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WOUNDED WARRIOR PROJECT

Statement of
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On

Wounded Warrior Project's 2023 Legislative Priorities

March 8, 2023

Chairmen Tester and Bost, Ranking Members Moran and Takano, distinguished members of the Senate and House Committees on Veterans' Affairs – thank you for inviting Wounded Warrior Project (WWP) to submit the following written statement that highlights our legislative priorities for 2023.

This year, WWP will mark 20 years of dedication to our mission to honor and empower wounded warriors. Our work started in 2003 when a group of patriotic citizens decided to act after seeing the first wounded Service members return home from the battlefields of Iraq and Afghanistan. At hospital bedsides, they provided care, comfort, and support to injured warriors who were beginning paths of recovery and rehabilitation. Today, more than 800 dedicated teammates across the nation and overseas are continuing that service and doing so for over 183,000 veterans and Service members registered with WWP and 46,000 of their family members similarly registered with WWP.

After nearly two full decades of commitment, and with the aid of passionate supporters at every step along the way, WWP has helped transform the way post-9/11 wounded, ill, and injured veterans and Service members are empowered, employed, and engaged in our communities. We have grown to offer more than a dozen direct service programs focused on connection, independence, and wellness across mental, physical, and financial domains to create a 360-degree model of care and support. This holistic approach empowers warriors to create a life worth living and helps them build resilience, coping skills, and peer connection. In Fiscal Year 2022 (October 1, 2021, to September 30, 2022), WWP:

- Provided warriors and family members with more than **54,700** hours of treatment for post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), substance use disorder (SUD), military sexual trauma (MST), and other mental health conditions;
- Placed more than **19,700** emotional support calls to warriors and their families to help mitigate psychological stress and improve quality of life and resilience;

- Delivered over **200,000** hours of in-home and local care through our Independence Program to the most severely injured warriors, helping them reach and maintain a level of autonomy that would not otherwise be possible;
- Helped place over **1,700** warriors and family members with new employers;
- Secured over **$146 million** in Department of Veterans Affairs (VA) disability compensation benefits for warriors;
- Facilitated over **1,200** warrior-only peer-to-peer support group meetings; and
- Hosted more than **6,400** virtual and in-person events, keeping warriors and their families connected and out of isolation.[1]

Wounded Warrior Project has proudly delivered these life-changing impacts while also appreciating that a single organization cannot meet the needs of post-9/11 veterans and their families alone. Collaboration is at the core of all we do, a critical driver of the innovation, efficiency, and excellence we strive to reach. Since 2012, WWP has supported 218 military and veteran-connected organizations through grants. These targeted investments help to expand our reach, diversify engagement opportunities, augment our programs and services, and ultimately improve outcomes for all veterans and their families. In FY 2021 alone, WWP grants to partner organizations extended our impact to more than 36,000 veterans, caregivers, family members, and military-connected children.[2] These partnerships touched nearly every aspect of veteran well-being, targeting issues like social connection, support for the Special Operations community, brain health, family resiliency, emergency financial assistance, transitional housing, and many more.

Bringing focus to today's hearing, Congress has a critical role in our work to change the landscape of support for wounded warriors. WWP is committed to helping your committees identify, develop, and pursue public policy changes that will have the biggest impact on the wounded warriors we serve. Just as the 117th Congress answered our call to pursue initiatives we identified during this annual hearing in 2022, we hope that the perspectives offered today will inform the pursuits of the 118th Congress and help deliver large scale impact in the areas below. Unless noted otherwise, the data below and throughout this testimony are reflective of warriors who are registered with WWP as alumni and who completed our Annual Warrior Survey. [3] These statistics are not intended to represent all U.S. veterans.:

- ***Mental Health & Suicide Prevention:*** *Mental health issues continue to rank as the top service-related health issues among WWP registered alumni. Approximately 3 of every 4 warriors report experiencing PTSD (76%), anxiety (76%), or depression (74%) – and all of these conditions have a statistically significant negative impact on warriors' quality of life. (page 3)*

- ***Women Veterans****: Women comprise 17% of the WWP warrior population and have accounted for over 30% of the increase in veterans enrolled for VA healthcare over the past 5 years. (page 8)*

[1] For more information on WWP's programming impact, please see Appendix.
[2] For more information on WWP's partners, please see Appendix.
[3] Figures that follow are informed by WWP's 2022 Annual Warrior Survey. A full copy of the report can be viewed at https://www.woundedwarriorproject.org/mission/annual-warrior-survey.

- ***Financial Security****: The WWP warrior unemployment rate declined significantly since 2021 – falling from 13.4% to 6.8% – yet remains higher than the national average. Nearly two-thirds of warriors (64.2%) said they did not have enough money to make ends meet at some point in the past twelve months. (page 11)*

- ***Toxic Exposure****: Prior to the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act (the PACT Act) becoming law, 4 in 5 (80.3%) warriors filed disability claims for exposure-related conditions, but less than one-third were successful (32%). (page 14)*

- ***Brain Health****: Approximately 1 in 3 (36.5%) warriors self-report a TBI during service. As the WWP warrior population continues to age, brain injury, including TBI, becomes increasingly important to monitor, diagnose, and study. (page 17)*

- ***Caregivers****: Approximately 31% of WWP-registered warriors reported a need aid and assistance from another person due to service-connected injuries or health problems; however, nearly half (49.3%) who report needing that aid and assistance said they are not receiving it. (page 20)*

- ***Enhanced Quality of Life****: WWP's vision is to foster the most successful, well-adjusted generation of wounded Service members in our nation's history. We believe that being a successful, well-adjusted generation is predicated on an enhanced quality of life. (page 23)*

- ***VA Workforce & Modernization****: Nine in 10 warrior survey respondents have a service-connected disability (91.3%) and report access to VA health care (90.5%). A high-functioning VA is critical to the current and future well-being of WWP warriors. (page 26)*

MENTAL HEALTH AND SUICIDE PREVENTION

Ensuring timely access to high quality mental health care and preventing veteran suicide are two of the strongest points of priority alignment between Congress, VA, and WWP. As in years past, these issues are particularly important in the community of post-9/11 wounded warriors that WWP serves. Mental health conditions continue to be among the top service-related health issues reported by wounded warriors registered with WWP, with PTSD (75.9%), anxiety (75.7%), and depression (74.3%) all affecting a majority of respondents.

Closer inspection of our Annual Warrior Survey data and comparison with the broader U.S. population tells a more complete story. VA reports that about 6% of the general population will experience PTSD at some point in their lives and that approximately 29% of the post 9-11 veteran population will do so.[4] The Annual Warrior Survey consistently shows that WWP warriors experience PTSD at a much higher rate. When asked about PTSD symptoms in the past

[4] *How Common is PTSD in Veterans?*, U.S. DEP'T OF VET. AFFAIRS, http://www.ptsd.va.gov/understand/common/common_veterans.asp (last visited Feb. 27, 2023).

month, 48.6% of all WWP warriors reported a presence of PTSD symptoms – validated, in part, by the fact that WWP warriors had an average PCL-5 score of 33.0[5], which falls within the range indicating the presence of PTSD symptoms.

Similarly, an estimated 31.1% of U.S. adults experience an anxiety disorder at some point in their lives.[6] However, this number is notably higher among WWP warriors, with nearly half (46.7%) presenting with moderate to severe anxiety symptoms. And while depression is one of the most common mental health disorders worldwide,[7] WWP warriors appear to be affected disproportionately. When asked about depressive symptoms in the past two weeks, more than half (54.9%) of WWP warriors presented with moderate to severe depressive symptoms. All of these mental health conditions can have a significant impact on quality of life.

To that end, veteran suicide continues to be a national public health crisis that requires a large-scale coordinated response. Nearly one in five WWP registered warriors report an attempted suicide at some point in their lives and nearly 30% have had suicidal thoughts in the past 12 months. Thankfully, according to VA's *2022 National Veteran Suicide Prevention Annual Report*, fewer veterans died by suicide in 2020 than the year before and 2020 had the lowest number of veteran suicides since 2006. While this is good news, veteran suicide rates in 2020 were over 57% higher than the rate of suicide in non-veteran adults and suicide was the second leading cause of death among veterans under the age of 45. In 2020, there were 6,166 veteran deaths by suicide.

Within this context, WWP invites Congress to join our focus on the following areas where we believe impact can be greatest:

Community Alignment

Wounded Warrior Project has been a consistent provider and advocate for a continuum of mental health programs to help warriors and their families build resilience and overcome mental health struggles. We believe this support is necessary from organizations like us, as well as VA and other government entities. WWP supports continuing to pursue a public health approach that coordinates action from all government as well as public-private partnerships.

Your committees have made great strides towards this approach in recent years. Last fall, VA announced the first awardees of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. This program was established as part of the historic *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (P.L. 116-171 § 201) that was signed into law in 2020. WWP was excited to see over $50 million awarded to 80 organizations that are working to prevent suicide by connecting more veterans with clinical and non-clinical services in their communities.

Mission Daybreak is another great example, where VA recently finished awarding $20 million in grants aimed at developing innovative solutions to reducing veteran suicide. This

[5] The PCL-5 is a 20-item self-report measure that assess the 20 DSM-5 symptoms of PTSD.
[6] *Any Anxiety Disorder*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder (last visited Feb. 28, 2023).
[7] *Depression*, WORLD HEALTH ORG., https://www.who.int/news-room/fact-sheets/detail/depression (last updated Sept. 13, 2021).

effort is an exciting illustration of what is possible with a public-private partnership approach to this crisis. Awardees are pursuing diverse approaches incorporating innovations like smart phone technology and artificial intelligence to help reduce veteran suicide. Similarly, the Governor's Challenge has brought together state leaders from 35 states to develop clinical and community-based interventions to prevent suicide. WWP was encouraged by a provision included in the *Support the Resiliency of Our Nation's Great (STRONG) Veterans Act* (P.L. 117-328, Div. V § 303) to allow Native American tribes to participate in the Governor's Challenge as well.

To maximize the impact of these programs and the impact of upstream intervention and collaboration on reducing veteran suicide, we encourage Congress to help ensure sufficient funding and alignment of these efforts. While efficient use of taxpayer dollars should be considered within these programs, it is also important to be mindful that onerous reporting and administrative tasks can stifle the speed of progress and limit impact. Finding the right balance will be key in our continuing pursuit of reducing veteran suicides through innovative approaches in clinical and nonclinical settings.

Opioid and Substance Use Disorders

Opioid and substance use disorders (SUDs) continue to be an issue facing many veterans, and wounded veterans in particular. More than two in five WWP warriors screened positive for potentially hazardous drinking or active alcohol use disorders (43.5%) and over 6% showed a moderate to severe level of problems related to drug abuse. Additionally, substance abuse is more than twice as common among warriors with two or more mental health conditions.

