VA's "National Veteran Suicide Prevention Annual Report of September 2022," in each year, from 2001 through 2020, age- and sex-adjusted suicide rates of veterans exceeded those of non-veteran U.S. adults. The differential in adjusted rates was smallest in 2002, when the veteran rate was 12.1 percent higher than for non-veterans, and largest in 2017, when the veteran rate was 66.2 percent higher. In 2020, the rate for veterans was 57.3 percent higher than that of non-veteran adults.²⁹

Two out of three veteran suicides are over 55 years of age. Fourteen of 20 do not get care at a VA healthcare facility. Former Ranking Member of HVAC Dr. Phil Roe (R-TN) was quoted as saying that more and more millions of dollars are being expended to make an impact on the number of veterans who die by their own hand, yet the numbers do not seem to lessen. Mountains of studies,

²⁹ <https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf>

funded by millions of VA and DOD dollars, seemed only to develop recommendations revolving around the need to learn why veterans kill themselves by suicide . . . by funding yet more studies.

The why's may be unique for those who attempt to take their life, but they are no mystery: demons borne of the horrors of war, horrors they have experienced. Returning from a war zone to a society that does not know, or understand, what they went through too often leads to drinking and/or drugging to ease the pain. In addition to these self-medicating behaviors, too many returned veterans experience fiscal uncertainties, failed relationships, and the loss of hope.

Permitting veterans to seek help from non-VA practitioners may help some. This will be costly, and the overall effectiveness difficult to gauge. The answers may lie in community. Increased reliance on "battle buddies" may be viable for recent veterans but not necessarily for those who served in Vietnam a half-century ago. We want to help VA create a culture that proactively seeks out lonely, homeless, family-less, disenfranchised veterans and brings them in from the cold.

In addition, let the experts at VA, clinicians who have been dealing with veterans every day, do what they do best. According to the testimony of Dr. C. Edward Coffey, Affiliate Professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, a leading expert on achieving system-wide culture change within a health system to reduce suicide deaths, given before the House Veterans Affairs Committee, regarding a promising initiative to disrupt suicide attempts:

In conjunction with our National Center for Patient Safety, we developed the "Mental Health Environment of Care Checklist." Interdisciplinary inspection teams to assess the environment for hazards and determine actions that need to be taken to protect our veterans use this tool. The rate of suicide prior to the implementation of the checklist was 4.2 deaths per 100,000 admissions. It is now less than one per 100,000 admissions.

What Congress might do is enact a law that will make mandatory the insertion of this single question on every death certificate: Did the deceased ever serve in the Armed Forces of the United States? This simple step will enable researchers to do a more thorough medical postmortem of anyone determined to have committed suicide. This change, in turn, would add to our understanding of the why's and wherefores of a real American tragedy, and allow us to get off the expensive hamster-wheel of inconclusive research.

VVA supports the VA for announcing the treatment of veterans in acute suicidal crisis, inpatient or crisis residential care for up to 30 days, and outpatient care for up to 90 days. They will be able to go to any VA or non-VA healthcare facility for emergency healthcare at no cost. Veterans do not need to be enrolled in the VA system to use this benefit.

In closing, VVA appreciates the efforts of both committees in the 117th Congress for your bipartisan support in passing the *PACT Act*, and the many laws that enhance the quality of life for our veterans, caregivers, survivors, widows, and their families. We look forward to answering any questions that you may have regarding our testimony before the committees, and to working with you in the 118th Congress to support our heroes who have proudly served our great nation.

Vietnam Veterans of America

Funding Statement

March 1, 2023

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For further information, contact:

Sharon Hodge
Executive Director for Policy and Government Affairs
(301) 585-4000, extension 111

Jack McManus

Jack McManus was elected to serve as VVA National President at VVA's 20th National convention, held in November 2021, in Greensboro, North Carolina. First elected VVA national treasurer in 1995, he was re-elected to the position in 1997, and again in 2019. He previously served as the VVA Michigan State Council president from 1989 to 1996, overseeing the largest state program in VVA. In 1997, he was awarded VVA's highest honor, the VVA Commendation Medal, for his extraordinary service to the organization, to all veterans, and to the community at large. The VVA New York State Council has also recognized him with its own Commendation Medal.

