**STATEMENT FOR THE RECORD**

**PARALYZED VETERANS OF AMERICA**

**FOR THE**

**SENATE COMMITTEE ON VETERANS’ AFFAIRS**

**ON PENDING LEGISLATION**

**JUNE 23, 2021**

Chairman Tester, Ranking Member Moran, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on pending legislation impacting the Department of Veterans Affairs (VA) that is before the Committee. No group of veterans understand the full scope of benefits and care provided by VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). PVA provides comment on the following bills included in today’s hearing.

**S. 372, the Ensuring Quality Care for Our Veterans Act**

This legislation requires VA to establish a third-party process for the review of any instance in which a veteran has been treated by a VA provider later found to have a revoked license. It also requires VA to notify veterans if it is determined that an episode of care or services they received was below established levels for acceptable care. PVA supports this common sense approach to help protect the health and well-being of our nation’s veterans.

**S. 612, the Improving Housing Outcomes for Veterans Act of 2021**

The Annual Homeless Assessment Report[[1]](#footnote-1) released by the Department of Housing and Urban Development (HUD) revealed that veteran homelessness increased in 19 states between 2019 and 2020. The yearly study illuminates the unacceptably high figure that on any given night 37,252 veterans remain homeless. To effectively combat this problem, VA must harmonize its use of all of the individual programs at its disposal. We believe passage of the Improving Housing Outcomes for Veterans Act, which would streamline veteran homelessness assistance through the Coordinated Entry Program, will help get important resources to these individuals sooner.

**S. 613. the PAWS for Veterans Therapy Act**

This legislation would require VA to establish a pilot program to provide grants to 501(c)(3) organizations to test the effectiveness of addressing veterans’ post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms through training service dogs. Eligible organizations must provide service dogs to veterans with PTSD and be accredited by, or adhere to comparable standards of, an accrediting organization and have expertise in training service dogs and the use of service dogs. Grant recipients would also need to meet several requirements, some of which include covering all costs incurred in excess of the grant amount; agreeing to reaccept or replace the service dog, if necessary; providing a wellness certification for each dog; employing at least one person with clinical mental health experience; and ensuring that veterans participating in the program receive training from certified service dog training instructors. Organizations must also agree to allow participating veterans to keep the dog unless the veteran and the veteran’s health provider decide it is not in the best interest of the veteran. VA will have no additional responsibility to provide for any service dog benefits and will have no liability with respect to the dog. The bill also requires a congressional briefing and report by the Comptroller General of the United States.

Although PVA supports allowing VA to explore new therapies for veterans with PTSD to include training of service dogs, we are concerned about the pilot program’s focus on providing these veterans with service dogs in addition to any benefits associated with training them. VA does not provide guide dogs or service dogs for veterans. Instead, organizations provide these animals and VA bares no direct cost. This bill would have VA provide grant funding for not only training opportunities but also for service dogs only for veterans with PTSD, excluding veterans with other mental health conditions and physical disabilities who could also benefit from having a service dog. We are also concerned that organizations eligible for the funds would not have to be accredited by Assistance Dogs International or the International Guide Dog Federation. Under Section 17.148 of Title 38 of the Code of Federal Regulations, VA will only provide veterinary health insurance and other ancillary benefits for guide dogs and service dogs used by veterans with physical disabilities who have dogs from organizations accredited by these organizations.

Although it already has the statutory authority (Section 1714 of Title 38 of the United States Code) to do so, VA has elected not to provide these benefits for veterans with mental health disabilities beyond those who are using a service dog to assist with a mental health mobility disability. Instead, VA has awaited additional evidence, including the completion of its study, on the efficacy of using service dogs to mitigate the effects of PTSD. Recently, VA completed this study. We believe that VA should expeditiously determine the next steps for deciding whether to provide veterinary health insurance and other ancillary benefits for service dogs to assist with mental illnesses, including PTSD. Specifically, we hope VA will amend its regulations to provide benefits for these dogs on par with guide dogs and other service dogs.

**S. 727, the CHAMPVA Children's Care Protection Act of 2021**

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) provides comprehensive health care benefits for dependents of permanently and totally disabled veterans, survivors of veterans who died because of a service-connected disability, survivors of veterans who at the time of death were permanently and totally disabled from a service-connected disability, and survivors of service members who died in the line of duty. Unfortunately, dependent children lose eligibility for CHAMPVA at age 18 if they are not a student or at age 23 otherwise.

