**Wounded Warrior Project**
4899 Belfort Road, Suite 300
Jacksonville, Florida 32256
O 904.296.7350
F 904.296.7347

WOUNDED WARRIOR PROJECT®

# WOUNDED WARRIOR PROJECT

## STATEMENT OF
## RENÉ C. BARDORF
## SENIOR VICE PRESIDENT OF GOVERNMENT & COMMUNITY RELATIONS

## ON

## WOUNDED WARRIOR PROJECT'S 2019 LEGISLATIVE PRIORITIES

## MARCH 7, 2019

Chairmen Isakson and Takano, Ranking Members Tester and Roe, members of the Senate and House Committees on Veterans' Affairs – thank you for inviting Wounded Warrior Project (WWP) to submit the following written testimony on our legislative priorities for 2019. Over the next several months, we are hopeful that we can assist your work to improve the lives of veterans and their families and build upon the remarkable success of the 115th Congress.

Wounded Warrior Project's mission is to connect, serve, and empower our nation's wounded, injured, and ill veterans. Through the generosity of donors across America, in 2018, **WWP provided nearly $200 million in life-changing programs and services to more than 156,000 wounded warriors and family support members**. Despite the ramping down of operations in Iraq and Afghanistan, the need is great and growing and our numbers continue to grow as approximately **1,500 additional veterans register with WWP every month**.

Since our inception in 2003, WWP has grown from a small group of friends and volunteers delivering backpacks filled with comfort items to the bedside of wounded warriors here in our nation's capital, to an organization of nearly 700 employees spread across the country and overseas delivering over a dozen direct-service programs to warriors and families in need. Our programs and services are based on five distinct organizational pillars:

- Mental health and wellness
- Career and Department of Veterans Affairs (VA) benefits counseling
- Physical health and wellness
- Personal independence of the most severely injured
- Social connection and engagement

In our public awareness efforts, WWP has provided more than 7 million concerned, patriotic American donors of every background and political persuasion a meaningful pathway to support our veterans who have become wounded, injured, or ill as a result of their military service. Because our donors believe in our mission, we can inspire constituents to care deeply about the issues impacting our veterans and transform the way America's wounded, ill, and injured veterans are empowered, employed, and engaged in our communities. **Since 2003, WWP has delivered $1.3 billion in programs and services to injured service members, veterans, and their families at no cost to participants**.

In addition to the direct programs and services we provide wounded warriors and their families, we advocate on the behalf of more than 20 million veterans of all generations – especially the 3.3 million post-9/11 veterans. As a military service organization, we advocate for 1.3 million current active duty service members and their families. In these pursuits, WWP is proud to have partnered during the 115th Congress with our peers in the veteran space to accomplish the passage of the *Department of Veterans Affairs Maintaining Internal Systems and Strengthening Integrated Outside Networks Act* (*MISSION Act*) (P.L. 115-182), the *Harry W. Colmery Veterans Educational Assistance Act of 2017* ("Forever G.I. Bill") (P.L. 115-48), and the *Department of Veterans Affairs Accountability and Whistleblower Protection Act* (P.L. 115-41). WWP also helped pass legislation through the *John S. McCain National Defense Authorization Act for Fiscal Year 2019* (P.L. 115-232) to expand military commissary benefits to Purple Heart medal recipients, to authorize the Department of Defense (DoD) to partner with external organizations to provide intensive outpatient treatment for victims of military sexual trauma, and to ensure families of the fallen continue to receive death gratuity payments in the event of a government shutdown.

Wounded Warrior Project advocates for and materially contributes to the continued health and viability of the larger veteran community. Since 2012, WWP has provided $80.9 million in grants to 158 other veteran and military service organizations to augment our direct services and fill gaps in care and services across the military and veteran community. In 2018 alone, we granted nearly $15 million to 34 partner organizations such as Veterans of Foreign Wars (benefit claims assistance), Vietnam Veterans of America and the Tragedy Assistance Program for Survivors (toxic exposure research and awareness), and The Mission Continues (social connection and volunteerism) in order to amplify our collective efforts to care for the veteran community. We believe in the power of collaboration and we know that no organization or government agency can do it alone.

Wounded Warrior Project believes in making data-driven decisions to maximize organizational effectiveness and ensure wise use and proper stewardship of our donors' contributions. To this end, we use a rigorous, scientific annual warrior survey – with over 33,000 respondents in 2018 alone, it is the largest and most comprehensive survey of today's veterans – to determine the needs of those we serve and inform our spending on programs and services. The 2018 survey – our ninth and most recent[1] – revealed several important trends within the wounded warrior community that have helped inform our legislative priorities for the 116th

[1] *See* Appendix A. April Fales et al., *2018 Wounded Warrior Project Survey Report of Findings*, WOUNDED WARRIOR PROJECT (2018) available at https://www.woundedwarriorproject.org/media/183005/2018-wwp-annual-warrior-survey.pdf.

Congress. In the testimony that follows, we have identified the areas where your committees can make the biggest impact on the lives of our nation's wounded warriors and their families and caregivers.

## Community Care

The *MISSION Act* marks the most critical transition point between the 115th and 116th Congress. As the veterans' community pivots from enactment to implementation, our forward thinking must be guided by the tenets that united more than 30 veteran and military advocacy organizations in support of a bill that passed by sweeping margins in both chambers of Congress.

At its core, the *MISSION Act* was crafted to give the brave men and women who have worn our nation's uniform timely access to high-quality, comprehensive, and veteran-centric care – and an integrated system of care that puts the Department of Veterans Affairs (VA) on a strong, sustainable foundation buttressed by responsible VA-managed support from community care providers. Meeting these goals will require transparency, oversight, and strict adherence to the belief that our veterans are best served by a health care system designed to amplify access and quality regardless of whether care is provided within VA or through non-VA providers in local communities.

Our data indicates that *MISSION Act* success will have a direct and crucial bearing on the health of all veterans, especially the post-9/11 wounded, ill, and injured veterans we serve. WWP routinely encourages enrollment and processes disability claims during programmatic engagements and, as a result, more than three-quarters (75.2 percent) of responding warriors are enrolled in the Veterans Health Administration (VHA) – a share that has continued to rise since 2014 (59.2 percent) and which is up nearly 5 percent since 2016 alone. Almost 7 in 10 warriors use VA as their primary care provider (68.4 percent), and difficulty accessing VA was the top-cited reasons for not choosing VA for primary health care (45.2 percent). As VA remains positioned as the coordinator of care, the new *MISSION Act* regulations – and their successful implementation – must be the product of inclusive, deliberative, and transparent collaboration amongst VA personnel, veteran service organizations and external private sector partners.

In addition to our advocacy alongside our peer organizations and our ongoing dialogue with the veterans we serve, WWP is informed by the experiences we have shared as a funder and collaborator in the Warrior Care Network (see discussion in "Mental Health" section below), a partnership with four civilian academic medical centers (AMCs) fueled by over $240 million in funding from WWP spanning FY 2015 to FY 2023.[2] By partnering and collaborating with private health care providers who with insurers and patients of all varieties, in addition to our direct contact with warriors, WWP believes *MISSION Act* rules and implementation affecting the areas below will be the most critical to the success of the new Veterans Community Care Program:

[2] This figure represents an initial grant of $78.4 million for FY 15 to FY 17, and a second commitment of approximately $165 million for FY 18 to FY 23.

- **Ease of enrollment in provider networks**: Many community-based providers declined to enroll as Veterans Choice Program providers due to perceived or actual challenges in the registration process, including a lack of awareness that the program exists.[3] Congress must help VA ensure that policies are in place to make provider registration as efficient as possible without sacrificing quality review and due diligence.

- **Timeliness of reimbursements**: Section 111 of the *MISSION Act* aspires to a system where providers are generally reimbursed within 30 days. While the Veterans Choice Program (P.L. 113-146) also aspired to prompt payment, failure to meet those goals led to negative consequences affecting both veterans and providers. To avoid the need for legislation like the *Protecting Veterans Credit Act*[4], Congress must provide enough oversight to guarantee providers are paid on time and veterans do not assume unwarranted financial burdens. This is by far the most substantial obstacle that Warrior Care Network AMCs cited regarding their experience and, in some cases, lack of enrollment in the Veterans Choice Program.

- **Embracing innovation in care delivery and payments**: Section 152 of the *MISSION Act* authorized – and VA has since established – a Center for Innovation for Care and Payment to develop new, innovative approaches to testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of and access to care furnished by VA. As the steward of taxpayer dollars dedicated to the health and well-being of veterans, Congress has a vested interest in tracking the developments of this center and encouraging action and partnership with the private sector on successful, scalable models of both care and payment.