Unfortunately, these trends are consistent with other research on the post-9/11 veteran community. According to the RAND Corporation[8], post-9/11 veterans are at higher risk for co-occurring SUDs and mental health disorders. Veterans screening positive for PTSD or depression are almost 20% more likely to screen positive for hazardous alcohol use or a potential SUD. SUD is also a factor in veteran suicide. According to VA, mental health or SUD diagnoses were present for 58% of veterans who died by suicide in 2020 (as measured by Veterans Health Administration (VHA) diagnoses).[9] Of those, 19.6% were diagnosed with alcohol use disorder, 8.3% had cannabis use disorder, and 4.9% had opioid use disorder. From 2001 to 2020, suicide rates fell for recent veteran VHA users with diagnoses of alcohol use disorder and SUDs but rose for those with opioid use disorder, cocaine use disorder, cannabis use disorder, and stimulant use disorder.

For these reasons, WWP was pleased to see Congress initiate a study on VA treatment for co-occurring SUDs and mental health disorders through the *STRONG Veterans Act* (§ 505). Expanding VA capacity to treat co-occurring conditions may prove critical in consideration of the fact that many mental health treatment facilities – particularly within VA's community care network – require veterans to abstain from substance use. WWP would be pleased to work with

[8] ERIC R. PEDERSON ET AL., RAND, IMPROVING SUBSTANCE USE CARE: ADDRESSING BARRIERS TO EXPANDING INTEGRATED TREATMENT OPTIONS FOR POST-9/11 VETERANS (2020).
[9] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, 2022 NATIONAL SUICIDE PREVENTION ANNUAL REPORT 26 (Sept. 2022).

Congress to explore further solutions informed by this study and our own experience working with warriors.

In 2022, one in four warriors who reached out to WWP for outpatient mental health services had a moderate or severe alcohol score. In addition, a high percentage of warriors present at risk for multiple conditions at intake; specifically, 23% for depression and alcohol; 23% anxiety and alcohol; and 22% for PTSD and alcohol. In response to these trends, our Warrior Care Network program launched a SUD track for warriors with these co-occurring conditions. A primary goal of the SUD intensive outpatient track is to increase access to and successful completion of trauma-focused treatment for warriors with PTSD who are also in early recovery or are managing active substance misuse. Since its launch in 2020, the track has grown to serve 7% of warriors enrolled in Warrior Care Networks's intensive outpatient program, indicating a need to continue expanding services for these veterans.

Access Standard for Residential Care

Another solution to address these co-occurring mental health and substance use disorders is increasing access to VA's Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) or similar community-based alternatives. Veterans in need of inpatient residential care must be able to access it in a timely and efficient manner. The *VA MISSION Act* (P.L. 115-182 § 104) required VA to establish access standards for community care and VA subsequently promulgated such standards for primary care, mental health, non-institutional extended care, and specialty care. However, VA did not include a specific access standard for residential care.

Instead, VA relies on VHA Directive 1162.02 to establish when a veteran is eligible for residential care in the community. The Directive states that veterans requiring priority admission must be admitted within 72 hours. For all other veterans, they must be admitted as soon as possible after a decision has been made. If they cannot be admitted within 30 days, they must be offered treatment at a residential program within the community.

Unfortunately, this is not the case in all instances. A recent report from VA's Office of Inspector General (OIG) found that staff at VA North Texas placed patients on waitlists for two to three months and failed to offer referrals for community-based residential care for most of fiscal years 2020 and 2021.[10] They found that this failure to discuss and offer alternative treatment options as required by VHA may have contributed to an increased risk of negative outcomes for the veterans. According to the OIG, VA North Texas leadership misinterpreted the national MH RRTP policy and provided inaccurate information to staff.

This is a pattern that, although not universal, WWP has seen while assisting warriors around the country. Our Complex Case Coordination team has worked to place veterans into suitable residential care programs outside VA when local VA facilities have reached their capacity. Similar to examples provided in the OIG report, our efforts have been frustrated when VA relies on its ability to maintain periodic clinical contact with the veteran until space is opened up rather than offering community-based alternatives. Some medical centers have been

[10] OFF. OF INSP. GENERAL, U.S. DEP'T OF VET. AFFAIRS, NONCOMPLIANCE WITH COMMUNITY CARE REFERRALS FOR SUBSTANCE ABUSE RESIDENTIAL TREATMENT AT THE VA NORTH TEXAS HEALTH CARE SYSTEM (Jan. 2023).

less willing to refer to the community than others. As this process drags out (sometimes more than 30 days), there is increased risk of losing the veteran to contact or changing their willingness to enter treatment or further engage with VA.

The *STRONG Veterans Act* included an important provision related to these issues that WWP was pleased to see. Section 503 includes requirements for VA to conduct studies on veteran's access to MH RRTP care, including whether there are sufficient bed spaces, locations, and the impact on average wait times. We look forward to reviewing these findings when they are released and working with the committees to act on any recommendations made. Congress can also pursue legislation to ensure MH RRTP is included in VA access standards for care.

Telehealth

Lastly, WWP asks that your committees continue to leverage the benefits of telehealth. Since the onset of the COVID-19 pandemic, VA has been a leader in embracing telehealth. VA has seen a rapid rise in the numbers of veterans using telehealth to receive their care, and telehealth is similarly popular in the WWP warrior community. Among warriors who were offered a telehealth appointment in the last 12 months, 89.3% reported using telehealth during that period. Among those not offered a telehealth appointment, a majority (63.9%) said they would have used it if presented as an option. Telehealth is a cost-effective way to improve access to care for many warriors that may face barriers to care, including long driving distances, work schedules, and the need for child care.

Expanded access to telehealth for veterans around the country should not be reversed. The authority currently allowing VA to conduct telehealth appointments and prescribe medications across state lines is set to expire this May with the end of the national emergency pandemic measures.[11] While Congress has extended providers' abilities to conduct appointments on telehealth platforms for two years[12], their ability to prescribe certain medications without in-person evaluations and across state lines will end. This will cut off millions of veterans' access to their prescriptions and medical care, especially in rural and remote areas of the country. We urge you to take the necessary action to ensure veterans do not lose this access to care.

Broadband access and state jurisdictional matters are additional issues some veterans face when accessing telehealth. Broadband access continues to be an issue for some veterans. In 2019, the Federal Communications Commission (FCC) estimated that 15 percent of veteran households did not have an internet connection. VA and the FCC have introduced programs to attempt to bridge this digital divide, including Digital Divide Consults, Accessing Telehealth through Local Area Stations (ATLAS), and the Lifeline and Affordable Connectivity Program. Non-VA providers ability to practice over state lines like their VA counterparts also creates

[11] See *How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency*, DRUG ENF. ADMIN., U.S. DEP'T OF JUSTICE, https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf (last visited Mar. 1, 2023); see also 42 U.S.C. § 247d.
[12] Pub. L. No. 117-328, § 4113.

barriers to care – perhaps most critically in mental health, as more than 150 million Americans live in a federally designated mental health professional shortage area.[13]

Accordingly, WWP supports increasing veterans access to mental health treatment through interstate compacts. The Psychological Interjurisdictional Compact (PSYPACT) is an interstate compact designed to facilitate the practice of telepsychology across state boundaries. There are now 35 states that have enacted PSYPACT legislation, giving veterans in these states easier access to additional mental health providers. We encourage your committees to support policies that encourage interstate compacts like PSYPACT (which only applies to psychologists), that will improve care options for veterans. Social work, which comprises a significant percentage of the nation's mental health work force both in and outside of VA, may be a good place to start.

We believe more veterans should be connected to telehealth care by continuing to address these issues. We urge you to support the expansion of telehealth options for veterans by increasing broadband access, improving IT infrastructure, growing VA care access points, and exploring interstate medical practice rules for community mental health providers. Among many considerations to keep in mind, we hope Congress will work with VA and other stakeholders to ensure a proper balance is found between the efficiencies of using telehealth and veteran preferences. Best medical interests should be paramount and there are occasions when the value of in-person appointments outweigh matters of time and convenience.

WOMEN VETERANS

Women veterans are the fastest growing group in the veteran population, projected to comprise 18% of the veteran population by 2040.[14] A similar trend has already been realized at WWP, where more than 32,000 women warriors make up 17% of all WWP Alumni. With this recognized, there remain many unique opportunities to address women veterans' needs while providing advocacy and support for them in the process.

Two years ago, WWP released the Women Warriors Initiative Report, which provided insight and clarity into the needs of women warriors. However, needs change over time, especially for the veteran population. Our prior research showed women veterans have needs around the following areas: access to care, mental health, transition, isolation, and financial stress. Congress addressed several of these in recent years with passage of the *Deborah Sampson Act* (P.L. 116-315 §§ 5101-5503), the *MAMMO Act* (P.L. 117-135), and the *VA Peer Support Enhancement for MST Survivors Act* (P.L. 117-271), yet there is still work to be done, and we look forward to continuing our advocacy for women veterans through the 118th Congress.

Access to Gender-Specific Care

[13] BUREAU OF HEALTH WORKFORCE, HEALTH RES. AND SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS STATISTICS, FIRST QUARTER OF FISCAL YEAR 2023 (Jan. 2023).
[14] *Women Veterans Health Care*, U.S. DEP'T OF VET. AFFAIRS, https://www.womenshealth.va.gov/materials-and-resources/facts-and-statistics.asp (last visited Mar. 1, 2023).

Wounded Warrior Project believes women veterans should be able to access and navigate culturally competent systems of care to ensure a high quality of life after their military service. Women veterans are more likely to be exposed to health risks that contribute to disparities when compared to their civilian peers, resulting in issues with reproductive health, mental health, and physical health.[15] Gaps within VA as well as the civilian health care system should be addressed with urgency to improve access and quality of health care for women veterans.

In a world that has been severely impacted by the effects of COVID-19, aspects such as telehealth have increased the ability for veterans to connect with healthcare options that are convenient for them. Women veterans are more likely than their male counterparts to utilize telehealth appointments with research telling us that these efforts may reduce gender-specific access barriers.[16] We continue to applaud VA for their efforts to increase and continue usage of Video Virtual Connect options for a variety of mental and physical health care needs.

Women veterans should be provided with options to receive care from gender-specific providers to establish a greater amount of trust. The VA budget should continue supporting expansion of the program office and budget for women veterans' health care, to include initiatives like the Women's Health Innovation and Staffing Enhancement (WHISE) Initiative and full-time Women's Peer Specialists (WMH PS). To illustrate the need, a shortage of OB-GYN providers nationwide and an overall lack of women veteran awareness of reproductive and women health services has resulted in women veterans being referred out of VA.[17] Women primary care providers reported higher rates of burnout and lower rates of being treated professionally (being treated with civility) than male primary care providers.[18]

The impact of having a gender-specific provider, especially for women patients, is a positive one. Veterans having access to gendered providers can lead to higher rates of satisfaction related to perceived access to care, higher rates of compliance with provider recommendations, and higher rates of positive perceived overall health outcomes, but availability of women providers specifically varies nationwide in VA facilities and does not meet the demand of veterans.[19] There is a lack of women providers within VA, but adequate staffing and support for women providers placed in comprehensive women veteran health clinics can contribute to lower rates of attrition.[20] Congress can pass legislation expanding gendered services within the VA, specifically targeting the existing women veteran health clinics and the Center for Women Veterans.

