DUANE J. MISKULIN, NATIONAL COMMANDER, AMVETS

STATEMENT OF

DUANE J. MISKULIN
AMVETS NATIONAL COMMANDER

BEFORE THE

JOINT HOUSE AND SENATE VETERANS AFFAIRS COMMITTEE

CONCERNING

AMVETS LEGISLATIVE GOALS AND OBJECTIVES OF 2010

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STATEMENT OF DUANE J. MISKULIN
AMERICAN VETERANS (AMVETS) NATIONAL COMMANDER
BEFORE A JOINT SESSION OF THE COMMITTEES ON VETERANS' AFFAIRS
UNITED STATES SENATE
UNITED STATES HOUSE OF REPRESENTATIVES

March 18, 2010

Chairman Akaka, Chairman Filner, Ranking Member Burr, Ranking Member Buyer and members of the Senate and House Veterans' Affairs Committee. I am Duane Miskulin, National Commander of AMVETS. On behalf of AMVETS, the AMVETS Ladies Auxiliary, the Sons of AMVETS and our other subordinate organizations, thank you for giving us the opportunity to present our legislative agenda for 2010.

AMVETS (American Veterans) has been a leader since 1944 in helping to preserve the freedoms secured by the Armed Forces of the United States of America. Today, our organization continues its proud tradition, providing not only support for veterans and active duty military service members in receiving their earned entitlements but also countless numbers of community services which enhance the quality of life for this Nation's citizens.

Our guiding principles in setting AMVETS legislative agenda lay in three documents: our annually adopted resolutions, our Legislative Goals and Objectives, and the report from the AMVETS sponsored "National Symposium for the Needs of Young Veterans." The resolutions target specific areas of need that have been voted on and approved by our membership. Our goals and objectives provide an overview of six key areas that AMVETS supports, and lastly, the Symposium report reflect the short comings of both DoD and the VA transition, healthcare and benefits system and provides recommendations to improve or eliminate the short comings.

VA BUDGET

AMVETS wants to thank and recognize both Veterans Affairs Committees and the entire Congress for the efforts they have taken to improve the lives of our veterans. In the past four years Congress has increased discretionary funding by nearly 50%. Veterans today have better access to a higher quality health care system than ever before. We can truly say, this is not our father's VA.

We also want to thank you again for Advanced Appropriations. In 2010, Congress provided approximately $48.2 billion for the medical care accounts for FY 2011. This amount, combined with medical care collections provided $51.5 billion for VA medical care accounts one year in advance, falling just short of The Independent Budget's FY 2011 recommendations. AMVETS views this as a success.

CLAIMS BACKLOG

The claims backlog continues to grow and perplex Congress, VA and veterans. Due to the new Agent Orange presumptions, projections for FY 2011 predict a continued rise in claims. Congress has responded to the needs of VA and provided funding for more than 4000 full-time claims processors positions, but increased manpower alone will not eliminate the backlog or the institutional inconsistencies and shortfalls that plague the compensation and pension claims process. VA has taken steps to identify problems and is working to institute solutions, and AMVETS looks forward to providing our insight as we develop immediate, mid and long-term solutions to this problem.

Compensation claims development and adjudication is complex and time consuming. Inadequately trained employees fail to recognize claims that are adequately prepared and continue to develop claims that are ready to be rated. When VA notifies a claimant that s/he can submit a private medical opinion, they do not explain what elements make the private opinion adequate. Currently, the accountability mechanism, the Systematic Technical Accuracy Review (STAR) program allows for a sample that is too small to determine the accuracy of the claims process of a Regional Office (RO). STAR also has made it possible for even new processors to have "single signature" authority. This system of oversight has contributed to the backlog by causing claims to be remanded. The employee work-credit system is an ineffective measure of productivity. It measures productivity quantitatively, allowing for credit to be given regardless of quality of the claim. And there is still an indication that staffing levels may be too low for the number and complexity of cases coming out of the conflicts in Iraq and Afghanistan.

The combination of these issues within the claims process has reduced the productivity and efficiency of the VBA, and it directly results in veterans not receiving their disability payment in a timely manner.

VA should undertake an extensive uniform training program to educate its adjudicators on how to weigh and evaluate medical evidence. In addition, to complement recent improvements in its training programs, VA should require mandatory and comprehensive testing of the claims process and appellate staff. To the extent that VA fails to provide adequate training and testing, Congress should require mandatory and comprehensive testing and under which VA will hold trainees accountable.