- **Using value-based reimbursement models to enhance mental health care quality**: Section 101(i) of the *MISSION Act* allows VA to incorporate value-based reimbursement principles to promote the provision of high-quality care, and this permission can and should be used to help encourage innovative models in physical and mental health treatment. While the health care industry has embraced bundled payment approaches to address episodes of care for hip surgery, diabetes, stroke, cancer treatment, and others, VA lags behind, and the expanded migration of this practice to mental health would allow VA to be a pioneer in an area where veterans are catastrophically suffering and drive the wider mental health care industry towards better quality and more cost-effective outcomes.

As VA recruits more quality providers to its community care networks and finds new ways to tie payments to better outcomes, there will be stronger potential to meet demand with high-quality care – particularly in mental health. Whether that demand is met within VA or in the community, the National

[3] Terri Tanielian et al., *Ready or Not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans*, RAND CORP. (Mar. 1, 2018).
[4] John Delaney, Opinion, *Protect Our Veterans from Financial Harm*, CUMBERLAND TIMES NEWS, July 16, 2016, at 4A.

Academy of Medicine (as the Institute of Medicine) has observed that "mental health and primary care are inseparable; any attempts to separate the two leads to inferior care;" so as VA remains the coordinator of care through primary care in its new, modernized, and streamlined purchased care system, the health care landscape is primed to deliver better outcomes.[5] And as we pair these new models for purchasing care in the community with outcome-based care for invisible wounds, research strongly suggests that veterans will decrease their overall health care utilization during the following year, thereby promoting better health and increased costs savings to the government.[6]

## Mental Health

Whether because of mental ("invisible wounds") or physical trauma ("visible wounds") or a combination of both, every veteran that registers with WWP has a unique path of individual and collective recovery that they can pursue through our direct services and other support networks; however, understanding these warriors as a larger population provides us with necessary insights to help guide our path to aiding and meeting their collective and individual needs. For the fourth year in a row, post-traumatic stress disorder (PTSD) was the most frequently reported health problem from service (78.2 percent) according to our 2018 survey, followed closely by depression (70.3 percent), anxiety (68.7 percent), and even sleep problems (75.4 percent), an issue frequently linked to mental health challenges. Accordingly, mental health programs are WWP's largest programmatic investment – in 2018, WWP spent $63.4 million on our mental health programs – and we hope Congress can be guided by many of the lessons we've learned as the veteran service community's leading provider and funder of mental health programming.

For the 116th Congress, WWP strongly encourages the committees to embrace a comprehensive approach to mental health care that includes a strong foundation of evidence-based treatments, including traditional talk therapy and pharmacological treatment (where indicated and necessary), and which embraces a commitment to extend to alternative and integrative modalities that embrace holistic approaches to wellness that encourage "post-traumatic growth," such as that being pursued by VA in its Whole Health initiative. Research has shown that evidence-based mental health treatment works, but it is WWP's belief that to more efficiently address the community's challenges with mental health – including veteran suicide – we must move beyond the healthcare/crisis management model towards an integrated and comprehensive public health approach focused on resilience, prevention, and evidence-based treatment.

[5] "High quality evidence from more than 90 studies involving over 25,000 individuals support that CCM (Collaborative Care Model) improves symptoms from mood disorders and mental health-related quality of life." (Millbank Fund, 2016). "Integrating behavioral health and primary care, when adapted to fit into community practices, reduced depression severity and enhanced patients' experience of care. Integration is a worthwhile investment." (Journal of the American Board of Family Medicine, March 2017).

[6] Peter Tuerk et al., *Health Service Utilization Before and After Evidence-Based Treatment for PTSD*, PSYCHOL. SERV. J. (Nov. 12, 2012) available at www.ncbi.nlm.nih.gov/pubmed/23148769. For a discussion on cost savings, see Terri Tanielian et al., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Service to Assist Recovery*, RAND CORP. (2008) at 189 (estimating over $2 billion in savings over two years).

Our community needs a multi-pronged approach to prevention and treatment – a combination of clinical, non-clinical, and peer-to-peer community-focused efforts. High touch programs at WWP – which generally begin with peer-to-peer program engagement – have been successful at linking veterans with resources focused on resilience, well-being, and community. Just as veteran service organizations are highly aware of VA clinical offerings and can push veterans towards those services, VA can and should invest more in its own non-clinical engagements and raise its awareness of those being offered by private institutions, nonprofit organizations, and state and local governments in the communities where veterans live. To that end, WWP urges Congress to:

- **Encourage and enable VA to improve collaboration with private sector programs and services assisting veterans**: As Congress and VA work to expand VA's clinical footprint through the *MISSION Act*, there remains great opportunity to integrate not only medical services, but also to build from that foundation, linking to existing referral networks of non-clinical community supports. The creation of a network bridging non-profit with governmental – clinical with non-clinical – could help veterans better navigate the many services that are available to them. If done correctly, this has the potential to be transformative; non-clinical supports are in many cases as essential for a veteran's success as high quality clinical care. WWP is pleased to see the Senate Committee on Veterans' Affairs already pursuing these ideas in draft legislation and we are poised to assist in the drafting process through examples of how this approach is already showing tremendous results such as greater social connection, more economic opportunities, and improved resilience and quality of life.

A sterling example of this approach can be found in WWP's Warrior Care Network. This innovative program is a partnership between WWP and four world-renowned national AMCs: Massachusetts General Hospital, Emory Healthcare, Rush University Medical Center, and UCLA Health. Warrior Care Network delivers specialized clinical services through innovative two- and three-week intensive outpatient programs that integrate evidence-based psychological and pharmacological treatments, rehabilitative medicine, wellness, nutrition, mindfulness training, and family support with the goal of helping warriors thrive, not just survive. Guided by WWP leadership, all AMCs commit to sharing data and discovering and promoting best practices.

Through these two- to three-week cohort-style programs, participating warriors receive more than 70 direct clinical treatment hours (over a year's worth of evidence-based cognitive processing therapy, cognitive behavioral therapy, and/or prolonged exposure therapy if practiced in traditional outpatient style) as well as additional supportive intervention hours (e.g. nutrition, fitness, yoga, equine therapy). Each AMC has specific programming for caregivers and family members at some point during the intensive outpatient program, including family weekend retreats, psychoeducation, or telehealth support.

Providing warriors with best in class care that combines clinical and complementary treatment is still only part of the Warrior Care Network's holistic approach to care. While AMCs provide veteran-centric comprehensive care, aggregate data, share best practices, and coordinate care in an unprecedented manner, a Memorandum of Agreement (MOA) between WWP and VA has been structured to further expand the continuum of care for the veterans we treat. In February 2016, the VA signed this MOA with WWP and the

Warrior Care Network to provide part-time personnel and collaboration of care between the Warrior Care Network and VA hospitals nationwide. Updated in 2018, our current MOA, dedicates a full-time VA employee (liaison) to each AMC to facilitate national referrals throughout the VA system as indicated for mental health or other needs, and also provide group briefings about VA programs and services, and individual consultations to learn more about each patient's needs.[7] This first-of-its-kind collaboration with VA is critical for safe patient care and enables successful discharge planning. At WWP, we believe cooperation and coordination like this can serve as a great example of "responsible Choice" in the VA health care system.

Warriors who complete the Warrior Care Network program are seeing results. Prior to treatment, over 83 percent of patients reported PTSD symptoms at the severe to moderate range based on the PCL-5 clinical assessment, with the aggregate average being 51.1 (severe PTSD). Following treatment in the intensive outpatient programs, PTSD symptoms had a significant statistical decrease of 19.4 points to 31.7 (minimal PTSD).[8] A similar pattern was seen for symptoms of depression, with a mean score of 16.0 at intake and a decrease to 10.2 at follow-up on the PHQ-9 assessment. These changes translate into increased functioning and participation in life, based on the decrease of psychological distress caused by severe to moderate levels of PTSD and depression.

It is also worth noting here that, although effective if completed, many who begin evidence-based mental health treatment (cognitive processing therapy and prolonged exposure) in non-intensive outpatient (IOP) formats – including highly controlled and selective clinical trials[9] – discontinue care before completion. While drop-out rates in those formats are normally between 30 and 40 percent[10], the IOP model used by Warrior Care Network has a completion rate of 94 percent. When combined with clinically significant decreases in mental health symptoms, this figure is illustrative of the successful approach the Warrior Care Network has taken – and patients agree. Ninety-six (96.1) percent of warriors reported satisfaction with clinical care received and another result that could indicate that mental health stigma is being minimized is that 95 percent of warriors said they would tell a fellow veteran about Warrior Care Network.