Shortly after the passage of P.L. 111-148, the “Patient Protection and Affordable Care Act,” commercial health insurance companies increased the age for covered dependents from 21 years of age to 26 years. In 2010, the Department of Defense increased coverage for TRICARE beneficiaries; so, the only qualified dependents that are not covered under a parent’s health insurance policy up to age 26 are those of 100 percent service-connected disabled veterans covered under CHAMPVA. PVA strongly supports this legislation and hopes it will be quickly passed by Congress to ensure that dependent children of severely disabled veterans are afforded the same health care protection as all other children.

**S. 796, the Protecting Moms Who Served Act of 2021**

This bill codifies the current maternity care coordination program at VA and directs the Secretary to provide community maternity care providers training and support with respect to the unique needs of pregnant and postpartum veterans, particularly regarding mental and behavioral health conditions relating to military service. Additionally, the legislation requires the Comptroller General of the United States to provide to Congress and make available to the public a report on maternal mortality and severe maternal morbidity among pregnant and postpartum veterans, with a particular focus on racial and ethnic disparities in maternal health outcomes for veterans.

PVA supports this legislation aimed at improving maternal mortality outcomes for women veterans. A recent research study found that among Post-9/11 women veterans, “Severe maternal morbidity affects a significant number of veteran women.”[[2]](#footnote-2) It noted, “VA is uniquely positioned to develop innovative comanagement strategies, especially in the area of perinatal mental health.”[[3]](#footnote-3) According to VA, since 2000, there has been a 14-fold increase in VA-funded deliveries. Twenty percent of women veterans have been diagnosed with PTSD which can lead to pregnancy complications such as a preterm birth, gestational diabetes, and preeclampsia.[[4]](#footnote-4) There are also combat-related injuries that can impact fertility such as genital and pelvic trauma, and spinal cord injuries.[[5]](#footnote-5) We note, however, that there is little research on the maternal mortality outcomes of women veterans with SCI/D and ask that, when possible, research, best practices, and information gathered include information on these veterans.

**S. 887, the VA Supply Chain Resiliency Act**

The response to COVID-19 exposed significant weaknesses in VA’s supply chain, and some PVA members were affected by them. Early in the pandemic, VA was forced to limit supplies like gloves, gowns, and pads normally provided to SCI/D patients for critical procedures performed in their homes such as bowel, bladder, and wound care. This was a source of great concern when members who relied on VA to prescribe these items had to turn to the private sector to try to obtain them. The VA Supply Chain Resiliency Act could help prevent situations like this from happening again by including VA in the Department of Defense’s Warstopper program. Inclusion in that program will give VA greater access to critical supplies like N95 masks, gloves, and gowns and compliment the Department’s own efforts through its newly established Regional Readiness Centers.

**S. 951, the PAWS Act of 2021**

This legislation would direct VA to carry out a program to provide service dogs to veterans with PTSD who have completed evidence-based treatment for PTSD but who continue to have a PTSD diagnosis. Although we support access to service animals for veterans with disabilities, we believe that the next course of action is for VA to expeditiously determine how its recently completed research on the effectiveness of service dogs to improve the quality of life for veterans with PTSD should be used to modify its existing regulations. We also have concerns about equity as this legislation would require VA to provide grants to organizations that provide service animals for veterans with PTSD but not to assist those with other disabilities. VA does provide veterans with guide, mobility, and hearing dogs with some benefits but does not provide assistance for an organization to provide and train the animal which can be very expensive and limits access.

**S. 1040, to amend title 38, United States Code, to expand eligibility for hospital care, medical** **services, and nursing home care from the Department of Veterans Affairs to include veterans of World War II**

PVA supports this bill which would expand eligibility for VA medical services and nursing home care to veterans of World War II (WWII) who are not already covered. VA believes about 300,000 of the roughly 16 million American WWII veterans were still alive as of February 2021, and unfortunately, about 370 of them die each day.[[6]](#footnote-6) Statistics show the youngest WWII veterans are in their 90s and the oldest are over 100 years old. Unless they are already eligible for enrolment in priority group one through five, this bill would ensure WWII veterans are enrolled in priority group six, which at one time included the remaining veterans of the Mexican Border Period and World War I.[[7]](#footnote-7)

**S. 1198, the Solid Start Act of 2021**

VA began the Solid Start Program in 2019 with the ambitious goal of contacting every veteran three times by phone in the first year after their separation from the military to check in on them and connect them to VA programs and benefits. PVA has supported this effort from the beginning because we saw the value of reaching out to these veterans at key points during their transition. To our knowledge, the program is working well, and in addition to providing information and assistance to veterans, it has saved lives. PVA supports S. 1198, the Solid Start Act of 2021, which would make the current program permanent with special emphasis tohelp women veterans connect with VA resources and ensure VA provides information to veterans about state and local resources, as well as connections to local chapters of veterans service organizations (VSOs).