During his career as a private businessman, McManus's company employed approximately 3,500 in two service-sector businesses, with \$150 million annually in sales. In 1978, his company was recognized as the first drug-free workplace in the building service contracting industry. The company also emphasizes special hiring programs for handicapped individuals, ex-offenders, and rehabilitated substance abusers for its internal rehabilitation programs. From 1978 to 1985, McManus was the program manager for his company's contract with the Kennedy Space Center space shuttle program in Florida.

Originally from New York City, Jack McManus joined the Air Force in 1965, where he served until 1969. Between 1967 and 1968, he was assigned to Operation Ranch Hand in Vietnam.

Jack received his B.A. in Business Management from New York University in 1973. He resides in North Carolina with his wife, Jackie. He is a recipient of numerous business and community awards.

Attachment A- Vietnam Burn Pits

Figure 1: Burn-barrel (burn out) latrine diagram. Bureau of Medicine and Surgery, (1991), *Manual of Preventive Medicine*, Chapter 9: “Preventive Medicine for Ground Forces,” NAVMED P-5010, Washington, D.C.



Images of soldiers performing this task shows that the fire often produced smoke. In addition to the visible air pollution and temporary, acute health effects like eye and throat irritation, breathing difficulties, and skin irritations, there are volatile organic compounds (VOCs) released from burning feces.^[2] Among these VOCs several are known to cause severe, chronic illness:

1. Styrene which can irritate the eyes and breathing passages. Exposures to styrene is addressed in specific [OSHA standards \(29 CFR 1910 and 29 CFR 126\)](#). Long-term exposure is associated with injury to the nervous system.^[3]
2. Toluene exposures can irritate the eyes, nose, and throat. Headache, dizziness, confusion, and anxiety, along with dry or cracked skin has been reported. Long term exposure may lead to tiredness, slow reaction time, sleeplessness, and numbness in the hands or feet. Toluene exposures can damage the female reproductive system. Exposures to toluene is addressed in specific [OSHA standards \(29 CFR 1910 and 29 CFR 126\)](#).
3. Indole toxicity appears consistent with other synthetic cannabinoid receptor agonists (SCRAs). Clinical features include agitation and aggression, reduced consciousness, acidosis, hallucinations and paranoid features, tachycardia, hypertension, raised creatine kinase, and seizures.^[4]

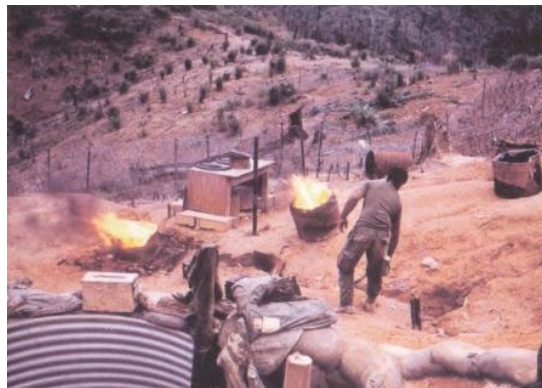
^[2] Catherine E. Garner, Stephen Smith, Ben de Lacy Costello, Paul White, Robert Spencer, Chris S. J. Probert, and Norman Ratcliffe, (2007) “Volatile Organic Compounds from Feces and their Potential for Diagnosis of Gastrointestinal Disease,” *FASEB J* 21(8), 1675-88.

^[3] Centers for Disease Control and Prevention, “Styrene Factsheet,” National Biomonitoring Program, https://www.cdc.gov/biomonitoring/Styrene_FactSheet.html.

^[4] Simon L. Hill, Michael Dunn, Celine Cano, Suzannah J. Harnor, Ian R. Hardcastle, Johann Grundling, Paul I. Dargan, David M. Wood, Simon Tucker, Thomas Bartram, Simon H. L. Thomas, (2018), “Human Toxicity Caused by Indole and Indazole Carboxylate Synthetic Cannabinoid Receptor Agonists: From Horizon Scanning to Notification,” *Clin Chem* 64(2), 346-354, DOI: [10.1373/clinchem.2017.275867](https://doi.org/10.1373/clinchem.2017.275867).