We strongly believe that the Warrior Care Network IOP is a model for the future of treatment for moderate to severe PTSD, and our experience here also guides our belief that Congress must work with VA to strive towards innovation in care delivery and reimbursement. Among other areas where Congress can affect change in mental health policy:

- **Continue to strive to reduce veteran suicide**: Suicide prevention must move beyond the healthcare/crisis management model towards an integrated and comprehensive public health

[7] From 2016 to 2018, these VA Liaisons were part-time. For the period from October 2017 to January 2019, the VA Liaisons opened 702 VA referrals, briefed 680 veteran cohorts on VA programs and services, and provided over 2,300 individual consultations with veteran patients.
[8] Note: A change in score greater than 5 is indicative of clinically significant change rather than statistical change.
[9] Zac Imel et al., *Meta-analysis of Dropout in Treatments for Post-traumatic Stress Disorder*, J. OF CONSULTING & CLINICAL PSYCHOL. 394 (Jan. 21, 2013).
[10] Shannon Kehle-Forbes et al., *Treatment Initiation and Dropout from Prolonged Exposure and Cognitive Processing Therapy in a VA Outpatient Clinic*, PSYCHOL. TRAUMA THEORY, RES., PRACTICE, & POL'Y, 107 (JUN. 29, 2015); Cassidy A. Gutner et al., *Time Course of Treatment Dropout in Cognitive-Behavioral Therapies for Posttraumatic Stress Disorder*, PSYCHOL. TRAUMA: THEORY, RES., PRACTICE, & POL'Y, 115 (Jun. 22, 2015).

approach focused on resilience and prevention. Working collaboratively with the executive branch, Congress should identify what measures from the Joint Action Plan on the Executive Order on Mental Health Care for Transitioning Service Members are successfully addressing veteran suicide and take appropriate legislative action, including appropriations, to ensure those actions continue. This review should continue alongside existing efforts to increase access to high quality mental health care and train more mental health care providers.

- **Increase studies of Vietnam Era veterans**: According to VA data from 2015, rates of suicide were highest among younger veterans (ages 18 to 34) and lowest among older veterans (ages 55 and older). However, 58.1 percent of all veteran suicides in 2015 were among older veterans. While Congress should strive to reduce suicide rates and volume among all veteran demographics, it should consider directing more research on Vietnam Era veterans to gain a clearer understanding of the underlying psycho-social and biological challenges that tend to be exacerbated with age. Scientific studies may provide valuable insight into issues that are plaguing older veterans. That insight may also provide greater awareness into an aging population of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans so that essential, time sensitive resources can be better focused as younger veterans – both current and future – begin to age.

- **Pursue postvention programming with family members**: While VA is appropriately dedicating considerable resources to veteran-centric pursuits to reduce suicide, much can be gleaned from working with survivors to identify better approaches to identifying warning signs and empowering families to intervene effectively. A partnership WWP helps fund between Massachusetts General Hospital and the Tragedy Assistance Program for Survivors (TAPS) that created a 2-week intensive clinical program for traumatized families of the fallen and helped develop an after-care network that is saving lives by raising awareness about suicides among veterans and active duty service members.[11]

- **Maintain focus on improving military transitions**: As highlighted by DoD's Defense Suicide Prevention Office, service members transitioning out of DoD are at a higher risk of suicide within the first 90 days of separation – a trend consistent over a 14-year period. Over that period, approximately 50 percent of suicide deaths occurring in the first three months of separation happened within the first 17 days of separation. As Congress continues to work with the executive branch to improve and monitor military-to-civilian transition, WWP encourages the committees to review The Veterans Metric Initiative (TVMI) study commissioned by the Henry Jackson Foundation – and funded, in part, by WWP – which focuses on post-military well-being. The TVMI study's findings regarding vocation, finances, health, and social relationships may provide compelling evidence to guide future initiatives.

[11] Brian McQuarrie, *I Couldn't Be the Only One Having this Experience*, BOSTON GLOBE (Feb. 23, 2019) available at https://www.bostonglobe.com/metro/2019/02/22/couldn-only-one-having-this-experience/Mx8wUfUEVV2RaSgvPsQ9eM/story.html.

## Brain Injury

Suicide prevention is rightfully positioned as VA's top clinical priority. WWP metrics and programmatic investments reflect our organization's similar acknowledgement that mental health treatment is today's most critical need for the majority of post-9/11 veterans we serve. As we strive to spotlight the areas where the need for congressional interest is needed, however, we strongly encourage the committees to give increased attention to the current and long-term care needs of veterans living with effects of traumatic brain injury (TBI).

While injuries are often invisible and as unique as each warrior, 41.2 percent of warriors surveyed in 2018 describe TBI as an injury suffered on account of service, up from 40.6 percent in 2016. Another 14.4 percent describe suffering from injuries related to head injuries not categorized as TBI. Regardless of classification, head injuries are unpredictable with respect to symptom development and progression, often becoming increasingly debilitating over time.

Traumatic brain injury has affected over 380,000 servicemembers since 2000, including over 46,000 who have suffered moderate to severe TBI (vs. mild TBI (mTBI)).[12] Particular injuries following TBI and each individual's response to treatment vary greatly; "severe TBI is not a discrete event with unchanging long-term impairments and static global outcomes, but a lifelong condition with potentially permanent impairments and comorbidities that affect the brain and other body systems."[13] TBI prompts symptoms "across multiple timelines, multiple health domains, and multiple body systems," making care decisions and timelines more difficult to predict and address than other diseases, such as cancer, which may require long term care.[14] The complexity of improving patient care is further exacerbated by disparities in treatment and terminology within healthcare systems as well as geographic and cost limits to care that vary for each individual.

While moderate to severe TBI are likely to be immediately devastating to one's health, many long-term effects of TBI impact even those with mTBI who may initially forego treatment for injury. These include immediate concerns such as post-concussion syndrome as well as increased long-term risks for Alzheimer's disease, amyotrophic lateral sclerosis (or ALS), Parkinson's disease, and early-onset dementia.[15] Further, significant complexity in treatment and recovery for TBI make research efforts and decisions about the appropriate type, level and frequency of treatment for each patient more difficult.[16] Lastly, irrespective of

[12] *DoD Numbers for Traumatic Brain Injury, Worldwide Totals*, DEP'T OF DEFENSE (Jun. 21, 2018) available at http://dvbic.dcoe.mil/files/tbi-numbers/worldwide-totals-2000-2018Q1-total_jun-21-2018_v1.0_2018-07-26_0.pdf.
[13] Joseph T. Giacino et al., *Rehabilitation Access and Outcome after Severe Traumatic Brain Injury: A TBI Model System-Sponsored Stakeholder Summit*, 9 (May 16, 2016) available at http://media-ns.mghcpd.org.s3.amazonaws.com/spauldingtbi/rehabilitation-access-and-outcome-after-severe-tbi-briefing-book.pdf.
[14] *See id.*
[15] Helen M. Bramlett & W. Dalton Dietrich, *Long-Term Consequences of Traumatic Brain Injury: Current Status of Potential Mechanisms of Injury and Neurological Outcomes*, J. NEUROTRAUMA (Dec. 1, 2015) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4677116/; *Chronic Traumatic Encephalopathy*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/chronic-traumatic-encephalopathy/symptoms-causes/syc-20370921 (last visited Jan. 30, 2019); Erin Bagalman, *Health Care for Veterans: Traumatic Brain Injury*, CONG. RESEARCH SERV., 4 (Mar. 9, 2015).
[16] Joseph T. Giacino et al., *Rehabilitation Access and Outcome after Severe Traumatic Brain Injury: A TBI Model System-Sponsored Stakeholder Summit*, 9 (May 16, 2016) available at http://media-ns.mghcpd.org.s3.amazonaws.com/spauldingtbi/rehabilitation-access-and-outcome-after-severe-tbi-briefing-book.pdf.

severity, VA has traditionally relied on caregivers to provide much-needed support for patients, but caregivers may not be sufficiently able to care for veterans as they age and face health declines themselves.

In sum, research in the private sector has uncovered correlations between head injuries and long-term, debilitating illnesses that will require increasing levels of long-term therapy. In the absence of appropriate care – or even poor coordination of care that exists but is either unknown or inaccessible – TBI patients are at an increased risk for homelessness, incarceration and institutionalization, all of which are unacceptable outcomes.[17] In the coming years, VA is likely to face increased numbers of veterans who suffer from long-term consequences of TBI (including mTBI) and chronic traumatic encephalopathy (CTE), including significant cognitive, behavioral, and physical health challenges that cannot be resolved by caregivers alone, and must be prepared to support these patients with improved access to long-term care in a variety of settings. In order to help the veterans' community address current and future challenges related to TBI, WWP calls upon Congress to consider the following:

- **Bring clarity to the current landscape of needs and resources**: As the medical community's understanding of TBI is still evolving, so too must our evaluation of federal, state, and community resources. Particularly for younger veterans with complex needs, these resources can be hard to navigate, often lack appropriate oversight, and can go untapped when assigned to geriatric/elderly portfolios and spread out due to unaligned management both within and across state and federal agencies. Congress should consider convening an oversight hearing or commission to explore these issues further.

- **Invest in research to illustrate the scope of the problem**: As discussed above, mild and moderate TBIs carry potential to manifest in more severe symptomatology over time. While the needs of veterans with severe TBI can be better understood today and have more predictable outlooks into the future, less severe cases – as they evolve on a wide sphere – have potential to create significant stress for VA's care system if not properly anticipated. WWP calls on Congress to commission the National Academy of Medicine to investigate the progression of mild and moderate TBI to better prepare VA for the challenge of supporting these injuries in the future, and to empower and encourage VA to partner and fund TBI research with the private sector, much like DoD has accomplished for their active duty counterparts.