**S. 1280, the Veteran Families Health Services Act of 2021**

This bill would expand fertility treatment available through VA and the Department of Defense (DOD). Specifically, it would allow servicemembers to cryopreserve their gametes before deployment to a combat zone or hazardous duty assignment and following an injury or illness. It would also permanently authorize fertility treatment and counseling, including assisted reproductive technology (ART), including IVF, for veterans and servicemembers, as well as allow for the use of donated gametes. In addition, it improves the eligibility rules to ensure that veterans’ and servicemembers’ spouses, partners, and gestational surrogates are included, as appropriate. S. 1280 also includes language to provide support for servicemembers and veterans to navigate their options and find a provider that meets their needs, while ensuring continuity of care after a permanent change of station or relocation. Finally, it codifies the provision of adoption assistance and requires VA and DOD to facilitate research on the long-term reproductive health needs of veterans.

PVA strongly supports this legislation which goes a long way toward ensuring men and women who experience infertility due to injuries or illnesses incurred in service to this country are able to have families of their own and upholds the sacred responsibility Congress has in restoring to veterans what has been lost in service, to the fullest extent possible. Under the current restrictions on VA provided ART, many veterans who have service-connected infertility are left out. For example, a very small number of women veterans have service-connected injuries that preclude successfully caring a child conceived through IVF to term due to their disability. In such an instance, use of a surrogate may be their only option.

Sadly, veterans like these women have to pay out of pocket, dipping into retirement funds or going deep into debt in order to start or grow their family. Veterans should not have to risk future financial stability in order to have a family. They protected our families, and we should ensure they are able to have a family of their own.

Codifying and protecting the provision of ART services allows veterans to plan their families when the time is right for them. Conception is unpredictable. Veterans should not have the additional anxiety of rushing to have a family out of fear this service, which is currently dependent on year to year funding, might not be available in the future.

And finally, we are thankful for the research requirements included in S. 1280. There has been little research and attention given to female infertility and the impact of service on reproductive health from other military-related sources like toxic exposures from chemicals and burn pits. We hope that this bill would advance the understanding of how SCI/D affects the reproductive life cycle of women veterans and better understand the various factors that come into play in the reproductive continuum of men and women veterans with SCI/D such as race, ethnicity, gender, and disparities in care.

**S. 1319, the VA Quality Health Care Accountability and Transparency Act**

VA provides services directly to veterans, survivors, and other customers; so, clarity in all its communications is critical. This bill requires VA to make certain staffing and quality of care data publicly available on its Access to Care internet website (or a successor website). Among other elements, the information published on the website should include statistics related to patient wait times, effectiveness of care, and staffing and vacancy information. The website must be (1) directly accessible from the main VA website and the main websites of each VA medical center, and (2) understandable and usable by the public. VA would also be required to implement a self-auditing process to assess the accuracy and completeness of data it posts, and through an agreement with the Inspector General of the VA or another entity, validate the results. Additionally, the Government Accountability Office (GAO) would be tasked with reviewing the website to assess VA's compliance and to provide recommendations on how to improve the website. VA currently publishes patient safety, quality of care, outcome measures and patient wait times on its Access to Care website. Also, staffing and vacancy information is publicly available as required by Public Law 115–182.[[8]](#footnote-8) However, combining all this information on a single site with additional efforts to ensure the veracity of the data, make it more visible, and easier to access could be extremely beneficial for veterans and their families.

**S. 1467, the VA Medicinal Cannabis Research Act of 2021**

There is a growing body of evidence that cannabinoids are effective for treating conditions like chronic pain, chemotherapy induced nausea and vomiting, sleep disturbances related to obstructive sleep apnea, multiple sclerosis spasticity symptoms, and fibromyalgia. S. 1467 directs the VA Secretary to carry out a clinical trial of the effects of cannabis on health conditions like these as well as PTSD. PVA supports evidence-based alternative treatments, including research into the efficacy of medical cannabis. A series of clinical trials on the use of medicinal cannabis would help to determine if it could provide any medical benefits for veterans.