Another area where the committees can act is residential substance use care. WWP supports the *Women Veterans TRUST Act* (117th, H.R. 344), which would require VA to implement a women-specific pilot program to treat and rehabilitate women veterans with drug or alcohol dependency. Programs such as what the *Women Veterans TRUST Act* aims to develop

[15] Jodie G. Katon et al., *Reproductive Health of Women Veterans: A Systematic Review of the Literature from 2008 to 2017,* 36(6) SEMS. REPROD. MED. 315, 315-22 (2018).
[16] Jan A. Lindsay et al., *Getting Connected: A Retrospective Cohort Investigation of Video-to-Home Telehealth for Mental Health Care Utilization Among Women Veterans*, 37(Sup. 3) J. GEN. INTERNAL MED. 778, 778-85 (2022).
[17] Lori M. Gawron et al. *Women's Health Provider Perspectives on Reproductive Services Provision in the Veterans Health Administration*, S. MED. J. 116 (2), 181-87 (2023).
[18] Eric A. Apaydin et al., *Gender Differences in the Relationship Between Workplace Civility and Burnout Among VA Primary Care Providers*, 37(3) J. GEN. INTERNAL MED. 632, 632-36 (2022).
[19] Rachel Kimmerling et al., *Access to Mental Health Care Among Women Veterans*, 53(4 Suppl 1) MED. CARE 97, 97-104 (2015).
[20] Rachel Schwartz et al., *Retaining VA Women's Health Primary Care Providers: Work Setting Matters*, 36 J. GEN. INTERNAL MED. 614, 614-621 (2021).

would help fill in gaps that currently exist within the VA, specifically with regard to mental and behavioral health. Meeting women veterans where they are is one way to build trust and strong relationships with individuals who have historically felt overlooked when it comes to VA care.

Ongoing Support and Community for Military to Civilian Transitions

Wounded Warrior Project celebrates women veterans and the sacrifices they made while in the Armed Forces; we support community-based efforts to welcome warriors home after they complete their service. Ambiguity and a lack of clarity or purpose as an individual moves onto a new path in life have been found to lead to negative physical and mental health concerns.[21] For women specifically, results from our Women Warrior Initiative Survey (2020) revealed women veterans are less likely to identify that their military experience was positive and fewer women veterans feel their community respects them as veterans, while also indicating a slightly lower quality of life than their male counterparts.

Wounded Warrior Project continues to believe that as women leave the military and transition to veteran status, women-only peer support programming can be beneficial. Women veterans have identified they lack support from their partners, family, and even from military peers during and after the military transition process.[22] Programs such as symposiums hosted by the Office of Outreach, Transition and Economic Development within VA and the Women's Health Transition Training through the Center for Women Veterans seek to help transitioning Service members, but such opportunities are considered optional during the VA Transition Assistance Program (TAP).

The committees have a role to help oversee the administration of these programs and their alignment with other federal offerings. For example, despite the involvement of several agencies including Labor, Education, Homeland Security, and VA, issues persist with awareness and engagement within mandated transition programs such as the TAP or the Executive Transition Assistance Program (ETAP), as veterans have reported not being allowed to attend components due to deployment tempo, lack of awareness from commands, and structural issues with the programs.[23] Furthermore, there is an increasing amount of mentorship programs focusing on women Service members, but there are still gaps when looking at identity and purpose in those programs – specifically around the military transition.[24]

Military Sexual Trauma (MST)

Women are at a disproportionately higher risk of experiencing military sexual trauma (MST), with 15.1% of women from the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) reporting a history of MST during preliminary screenings for healthcare services.[25] The problem is even more pronounced among those who are registered with WWP.

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[21] Parvaneh Bahrami et al., *Modeling the Impact of Mentoring on Women's Work-Life Balance: A Grounded Theory Approach*, 13(1) ADM. SCI. 6, 6-14 (2022).
[22] Nicholas A. Rattray et al., *Modeling Contingency in Veteran Community Reintegration: A Mixed Methods Approach*, 17(1) J. Mixed Methods Research 70, 70-92 (2023).
[23] Kari L. Fletcher et al., *Transition Services Utilization Among US Women Veterans: A Secondary Analysis of a National Survey*, 8(1) J. VET. STUDIES 164, 164-74 (2022).
[24] Linna Tam-Seto et al., *Scoping Review of Mentorship Programs for Women in the Military.* 8(1) J. MIL. VET. FAMILY HEALTH 15, 15-21 (2022).
[25] Rachel Kimerling et al., *Military-Related Sexual Trauma Among Veterans Health Administration Patients Returning from Afghanistan and Iraq*. 100(8) Am. J. Public Health 1409, 1409-12 (2010).

Approximately 4 out of 9 women (44.6%) who completed the 2022 Annual Warrior Survey reported experiencing MST in service.

Fortunately, Congress has already helped address some of the challenges associated with MST after service including the lack of peer support and likelihood of retraumatization when seeking disability compensation. The *MST Claims Coordination Act* (P.L. 117-303) aims to ensure that during or immediately after a medical exam, hearing before the Board of Veterans Appeals, or other relevant event, the Veterans Benefits Administration must coordinate with the Veterans Health Administration to provide veterans information on available resources relating to MST. Similarly, the *VA Peer Support Enhancement for MST Survivors Act* (P.L. 117-271) now requires that VA ensure each individual who files a claim relating to MST is assigned a peer support specialist during the claims process, unless they elect not to.

Wounded Warrior Project hopes these new laws will be a focus of oversight and inspire similar measures to better serve those affected by MST. One supported by WWP but not passed in the 117th Congress is the *Servicemembers and Veterans Empowerment and Support Act* (117th, H.R. 5666/S. 3025). This bill would lower burden of proof established in VA policy nearly 20 years ago and ensure that this relaxed evidentiary standard is appropriately extended to all mental health conditions (not just PTSD) resulting from sexual assault.

FINANCIAL SECURITY

Along with physical and emotional health, financial security is an important factor in overall wellness and a key component to a veteran's success after service. While veteran unemployment has hit pre-pandemic lows, too many warriors and their families continue to experience financial uncertainty. Nearly 2 out of 3 (64.2%) respondents to our Annual Warrior Survey reported that they did not have enough money to make ends meet at some point in the past twelve months with a majority (81.8%) reporting that the increasing cost of goods, like food, was a top cause of their financial strain. In FY 23, WWP is on pace to exceed our projected emergency financial assistance to warriors by 62 percent.

One of the most critical keys to success for the post-9/11 wounded, ill, and injured post-9/11 veterans we serve is maximizing the value of VA benefits and services. Despite high levels of education (42.3% with a bachelor's degree or higher) and low levels of unemployment (6.8%), over a quarter (26.8%) said they worked but did not earn enough money. Congress can help by focusing oversight on programs to help veterans find better paying jobs, particularly those that help veterans develop vocational skills that are in high-demand or more likely to be accommodating to service-connected injuries. Veterans Employment Through Technology Education Courses (VET TEC), a five-year pilot program that began in May 2019, and Veteran Readiness and Employment (VR&E) are two examples. Legislative changes can also bring improvements to veterans' financial security. Our recommendations for such changes are below.

Concurrent Receipt

In 2004, Congress passed a law allowing military retirees with at least 20 years of service who are rated at least 50 percent disabled to collect their full Department of Defense (DoD) retired pay and their full VA disability compensation benefits. For these individuals, DoD retirement is no longer reduced according to VA disability income (dollar for dollar). Unfortunately, those with combat-related injuries and less than 20 years of service were left behind. These medical (Chapter 61) retirees must give up a portion of their earned benefits due to combat-related injuries or illnesses that shortened their military careers.

Wounded Warrior Project strongly believes that DoD retirement pay and VA disability compensation are distinct benefits established by Congress for two different purposes. A significant percentage of Congress has already expressed that it agrees. Legislation that originated in the 116th Congress was reintroduced in the 117th Congress and amassed considerable support. The *Major Richard Star Act* (S. 344, H.R. 1282) would allow Chapter 61 retirees whose disabilities arose from combat-related activities – and eligible for Combat Related Special Compensation – to receive both their DoD retirement pay and their VA disability compensation concurrently and permit approximately 50,300 veterans to receive the benefits they have been denied until now[26]. Bicameral, bipartisan majorities were ultimately unsuccessful in passing this legislation, but we are hopeful of building upon the support of 336 Representatives and 67 Senators in the 117th Congress and delivering results for those 50,300 wounded warriors in the 118th Congress.

Veteran Readiness and Employment (VR&E)

The VR&E program, offered by VA, aids with job training, employment, resume development, and job-seeking skills coaching for veterans whose service-connected disabilities make it hard to prepare for, obtain, or maintain employment. The VR&E program has become a valuable asset in VA's employment and educational portfolio. A meaningful number of WWP warriors – one in five (20.7%) – have used, or are using, the VR&E program. This notably high usage combined with the actual and potential impacts of participation suggests that VR&E improvements can drive better outcomes for wounded warriors.

Research at the state level further validates that VR&E participation can help individuals make significant financial progress and create wider social impact. Specifically, Vocational Rehabilitation Agencies for disabled Americans are present in the state governments throughout the United States and have proven to be an effective resource for those looking to resume gainful employment. The Social Security Administration notes that for every one dollar spent on these programs, ten dollars in tax revenue are generated from the re-employed.[27] Similarly, the recently passed *VENTURE Act* (P.L. 117-333 § 14) expanded the Self-Employment Track and increased the likelihood that more veteran-owned businesses will compete for federal contracts as Service-Disabled Veteran Owned Small Businesses (SDVOSBs).

Despite these positive indicators of value, warriors are being denied access to VR&E due to an arbitrary delimiting date that does not consider a current disability's effect on efforts to

[26] U.S. DEP'T OF DEF., STATISTICAL REPORT ON THE MILITARY RETIREMENT SYSTEM FY 2021, September 2022.
[27] Jody Schimmel Hyde & Paul O'Leary, *Social Security Administration Payments to State Vocational Rehabilitation Agencies for Disability Program Beneficiaries Who Work: Evidence from Linked Administrative Data*, 78(4) SOCIAL SECURITY BULLETIN (2018), *available at* https://www.ssa.gov/policy/docs/ssb/v78n4/v78n4p29.html.

seek or maintain gainful employment. Under current regulations, a veteran is only eligible for VR&E for 12 years from the date of their military discharge or the date they received a compensable disability evaluation.[28] The regulations do not consider whether a veteran's condition deteriorates after the initial rating or whether additional service-connected conditions have been recognized.