- **Provide clear authority and direction to VA to provide specialized assisted living services and improved rehabilitative care for veterans with TBI**: While VA managed a pilot program to provide assisted living care to TBI patients for over ten years, the report to Congress that followed the pilot provided little qualitative insight into the program or the benefits experienced by patients in

[17] Amy Bukowski, et al., *Traumatic Brain Injury in the District: The Ignored Injury*, TBI WORK GROUP IN WASHINGTON, D.C. (July 25, 2018) available at http://www.uls-dc.org/media/1150/tbi-white-paper-final-7-25-18.pdf.

the program. Over 250 veterans benefitted from the program, receiving care at 47 facilities.[18] No clear alternative to care has emerged since the pilot sunset in 2018; however, anecdotal evidence in the report supports the conclusion that the program was helpful, but more information is needed to determine where and how veteran patients benefitted.[19]

WWP has learned through its direct programming experience that the families and caregivers of young, post-9/11 veterans with moderate to severe TBI prefer their veterans at home. Many have chosen to participate in VA's Program of Comprehensive Assistance for Family Caregivers, and veterans are benefitting from their exceptional commitment and sacrifice. While this remains an option today, it will not always be the case. As this caregiver population ages, faces potential caregiver burnout, and the symptoms of moderate to severe TBI progress in number and severity, there is reason to be deeply concerned by a potential public health crisis if VA is unprepared to provide necessary care for this population – which also includes those who do not currently have the benefit of a caregiver or community support system.

With the sunset of the AL-TBI program, VA does not offer suitable options for care now and is unprepared for the foreseeable wave of need that is now 5 to 10 years on the horizon. Guided by the suggestions above, Congress must legislate that VA correct the current landscape and acknowledge that today's arrangements for care for veterans in their 20s, 30s, and 40s[20] cannot be sustained as many of their caregivers approach their 70s and 80s. Addressing this looming problem will take a community-driven solution.

## Caregivers

As a crucial component of delivering on our mission to honor and empower wounded warriors with all ranges of disability, WWP has been particularly engaged and proud to advocate on behalf of seriously injured post-9/11 veterans. That advocacy extends to the hidden heroes at their side during recovery and rehabilitation – our nation's military and veteran caregivers. As a leading voice in the passage of the *Caregivers and Veterans Omnibus Health Services Act of 2010* (P.L. 111-163), WWP is uniquely positioned to amplify the concerns of this community through data, experiences, and longstanding relationships that have evolved through our programming footprint.

Wounded Warrior Project's advocacy in the caregiver policy arena is largely informed by the community support and care coordination we provide through our Independence Program, a long-term support program available to warriors living with a moderate to severe traumatic brain injury, spinal cord injury, or other neurological condition that impacts independence. As more than 32 percent of our 2018 Annual Survey respondents reported needing the aid and attendance of a caregiver, WWP continues to partner with specialized

[18] *Assisted Living Pilot Program for Veterans with Traumatic Brain Injury (AL-TBI)*, DEP'T VETERANS AFFAIRS (last visited Mar. 1, 2019) available at https://www.polytrauma.va.gov/about/AL-TBI.asp.
[19] *See id* (indicating that several patients continued treatment at personal expense, demonstrating the value to the individual and/or caregiver).
[20] According to survey results, the average WWP alumnus is 39.7 years old, and the average Independence Participant is 41 years old.

neurological case management teams at Neuro Community Care and Neuro Rehab Management to provide individualized services through our Independence Program. These teams focus on increasing access to community services, empowering warriors to achieve goals of living a more independent life and continuing rehabilitation through alternative therapies. Services are highly individualized and supplement VA care, including: case management, in-home care, life skills coaching, traditional therapies (physical, occupational, speech, etc.), alternative therapies (art, music, equine, etc.), and community volunteer opportunities. These services are provided for free and augment/compliment what our warriors receive from the VA.

In this context, WWP has worked closely with VA – our most critical partner in caring for seriously injured warriors – to ensure that the Program of Comprehensive Assistance for Family Caregivers (the Program) is carried out as effectively as possible. This task has changed in scope following the rightful but overdue expansion to caregivers of all generations through the *MISSION Act*. Like other veteran service organizations, WWP has concerns about the Program's current operations and its approaching expansion. Through working groups and other engagements, we are providing VA with our input on current policy and regulatory ideas to improve efficiency and information technology systems, and exploring the possibility of a permanent caregiver designation. Like our recommendation on community care, successful implementation must be the product of inclusive, deliberative, and transparent collaboration amongst VA personnel, veteran service organizations and external private sector partners.

Successfully managing these concerns amidst the Program's expansion will be critical. Current estimates suggest that approximately 75,000 veterans will join the Program once it becomes open to other generations – or 50,000 more veterans than the Program currently serves.[21] Historically, the Program has had insufficient resources and staff to respond to all the needs of enrolled veterans. There lacks consistency in eligibility determinations, tier assignments, and revocations. There is not a comprehensive, well-guided appeals process like that of the Veterans Benefits Administration (VBA) that is clear and precise and involves the representation of veterans or veteran service organizations. As the Program expands eligibility, WWP will continue to work with VA to ensure that the needs of veterans continue to be addressed without a lack of programmatic resources. As Congress provides oversight of the expansion implementation, it should consider:

- **Oversight of the Program's expansion to all generations**: As VA implements the expansion of the Program, Congress should continue to request quarterly updates from VA, help identify gaps that need to be filled, and carefully consider any proposed changes that would affect Program eligibility, tier reductions, revocations, transition, and appeals.

- **Appropriate funding that does not reduce or diminish other VA services**: Given the projected increase in Program participation, VA will be under considerable pressure to deliver a consistent, quality program unless sufficient funding is provided. That funding should not come at the expense

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

of other VA programs and services. Congress has committed to Program expansion and supporting caregivers of all generations, and that commitment should include raising budget caps for VA when necessary.

- **Ensure an adequate and timely information technology (IT) solution**: Without proper IT to track, manage, and assist a national complex care management program, VA will struggle to provide timely assistance, address programmatic inconsistencies, and provide proper care. Congress must continue their oversight to ensure timely acquisition and implementation of an appropriate IT system.

- **Ensure adequate staffing**: The projected influx of Program participants will demand additional VA personnel. Congress must work with VA to ensure that Program expansion is met with corresponding increases in Program staff that can properly respond to veteran and caregiver needs. We ask Congress to ensure that VA has the resources needed to properly implement the new Caregiver Program.

While Congress should take great care to follow these suggestions, it can reasonably be expected given past performance that the Program may again be criticized for unexpected revocations and tier reductions. As WWP has requested in the past, Congress should be prepared to ask VA to review all previous tier reductions – and revocations – for accuracy and consistency and consider reforms to the appeals process, including consideration of whether current processes and oversight procedures are adequate to ensure fair outcomes and uniformity around the country.

## Toxic Exposure

For thousands of service members who served in the post-9/11 generation, environmental and chemical hazard exposures have carried real and potential health risks. Accordingly, WWP has a strong interest in Congress' work on studying and addressing any harm to veterans that may have been caused by toxic exposure illnesses related to service.

Service members and veterans seem to be suffering from uncommon illnesses or unusual early onset of more familiar diseases like cancer. It appears that service members exposure to toxins such as burn pits, depleted uranium, toxic fragments, or other hazards typically seen on overseas deployments, may be emerging as common threads among post-9/11 veterans who are sick, dying, or already deceased. We believe there could be possible causation between deployment and illnesses. This is alarming and should give us all pause. Debates in scientific and medical communities have not reached consensus on the relationships between certain toxic exposures and presumed health outcomes which is why the issue must be further researched. There are

more than 165,000 veterans enrolled in the VA's Burn Pit Registry – all of whom served on or after 9/11 and were deployed to a base or station where open burn pits were used. That said, it is unclear to veterans if exposure to other relevant toxins is recorded in the registry. We believe they should be and each exposure must be classified by toxin type.[22]

While the burn pit numbers are alarming in their own right, these numbers pale in comparison to the population of service members who were exposed to other toxins for which there is no registry. Health outcome studies such as those performed by the National Academy of Medicine, and the Committee on the Assessment of the VA Airborne Hazards and Open Burn Pit Registry, have shown that "not only are the emissions released by burn pits a complex mixture of various chemicals and particulates that depend on factors such as the composition of the trash burned, accelerant used, temperature, ventilation, and the burn rate, but the composition and magnitude of air pollutants on military bases in theaters of operation are also affected by a variety of other anthropogenic and natural toxicants."[23]

These concerns were the impetus behind a new partnership between WWP, the Tragedy Assistance Program for Survivors (TAPS), and Vietnam Veterans of America (VVA) to bring public awareness and to investigate the harmful effects of toxic exposures in the military. Together our current efforts are focused on gathering information on where research is being conducted and what data is being collected that will help us better understand the risks and effects of toxic exposure so that we may work to ensure service members, veterans, and survivors have access to the care and benefits they need. To drive results, our initiative requires additional support. WWP is leading an effort to bring together a newly formed veteran and military toxic exposure working group and will be joining forces with other veteran service organizations and military service organizations to advocate on this issue. To date, a significant number of organizations have agreed to work together to develop and push for the passage of legislation this year. Additionally, WWP has already committed nearly $400,000 in funds to address the needs associated with toxic exposure. In line with our current efforts, WWP calls on members of these committees to:

- **Join the Congressional Burn Pit Caucus**: Information is key in understanding how we can pass meaningful legislation for those affected by burn pits and other toxins while serving this country. The Congressional Burn Pit Caucus, which was established by Representative Ruiz (CA-36) and Representative Wenstrup (OH-02) is a great place to work with other members in a non-partisan setting on environmental factors not only focused on burn pits but all toxins.