VA must notify a claimant, in appropriate circumstances, of the elements that make medical opinions adequate for rating purposes. Congress should amend section 5103A(d)(1) to provide that when a claimant submits a private medical opinion that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request another medical opinion from a Department healthcare facility. As well as develop standardized, downloadable forms for certain conditions that will provide all needed information so duplicate exams can be avoided.

VA must establish a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit errors while simultaneously providing employee motivation for the achievement of excellence. Serious discussions must take place that will lead to an improved work credit system. Currently, the system forces employees to rush, causing inaccurate claims. The system must uniformly provide credit, looking not just at the number claims adjudicated, but at the difficulty and scope that each claim presents.

AMVETS believes that some claims are "ready to rate" and that efforts must be taken to ensure these claims don't bog down the backlog by traveling through the entire process when they could be sent straight to a claims rater. Also, there are other claims that could be partially rated or be given an interim rating based on presumptive conditions. Veterans will be served more quickly, given access to VA healthcare, and have the assurance their claim is being handled. A majority of the institutional knowledge regarding claims is at the back end of the process. VBA must place experienced decision-makers in triage so these ready to rate and partial and interim ratings will be identified and sent through a fast track. AMVETS looks forward to discussing these and other

options for improving the accuracy and timeliness of veterans claims.

EDUCATION

Education benefits have been the single greatest recruitment tool for the Department of Defense. Occasionally, Congress will provide a new benefit for our servicemembers which coincides with the sacrifices that are made. Historically, educational benefits do not overlap to where servicemembers are eligible for multiple benefits. Today that has changed. Now enlisting servicemembers must make benefit choices without understanding the full scope of the benefits, and servicemembers from the current era of conflict who have already separated from service are not receiving an equal benefit in relation to their cohorts who are still serving on active duty.

With the addition of the Post-9/11 GI Bill many unintended consequences have occurred, the most acute of these problems is timely payment of the benefit to veterans. AMVETS commends VA's willingness to provide emergency funds to veterans who have not received their book and living stipends. However, VA is working with an analog system that is labor intensive for the claims processors who will continue to be overworked and each semester there will be considerable backlogs and veterans will continue to wait for promised benefit payments. Along with the processing issue, there are disparities between Chapter 30 and Chapter 33 benefits as well as parity issues and confusion within Chapter 33.

If VA continues to have processing issues that deny timely payment to veterans, the idea and hope of educating our veterans will be lost. Allowing competing benefits will cause a great portion of veterans to receive a benefit that is less, strictly based on the type of educational program they peruses. Multi-benefit options will cause enlistees to unnecessarily buy into Chapter 30 benefits that will never be used as well as denying benefits to enlistees who either assume or are told Chapter 33 benefits will cover all educational options. Many veterans choose, often out of necessity, to pursue degrees through non-traditional, on-line universities. Depriving these veterans a living stipend will financially place an added burden on these veterans. Also, because of the nature of their service, members of the National Guard who are called to serve under title 32 are not awarded time toward Chapter 33 benefits.

The Yellow Ribbon program was a great addition to the Post-9/11 GI Bill, but due to the complex nature of the tuition and fees system the VA is using an arbitrarily payment method that does not correlate with the cost of education. This complex system can also be confusing to veterans causing them to assume their tuition and fees will be covered, but later realize they can owe thousands of dollars to their university.

It is imperative that while we wait for a paperless, electronic benefits process, VA must be provided the funds necessary to hire more education claims processers. VA's hiring estimate was based on the assumption that each claim could be processed in 15 minutes (based on Chapter 30 claims processing times). However, Chapter 33 claims take more than one hour to complete. VA must also continue to work to build an IT system that will reduce the processing time, by setting milestones of achievement that are reported to Congress on a quarterly basis.

There are also four other shortfalls that deny veterans' complete or partial access to Chapter 33 benefits that must be addressed:

1. All veterans receiving Chapter 33 benefits must be entitled to a living stipend.
2. Members of the National Guard serving on active duty under title 32 must be afforded the same ratio of time to benefits under Chapter 33 as those veterans who served on active duty under title 10.
3. Apprenticeships, on-the-job training, certificate and vocational programs must also be included as educational options under Chapter 33.
4. The tuition and fees payment determination must be modified to pay in full the total amount of tuition and fees for all undergraduate students and base Yellow Ribbon payments on a national average.