**S. 1863, the Guaranteeing Healthcare Access to Personnel Who Served Act**

The Guaranteeing Healthcare Access to Personnel Who Served (GHAPS) Act would change current laws and regulations to improve veterans’ access to health care, including access to VA’s new Community Care Networks (CCNs).

Section 101 of the bill would codify VA health care access standards that were required by the VA MISSION Act of 2018 (P.L. 115-182). Specifically, the bill would make permanent the current access standards for primary care, mental health care, and non-institutional extended care services which are 20 days waiting time for an appointment or 30 minutes average driving time from the veteran’s residence. For specialty care and services, the current access standards are 28 days waiting time or 60 minutes average driving time. The bill would also apply the same access standards for CCN providers; however, it would create a waiver process for the Third Party Administrators (TPAs) of the CCNs for geographic areas that had a scarcity of medical providers. This section would also require VA to review these access standards at least every three years.

PVA believes it would be premature to codify the Department’s current access standards so we do not support this section. When VA released its rulemaking on access standards, PVA voiced concerns about VA’s drive time access standards. Drive time standards were previously considered during the debate over the original Choice program and were a component of an earlier community care access pilot for rural veterans, Project ARCH. We agree access standards are critical in determining if VA and community health care providers are providing timely health care to veterans. However, according to VA’s November 2020 Access Standard report to Congress, VA indicated that the drive time and wait-time standards in the CCN were not fully aligned with the MISSION Act access standards. The CCN contractual network adequacy standards on drive time and appointment availability (a.k.a. “wait time”) were based on prior utilization patterns, needs of the veteran population, and industry standard metrics for network sizing. While VA shared this report with Congress in November 2020, we have not seen any additional data that supports VA’s access standards are the right measurements and are applied consistently throughout the Department.

We also have concerns about the waiver provision for VA’s TPAs and the provision mandating that in determining a veteran’s eligibility to receive community care, VA cannot take into consideration the availability of telehealth. PVA believes It is premature to authorize waivers for TPAs not meeting the access standards until such standards and quality standards for CCNs are equivalent to VA standards. We also think telehealth options should not be dismissed. During the pandemic, when VA discontinued routine appointments, and access to community care providers were cut, telehealth became the primary option for serving veterans health care needs. To dismiss telehealth from VA’s access standards does not speak well of the Veterans Health Administration’s (VHA) Telehealth program, and the efforts they took to ensure veterans had a viable option during the pandemic to meet their health care needs.

Section 102 requires VA to develop strategic plans to ensure continuity of care in the case of the realignment of a medical facility of the Department. The Asset and Infrastructure Review (AIR) Commission which is scheduled to get underway soon may recommend closing or realigning some VA facilities resulting in veterans being referred to the local community for care. It is evident that the intent of the language in this section is to ensure VA is prepared to address the handoff of care when or if that time comes. This effort is laudable, but we believe the language should be modified to ensure VA has operational plans verses strategic ones for the handoff to ensure an actual transition can take place. Also, a provision should be added to ensure VA does not close or reduce a facility before these operational plans are in place and have been fully tested to ensure veterans’ continuity of care.

Sections 112through 114 require VA to establish a pilot program that allows veterans to set their own appointments. PVA supports the test project and believes it should be included as a part of Cerner’s scheduling package where veterans can have access to scheduling a VA or community care appointment.

PVA supports Sections 121 and 122 which would strengthen the credential verification process for CCN providers and ensure veterans are receiving proper care.

Section 201 requires VA in consultation with the Office of Connected Care, Executive Director of Telehealth, Office of Rural Health, and Office of IT Operations, to develop a strategic plan to ensure telehealth technologies and modalities delivered to veterans are effective and routinely monitored for quality control. As indicated above, veterans benefited greatly from VA’s use of telehealth during the pandemic, and we have no doubt it will play a greater role in the way the Department delivers care in the future. Still, there are instances where the use of telehealth is the least desired means to deliver care. PVA believes carefully assessing telehealth’s capabilities and developing a strategic plan for its use is not only wise, but highly recommended.