4. 3-methylfuran. Although there is no direct evidence that inhaled furan causes hepatotoxicity in humans^[5], available data make it reasonable to expect that the liver would be a target organ. Furans can build up in the fatty tissues. The U.S. Environmental Protection Agency (EPA) has said furans are likely cancer-causing substances to humans. In addition, people exposed to furans have experienced changes in hormone levels. Animal studies show changes in the development of the fetus, decreased ability to reproduce, and suppression of the immune system.^[6]

[1] Simon L. Hill, Michael Dunn, Celine Cano, Suzannah J. Harnor, Ian R. Hardcastle, Johann Grundling, Paul I. Dargan, David M. Wood, Simon Tucker, Thomas Bartram, Simon H. L. Thomas, (2018), "Human Toxicity Caused by Indole and Indazole Carboxylate Synthetic Cannabinoid Receptor Agonists: From Horizon Scanning to Notification," *Clin Chem* 64(2), 346-354, DOI: [10.1373/clinchem.2017.275867](https://doi.org/10.1373/clinchem.2017.275867).



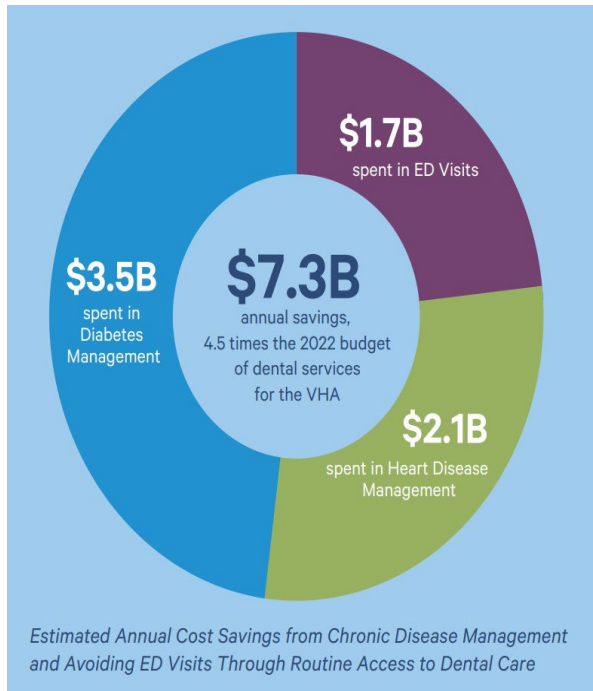
[1] National Research Council (U.S.) Committee on Acute Exposure Guideline Levels, (2010), *Acute Exposure Guideline Levels for Select Airborne Chemicals: Volume 9*, "Furan Acute Exposure Guideline Levels," Washington, D.C.: National Academies Press.

[1] U.S. Environmental Protection Agency, "Dioxins and Furans," Agency for Toxic Substances and Disease Registry, Division of Toxicology, Archived Document, <https://archive.epa.gov/epawaste/hazard/wastemin/web/pdf/dioxfura.pdf>.

[5] National Research Council (U.S.) Committee on Acute Exposure Guideline Levels, (2010), *Acute Exposure Guideline Levels for Select Airborne Chemicals: Volume 9*, "Furan Acute Exposure Guideline Levels," Washington, D.C.: National Academies Press.

[6] U.S. Environmental Protection Agency, "Dioxins and Furans," Agency for Toxic Substances and Disease Registry, Division of Toxicology, Archived Document, <https://archive.epa.gov/epawaste/hazard/wastemin/web/pdf/dioxfura.pdf>.

Attachment B Dental



Recent research estimated a \$5.6 billion cost savings associated with periodontal care for veterans with heart disease and diabetes. This underscores the financial gain possible by expanding VA dental coverage.³⁰ Another way to look at the economic impact of improved access to VA dental care is absorbing the cost of dental emergency department (ED) visits. The American Institute of Dental Public Health and CareQuest Institute for Oral Health estimates expanding VA access to routine dental care saves \$1.7 billion spent in ED visits. The estimated annual cost savings from chronic disease management and avoiding dental ED visits through routine access to VA dental care is \$7.3 billion. This is 4.5 times the entire 2022 budget for VHA’s dental services. Currently, both (out-of-pocket) and taxpayers are supporting expensive care through ED visits and inadequate chronic disease management.

Figure 3. Return on investment for expanding VHA dental care.³¹

³⁰ The American Institute of Dental Public Health and CareQuest Institute for Oral Health. (2022). “Veteran Dental Care Stimulates the Economy and Improves Oral Health.” April 2022. Boston, MA. https://aidph.org/wp-content/uploads/2022/04/CareQuest-Institute_AIDPH_Follow-Up-Report_CMYK_4.11.22.pdf.