AMVETS also supports combining the Montgomery GI Bill (MGIB), Chapters 30 and REAP benefits from Chapter 1607 into Chapter 33 (Post 9/11). Consolidation will simplify the benefits, eliminate the need for servicemembers to buy into MGIB not knowing which benefit will be needed when servicemembers or veterans are prepared to attend an educational program. If consolidating the benefits is unattainable there must be a modification of Chapter 30 benefits to extend eligibility to 15 years as well as remove the mandatory buy-in that is currently in place, as well as provide portability of Chapter 1607 benefits to the IRR. And in an effort to provide equal benefits to same-era veterans, veterans of the wars in Iraq and Afghanistan who have completely or partially completed their educational goals must be provided the option to repay student loans that were accrued under the old benefits system with the remainder of their Chapter 33 entitlement.

REINTEGRATION
After returning from combat zones, many servicemembers are left to reintegrate into civilian life with no assistance, or through a system that is that is frustrating and hard to navigate without guidance. Often those who have completely separated from military service are left isolated and uninformed of the services and benefits that are available to them. For the mental health of our returning veterans, it is critical that we take steps to wholly assess their well-being and direct them to any services they may need.

Servicemembers returning from OIF/OEF deal with a caveat of reintegration issues. Many are either unaware of services available to them or find the system to frustration to navigate. Unemployment rates are unacceptably high, and mental illnesses, such as Post Traumatic Stress Disorder (PTSD), are left untreated which result in increased rates of domestic violence, homelessness and suicide rates among servicemembers.

Veterans are nearly twice as likely to be unemployed as their civilian counterparts. According to the Bureau of Labor Statistics, veterans ages 18-24 have an unemployment rate of 14.1 percent.

VA estimates that over 131,000 veterans are homeless.

The Department of Veterans Affairs recorded 144 such cases. The suicide rate among veterans aged 20 to 24 was 22.9 per 100,000 in 2007—four times higher than non-veterans in the same age bracket.

There is an average of 10 failed suicide attempts for each actual loss of life, the figures suggest that more than 1,600 serving army and marine personnel tried to kill themselves last year.

An estimated 30 percent of soldiers who took their own lives in 2008 did so while on deployment. Another 35 percent committed suicide after returning from a tour of duty.

An early 2009 study by multiple mental health agencies and providers showed that an estimated 24.6% of troops returning from Iraq and Afghanistan will meet all criteria necessary for a diagnosis of PTSD. These rates are shown to increase by up to 9% for the groups studied that served multiple deployments.

The Department of Veterans Affairs must implement a program(s) that will act as a de-boot camp for our servicemembers who are transitioning back into civilian life. Many of the issues that lead to destructive behavior can be positively dealt with through intervention. Having an opportunity within six months of separation can drastically reduce the number of suicides, domestic disputes, joblessness/homelessness, allowing our veterans to more seamlessly reintegrate into society.

AMVETS reintegration concept will require:

• All veterans who have served on active duty status and who have been forward deployed to a combat zone as defined by the Secretary shall attend a five to seven day-long reintegration program at approximately 90-180 days after release from active duty.
o Lodging will be provided for the servicemember and his/her dependents
o Travel expenses shall be reimbursed
o Appropriate age child care will be provided for dependents
• All veterans shall be given a mental health care screening
o This self-evaluation shall be followed up by a person-to-person session with a certified mental health provider. (Perhaps with spouse included)
o Any veteran who presents signs of PTSD shall be scheduled for an appointment with VA mental health services nearest his/her home of record
• All veterans shall be enrolled into the VA health care system
• All veterans shall be given the opportunity to receive further TAP classes
• Educational seminars and roundtable discussions shall be provided to the veteran and his/her spouse. Discussions shall include:
o What is and is not normal readjustment behavior
o Identifying and addressing readjustment behaviors that could become destructive
o Anger management
o Chemical abuse prevention
o Compulsive behavior prevention

DoD already funds several similar programs to address many of these issues for service members who are preparing for or returning from deployment. AMVETS wants to see uniform implementation of this “De-Boot Camp” program, particularly for members of the National Guard and reserves who do not have access to traditional actives duty TAP resources.

RURAL/REMOTE VETERANS
Currently about 3 million (or over 44%) veterans enrolled in the VA Healthcare System live in rural or remote areas. Rural Americans serve at rates higher than their proportion of the population. Though only 19% of the nation lives in rural and remote areas, 44% of U.S. Military recruits are from rural America.