- **Establish a study on burn pits and other toxins that might have affected deployed OCONUS (Outside Continental United States) service members by the National Academy of Medicine**: WWP requests that this report include what research is currently being conducted on this topic,

[22] David A. Butler et al., *Assessment of the Department of Veterans Affairs Airborne Hazards and Open Burn Pit Registry*, NAT'L ACAD. OF SCI., ENG'G & MED. (Feb. 28, 2017).
[23] *See id.*

identification of the negative effects of exposure from burn pits and other toxins, an estimate of how many service members might have been affected, and what Congress, the federal government, and VSO/MSO community can do to assist these service members and veterans. Additionally, new epidemiological data on the entire post-9/11 cohort should be collected to understand exposures and current short- and long-term health problems related to their military service. WWP would also like to see an in-depth report on the DoD Periodic Occupational and Environmental Monitoring Summary (POEMS). These reports have a vast amount of data regarding environmental exposures in Afghanistan and Iraq. Conducting a report that can capture this data in a way that promotes informed legislative action is critical for future progress on this issue.

In sum, WWP is committed to helping guide and remain apprised of any policy changes regarding toxic exposure and the VA Burn Pit Registry. We were pleased to see that Senator Klobuchar (D-MN) and Senator Sullivan (R-AK), along with Representative Gabbard (D-HI) and Representative Mast (R-FL) have re-introduced the *Burn Pits Accountability Act* (H.R. 663, S. 191) in the 116th Congress. We request Congress to continue working towards legislation that not only addresses the lack of data between exposures to burn pits in combat zones and possible disabilities but also other toxic exposures while working alongside the veteran community in providing care to those affected.

## Education

Wounded Warrior Project was concerned with the implementation delays of the Forever G.I. Bill but is pleased that VA continues to work with the VSO and veteran community in addressing implementation shortcomings identified during the 115th Congress. WWP will continue to work with VBA to inform our student alumni of changes and ensure that they receive all the benefits they are owed. WWP calls on Congress to continue oversight into the implementation of the Forever G.I. Bill and ensure that VA does, in fact, distribute all past-due funds to student veterans.

As the use of the G.I. Bill grows among transitioning service members, we also ask Congress to:

- **Provide oversight and direction to VA regarding the protection of student veterans**: As policies change in the federal government, it is important for Congress to review these changes and ensure that they are still in the best interest of students. Too often, we have seen that broad changes have unintended consequences on the student veteran community.

- **Address the 90/10 loophole**: Currently, schools must have at least 10 percent of their entire funding from revenue sources that are not considered federal funds. G.I. Bill payments to schools are considered non-federal funds so they count as part of the 10 percent calculation. The need to stay within the 90/10 percentage creates an incentive for less than reputable schools to attract veterans

into their programs. While some schools are a good fit for veterans, others are known to be considered less than reputable schools that will attract transitioning service members and veterans using any means possible. This includes aggressive marketing into programs where employment prospects are low and providing misinformation about program requirements. WWP would like to see more oversight from Congress into this issue and is pleased to see that Chairman Takano (CA-41) is leading the charge in protecting student veteran funds from these schools.

Education is a powerful tool available to transitioning service members and veterans. We look forward to working with the Committees on Veterans' Affairs on education issues to ensure a smooth transition from military service into the civilian workforce.

## Specially Adapted Housing (SAH)

Through our Independence Program (IP) and our Veterans Disability Benefits Services Team, WWP assists veterans and service members in need of home modifications for daily living if they do not qualify for VA Specially Adapted Housing (SAH) grants, which provide allowances to service members and veterans with certain permanent and total service-connected disabilities. These grants help with the purchase or construction of an adaptive home or modifications of an existing home to help accommodate a disability. While SAH grants have been helpful to many WWP alumni, the grant process can be improved with congressional action.

Eligible SAH grantees include those who have lost the use of both arms and/or both legs, those who are blind in both eyes, and those who have certain severe respiratory injuries, or certain severe burns. The total amount of funds that an individual can use is currently $81,080. A veteran or service member can access these funds up to three times and cannot exceed the capped amount.

Although warriors are maintaining that the SAH program is administered well by VA and is considered a much-needed benefit to those with severe injuries and illnesses, WWP is currently advocating to:

- **Allow full SAH benefit reinstatement every ten years:** As younger veterans grow, get married, have families, their needs in an adaptive home change drastically. This is also true for those whose disabilities get worse over time. A veteran with a prosthetic leg might be fine to walk around their home when they are in their thirties, but they might require a wheelchair when they become senior citizens. We suggest the full SAH benefit be reinstated to those in the program every ten years to accommodate moving and normal life changes.

We encourage warriors to thrive in their work and personal lives. Often they must move to take advantage of opportunities to improve their socioeconomic conditions. It is not reasonable to expect a veteran to buy a home and never leave over their entire life. This benefit is reserved for those catastrophically injured

and deserve our assistance throughout their entire life, not just one portion of it. We are pleased to see that Ranking Member Roe (TN-1) is taking a leading role in the development of possible legislation on this issue.

## ***FAIR Heroes Act***

At the start of the 115th Congress, WWP identified one of its top legislative priorities as ending health insurance premium discrimination against some of the most seriously injured medical retirees. As the 116th Congress begins, WWP is renewing its commitment to ending this problem. Thanks to the leadership of Representative Susan Davis (D-CA) and former Senator Bill Nelson (D-FL), Congress can pass the *Fair Access to Insurance for Retired Heroes Act* (*FAIR Heroes Act*) – the first bill of its kind – and offer these veterans the opportunity to choose the health insurance plan that fits their needs and budget.

Like regular military retirees (20+ years in service), medically retired veterans (chapter 61) have earned the benefit of being able to enroll in low-cost TRICARE health insurance plans for the rest of their lives. Unlike regular military retirees, however, medically retired veterans with injuries so severe they cannot return to work must enroll in Medicare Part B in order to maintain access to TRICARE (which becomes TRICARE for Life). Consequently, these veterans must pay an annual premium/enrollment fee for health insurance that is approximately five times the amount that regular military retirees pay for their TRICARE benefits. Even for those medically retired veterans who return to work, Medicare laws are structured to extend eligibility for the program an additional eight and a half years, thereby extending the inability to access a traditional, low-cost TRICARE plan even longer – all while paying increased premiums that can add up to more than $10,000 in that time for care they may not necessarily want or use.

The *FAIR Heroes Act* is designed to help medically retired veterans (and future medically retired veterans) who are unhappy with their current health insurance. Generally speaking, this is a veteran who would prefer a traditional, low-cost TRICARE plan rather than Medicare Part B (with TRICARE for Life as wraparound). The *FAIR Heroes Act* does not abridge a medically retired veteran's access to Medicare Part B. Rather, it allows an option of remaining enrolled in a traditional, low-cost TRICARE plan if such a plan works better to address a particular veteran's health and financial needs. The *FAIR Heroes Act* includes an educational component to help ensure that a veteran's health care insurance choice is as informed as possible. Accordingly, WWP implores Congress to:

- **Pass the *FAIR Heroes Act***: The *FAIR Heroes Act* has not been re-introduced in the 116th Congress yet; however, the *John S. McCain National Defense Authorization Act for Fiscal Year 2019* ("FY 19 NDAA," Sect. 734, P.L. 115-232) mandates a report on the populations affected by these overlapping health insurance systems. Ideally, this population – which has been estimated to be

approximately 29,000 by the Center for a New American Security[24] – figure should generate a reasonable cost for the bill that can generate swift support for a legislative fix that is many years overdue. We urge all committee members to support the *FAIR Heroes Act* once it is introduced in the 116th Congress.