This issue was partially addressed by the enactment of the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* (P.L. 116-315 § 1025), which removed this delimiting date for all veterans who were discharged after January 1, 2013. The remaining issue to solve in this context is how to support those discharged before that date; veterans discharged before are still subject to the 12-year delimiting date. WWP asks that the 12-year delimiting date be removed for all veterans. VA already has the authority to waive the 12-year rule on a case-by-case basis if the veteran is determined to have a "serious employment handicap."[29] However, the standards used to make that determination are not clear and, without specific guidance to follow, a Vocational Rehabilitation Counselor (VRC) is ultimately left to make a subjective decision whether to grant the veteran eligibility to the program. Wider and more predictable participation should be the goal.

Claims File Access

A simple and straightforward way to assist veterans on their paths to a more secure financial future is to modernize the way they can access their benefits claims file. Creating a "C-File" is often VA's first step to helping a veteran with their claim for a service-connected disability. The C-File may contain the veteran's service records, VA exam results, additional information submitted by the veteran, and anything else VA deems necessary to decide a disability claim. A veteran may want to view their C-File to ensure all the information it contains is accurate and complete before the claim is decided or to better understand how VA reached its decision.

Unfortunately, the process for a veteran to be able to view their C-File is antiquated and inconvenient. Currently, if a veteran wants to view their C-File, their options are: (1) making an appointment with their VA Regional Office (RO) to physically view the C-File in person; (2) submitting VA Form 3288, *Request for and Consent to Release of Information from Individual Records*, by mail or fax with no confirmation of receipt and a wait period that may last several months; or (3) submitting a *Freedom of Information Act* (FOIA) request, which is difficult for veterans who are not familiar with the procedure. All three scenarios can easily create unnecessary inconvenience for the veteran, and meaningful processing time for VA – to include providing the C-file on compact discs that are not immediately compatible with many new computers.

Legislation can solve this problem. If enacted, the *Wounded Warrior Access Act* (H.R. 1226), would modernize this process by allowing veterans to electronically request and receive their C-Files easily and securely. It would also create reasonable timeliness standards for VA to confirm receipt of the request and provide the veteran with their records. This would make the

[28] 38 CFR § 21.41
[29] 38 U.S.C. § 3103(c)

process more convenient for veterans, increase veterans' faith in VA transparency, and decrease unnecessary appeals since more veterans will have access to all the information VA used to decide their claims. This legislation passed the House in the 117th Congress (H.R. 5916) and has WWP's support for the 118th.

TOXIC EXPOSURE

Just as our nation has a responsibility to provide health care and benefits to veterans who suffer physical and mental injuries in service, we must also meet the needs of those who suffer from illnesses associated with toxic exposures. Our Annual Warrior Survey illustrates the extent to which post-9/11 veterans suffered exposure to toxic substances during their service. Among those deployed in support of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn, 80.3% reported serving near a burn pit, meaning a burn pit was located either on their base or close enough that they could see smoke. Of those, 82.6% reported being near a burn pit on a daily or weekly basis. Consequently, many now suffer from respiratory conditions, cancers, and other serious illnesses. Historically, less than one-third of them who filed disability claims with VA for exposure-related condition were successful in obtaining service connection.

Last year, Congress addressed this issue by passing the *Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022* (P.L. 117-168), which was signed into law on August 10, 2022. This comprehensive legislation accomplished each of WWP's priorities with respect to toxic exposure: guaranteeing access to VA health care for all veterans who were exposed to toxic substances; conceding exposure to burn pits and airborne hazards for veterans who served in areas where they are known to have been present; creating a list of presumptive conditions associated with those exposures; and establishing a VA decision-making model to create new presumptive conditions in the future.

Together, these provisions represent the largest expansion of veterans' health care and benefits in decades. WWP deeply thanks the Members of the Committees and their staff for your dedicated, bipartisan work to pass this historic law and is committed to working with Congress and VA to support its full implementation. Although we do not have any immediate legislative requests for the 118th Congress, we are committed to supporting your oversight of the *PACT Act*, specifically in the areas below:

Disability Claims Processing

Prior to the passage of the *PACT Act*, many veterans who submitted VA disability compensation claims for toxic exposure-related conditions (particularly those who suffered exposures during post-9/11 deployments) often faced significant challenges to establish service connection. As exposure to burn pits and other toxic substances was often not documented in the veteran's military record, and associated conditions may manifest several years after discharge, VA was often unable to determine a link between the veteran's illness and their service, leading to a denial of the claim.

The *PACT Act* addressed this by establishing over 20 new presumptive conditions related to toxic exposures, allowing VA to presume these conditions are service connected for veterans

who served in areas of known exposure. Most of these conditions are cancers and respiratory illnesses associated with Gulf War and post-9/11 service in Iraq, Afghanistan, and surrounding areas. The new law also established two new conditions associated with Agent Orange exposure and expanded qualifying service locations for Agent Orange and radiation exposure.

This large expansion of new presumptive conditions has understandably resulted in a significant influx of new VA disability claims. As of February 4, 2023, the Veterans Benefits Administration (VBA) has received 294,920 *PACT Act*-related claims since the bill was signed into law on August 10, 2022, leading to an increase of 23.8% in total claims received over the same time period last year.[30] Although this larger workload will create a temporary increase to the claims backlog, we believe this is necessary to ensure that exposed veterans, many of whom have been filing claims unsuccessfully for years, are finally able to access the benefits they need. VA has already begun implementing provisions of the legislation that granted the ability to hire additional employees, improve training, and enhance technology, and WWP believes it is critical that Congress continues to fully fund these important authorities.

Since VA began processing for all *PACT Act* claims on January 1, 2023, the Veterans Benefits Administration (VBA) has completed 53,096 claims, approximately 85% of which have been granted.[31] This represents a significant improvement over the less than one-third grant rate warriors reported before the passage of the bill, and WWP National Service Officers have not observed any systemic issues with the decisions that have been issued since. Still, they have noticed a degree of inconsistency with the way *PACT Act* claims are processed, particularly with respect to unnecessary exams and medical opinions being ordered when the evidence in the file – showing service in a designated exposure area and a qualifying disorder – is sufficient to grant the claim without further development. Although we recognize a very short time has passed since claims processing began, we encourage VBA to consider whether supplemental training may be necessary to increase consistency and accuracy of decisions.

Although regulations for the *PACT Act* have not yet become final, VBA is currently processing claims in accordance with a policy letter that was published in the Federal Register on December 22, 2023.[32] Among other guidance, this letter outlines 72 diagnostic codes that fall under the 23 new presumptive disabilities umbrella categories enumerated in the legislation. While WWP is generally pleased with this guidance, we were disappointed to see that leukemia, a rare and potentially deadly cancer that some exposed warriors are experiencing, was not included under the categories of "Lymphoma cancer of any type" or "Lymphomatic cancer of any type."[33] We note that leukemia and lymphoma are similar diseases in that they are both considered hematologic cancers.[34] WWP encourages VA to consider including leukemia as a presumptive condition when rulemaking becomes final and plans to reiterate this in our public comment as part of the rulemaking process.

Access to Health Care

[30] U.S. DEP'T OF VET. AFFAIRS, *PACT Weekly Report*, Feb. 4, 2023.
[31] *Id*.
[32] *Processing Claims, Honoring Our Pact Act of 2022*, 87 Fed. Reg. 78,543 (Dec. 22, 2022).
[33] Pub. L. No. 117-168, § 406.
[34] CTRS. FOR DISEASE CONTROL AND PREV., *Hematologic Cancer Incidence, Survival, and Prevalence*, 30 U.S. Cancer Stat. (Sept. 2022), *available at* https://www.cdc.gov/cancer/uscs/pdf/USCS-DataBrief-No30-September2022-h.pdf.

One of the *PACT Act*'s most significant provisions guarantees access to VA health care for all post-9/11 veterans who served in Iraq, Afghanistan, and other surrounding areas of known exposure. Recently discharged combat veterans now have a 10-year enhanced enrollment period (up from 5 years), and veterans who were discharged more than 10 years ago have a limited one-year period to enroll for care (October 1, 2022, to September 30, 2023). For exposed veterans who miss the one-year open enrollment, there is a 10-year phase-in for permanent access to Priority Group 6 enrollment based on discharge date. WWP strongly advocated for these provisions since post-9/11 veterans who were exposed to burn pits and other toxic substances are an at-risk population, and it is critical that they have guaranteed access to clinical screening, early detection, and potentially lifesaving treatment if illnesses are diagnosed.

However, we also recognize that one-year open enrollment followed by the 10-year phase-in leaves some potential gaps in eligibility. For instance, a veteran who was discharged in 2006 after being exposed to burn pits in Afghanistan and who misses the one-year open enrollment period ending on September 30, 2023, would become ineligible for enrollment under the new statute until October 1, 2026 (unless they are able to establish service connection or eligibility under some other authority). If the veteran was discharged in 2007, they would be ineligible from September 30, 2023, to October 1, 2028.

Modest measures can be taken to address any gaps in eligibility that may exist for exposed veterans. First, Congress can consider extending the one-year open enrollment period for an additional year if data reflects that a relatively small number of veterans enrolled. Such action would protect against lack of awareness or urgency among the post-9/11 community. Second, the Veterans Health Administration (VHA) can continuously evaluate the number of veterans who enroll for care under the *PACT Act* throughout the 10-year phase-in to determine the impact on the capacity to deliver high quality and timely care. If VHA has sufficient resources to meet additional demand at any point, we encourage VA to use its existing authority to modify the phase-in to an earlier date to grant permanent access to care for more exposed veterans sooner.

Toxic Exposure Presumption Process

In recognition of the challenges associated with establishing direct service connection for toxic exposure-related conditions, Congress has historically created mechanisms to require VA to decide whether to establish presumptive service connection when scientific data show a link between specific exposures and associated illnesses, as it did for Vietnam veterans with the *Agent Orange Act of 1991* (P.L. 102-4). However, no law existed prior to the passage of the *PACT Act* to require VA determinations on illnesses associated with all toxic exposures, regardless of location or period of service.

The *PACT Act* established a permanent VA Working Group to continuously review evidence and receive input from Veterans Service Organizations (VSOs) and the public on all potential exposure-related conditions in veterans and their family members who were military dependents, now and in the future. This Working Group is required to make recommendations to the Secretary of Veterans Affairs on whether to establish a presumption of service connection

for an exposure related condition. To form its recommendations, the Working Group will continuously review scientific literature, VBA claims data, and other factors including the level of disability and mortality caused by the condition, whether conditions are deployment-related, the rarity of conditions, and the quantity and quality of the information available.

Previous decision-making models that studied the health effects of airborne hazards present on post-9/11 deployments have been limited by a lack of good exposure characterization. For this reason, WWP encourages the Working Group to consider research on toxic exposures in the general population conducted by agencies such as the Centers for Disease Control and Prevention and the Environmental Protection Agency in forming its recommendations about conditions related to military exposures.