There is an overwhelming national misconception that all veterans have access to comprehensive care. Unfortunately, this is simply not true. Access to the most basic primary care is often difficult in rural America. While the VA's medical centers and outpatient clinics provide excellent care to veterans, many veterans living in rural areas never have the opportunity to take advantage of this excellent care because of the need to travel long distances, lack of outreach and education on the services available to them, difficulties due to physical disabilities, age, or financial restraints. As today's combat veterans returning to their rural homes in need of specialized care due to war injuries (both physical and mental) will likely find access to that care extremely limited.

According to a 2006 study of the Carsey Institute, the death rate for rural soldiers is 60% higher than the death rate for those soldiers from cities and suburbs, due to the multiple obstacles they face in their efforts to receive care as opposed to their urban counterparts. In 2009 85% of all mental health shortages can be found in rural America. A lack of qualified mental health professionals, shortage of psychiatric hospital beds and the negative stigma of mental illness, often result in many rural residents not getting the care they so desperately need. Although Vet Centers provide mental health services, they are not consistently available at the local, rural level. Currently, it appears that Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) will most likely be the highest suffered injuries of the Afghanistan and Iraqi wars. Such wounds require highly specialized care. The current VHA TBI Case Managers Network and trained PTSD Clinicians are vital, but access to these services is extremely limited for rural veterans and immediate expansion is needed. According to a published 2009 OIG report waiting periods for outpatient mental health care is four to eight weeks. Unfortunately, due to lack of uniformed data tracking policies it is not known what the average wait for specialized physical specialty care is. Despite the creation of local access points, the greatest barrier to getting health care continues to be distance. The rural veteran population, moreover, needs more care than ever. Veterans aged 85 and older have become much more numerous and will continue to grow until 2036. Furthermore, many young veterans from the wars in Iraq and Afghanistan suffer from severe medical problems and they still need care after returning to their rural hometowns, thus leading to untreated mental and physical problems. Many of these often lead to substance abuse, homelessness, and financial problems.

In an effort to better serve today's rural and remote veterans, AMVETS believes that VA's next steps must involve identifying qualifying communities, identifying local providers willing and able to participate, and beginning with acquisition and exchanges of medical information as well as addressing pharmacy benefits and performance. Another important step is the wider implementation of telemental health services. VHA Telemental Health is the delivery of services using virtual linkages between VHA patients and Mental Health providers separated by distance or time. AMVETS strongly supports the use of telemedical services due to the fact they can provide a cost-efficient solution to access-to-care problems in rural areas. Telemedicine – particularly telemental health counseling – offers the same care to veterans that an urban VAHC offers on site. This type of care will positively affect a huge number of veterans, who might otherwise not receive care.

Next, due to the higher rate of physician change, VA must develop new methods (to complement the current Medical Model) to meet the needs of rural veterans while ensuring continuity of care

and documentation of treatment episodes in the electronic medical record for accurate and accessible medical records.

Finally, annual evaluative practices will help clarify the current issues that impact rural veterans' healthcare, and recommend changes or new initiatives. AMVETS stresses that we all must all be mindful of long-term needs and costs of our returning soldiers and veterans population. The wounded veterans who return today will not need care for just the next few fiscal years; they will need care for the next half century. While access for rural and remote veterans can be daunting, VA must ensure that every possible step is being taken to ease the access and quality of care to our rural veteran population.

WOMEN VETERANS

In 2008, 281,000 female veterans were treated in the VA health care system. This was an increase of 12% over the previous year and over the next five years; this number is expected to grow by 30%. As of October 2008, there were over 1.8 million women veterans in the United States. This represents about 7.7% of the total veteran population. Nearly 112,000 of the total female veterans' population are Operation Enduring Freedom & Operation Iraqi Freedom (OEF/OIF) veterans. 86% of all OEF/OIF women veterans are under the age of 40, with nearly half being between the ages of 20 and 29. While VA estimates that the total number of veterans will decline by 37% between 2008 and 2033, the number of women veterans will increase by nearly 20% during the same time period. As a result of our ever-changing female veterans' population, it is of the utmost importance that VA has the capabilities and programs in place to treat the complex physical and mental of our women veterans' population.