PVA supports Section 202 which requires GAO to conduct a study of third-party transportation services available for rural veterans to determine if there are gaps that could and should be covered through additional programs and services. Our lone recommendation here is that language should be added to ensure the needs of catastrophically disabled veterans are considered as part of the study.

PVA supports Section 203 which requires GAO to assess VA’s use of telehealth to serve rural veterans and inform Congress of any future legislative actions needed in this area.

PVA has no objections to Section 301 which directs VA to study the possibility of expanding its Program of Comprehensive Assistance for Family Caregivers (PCAFC) to the caregivers of veterans residing in the Philippines or to Section 302 directing GAO to study the quality and availability of care to veterans residing abroad. We recognize that service-disabled veterans residing in these areas may have undisclosed health care needs and the information derived from these studies could help VA provide better care for them.

Section 401 would require VA to complete an analysis of the feasibility and advisability of making repetitive transcranial magnetic stimulation (rTMS) available at all VA medical facilities and electro-convulsive therapy (ECT) available at one medical center located within each VISN for the treatment of veterans who have a diagnosis of treatment-resistant depression. rTMS and ECT are good programs for treatment resistant depression and PVA supports the use of emerging medical technologies to ensure the best care is available for veterans.

Section 402 would modify VA’s resource allocation system (VERA) to include peer specialists. PVA strongly supports this provision as a means of expanding the use of peer support throughout VA.

Section 403 directs VA to complete a gap analysis study of its use of psychotherapeutic interventions that are highly recommended and widely used clinical practice guidelines. Defining and analyzing existing **gaps could help VA** ensure veterans continue to receive the highest quality mental health care.

PVA supports Section 501 which would create a one-stop online health care education portal where veterans can access interactive information on VHA processes and their rights. The online portal which VSOs will help design would include interactive modules for veterans to engage with VA.

Finally, Section 502excludes VHA’s research activities from the requirements of the Paperwork Reduction Act (P.L. 96-511) in the same manner that the National Institutes of Health receives for sponsored research. PVA strongly supports the elimination of this obstacle to critical biomedical research.

**S. 1875, the Veterans’ Emergency Care Claims Parity Act**

PVA supports the Veterans Emergency Care Claims Parity Act which would extend the claim filing period to 180 days and prevent veterans from being charged for care if certain conditions are met. It also requires VA to regularly publish information pertaining to emergency care and the claims process on one or more publicly available websites.

**S. 1965, the Planning for Aging Veterans Act of 2021**

PVA endorses the Planning for Aging Veterans Act of 2021 which requires VA to develop a strategy addressing the current and future long-term care needs of veterans and identifying areas for future investment. We are especially concerned with VA’s lack of long-term care beds and services for veterans with SCI/D. Many aging veterans with an SCI/D are currently in need of VA long-term care services. Unfortunately, VA is not requesting and Congress is not providing sufficient resources to meet the current demand. In turn, because of insufficient resources, VA is purchasing private nursing home care instead of providing sufficient in-house specialty long-term care for these veterans. However, it is difficult to find placement in the community for veterans who are ventilator dependent and those who require bowel and bladder care.

VA designated six specialized long-term care facilities because of the unique, comprehensive medical needs of veterans with SCI/D, which are usually not appropriately met in community nursing homes and non-SCI/D–designated facilities. SCI/D centers provide a full range of services and address the unique aspects of delivering rehab, primary, and specialty care. When hospitalized in an acute SCI/D center, these veterans require more nursing care than the average ambulatory hospitalized patient. In SCI/D long-term care units, the distribution of severely ill veterans is even more pronounced as a sizable portion require chronic pressure ulcer, ventilator, and bowel and bladder care due to secondary complications of SCI/D issues. Currently, the Long Beach VA Medical Center provides the Department’s only SCI/D long-term care facility west of the Mississippi to serve 11 acute SCI/D centers. It has a capacity of 12 inpatient beds and because it is always at capacity, there are always veterans waiting for the opportunity to be admitted. Ongoing projects at the San Diego and Dallas VA medical centers will add future long-term care bed space, but these projects are years away from completion and will still not sufficiently address the existing need. We strongly recommend VA develop an SCI/D long-term care strategic plan as part of the larger long-term care strategy effort directed by this legislation.