When reviewing locations of potential exposure, WWP encourages the Working Group to include military humanitarian missions in addition to combat deployments. For example, the U.S. Indo-Pacific Command frequently deploys Service members in disaster relief efforts which can potentially result in exposures, such as the 2011 Fukushima nuclear accident in Japan following an earthquake and tsunami.[35] We recommend that the Working Group routinely evaluate all military humanitarian missions to determine potential exposures and associated health risks, especially those that involve responses to earthquakes and flooding.

Additionally, WWP encourages the Working Group to expand the types of conditions it considers for association with burn pits and other toxic substances present on post-9/11 deployments beyond respiratory conditions and cancers. These categories of conditions do not capture the full range of illnesses that exposed post-9/11 veterans are experiencing. In our most recent survey, the health condition veterans most commonly believed to be associated with their toxic exposure was neurological problems (35.1%). Hypertension (33.2%), Chronic Multisymptom Illness (24.4%), immune system problems (10.5%), and liver conditions (7.8%) were also conditions that veterans commonly believe are associated with exposures while in service. WWP looks forward to working with VA to help identify these and other conditions that we believe warrant further consideration.

BRAIN HEALTH

For many post-9/11 veterans, brain health is a crucial factor in overall quality of life. Brain trauma, specifically traumatic brain injury (TBI), has been referred to as a "signature injury" for post-9/11 veterans, and this remains true for many we serve. Nearly 3 in 4 warriors (73.2%) responding to our Annual Warrior Survey report being injured and experiencing symptoms typical of head-related trauma immediately following those events. Further, approximately 36.5% of WWP warriors self-reported experiencing TBI during their military service.

Unfortunately, brain injury has a significant negative impact on warrior's quality of life. Some of the most common symptoms reported from warriors after a brain injury include feeling

[35] *Fukushima Nuclear Accident 2011*, U.S. DEP'T OF VET. AFFAIRS, https://www.publichealth.va.gov/exposures/radiation/sources/fukushima.asp (last visited Mar. 1, 2023).

anxious or tense, problems with sleep, and irritability. Overall, warriors with a history of brain injury report a lower quality of life than the median of the general U.S. population. Additionally, recent literature suggests that TBI results in excess mortality (predominantly from suicides or accidents) in the post-9/11 military and veteran population.[36] We are also aware of the comorbidity of TBI and mental health disorders, specifically PTSD and substance use disorder. The confluence of symptomology between TBI and mental health disorders results in diagnosis and treatment challenges. Recent published research concluded that a history of TBI is consistent with severe substance use issues and presentation of mental health symptoms.[37] These studies, together, suggest that TBI should be viewed as a singular, independent factor that contributes to an overall decline in quality of life, presents as an elevated risk factor for suicide, and drives mental health symptom reporting and substance use dependence.

TBI Research

Wounded Warrior Project has long advocated for new and continuing investments into research on TBIs. While we have begun to learn much more about TBI and its impacts, more can and should be known about the expected course of neurological and cognitive functioning after TBI. As the population of post-9/11 veterans living with the aftereffects of TBI continues to grow, we believe we must continue to invest resources in finding better ways to manage and treat their conditions and meet their long-term needs.

This year, the *Traumatic Brain Injury Act* (P.L. 104-166) will be up for reauthorization. Initially passed in 1996, the *TBI Act* was the first federal legislation to address TBIs through prevention, research, and the delivery of grants to states to address issues surrounding TBI. Since 1996, it has been reauthorized four times and has included important updates including authorizing the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) to work with DoD and VA to study the incidence and prevalence of TBI in the military and veterans' populations in 2008. The *TBI Act* has been instrumental in creating federal policy related to brain health, and WWP supports reauthorization.

Last year, the RAND Corporation released a comprehensive report commissioned by WWP, *Improving Care for Veterans with Traumatic Brain Injury Across the Lifespan.* This report included findings on how to identify the long-term outcomes of TBI for post-9/11 veterans, the future needs of this population, effective treatments for TBI, and the availability of community-based resources. There were also several key recommendations made including the need for further investment in research. The report found that "the study findings indicate both demand and need for high-quality research examining veterans with TBI and corresponding treatments and outcomes." The report also highlighted a need to continue to collect and integrate better-quality data to better support the needs of veterans with TBI.

Thankfully, we have seen some important investments in this area. The Department of Defense and VA are currently funding several large research studies on the long-term effects of TBI and possible treatments. Additionally, Section 508 of *STRONG Veterans Act* (P.L. 117-328,

[36] Howard et al., *Association of Traumatic Brain Injury With Mortality Among Military Veterans Serving After September 11, 2001*, 5(2) JAMA NETW. OPEN (2012), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788974.
[37] Julia Davies et al., *Traumatic Brain Injury History Among Individuals Using Mental Health and Addictions Services: A Scoping Review*, 38(1) J. HEAD TRAUMA REHAB. 18, 18-32 (2023).

Div. V) included $5 million for ongoing and future research at VA on brain health and TBI. The *National Defense Authorization Act (NDAA) for FY 2023* (P.L. 117-263) also included the "Warfighter Brain Health Initiative" that will unify efforts and programs across DoD to improve the cognitive performance and brain health of members of the Armed Forces. WWP was proud to advocate for these provisions and pleased to see them signed into law. To continue to build upon and improve our understanding of TBI and how best to care for veterans with TBI, WWP encourages a continued commitment to research and policies to identify and expand access to effective treatments and community-based supports.

Long Term Care and Support

Alongside the rise in TBI reported in the post-9/11 veteran population, WWP has also seen an increase in the need for more intensive care and services. This younger generation of veterans, and especially those with TBI, are increasingly needing long term services and supports (LTSS), including VA's facility-based services, end-of-life services, geriatric outpatient programs and home and community-based services earlier in life. We continue to see an increase in usage of VHA's Geriatrics and Extended Care (GEC) programs amongst veterans under the age of 65.

Warriors frequently cite barriers to receiving care for their physical injuries or health problems, including difficulty scheduling appointments, lack of availability, and lack of understanding of VA benefits and health care. These issues are especially important to address for veterans with TBI that often experience side effects including cognitive impairment that may impact their ability to affectively engage in their care. Many post-9/11 veterans experiencing the aftereffects of TBI are not aware of the LTSS currently provided by VA they may be eligible for to address these issues.

Further, in RAND's report, they also find there is a need to increase long-term systems of support for our veterans, including by expanding access to long-term care. Progress was made towards this goal last Congress with the passage of the *Long-Term Care Veterans Choice Act* (P.L. 117-328, Div. U § 165). This legislation authorizes VA to cover the cost of medical foster homes, an alternative to nursing homes for veterans who require nursing care but prefer to live in a non-institutional setting, for up to 900 veterans over a five-year period.

Wounded Warrior Project believes there are additional opportunities to provide long-term care for veterans, including by revisiting VA's policy of not paying for room and board in assisted-living facilities. The Assisted Living for Veterans with TBI (AL-TBI) pilot program ran from 2009 to 2018 and provided veterans with moderate to severe TBI who needed long term neurobehavioral rehabilitation placement in private TBI rehabilitation facilities. In an evaluation of the program, VA found that veterans participating in the program experienced improvements in physical and emotional health, TBI symptoms, and other outcomes. Unfortunately, today, veterans who wish to participate in VA's Traumatic Brain Injury – Residential Rehabilitation program must pay for their room and board. Legislation to remove this financial burden would remove a serious financial barrier to care for some veterans who need this heightened level of support and supervision.

CAREGIVERS

Military and veteran caregivers sacrifice every day to help our nation's most severely injured Service members and veterans and they play an essential role in their care and wellbeing. WWP, we have prioritized our efforts to support these warriors and their caregivers. Our Independence Program provides high-touch individualized support from a specialized case management team to approximately 800 warriors, many of whom rely on caregivers. Last year alone, we provided over 200,000 hours of in-home and local care to these warriors who often rely on caregivers within the Independence Program.

Working alongside the warrior, the warrior's family and caregivers, and a network of case managers familiar with local resources helps WWP deliver better quality of life and care to these warriors. Partnerships with organizations that directly provide specific services or programming for caregivers allow us to expand our impact even further. Since 2012, WWP has supported 18 organizations who serve military and veteran caregivers in order to better understand their needs and provide direct programs, clinical mental health services, respite, and the development of tools to share resources within the caregiving community.

Caregivers often play an indispensable role in helping coordinate services, locating resources, being a vocal advocate, and providing aid and assistance in the home. And while much of the support provided by our Independence Program helps warriors reach and maintain a level of autonomy that would not otherwise be possible, the support offered to these caregivers by VA – at a scale far beyond what WWP can provide – is often more critical to their well-being.

Program of Comprehensive Assistance for Family Caregivers

Among warriors currently receiving aid and assistance, 30 percent are currently participating in the Program for Comprehensive Assistance for Family Caregivers (PCAFC). Following passage of the *VA MISSION Act* (P.L. 115-182 § 161) in 2018, VA modified PCAFC eligibility criteria as the program grew to expand veterans and caregivers of all eras. One of the most significant changes was replacing a system that paid stipends to family caregivers based on hours spent providing personal care services to veterans with a system that requires the caregiver to provide personal care services each time a veteran completes one of several activities of daily living.

Surveys among the warriors and caregivers in our community have revealed that less than two percent of warriors with a service-connected disability rating of 70 percent or more (a new criteria for PCAFC eligibility) are completely dependent on someone else to complete ADLs that are aligned with the ADLs considered for PCAFC eligibility. Such information led WWP to caution that the proposed (now final) eligibility standards would likely exclude many veterans with moderate and severe needs that the program was designed to cover. In contrast, subsequent surveying revealed that WWP warriors who participate(d) in PCAFC rely on a caregiver who –

regardless of employment status and type (at home, virtual, hybrid, part-time, full-time, or unemployed) – generally spends more than 50 hours per week providing caregiving assistance.

In consideration of these factors, WWP is thankful to VA for its decision to continue providing stipends and support for the program's legacy participants until 2025 and believe this was the right decision. As Congress continues to oversee implementation, WWP urges you to keep these concerns in mind and calls for continued support and monitoring of the program.

Long Term Care

While PCAFC is an important program for many younger warriors with more severe injuries, VA's Geriatrics and Extended Care (GEC) services will ultimately reach more of these veterans as their conditions progress and they choose to receive long term support services (LTSS) at home. To this end, WWP supports the *Elizabeth Dole Home Care Act* (S. 141). Key provisions of the bill would instruct VA to provide informal GEC program assessment tools to help veterans and caregivers identify expanded services they are eligible for, codify existing GEC programs to ensure the availability of effective and enduring support, and assist caregivers denied or discharged from PCAFC into other VA-provided home-cased care and support.