Current VA data shows that as of 2008 over 20% of women veterans who served in OEF/OIF had been diagnosed with PTSD. Alarmingly, a large number of these cases were a result of sexual trauma while serving in the military. In 2006 and 2007, hypertension (high blood pressure), depression, and PTSD were the top three diagnostic categories for women veterans treated by VHA. In 2007 only 15% of women veterans used VA services, compared to almost 30% of all male veterans. In congressional testimony given on July 16, 2009, VA stated that this under utilization of VA health care by female veterans was most likely the result of the numerous barriers that the current care models at many VA facilities present to women. While most male veterans can receive the full spectrum of primary and preventative care services in one visit, most female veterans must schedule multiple visits to receive the same gender-specific care. This includes, but is not limited to, breast exams, cervical cancer screenings, and menopause management. Most VA Medical Centers (VAMC) and Community Based Outreach Centers (CBOCs) still have not implemented the most basic requirements to treat women veterans. This encompasses everything from simple privacy assurance to specialized gender specific healthcare and mental healthcare services and qualified providers. In July 2009 the United States Government Accountability Office (GAO) released their findings of a year long investigation of the current state of VA's treatment of women veterans. (GAO-09-899T) Their findings concluded that not a single facility they inspected investigated was fully compliant with VA's policies related to ensuring the privacy of women patients. Most clinical settings check-in desks or windows were located in mixed gender waiting rooms or on high traffic public corridors. In fact, most were located within a few feet of the waiting room chairs. Also In exam rooms where gynecological exams are conducted, only one VAMC and two CBOCs, in which GAO inspected,

had the exam tables facing away from the door, as VA policy requires. They also noted there were no restrooms adjacent to the exam rooms either, as policy mandates.

AMVETS recommends the following:
• Development of a program designed to improve the provision of health care services to women. In addition, the VA shall project resource and staffing requirements to meet the health care needs of women veterans.
• Requires the Secretary to ensure that all mental health professionals have been trained in a consistent manner and that such training includes principles of evidence-based treatment and care for sexual trauma and PTSD.
• Implement mandatory availability of, but is not limited to, breast exams, cervical cancer screenings, and menopause management at all VAHCs and CBOCs. So women veterans may receive the gender specific yet equal preventive healthcare exams that are available to their male counterparts.
• Simple privacy assurances such as private or separate check-in areas and availability of feminine products in all VA restrooms.
• Advise the VHA USH on issues surrounding the transition and continuity of care for our nation's veterans, impacted by Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) within VA.

• Provides strategic direction for policy and oversight of the transition of health care services. Work with DoD to assure continuum of care for service members as they become veterans.

AMVETS supports legislation that would award a military service medal to members of the Armed Forces who served honorably during the Cold War Era. Presidents going back to Truman have recognized the significance of the Cold War. By creating the Cold War Victory Medal, this nation would certainly demonstrate its great respect and appreciation for the men and women who carried the burden of this policy.

As a member of the Citizens Flag Alliance, we continue to strongly support a constitutional amendment to protect our most sacred symbol. All 50 state legislatures have passed resolutions asking Congress to submit the flag amendment for ratification. We hope that a new flag protection amendment bill will be introduced and voted on quickly this Congress. It is time the voice of the American people be heard on this issue.

I would now like to briefly highlight some quality programs within the AMVETS organization that are making a difference in local communities. Since its inception in the 1950s, the AMVETS National Scholarship Program has awarded more than $2 million in scholarships to graduating high school students. For the past 20 years, AMVETS has sponsored a youth leadership program in cooperation with Freedoms Foundation at Valley Forge, Pennsylvania, that has served more than 800 youth to date.

At the Department of Veterans Affairs, AMVETS is proud to serve on the National Advisory Committee of Veterans Affairs Voluntary Service Program. Last year, more than 2,400 AMVETS, Ladies Auxiliary and Sons volunteers tallied over 175,805 hours of voluntary service at more than 140 VA Medical Centers. In addition, some 95,503 AMVETS from across the country invested more than 755,375 hours in helping veterans, the active military including the

Guard and Reserves, and providing an array of community services to enhance the quality of life for our nation's citizens. I am pleased to report that based on The Independent Sector Formula, AMVETS provided a total in excess of $22 million in voluntary service. These are just a few examples of the good work our people are doing out in the field.

Messers. Chairman, our obligations are many. I look forward to working with all of you to ensure the long-term sustainability of our veterans programs.

Again, thank you for extending me the opportunity to appear before you today, and thank you for your support of veterans. I hope all of you will be able to join us tonight for our annual congressional reception and Silver Helmet presentation to The Honorable Chet Edwards of Texas, to be held in room 334 of Cannon House Office Building from 5:30 to 7:30 p.m.

This concludes my testimony.