## DoD / VA Collaboration

Although the proportion of active duty service members among WWP alumni continues to decline – 6.4 percent in 2018, compared to 7.3 percent in 2017 and 9.5 percent in 2016 – serving this population remains a priority for WWP. The proportional decrease can be explained as deployment to combat operations continues to decline across the Armed Forces, and thus, combat-related injuries and illnesses among active duty service members continues to decline as well. That said, WWP is welcoming more veterans per month than ever before, the vast majority of whom are several years post-service. Nevertheless, our advocacy on behalf of our current service members embraces the ideas that the veterans of tomorrow will benefit from policies that promote their well-being in the present. In this context, WWP is advocating in several areas that affect our active duty population and which are interrelated with the veterans' issues under your committees' jurisdiction.

### Electronic Health Record Modernization (EHRM)

The new electronic health record (EHR) system should include a smooth transition of DoD medical records to the VA. This will create a seamless transition from military to civilian life. We believe a successful EHRM process will provide efficiencies and greater quality in patient and prescription data, all of which will lead to greater quality of care, identify high risk patients related to suicide and opioid abuse, and a greater quality of life.

Although the process is expected to take 10 years for both agencies, successful implementation will deliver – for the first time ever – a uniform platform (Cerner-based) to manage records and provide seamless capabilities across DoD and VA. The VA Cerner EHR implementation initial operating capability (IOC) in the Pacific Northwest is expected to go live and be fully-functionable by March 2020. While VA is deploying the new system, it will be imperative for VA to capitalize on lessons learned from DoD implementation process. This is critical for the success of the EHRM and the goal of interoperability with DoD. WWP believes Congress needs to exercise vigilant oversight of the implementation process to ensure high levels of interoperability and data accessibility between VA, DoD, and commercial health partners. The House and Senate Committees on Veterans' Affairs can provide oversight in the following ways:

[24] Phillip Carter, *Improving Federal Health and Benefits Programs to Support Seriously Wounded, Ill and Injured Veterans*, CTR. FOR A NEW AM. SEC. (Jul. 24, 2017) available at https://www.cnas.org/publications/reports/improving-federal-health-and-benefits-programs-to-support-seriously-wounded-ill-and-injured-veterans.

- **Learn lessons from DoD implementation and ensure VA/DoD collaboration**: Successful interoperability between DoD and VA has been a goal for decades. Although VA has different system requirements such as those relating to VA disability benefits, nearly 70 percent of its requirements are similar to those being implemented by DoD. As DoD's implementation progress began years earlier, VA has models it can learn from, and Congress should monitor VA's adherence to those models.

- **Ensure IT systems are properly coordinated**: While the *Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriation Act, 2019* (P.L. 115-244) included some funds to improve IT infrastructure, VA has often acknowledged achieving complete interoperability between medical devices, healthcare applications, and the EHR, will require the VA to update an outdated IT infrastructure. VA had to utilize $70 million from FY18 carryover to address unplanned infrastructure upgrades. WWP encourages the committees to ensure the Office of Electronic Health Record Modernization (OEHRM) is adequately coordinating with VA CIO to ensure a joint strategy going forward.

- **Promote interagency cooperation**: With less than a year before the first roll out of EHRM, WWP is concerned that no one has been designated to oversee the joint DoD/VA EHRM committee. Although the Interagency Program Office (IPO), which was put in place as a result of the *National Defense Authorization Act for Fiscal Year 2008* (P.L. 110-181), acts as the single point of accountability for DoD and VA development and implementation of EHR systems and capabilities, VA recently indicated[25] that DoD and VA Tiger teams will be recommending the best joint approach moving forward to replace the IPO office. Both agencies would one person to oversee a joint agency with an external-facing optic of being separate agencies.

## Military Transition

During the recent Military Civilian Transition (MCT) Summit 3.0, the Honorable James Byrne, Performing the Duties of the Deputy Secretary of Veterans Affairs, stated, "one of the most stressful endeavors anyone will take is transitioning from military service." Transitioning service members may face challenges related to unemployment, financial uncertainties, separation anxiety, and some lack of purpose. WWP has put programs in place to ease the hardship of this change as we believe these programs are paramount in easing service members out of military life and into the civilian world.

[25] *Review of the VA's Electronic Health Record Modernization: Hearing Before the S. Subcomm. on Military Construction, Veterans Affairs, and Related Agencies*, 116th Cong. (2019).

With approximately 200,000 service members leaving the military each year, it is critical that DoD, VA, and the Department of Labor (DoL) disseminate the right and relevant information pertinent to transition success, VA benefits, and job opportunities.[26] It is also as important to ensure that adequate programs and resources exist with ease of access for those who have transitioned out of military service long after separation. WWP supports a holistic approach to the military Transition Assistance Program (TAP) that reflects the input of all relevant stakeholders.

In November 2017, WWP was pleased to host leaders from DoD, VA, DoL, and over 10 veteran service and nonprofit organizations to the MCT Summit 1.0, the first of three summits. The intent of the summit was to explore the components of well-being and their relationship to a successful military civilian transition. WWP continues to be an active participant in VA's MCT Summits and remains committed to being deeply involved with government and nongovernment leaders alike who have a stake in the success of TAP.

An example of our commitment is represented by our funding partnership with the VFW to support the Benefits Delivery at Discharge (BDD) program. VFW Veteran Service Officers at BDD sites provide counsel to service members preparing to leave the military about benefits they earned and offers the opportunity to have disability claims submitted on their behalf to the VA. Claims are filed by the VFW's expert VSOs located at twenty-four BDD offices on military installations across the country.

From September 2017 to September 2018, WWP helped 4,554 warriors with disability claims amounting to $99,348,066 in compensation. Through the partnership with VFW described above, WWP was able to extend our organization's reach and impact by filing claims through the BDD program for 14,904 additional veterans, resulting in $155,302,117 in compensation. Combing our internal capacity with external partnership, WWP was able to generate more than $254,650,000 in VA compensation for more than 19,000 veterans.

***Impact on Other Programs***

Several proposals to amend the Transition Assistance Program (TAP) were introduced during the 115th Congress, including FY 19 NDAA Section 552. Given the recent legislative change and interest in seeing this critical program succeed, WWP urges Congress to give the DoD and VA time to develop and launch the new TAP program before making any significant changes during the 116th Congress. However, it is incumbent upon the Departments to work with Congress and key stakeholders to ensure they are identifying any potential shortfalls and meeting the intent of the law.

During this period of oversight, Congress should note that by requiring the TAP process to begin no later than 365 days before separation, other programs such as DoD's SkillBridge program, which must be

[26] Anna Zogas, *US Military Veterans' Difficult Transitions Back to Civilian Life and the VA's Response*, WATSON INST. OF INT'L & PUB. AFF. (Feb. 2017) available at https://watson.brown.edu/costsofwar/files/cow/imce/papers/2017/Zogas_Veterans%27%20Transitions_CoW_2.1.17.pdf.

utilized within 180 days of being discharged, may be impacted and require a legislative solution. Congress should ask the Departments to together assess and report on all transition related programs and services to determine which need to be updated or require additional legislative fixes.

Additionally, WWP has continued to support providing grants to organizations specializing in transition services, connecting transitioning service members with resources in their communities, and inclusion of accredited VSO's into the formal TAP curriculum. That said, WWP should be able to rely on the government to provide comprehensive services that don't require nonprofit subsidizing.

## DoD/VA Integrated Approach to Health Care

DoD and VA health systems are each responsible for providing health care to more than 9 million eligible beneficiaries, with some overlap between their populations.[27] According to the RAND feasibility assessment on "*Integrating Department of Defense and Department of Veterans Affairs Purchased Care*," approximately 1.5 million beneficiaries are enrolled in both the TRICARE and VA health system as a result of overlapping eligibility. Additionally, our 2018 Annual Survey indicates that 57 percent of respondents are eligible for TRICARE and three out of every four (75.2 percent) respondent utilizes VHA; one of the reasons WWP is both a military service origination (MSO) and a veteran service organization (VSO). Two of the DoD/VA Joint Executive Committee (JEC) priorities include integrated purchased care networks and the joint sharing of facilities and services.

### *Integrated Purchased Care*

Both DoD and VA provide care to service members, veterans, and family members through a mixture of platforms; direct care out of government owned or managed facilities and purchased care, utilizing community providers managed through third-party administrators (TPAs). As the integrated product team (IPT) develops a phased approach for planning and implementing an integrated purchased care network, we encourage the committees to work closely with DoD's committees of jurisdiction and the Departments on framing of MOU's for inter-agency provider credentials, demonstration projects, and purchased care acquisition planning. Additionally, just like DoD has solicited information from MSO and VSO's on DoD's T5[28] contract from the beneficiary prospect, the designated program management office in VA should do the same for VA integrated purchased care.

[27] Carrie M. Farmer et al., *Integrating Department of Defense and Department of Veterans Affairs Purchased Care*, RAND CORP. (2018).
[28] "T5" refers to DoD's next generation of TRICARE contracts.