Another critical component of the *Elizabeth Dole Home Care Act* – although subsequently removed during a February 2023 markup – would be to raise the expenditure cap for noninstitutional care alternative programs (currently set at 65 percent of what it would cost to care for the veteran in a local nursing home) to match what could be spent for care offered in an institutional setting. It is worth noting here that applicable GEC programs like Homemaker Home Health Aide, Veteran Directed Care, and Skilled Home Health Care that are popular with veterans and caregivers often provide services that do not overlap with the personal care services considered under PFAFC eligibility. Using one program should not limit availability of the other in all circumstances.

Caregiver Mental Health and Respite

Research shows that military and veteran caregivers have higher levels of mental health problems than civilian caregivers and non-caregivers. According to RAND Corporation's *Hidden Heroes: America's Military Caregivers*, 40 percent of post-9/11 caregivers are likely to suffer from major depressive disorder (MDD) and pre-9/11 caregivers are reportedly twice as likely to suffer from MDD.[38] More recent research published in the Caregiver Consortium Newsletter – a collaboration between VA caregiver researchers – suggests that the COVID-19 public health emergency contributed to worsening anxiety and mood, as well as increased stress.[39]

These reports reflect that although many caregivers feel their role has given them a sense of meaning and purpose, these positive emotions often coexist with feelings of strain or stress. According to the AARP and National Alliance for Caregiving's (NAC) *Caregiving in the U.S.*

[38] RAJEEV RAMCHAND ET AL., HIDDEN HEROES: AMERICA'S MILITARY CAREGIVERS 81 (RAND Corp., 2014), *available at* https://www.rand.org/pubs/research_reports/RR499.html.
[39] The Caregiver Consortium, *The Impact of COVID-19 Pandemic on Veteran Caregivers*, 1(2) CAREGIVER CONSORTIUM NEWSLETTER 4, 1-4 (2022), *available at* https://www.hsrd.research.va.gov/centers/dole/caregiver-consortium-newsletter-summer2022.pdf.

2020 report, these positive emotions can be accompanied by physical, emotional, and financial strain that can manifest in poorer health. Specific to mental health, nearly 4 in 10 caregivers consider their caregiving situation to be highly stressful, while an additional 28 percent report moderate emotional stress.[40]

Based on this research and a strong and enduring relationship with caregivers though our Independence Program and our partnerships with the Elizabeth Dole Foundation and the Rosalynn Carter Institute for Caregivers, WWP strongly believes that Congress can pursue policies to improve access to mental health care for caregivers. Under current law, VA provides counseling services – psychotherapy, counseling, training, or education, but not prescriptions or inpatient care – to caregivers only if a veteran's medical team determines that the service is "in connection with the treatment" of a veteran's disability[41]. A more relaxed standard may limit subjectivity in VA's decision to authorize care. Similarly, while WWP and others in the community have supported important work to provide respite and resources for our veteran caregivers, more must be done at the federal level. Section 5 of the *Elizabeth Dole Home Care Act* (S. 141) would guarantee the availability of respite care each year to caregivers of veterans enrolled in home care programs – a provision that WWP supports.

Long-term Financial Security

A recent study from the American Association of Retired Persons (AARP), *Caregiving Out-of-Pocket Costs*[42], found that nearly eight in 10 caregivers report out-of-pocket expenses related to their caregiving duties. They also found that their caregiving duties frequently have an impact on the caregiver's income. Approximately, one-third of caregivers reported having to take steps like changing their schedules or taking leave, resulting in an average loss of over $10,000 in salary per year. Although PCAFC helps mitigate some of these costs for a small percentage of veteran family caregivers, the potential for these financial stressors to return is enhanced by the ongoing uncertainty of PCAFC's future eligibility criteria.

Caregivers can face difficulties finding employment that is flexible enough to accommodate their caregiving duties. Many caregivers also place their career ambitions on hold to support their loved ones and face long-term financial uncertainty, particularly into typical retirement age. As caregivers reach retirement age, they also often face the added pressure of not having contributed to Social Security, creating an additional financial hardship. When a caregiver's duties change or end, the caregiver is then at a disadvantage in re-entering a job market they have taken time away from to provide for their loved one.

Many veterans and caregivers are also not being educated on the benefits they may already be entitled to. At WWP, we often find a lack of awareness within this community of benefits like Special Monthly Compensation, Service-Disabled Veterans Life Insurance, VA Life Insurance, and Survivor Benefits. These are all examples of benefits that would offer veterans and their caregivers additional financial security, often at a difficult time such as when the

[40] AARP & NAT'L ALLIANCE FOR CAREGIVING, *Caregiving in the U.S. 2020* 53 (May 2020), *available at* https://www.caregiving.org/research/caregiving-in-the-us/caregiving-in-the-us-2020/.
[41] 38 CFR § 71.50.
[42] Laura Skufca & Chuck Rainville, *Caregiving Can Be Costly – Even Financially*, AARP RESEARCH, June 2021, *available at* https://www.aarp.org/research/topics/care/info-2016/family-caregivers-cost-survey.html.

veteran passes away. While WWP has found success in working with caregivers on an individual basis to counsel through what benefits and services may be untapped, VA has potential to do so at much larger scale with better alignment across VHA and VBA and with more investment in proactive outreach and review of cases. Congress can assist by providing VA with the resources it needs to do so.

ENHANCED QUALITY OF LIFE

There are challenges ensuring an individual's quality of life remains high as they age. Our Annual Warrior Survey explores how different components of warriors' lives are interdependent and change over time. The holistic approach focuses on the multiple components of well-being – mental, physical, financial, social connection, and spiritual – and how those components are interdependent and impact warriors' quality of life. While the discussions that follow do not necessarily flow from findings in the Annual Warrior Survey, we are confident they address areas that make meaningful improvements in the lives of warriors we service.

Support for Rural Veterans

An estimated 4.7 million Veterans live in rural settings, with approximately 2.8 million who relying on VHA services for health care.[43] A growing number of WWP alumni live in rural areas. Our Annual Warrior Survey previously found approximately 5.2% of WWP warriors resided in rural areas, with rural veterans averaging $100 less in weekly wages and less likely to be in the labor force than veterans who lived in urban areas. Additionally, research has shown rural veterans tend to have poorer health outcomes, are less likely to utilize health care services, and are more likely to experience food insecurity when compared with their civilian counterparts.[44] This potentially complicates situations when veterans need medical care, as rural veterans have identified transportation as being a top challenge when maintaining their quality of life. Telehealth access has provided a mitigating factor for some medical services, such as for mental health. However, greater access to devices, access to quality broadband or other methods of interconnectivity, and geographically flexible programs such as screenings and brief interventions, especially for substance use and mental health, are still needed in rural areas.[45]

One area where these needs are more pronounced is in dental care. Rural veterans specifically are less likely to visit a dentist routinely and are more likely to have poorer oral health outcomes when compared to veterans who lived in more metropolitan settings.[46] Gaps were exacerbated by the COVID-19 public health emergency when dental care service utilization rates declined as most services except for emergencies were moved to telehealth services.[47]

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[43] *VA Research on: Rural Health*, U.S. Dep't of Vet. Affairs, https://www.research.va.gov/topics/rural_health.cfm (last visited Feb. 22, 2023).
[44] Yue Qin et al., *Grit But Not Help-Seeking Was Associated with Food Insecurity Among Low Income, At Risk Rural Veterans*, 20(3) INT. J. ENV. RES PUBLIC HEALTH (2023), *available at* https://www.mdpi.com/1660-4601/20/3/2500.
[45] Justin T. McDaniel et al., *Alcohol Screening and Brief Intervention Among Military Service Members and Veterans: Rural-Urban Disparities*, 168(3) BMJ MIL. HEALTH 186, 186-191 (2022).
[46] R. Constance Wiener et al., *Rural Veterans' Dental Utilization, BRFSS, 2014*, 77(4) J. PUB. HEALTH DENT. 383, 383-94 (2014).
[47] Sara Kintzle et al., *Satisfaction of the Use of Telehealth and Access to Care for Veterans During the COVID-19 Pandemic*, 28(5) TELEMEDICINE AND E-HEALTH 706, 706-711 (2022).

Telehealth services have remained popular after the height of the pandemic and there are potential opportunities to leverage these services and support an underserved population of veterans through teledentistry. As rural veterans are more likely than non-rural veterans to experience negative oral health indicators, dental screenings can be a method to prevent or provide early intervention before conditions impact overall physical health.[48] Some remote regions that have implemented teledentistry have engaged with specialists in other areas, providing access to unique and necessary consults for individuals who would otherwise not have the ability. Congress can ensure funding for a pilot program within VA that seeks to develop a teledentistry program built around preventative care screenings, especially for veterans who reside in remote or rural locations.

Gaps in care are certainly not limited to dentistry for rural veterans. Within mental health, WWP was pleased to testify in support of the *Sgt. Ketchum Rural Veterans Mental Health Act* (P.L. 117-21) and would welcome further expansion. This law expanded access to the Rural Access Network for Growth Enhancement (RANGE) Program, which specifically focuses on providing additional mental health care for veterans in rural areas. Efforts like these are vital to implement appropriately, especially if there could be additional value in other rural regions. Similarly, Congress can support state-level funding for developing Collaborative Systems of Care (CSC) programs, which are nurse-led care coordination programs that exist in several states. These programs focus on identifying veterans utilizing Federal Qualified Health Centers and connect them with VA services; they are a great way of building regional understandings to what veterans need.[49]

Healthcare Disparities for Underserved Populations

The military is more racially, ethnically, and culturally diverse today than it has been in prior years.[50] This translates to similar changes in the veteran population, requiring VSOs, DoD, and VA to work to ensure high quality services are available to address the nuanced needs of the populations. Inequities experienced by veterans may include disparities with claim rejection rates, unequal PTSD services and compensation rates, and variable discipline and discharge processes experienced by underserved veterans.

Academic research suggests using frameworks for services based on the social determinants of health could add perspective and flexibility to aid in reducing health care disparities.[51,52] This is complementary to the Total Force Fitness model currently used within the DoD to support Service members, which focuses on 8 domains of health and fitness including financial health, physical fitness and health, and social fitness.[53] Congress can pass the

[48] AMERICAN INSTITUTE OF DENTAL PUBLIC HEALTH & CAREQUEST INSTITUTE FOR ORAL HEALTH, *Improving the Oral Health of Rural Veterans Through Policy, Data Collection, and Care Delivery* 6 (2022), *available at*, https://www.carequest.org/system/files/CareQuest_Institute_AIDPH_Improving-the-Oral-Health-of-Rural-Veterans_11.29.22.pdf.
[49] M. Bryant Howren et al., *Behavioral Health Screening and Care Coordination for Rural Veterans in a Federally Qualified Health Center*, 49 J. BEHAVIORAL HEALTH SERVS. RESEARCH 50, 50-60 (2022).
[50] Amanda Barroso, *The Changing Profile of the U.S. Military: Smaller in Size, More Diverse, More Women in Leadership*, PEW RESEARCH CTR., Sept. 2019, *available at* https://www.pewresearch.org/fact-tank/2019/09/10/the-changing-profile-of-the-u-s-military/.
[51] Rachel L.J. Thornton, *Evaluating Strategies for Reducing Health Disparities by Addressing the Social Determinants of Health*, 35(8) HEALTH AFF. 1416, 1416-21 (2016).
[52] Khushbu Chelak & Swarupa Chakole, *The Role of Social Determinants of Health in Promoting Health Equality: A Narrative Review*, 15(1) CUREUS (2023), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9899154/.
[53] *Total Force Fitness*, DEF. HEALTH AGENCY, https://www.health.mil/Military-Health-Topics/Total-Force-Fitness (last visited Mar. 1, 2023).