**Senate Discussion Draft, to direct the Under Secretary for Health of the Department of Veterans Affairs to provide mammography screening for veterans who served in locations associated with toxic exposure**

As the title implies, this bill would direct VA to provide mammography screening for veterans who served in locations within specified dates associated with toxic exposure. Section 7322 of title 38, United States Code requires VA to begin screening women veterans with mammography for breast cancer at the age of 39 as well as directs VA to screen all veterans with other risk factors for breast cancer. Recognizing the role toxic exposure can play in increasing the risk of breast cancer, this bill adds specific locations and time frames for conducting mandatory mammography screening for all veterans. It also includes requirements for VA and DOD to report additional locations and time frames for possible inclusion in mandatory screening. And lastly, it requires comparisons of breast cancer rates among those who served in the locations included in the bill versus those who served in the military at the same time but not at the listed locations. PVA supports this bill and knows the importance that screening has in identifying cancers quickly so they can be treated as soon as possible.

**Senate Discussion Draft, the Building Solutions for Veterans Experiencing Homelessness Act of 2021**

Getting veterans into stable housing as we recover from a pandemic that is not yet over will require specific and targeted efforts that empower nontraditional solutions. PVA supports this bill which would increase the rates of grants awarded by VA to states for comprehensive services provided to homeless veterans; establish grant programs for substance and alcohol use disorder for recovering homeless veterans; help meet the health care needs of elderly veterans who were previously homeless and are transitioning to permanent housing; and test the feasibility of a grant program to improve transportation services for veterans. We ask the Committee to keep in mind that within the grant process, organizations should be required to demonstrate their capabilities in servicing veterans with catastrophic disabilities, when feasible.

**Senate Discussion Draft, the Department of Veterans Affairs Provider Accountability Act**

PVA supports this draft bill which requires VA to report major adverse personnel actions involving certain health care employees to the National Practitioner Data Bank and to applicable state licensing boards. We believe the key to providing exceptional health care to veterans starts with quality providers. If those providers have major adverse personnel actions, they should be reported to the proper licensing authorities to ensure they are unable to practice elsewhere within the VA health care system. The draft bill also requires VA to train applicable employees on licensure, employment, and reporting requirements annually, and bars the Department from entering into a settlement agreement regarding a claim by a VA employee under which it would be required to conceal a serious medical error or lapse in clinical practice that constitutes a substantial failure.

PVA would once again like to thank the Committee for the opportunity to submit our views on some of the legislation being considered today. We look forward to working with the Committee on this legislation and would be happy to take any questions for the record.

1. [The 2020 Annual Homeless Assessment Report (AHAR) to Congress (huduser.gov)](about:blank) [↑](#footnote-ref-1)
2. Combellick, J. L., Bastian, L. A., Altemus, M., Womack, J. A., Brandt, C. A., Smith, A., & Haskell, S. G. (2020). Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans. *Journal of women's health (2002)*, *29*(4), 577–584. [https://doi.org/10.1089/jwh.2019.7948](about:blank) [↑](#footnote-ref-2)
3. *ibid* [↑](#footnote-ref-3)
4. Veterans affairs. (2019, November 21). Retrieved April 11, 2021, from [https://www.va.gov/HEALTHEQUITY/Women\_Veterans\_and\_Pregnancy\_Complications.asp](about:blank) [↑](#footnote-ref-4)
5. Ginny L. Ryan, Investigator-Initiated Research 13-294 — Human Services Research & Development Study: Impact of Sexual Assault and Combat-Related Trauma on Fertility in Veterans, U.S. DEP’T OF VETERANS AFFAIRS (last visited June 14, 2019), [https://www.hsrd.research.va.gov/research/abstracts.cfm?Project\_ID=2141704065](about:blank). [↑](#footnote-ref-5)
6. Statistics on Number of living WWII Veterans - [How many World War 2 veterans are still alive in 2021? | Interesting Answers](about:blank#:~:text=According%20to%20the%20U.S.%20Department%20of%20Veterans%20Affairs%2C,2%20veterans%20are%20still%20alive%20as%20of%202018.) [↑](#footnote-ref-6)
7. Enrollment Priorities, [38 CFR § 17.36 - Enrollment - provision of hospital and outpatient care to veterans. | CFR | US Law | LII / Legal Information Institute (cornell.edu)](about:blank) [↑](#footnote-ref-7)
8. [VA-wide workforce data, In accordance with Public Law 115-182, the VA Mission Act of 2018, Section 505.](about:blank) [↑](#footnote-ref-8)