³¹ Ibid.

OTHER KEY LEGISLATIVE/POLICY INITIATIVES

S. 344, *The Major Richard Star Act* - VVA fully supports this important bill, which when enacted into law, would provide for concurrent receipt of veterans' disability compensation and retired pay for disability retirees with fewer than 20 years of service and a combat-related disability.

H.R. 366, *The Korean American Valor Act* - VVA fully supports this important bill when enacted into law would provide members of the armed forces of the Republic of Korea as a veteran of the Armed Forces of the United States VA health care benefits.

Medical Treatment of Women Veterans by Department Of Veterans Affairs - VVA asks congress to conduct a comprehensive assessment of the barriers to and root causes of disparities in provision of comprehensive medical, mental health, compensation, and pension examinations and residential treatment for women seeking care and treatment at the VA.

Hearing Loss Added to The List of Birth Defects Due To Exposure To Agent Orange - VVA urges Congress to pass appropriate legislation to have hearing loss in children and grandchildren of servicemembers and veterans, who were exposed to Agent Orange, be added to the list of birth defects recognized by the Department Of Veterans Affairs.

Ban The Manufacturing, Sale, And/or Use Of 2,4-D And Glyphosate- - VVA will seek legislation and administrative action to ban the manufacture, sale, and use of 2,4-D and glyphosate worldwide.

Service Connection for Hepatitis C - Thousands of veterans are contending they suffer from Hepatitis C and the secondary effects of such disease, especially dysfunction of the liver and pancreas. VVA urges Congress to pass appropriate legislation to establish Hepatitis C as a service-connected presumptive disability.

Just Compensation for Injuries Sustained By Active-Duty Military Personnel - VVA supports legislation to secure a more equitable compensation system for personnel injured on active duty, due to the negligence of government personnel.

Department of Veterans Affairs (DVA) Service- Connected Disability Compensation Payments & Military Retirement Pay Offset - VVA supports legislation which will allow concurrent payment of military retirement and Department of Veterans Affairs (DVA) compensation based upon length of service and/or compensation for any new or secondary disability established by DVA as service-connected after retirement and medically discharged veterans with less than 20 years of service.

Copy of Military Records Upon Discharge - VVA seeks legislation requiring that, upon release from active duty, the Department of Defense shall issue every veteran a copy of their official military personnel file and their service medical records, along with their DD214 and duty assignment sheet.

USS *Frank E Evans* - The USS *Frank E Evans* was on maneuvers with AHMS *Melbourne* during which a collision with the *Melbourne* occurred and 74 American sailors were killed. The criterion for a name being placed on the Vietnam Veterans Memorial is that the veteran earned the right by qualifying, at the time, for a Vietnam Service Medal. VVA supports legislation having the 74 sailors' names from the USS *Frank E Evans* inscribed on the Vietnam Veterans Memorial.

Possibility of Live POW/MIAs And Facilitating The Return Of Those Who Remain In Southeast Asia - VVA recognizes and acknowledges that the preponderance of information substantiates that there still exists the possibility that there may be live American POWs, or other Americans held against their will, from the Vietnam War. VVA will support legislation that protects such an individual and/or his family from punitive action or monetary penalty and extend the existing mission to include all post-Vietnam U.S. military personnel designated as Missing in Action or other such classification, because of later military operations and wars worldwide.

Honoring All Returned POW's and Giving Recognition of American Civilians Held As Pow/Interned During WWII- VVA declares its respect and admiration for those of our fellow comrades-in-arms of the Vietnam War and all this nation's wars who endured and survived captivity. VVA also extends to the families of ex-POWs our deepest respect. VVA supports legislation enacted by Congress to formally recognize the sacrifices of these individuals.

Forever POW/MIA Stamp - VVA urges Congress to enact legislation that recommends the re-issue of the POW/MIA stamp as a Perpetual/Forever Stamp by the United States Postal Service, to continue to recognize and honor the sacrifices and service of those brave men and women of the Armed Forces of the United States, who have been held captive as Prisoner of War, or are Missing in Action.

Support For Readjustment Counseling Service Programs - VVA strongly supports legislation authorizing and funding an expansion of the Vet Centers and Contract Care Provider Program. Both programs must include outreach to incarcerated veterans, homeless veterans, wives, widows, caregivers, and survivors diagnosed with PTSD and Substance Abuse. These programs should be an entitlement for all veterans.