Improving Social Determinants of Health Act (117th, S. 104, H.R. 379) which would allow the Centers for Disease Control and Prevention (CDC) to develop a program that could improve health outcomes and reduce inequities. This act would also authorize grants for organizations focusing on addressing the social determinants of health.

The VA's Center for Minority Veterans, Center for Women Veterans, and LGBTQ+ program have sought to reduce healthcare disparities for underserved populations of veterans; however, more can be done, especially in regions where there are large groups of unique populations. Congress can pass legislation that promotes equitable care and support, such as the *Serving Our LGBTQ+ Veterans Act* (117th, H.R. 5776) which seeks to establish a Center for LGBTQ+ veterans within VA, similar to other centers that exist for unique populations.

Home Adaptations

For many veterans with disabilities, navigating their homes while performing everyday tasks can be difficult or even dangerous. Home modifications are often necessary for them to live safely and independently. While the VA Specially Adapted Housing (SAH) grant program provides the necessary resources for veterans to buy, build, or modify existing homes to meet their accessibility needs, this program is restricted to veterans with the certain service-connected disabilities such as loss, or loss of use, of certain limbs, blindness in both eyes, or severe burns. Other veterans with disabilities that require home modifications, including elderly veterans, may qualify for grants under the VA Home Improvements and Structural Alterations (HISA) program. These grants are intended to allow those veterans to make modifications such as altering home entrances and counters, or installing wheelchair ramps, handrails, or roll-in showers.

Currently, the maximum allowable amount under the HISA program for veterans to make modifications to address a service-connected disability (or who have a disability rated 50 percent or greater) is $6,800. For all other veterans, the maximum allowable amount is $2,000. These amounts have not been increased to keep pace with rising home construction costs since 2009. As a result, HISA grants often do not cover the full cost of the modifications, and veterans who cannot afford additional out-of-pocket costs may be left with partially adapted homes or unfinished projects.

In the 117th Congress, WWP supported the *Autonomy for Disabled Veterans Act* (117th, H.R. 5819, S. 4721), which would have increased maximum amounts under the HISA program to $10,000 and $5,000 and would have provided an automatic annual increase to those amounts based on the consumer price index. We believe these improvements are necessary to ensure the HISA program continues to meet disabled veterans needs and we will continue to support similar legislation in the 118th Congress.

Dignified Air Travel

Air travel can be a stressful experience for anyone, but it presents unique challenges for veterans with severe disabilities, especially when negotiating Transportation Security Administration (TSA) checkpoints. The process of having to remove prosthetics or other

assistive devices, vacate wheelchairs, or make other accommodations to go through security can not only take quite a bit of a time but also leave a veteran stressed and frustrated. Furthermore, although *Federal Aviation Administration Act of 2018* (P.L. 115-254) established an advisory committee to identify barriers and recommend improvements for passengers with disabilities, disabled veterans continue to report a lack of awareness by TSA agents about how to handle medical devices, service animals, and other conditions requiring accommodations, sometimes leading to embarrassing or medically compromising searches.

To address these issues, WWP supports legislation that would provide TSA Pre-Check at no cost to severely disabled veterans who are amputees, paralyzed, blind, or require an assistive mobility device. This benefit is already offered to Active Duty, Reserve, and National Guard Service members. This legislation should also include provisions to enhance training for TSA agents on proper screening procedures for people with disabilities, with an additional emphasis on cultural competencies related to disabled veterans. WWP believes this would allow veterans a more dignified travel experience and will also improve efficiency and safety.

Security checkpoints are not the only aspect of air travel where disabled veterans encounter barriers. Boarding and deplaning from aircraft can also present significant challenges, especially for those who use wheelchairs. Since plane aisles are frequently too narrow to accommodate wheelchairs, veterans, and other people with disabilities, must often check them like luggage and be provided loaner chairs that may not be medically suitable. Similar to luggage, wheelchairs may then be damaged in the cargo hold or lost before reaching the final destination. According to the most recent Air Travel Consumer Report, over 900 wheelchairs were mishandled by airlines in November 2022 alone.[54] In order for a veteran to board the plane, they sometimes must allow an airline employee to lift them, a dangerous practice that can result in people being dropped and injured.

The *Air Carrier Access Amendments Act* would address these issues by requiring the Secretary of Transportation, in direct consultation with the Architectural and Transportation Barriers Compliance Board, to improve airplane accessibility standards for people with disabilities, including boarding and deplaning equipment, proper stowage of assistive devices, access to lavatories, and seating accommodations including in-cabin wheelchair restraints (if technologically feasible). WWP believes this would greatly improve the ability of disabled veterans to travel on airplanes with the safety and dignity to which they are entitled. Although we are aware that this legislation falls outside the jurisdictions of your committees, we encourage Congress to act swiftly to pass this important legislation.

DEPARTMENT OF VETERANS AFFAIRS WORKFORCE AND MODERNIZATION

Workforce

Despite sustained efforts, VA continues to face a workforce shortage and high turnover rates, resulting in longer wait times and disjointed care for veterans. According to its own June

[54] OFF. OF AVIATION CONSUM. PROT., U.S. DEP'T OF TRANSP., AIR TRAVEL CONSUMER REPORT 38 (Jan. 2023), *available at* https://www.transportation.gov/sites/dot.gov/files/2023-02/January%202023%20ATCR.pdf.

2022 report, VA experienced a 20-year high in its VHA staff turnover rate (9.9%) in FY 2021 partly due to higher wages and bonuses offered by private health care systems, COVID-19 pressures, and burnout.[55] The VA Office of the Inspector General similarly identified severe staffing shortages in critical health care areas including psychology (73 of 139 VHA facilities), psychiatry (71 of 139), primary care (60 of 139), and social work (44 of 139)[56]. These trends are distressing for a WWP warrior population that is mostly enrolled in VA health care (90.5%) but underutilizing the care that is available (67% rely on VA for primary health care, 54% for mental health care).

Fortunately, Congress has given VA tools to address these problems. The *RAISE Act* (P.L. 117-103, Div. S § 102) increased the pay limitation on salaries for nurses, advanced practice registered nurses, and physician assistants within VA – a key tool to help VA recruit and retain these critical health care workers that assist across all practice areas. The *STRONG Veterans Act* (P.L. 117-328, Div. V) includes provisions that will expand the Vet Center workforce (§ 102), create more paid trainee positions in mental health disciplines (§ 103), and offer more scholarship and loan repayment opportunities for those pursuing degrees or training in mental health fields (§ 104). For the 118th Congress, we encourage exploration into ways to assist VA in addressing the challenge of competing for talent amidst a nationwide shortage of medical personnel. It can start by passing the *VA CAREERS Act* (S. 10) which would notably increase pay caps for physicians (including psychiatrists), lower out-of-pocket costs for licensure exam costs and continuing education for other positions (like psychologists).

We note the impact on the mental health care field above to underscore the importance of addressing the national shortage of mental health care providers. VA is struggling to ramp up its Primary Mental Health Integration (PCMHI) program due to factors including national shortages of mental health providers, provider turnover, salary discrepancies for mental health care positions between VHA and the private sector, provider preferences to deliver care virtually rather than in person, and slow and complicated hiring processes.[57] These challenges are hardly surprising. The U.S. does not have enough mental health professionals to treat the roughly 1 in 5 U.S. adults with a mental illness.[58] More than 150 million Americans live in a federally designated mental health professional shortage area.[59] And the American Association of Medical College recently wrote that "within a few years the country will be short between 14,280 and 31,109 psychiatrists, and psychologists, social workers, and others will be overextended as well, experts say."[60]

One way for Congress to act outside of the VA system – but nevertheless helping veterans, particularly those in underserved areas – is to pass the *Mental Health Professionals*

[55] U.S. DEP'T OF VET. AFFAIRS, ANNUAL REPORT ON THE STEPS TAKEN TO ACHIEVE FULL STAFFING CAPACITY 3 (June 2022), *available at* https://www.va.gov/EMPLOYEE/docs/Section-505-Annual-Report-2022.pdf.
[56] OFF. OF INSP. GENERAL, U.S. DEP'T OF VET. AFFAIRS, OIG DETERMINATION OF VETERANS HEALTH ADMINISTRATION'S OCCUPATIONAL STAFFING SHORTAGES FISCAL YEAR 2022 6 (July 2022).
[57] U.S. GOV'T ACCOUNTABILITY OFF., VETERANS HEALTH CARE STAFFING CHALLENGES PERSIST FOR FULLY INTEGRATING MENTAL HEALTH AND PRIMARY CARE SERVICES 26 (Dec. 2022).
[58] SUBST. ABUSE AND MENTAL HEALTH SVCS., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2019 NATIONAL SURVEY ON DRUG USE AND HEALTH (*see* Fig. 51) (Sept. 2020), *available at* https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm#ami.
[59] BUREAU OF HEALTH WORKFORCE, HEALTH RES. AND SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS STATISTICS, FIRST QUARTER OF FISCAL YEAR 2023 (Jan. 2023).
[60] Stacy Weiner, *A Growing Psychiatrist Shortage and an Enormous Demand for Mental Health Services*, AAMC NEWS (Aug. 19, 2022), *available at* https://www.aamc.org/news-insights/growing-psychiatrist-shortage-enormous-demand-mental-health-services.

Workforce Shortage Loan Repayment Act (S. 462). This bill would authorize the federal government to repay up to $250,000 in eligible student loan repayment for mental health professionals who work in mental health shortage areas. Even as VA provided mental health treatment to 1.8 million veterans in FY 2021, approximately 60% of veterans lost to suicide in 2020 were not recently seen by VA.[61] An expanded mental health workforce is certainly one of several strategies to help ensure that care will be available when veterans seek it.

Case Coordination Services

Recent research indicates that 1 in 4 veterans who have been hospitalized with TBI will develop long-term disability[62] and not knowing where to get help is often the biggest barrier to care facing veterans who have sustained moderate to severe TBI[63]. In the experience of WWP's Independence Program and Complex Case Coordination team, this lack of awareness is not limited to those with brain injury and is often an issue across the spectrum of injury and illness, both visible and invisible.