*Joint Sharing of Facilities and Services*

For over 30 years, DoD and VA have had a history of health care resource sharing in agreements between military treatment facilities and VA Medical Centers (VAMCs) across the country. In 2001, Congress authorized a five-year demonstration project, the Captain James A. Lovell Federal Health Care Center (JALFHCC), which operates under an integrated governance structure to manage DoD and VA medical and dental care while continuing to meet the unique missions of both Departments.[29] JALFHCC is the only facility with a single budget that is applied to both DoD and VA functions which relies on the Joint DoD/VA Medical Facility Demonstration Fund (JMFDF) authorized annually via the NDAA. Additionally, through the Joint Incentive Fund (JIF), DoD and VA are able to enter joint sharing initiatives "at DoD/VA facility, regional and national levels to facilitate the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving the access to, and quality and cost effectiveness of, the health care provided to beneficiaries of both Departments."[30] As DoD moves the Medical Health System towards delivering services focused on readiness of the fighting force and the VA continues to face challenges with personnel shortages, we encourage the committees to study and report to Congress and the public about how joint sharing of facilities and services may benefit both population groups.

## Commissary, Military Exchanges, And Morale, Welfare (MWR) and Recreational Privileges

WWP and the Military Order of the Purple Heart (MOPH) spearheaded efforts to extend commissary, military exchanges, and MWR privileges to Purple Heart recipients, Medal of Honor recipients, former prisoners of war, veterans with service-connected disabilities, and their caregivers. This was one of the most significant expansions of military privileges for veterans and their caregivers in recent history. This historic expansion of military privileges will positively impact over three million eligible veterans and over 26,000 eligible caregivers. Additionally, it will provide significant cost savings for warriors, and associated increases in revenue will help support on-base quality-of-life programs for those who serve and their families. To ensure proper implementation, Congress must:

- **Monitor progress on credentialing and access**: Although the expansion passed during the 115th Congress, implementation does not go into effect until January 1, 2020. DoD, in collaboration with VA, must work together to address issues associated with identification credentials and installation access. Installation access for the above mention veteran population and caregivers requires an identification compatible with DoD's physical access control system. While DoD plans to implement electronic physical access control system (ePACS) at all major installations capable of

[29] *Captain James A. Lovell Federal Health Care Center Demonstration Project*, DEP'T OF DEFENSE & DEP'T OF VETERANS AFF. (March 2016).
[30] *DoD/VA Joint Incentive Fund Guide*, DEP'T OF DEFENSE & DEP'T OF VETERANS AFF. (May 2014).

supporting the VA Veteran Health Identification Card (VHIC), not all new eligible patrons are eligible for a VHIC.

- **Keep DoD on schedule**: To keep implementation on track, Congress should require an update from DoD on execution plans to ensure veterans and their caregivers are granted access on January 1, 2020. WWP stands ready to assist both DoD and VA in educating the new beneficiaries on how to exercise their new privileges.

## OTHER ITEMS OF INTEREST

### Prosthetics

As of June 2018, there have been a total of 1,719 OEF/OIF/OND/OIR/OFS amputee patients treated in all military treatment facilities (MTFs), 297 of which were upper extremity involvement. The demand on VA's healthcare system, just like the civilian population, has seen a growth of individuals with amputations. The total number of Veterans with amputations being seen at VA facilities increased from 25,000 in FY 2000 to almost 90,000 in FY 2016.[31] This is an increase of 325 percent. As VA's approach to prosthetic care evolves, Congress should be mindful of the following areas.

- **Prosthetic limbs and preference for DoD care**: Even years after separation, many amputees are choosing to return to military treatment facilities (MTFs) for prosthetic care instead of VA[32]. One of the main reasons why amputees are returning to MTFs is DoD's ability to fabricate on site and work with amputees to address a host of needs associated with an active life style. A younger and more active amputee population places different demands on VA's prosthetic department used to working with a much older and aging population. Congress should study why such a high portion of this generation's amputees are choosing to fly to an MTF instead of using the VA.

- **Osteointegration (OI)**: Although VA is running a feasibility research study out of the George W. Wahlen VA Medical Center in Salt Lake City, Utah, we are under the impression that DoD is taking the lead related to OI. Currently, DoD, out of Walter Reed National Military Medical Center (WRNMMC) is running a study where they have 14-15 lower extremity and 3 upper extremity candidates going through the OI process. This population base is young and extremely active. Of concern is that these patients are being seen at WRNMMC and once they return home, the local

[31] *VA/DoD Clinical Practice Guidelines for Rehabilitation of Individuals with Lower Limb Amputation*, DEP'T OF DEFENSE & DEP'T OF VETERANS AFF. (2017) at 10.
[32] At Walter Reed National Military Medical Center (WRNMMC) alone, a low estimate is that 25 percent of amputees that came through Walter Reed and who now live outside the National Capitol Region (NCR) are still flying in to get their prosthetic work done there.

VAMC may not be equipped to address follow-on needs or issues associated with OI. We encourage the committees to look at innovative technologies and medical procedures such as OI.

- **Adaptive recreation equipment**: WWP is concerned with the potential limitations created by the proposed definition of adaptive recreation equipment. The proposed regulation to amend 38 C.F.R. § 17.3210 would define adaptive recreation equipment in a way that would limit the access to adaptive recreational equipment to items specifically tied to a medical goal, and not provided "merely" to support a veteran's participation in an activity only for personal enjoyment. This can negatively impact both sedentary and highly active veterans, specifically wheelchair bound and amputee veterans, and as such, the proposed regulation defining adaptive recreation equipment is too restrictive and could adversely affect the veteran's quality of life and may negatively impact the veteran's whole health as it relates to both physical and mental well-being.

## CONCLUDING REMARKS

In closing, I would like to acknowledge the bipartisan and inclusive spirit that guides the work of these committees. The 115th Congress' work to expand educational benefits, modernize the appeals process, improve mental healthcare access, and improve our approach to community care was inspirational. Regardless of which side of the dais, panel, or aisle we sit, we share a sacred obligation to ensure that our veterans and their families get the support and care they have earned, and the success they deserve. At Wounded Warrior Project we are committed to that mission, and we are constantly striving to be as effective and efficient as possible. We look forward to working with you and your fellow lawmakers in the weeks, months, and years ahead.

**[PAGE LEFT BLANK INTENTIONALLY]**

# <u>Appendix</u>: 2018 Annual Warrior Survey Highlights & Survey Trend Data (2014 to 2018)

WOUNDED WARRIOR PROJECT®

★★★★★ WOUNDED WARRIOR PROJECT® ★★★★★

# 2018 ANNUAL WARRIOR SURVEY

Since 2003, Wounded Warrior Project® (WWP) has advocated for the men and women who serve our nation, transforming the way injured, ill and wounded veterans are empowered, employed, and engaged.

For the last 9 years, WWP has conducted the Annual Warrior Survey to gain the deepest understanding of the challenges more than 3 million post-9/11 veterans face every day.

This year, 33,067 WWP warriors participated, making it the largest, most statistically relevant survey of its kind. It has laid the foundation for modern methods of veteran care, and is a critical resource in addressing the evolving needs of warriors.