Establishing treatment and support programs may simply not be enough to solve the challenge of making care more accessible. Overlapping resources and nonuniform availability of federal, state, and local resources require a broad community effort to connect those in need with the services created for them. Even within VA, the word "Geriatric" – in reference to VA's Geriatric and Extended Care program office – can be a source of confusion or deterrence for both the younger veteran and their case manager or social worker to seek services. To overcome even this most basic barrier as well as others, solutions can range from better VA training to veteran-centric avenues like creating a menu of available program options tailored to the veteran/family and based on his or her needs and eligibility.

Such an approach has precedent. Pursuant to the *National Defense Authorization Act for FY 2008* (P.L. 110-181 § 1611), DoD and VA collaborated to launch the Federal Recovery Coordination Program (FRCP) that would assign recovering Service members with recovery care coordinators responsible for overseeing and assisting the Service member in their course through the entire spectrum of care, management, transition, and rehabilitation services available from the federal government. The program also called for assignment of medical care managers and non-medical care managers who were responsible for, among other tasks, helping resolve problems involving financial, administrative, transitional, and other matters that arose during recovery and transition.

In 2018, the FRCP transformed into the Federal Recovery Consultant Office (FRCO) in response to the Presidential Executive Order, "Comprehensive Plan for Reorganizing the Executive Branch." While this shift may have created some efficiencies, WWP encourages a fresh assessment of whether the FRCO can serve as a similar hub for veterans seeking more assistance with complex cases years after injury as difficult situations arise in response to

[61] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, 2022 NATIONAL SUICIDE PREVENTION ANNUAL REPORT 23 (Sept. 2022).
[62] Yll Agimi et al., *Estimates of Long-Term Disability Among US Service Members With Traumatic Brain Injuries*, 36(1) J. HEAD TRAUMA REHAB 1, 1-9 (2021).
[63] R. Jay Schulz-Heik et al., *Service Needs and Barriers to Care Five or More Years After Moderate to Severe TBI Among Veterans*, 31 BRAIN INJURY 1287, 1287-93 (2017).

progressive symptoms or changing care dynamics, like an aging caregiver who can no longer provide as they once did. WWP has and will continue to explore ways to improve the ability of veterans with moderate and severe TBI symptomatology – and other veterans requiring close attention for severe disabilities – to navigate the systems of care available to them. We invite the committees to join those efforts to explore ways to improve the ability of veterans to take advantage of the programs and resources available to them.

Electronic Health Record & Infrastructure Modernization (EHRM)

VA's transition to a new electronic health record (EHR) system is projected to take 10 years and scheduled to end in 2028. The intent of the new system is to connect VA medical facilities with DoD, the U.S. Coast Guard, and participating community care providers, allowing clinicians to easily access a veteran's full medical history in one location. The VA *EHRM* Integration Office manages deployment of the new system. This effort will create a seamless transition from military to civilian life. We believe a successful deployment of an EHR will provide efficiencies and greater quality in patient and prescription data, all of which will lead to greater quality of care; better identification of high-risk patients related to suicide, toxic exposures, and opioid abuse; and a greater quality of life for all veterans.

While VA is expected to complete the enterprise-wide implementation in several years, on October 3, 2022, VA again delayed the roll-out when it announced a delay of upcoming deployments of the new EHR until June 2023 to address challenges with the system to ensure it is functioning optimally for Veterans and VA health care personnel[64]. Since the initial deployment at the Mann-Grandstaff VA Medical Center in Spokane, Washington in October 2020, VA has successfully deployed the EHR at only four other VA Medical Centers. Additionally, a 2022 Freedom of Information Act (FOIA) request revealed that VA had experienced nearly 500 major incidents and at least 45 days of downtime since the system go-live in 2020[65].

Wounded Warrior Project shares the communities' concerns with the status of VA's EHRM efforts. However, we believe that a fully interoperable EHR between DoD, VA, and community providers should still be the goal for the community and encourage the Committees to continue this path. WWP is concerned by current efforts to abandon this goal and would suggest Congress play a larger role in oversight to ensure all stakeholders are held accountable. 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 committees can provide oversight in the following ways:

Lessons Learned from DoD Implementation

The DoD MHS GENESIS electronic health record will provide DoD's 9.6 million beneficiaries and 205,000 medical providers with a single, interoperable EHR. MHS GENESIS

[64] Press Release, U.S. Dep't of Vet. Affairs, VA Extends Delay of Upcoming Electronic Health Record Deployments to June 2023 to Address Technical and Other System Performance Issues (Oct. 13, 2022), *available at* https://digital.va.gov/ehr-modernization/news-releases/va-extends-delay-of-upcoming-electronic-health-record-deployments-to-june-2023-to-address-technical-and-other-system-performance-issues/.
[65] Hannah Nelson, *VA Data Shows 498 'Major Incidents' Since Oracle Cerner HER Go-Live*, EHR INTELLIGENCE (Aug. 22, 2022), available at https://ehrintelligence.com/news/va-data-shows-498-major-incidents-since-oracle-cerner-ehr-go-live.

is deploying in 23 "waves" across the Military Health System with full deployment anticipated at the end of calendar year 2023 and is currently operational at 103 military hospitals and clinics. While DoD also experienced challenges during the initial deployment phase, it appears to be on track to fully deploy within budget and on time. We encourage Congress to evaluate the differences in implementation efforts, and where applicable, monitor VA's adherence to those lesson learned and consider different models of governance and system integration approaches.

Individual Longitudinal Exposure Record (ILER)

Among the requirements of the *PACT Act*, DoD and VA are required to coordinate regarding Service members' and veterans' ability to update exposure records in the Individual Longitudinal Exposure Record (ILER). This application is used by the DoD and VA to track, record, and assess environmental and occupational exposure to potentially hazardous substances, data that is crucial to health care interventions and treatment for exposed warriors and can help VA better identify high-risk individuals. While it is vital for these exposures to be captured in the ILER record, it is just as critical that this information be migrated into a Service member or Veteran's EHR. As Congress exercises it oversight powers, we encourage you to also consider integration of critical systems into the EHRM efforts so that VA is not trying to solution for them after the fact.

CONCLUSION

Wounded Warrior Project thanks the Senate and House Committees on Veterans' Affairs, their distinguished members, and all who have contributed to a robust discussion of the challenges – and the successes – experienced by veterans across our great nation. Your actions over the next two years will have a significant impact on the next steps VA, and the greater community, takes to better serve veterans while considering questions related to its care, programming, assets and infrastructure, workforce, technology, and more. WWP stands by as your partner in meeting the needs of all who served – and all who support them. We are thankful for the invitation to submit this statement for record and stand ready to assist when needed on these issues and any others that may arise.

WOUNDED WARRIOR PROJECT®

★ FISCAL YEAR 2022 IMPACT ★

175,800+ WARRIORS | 44,500+ FAMILY MEMBERS | 58 NEW REGISTRANTS EACH DAY

Wounded Warrior Project® (WWP) is transforming the way America's veterans are empowered, employed, and engaged in our communities. Our direct service programs focused on connection, independence, and mental, physical, and financial wellness create a 360-degree model of care and support. This holistic approach empowers warriors to create a life worth living and helps them build resilience, coping skills, and peer connection, which are known to reduce the risk of veteran suicide. The following statistics represent program activity and impact during the 2022 fiscal year (10.01.21 – 09.30.22).

MENTAL HEALTH

THE RATE OF WWP WARRIORS EXPERIENCING 2+ MENTAL HEALTH CONDITIONS IS 3X HIGHER THAN EXPERIENCING JUST ONE. WWP ENSURES THEY NEVER HAVE TO FACE THESE CHALLENGES ALONE.*

54,700 +

hours of treatment for PTSD, traumatic brain injury, substance use disorder, and military sexual trauma

PROVIDED TO

1,300 +

warriors and family members

19,700 +

emotional support calls conducted with warriors and family members

RESULTING IN

73%

experiencing an improvement in their mental and emotional health

AND

58%

becoming more resilient, a key factor in preventing suicidal ideation

2,400 +

participants in Project Odyssey®, a WWP mental health program that teaches coping skills to improve resiliency

PHYSICAL HEALTH

POOR SLEEP AND CHRONIC PAIN ARE TOP ISSUES AMONG WWP WARRIORS. OUR PROGRAMS ARE DESIGNED TO HELP THEM SLEEP BETTER AND GET BACK TO ENJOYING LIFE.*

Among warriors who participated in WWP physical health and wellness coaching:

58%

experienced an improvement in sleep quality

AND

50%

experienced a reduction in pain, reducing the interference of physical injuries on daily life

AND

73%

experienced an improvement in mobility

60%

experienced an improvement in their mental and emotional health, demonstrating the importance of physical health on mental well-being

INDEPENDENCE

200,000 +

hours of in-home and local care provided to the most severely injured warriors, helping them reach and maintain a level of autonomy that would not otherwise be possible

FINANCIAL WELLNESS

WWP WARRIORS FACE HIGHER RATES OF UNEMPLOYMENT AND FINANCIAL DISTRESS THAN THE GENERAL POPULATION. WWP'S FINANCIAL WELLNESS PROGRAMS EMPOWER THEM TO OVERCOME THESE OBSTACLES.*

68,000 +

career coaching services provided, including resume review, interview prep, and post-placement counseling

RESULTING IN

1,700 +

warriors and family members achieving employment

$146.6 MILLION

economic impact of V.A. benefits claims filed by WWP

WITH AN

87%

approval rate

1,500 +

participants in the WWP Financial Education program, which helps warriors build a strong financial foundation through resources like educational seminars and one-on-one counseling

CONNECTION

WWP FOUND SOCIAL SUPPORT TO BE A PROTECTIVE FACTOR AGAINST SUICIDAL IDEATION AMONG WWP WARRIORS. OUR PROGRAMS AND EVENTS HELP KEEP WARRIORS CONNECTED AND OUT OF ISOLATION.*

6,400 +

virtual and in-person events, keeping warriors and their families connected and out of isolation

Among those who participated in these events:

97%

reported that they feel socially connected to their peers

AND

95%

said they have people they can depend on

1,200 +

warrior-only peer-to-peer support group meetings held

93%

of participants in WWP Soldier Ride events say they have greater self-confidence after participating in the event

*WWP 2022 Annual Warrior Survey

WOUNDED WARRIOR PROJECT®

COMMUNITY PARTNERSHIPS

Wounded Warrior Project (WWP) believes that no one organization can meet the needs of all wounded, injured, or ill veterans alone. Our Community Partnerships team reinforces our programmatic efforts and expands our impact by investing in like-minded military and veteran support organizations. Please refer to this list of current partners as you seek out resouces beyond WWP:

Wondering which of our partners might best suit your current needs?
The WWP Resource Center can help! Call 888.WWP.ALUM (997.2586)

Current List Of Partner Organizations (11.22)