## ★ UNEMPLOYMENT & HOMELESSNESS

**★ 12% ★**
OF NON-ACTIVE DUTY WARRIORS ARE UNEMPLOYED

**★ 6% ★**
WERE HOMELESS OR LIVING IN A HOMELESS SHELTER DURING THE PAST 24 MONTHS

### MOST FREQUENTLY CITED BARRIERS TO EMPLOYMENT:

**#1** **34%** MENTAL HEALTH ISSUES

**#2** **30%** DIFFICULTY BEING AROUND OTHERS

**#3** **21%** NOT PHYSICALLY CAPABLE

## ★ DEMOGRAPHICS

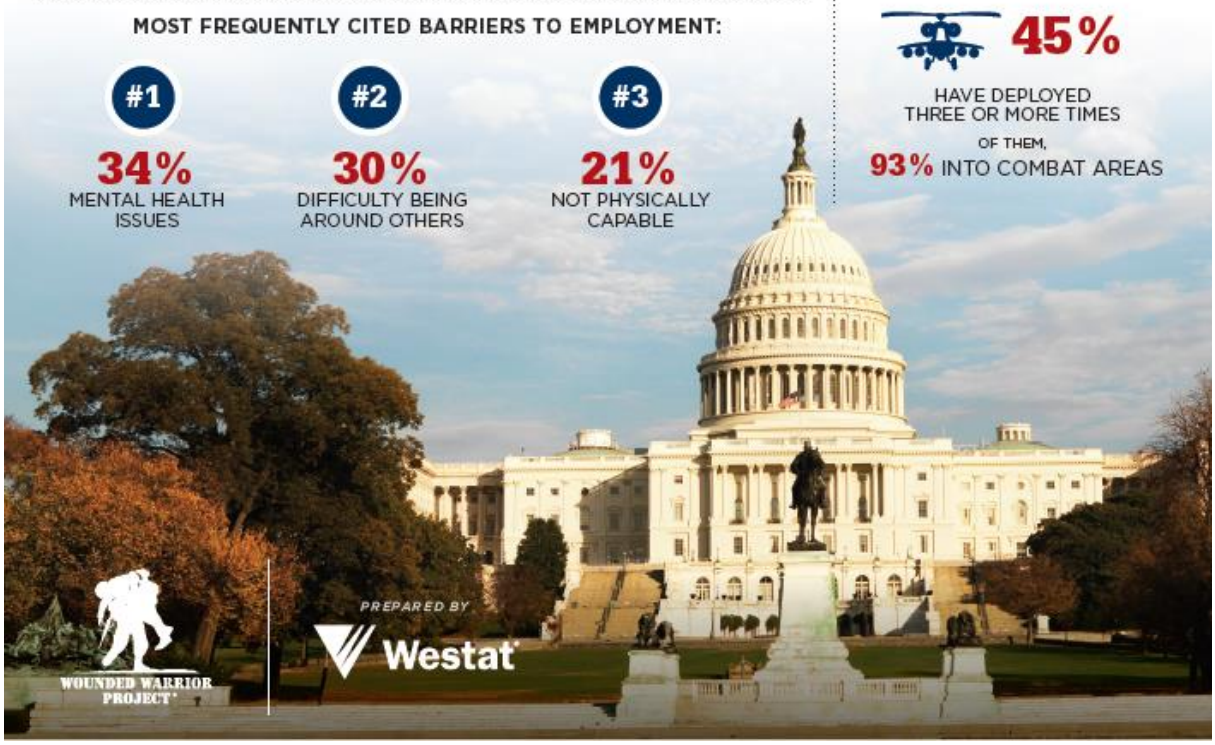
**6%** ARE ACTIVE DUTY

**84%** ARE MALE

**53%**
LIVE IN THE SOUTHERN REGION OF THE US

**45%**
HAVE DEPLOYED THREE OR MORE TIMES

OF THEM,
**93%** INTO COMBAT AREAS



WOUNDED WARRIOR PROJECT®

## ★ VA USAGE

★ **68%** OF WARRIORS USE THE VA AS THEIR PRIMARY HEALTH CARE PROVIDER

**WARRIORS RECEIVING VA DISABILITY BENEFITS:**

| 2014 | 2018 |
|---|---|
| 72% | 90% |

**WARRIORS RECEIVING HEALTH INSURANCE THROUGH THE VA:**

| 2014 | 2018 |
|---|---|
| 59% | 75% |

**WARRIORS WHO HAVE A DISABILITY RATING OF 80% OR HIGHER:**

| 2014 | 2018 |
|---|---|
| 43% | 62% |

## ★ EDUCATION

★ **36%** ★
HAVE A BACHELOR'S, MASTER'S, OR PROFESSIONAL/ DOCTORAL DEGREE

★ **23%** ★
OF WARRIORS ARE NOW ENROLLED IN SCHOOL

Of them, **70%** are pursuing a bachelor's degree

★ **28%** ★
HAVE UNPAID STUDENT LOANS

Of that, **33%** owe $30,000 or more

## ★ HEALTH

★ **90%** ★
HAVE 3 OR MORE INJURIES OR HEALTH PROBLEMS RELATED TO THEIR SERVICE TO OUR COUNTRY

★ **78%** ★
SUFFER FROM PTSD

★ **70%** ★
SUFFER FROM DEPRESSION

★ **41%** ★
SUFFER FROM TRAUMATIC BRAIN INJURY (TBI)

★ **75%** ★
SUFFER FROM FREQUENT SLEEP PROBLEMS

★ **33%** ★
OF WARRIORS HAD DIFFICULTY GETTING MENTAL HEALTH CARE

**37%** HAD SCHEDULING CONFLICTS

**33%** FEARED THAT TREATMENT MIGHT BRING UP PAINFUL OR TRAUMATIC MEMORIES

**19%** WERE CONCERNED THAT THEIR FUTURE CAREER PLANS WOULD BE JEOPARDIZED

★ **GET THE WHOLE STORY** Download the survey results at **AnnualWarriorSurvey.com**

WOUNDED WARRIOR PROJECT®

# ANNUAL WARRIOR SURVEY TREND DATA

## 2014 - 2018

## DEMOGRAPHICS

**84%** ARE MALE

**67%** ARE MARRIED

**92%** ARE/WERE ENLISTED

**66%** ARMY

*Gender, marital status, service branch demographics similar (within 1%) to 2014 survey data.

AVERAGE AGE OF WARRIORS IS **INCREASING**

36 (2014) TO 40 (2018)

ACTIVE DUTY PERCENTAGE IS **DECREASING**

20% (2014) TO 6% (2018)

PERCENTAGE OF WARRIORS WHO HAVE DEPLOYED 3 OR MORE TIMES IS **INCREASING**

34% (2014) TO 45% (2018)

## POSITIVE TRENDS

### ★ MENTAL HEALTH

MORE WARRIORS ARE USING **VA MEDICAL CENTERS** TO ADDRESS THEIR MENTAL HEALTH CONCERNS

63% (2014) TO 71% (2018)

**SLIGHT DECREASE** IN PERCENTAGE OF WARRIORS WHO REPORTED HAVING DIFFICULTY IN GETTING MENTAL HEALTH CARE

35% (2014) TO 33% (2018)

### ★ HEALTH CARE NEEDS

DECREASE IN WARRIORS WHO HAVE BEEN TO A **DOCTOR'S OFFICE OR CLINIC** (EXCLUDING ER VISITS) 10 OR MORE TIMES DURING THE PAST 3 MONTHS

17% (2014) TO 10% (2018)

### ★ EDUCATION

MORE WARRIORS HAVE ATTAINED A **BACHELOR'S DEGREE OR HIGHER**

25% (2014) TO 36% (2018)

IN 2018, 23% OF WARRIORS ARE NOW ENROLLED IN SCHOOL AND THE MAJORITY OF THEM ARE PURSUING A BACHELOR'S DEGREE (70% OF THOSE ENROLLED)

### ★ FINANCIAL STABILITY

MORE WARRIORS ARE **HOMEOWNERS**

46% (2014) TO 60% (2018)

MORE WARRIORS SAY THEIR **FINANCIAL STATUS IS BETTER THAN A YEAR AGO**

23% (2014) TO 27% (2018)

DATA FROM 2018 AND 2014 ANNUAL WARRIOR SURVEY

WOUNDED WARRIOR PROJECT®

# NOTABLE STATISTICS

## ★ VA RESOURCES

MORE WARRIORS ARE RECEIVING **VA DISABILITY BENEFITS**

72% (2014) TO 90% (2018)

MORE WARRIORS HAVE A **DISABILITY RATING OF 80% OR HIGHER**

43% (2014) TO 62% (2018)

MORE WARRIORS HAVE **VA HEALTH INSURANCE**

59% (2014) TO 75% (2018)

## ★ HOMELESSNESS

**HOMELESSNESS HAS NOT CHANGED** AND CONTINUES TO BE A CONCERN. RATES ARE SOMEWHAT HIGHER FOR FEMALE WARRIORS

**6% OF WARRIORS WERE HOMELESS** OR LIVING IN A HOMELESS SHELTER IN THE PAST 24 MONTHS

*Percentage of homeless warriors demographics same as 2014 survey data.

**FEMALE WARRIORS** SHOWED SOMEWHAT HIGHER RATES OF HOMELESSNESS OVER PAST 24 MONTHS THAN MALES

7% FEMALES COMPARED TO 5% MALES

*The percentages were 6% each in 2015, no breakdown for 2014.

## ★ EMPLOYMENT

WARRIOR **UNEMPLOYMENT** PERCENTAGE HAS DECREASED

20% (2014) TO 12% (2018)

## ★ PTSD

78% OF WARRIORS REPORT EXPERIENCING **PTSD AS A RESULT OF THEIR MILITARY SERVICE**

75% (2014) TO 78% (2018)

## ★ PHYSICAL HEALTH

**INCREASE IN PERCENTAGE** OF WARRIORS WHO ARE OBESE

43% (2014) TO 52% (2018)

MORE WARRIORS REPORTED THAT **PAIN INTERFERED WITH THEIR NORMAL WORK** BOTH INSIDE AND OUTSIDE OF THE HOME

62% (2014) TO 73% (2018)

MORE WARRIORS SAID THEY **ACCOMPLISHED LESS** THAN THEY WOULD LIKE IN THE PAST 4 WEEKS BECAUSE OF PHYSICAL HEALTH PROBLEMS

65% (2014) TO 85% (2018)

MORE WARRIORS NEED AID AND ATTENDANCE OF ANOTHER PERSON BECAUSE OF **INJURIES AND HEALTH PROBLEMS**

29% (2014) TO 32% (2018)

DOWNLOAD THE ENTIRE SURVEY AT
ANNUALWARRIORSURVEY.COM

DATA FROM 2018 AND 2014 ANNUAL WARRIOR SURVEY