

**PTSD CLAIMS: ASSESSING WHETHER VBA IS  
EFFECTIVELY SERVING VETERANS**

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**HEARING**

BEFORE THE

**SUBCOMMITTEE ON DISABILITY  
ASSISTANCE AND MEMORIAL AFFAIRS**

OF THE

**COMMITTEE ON VETERANS' AFFAIRS**

**U.S. HOUSE OF REPRESENTATIVES**

**ONE HUNDRED FIFTEENTH CONGRESS**

**FIRST SESSION**

TUESDAY, JULY 25, 2017

**Serial No. 115-26**

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: <http://www.fdsys.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

WASHINGTON : 2018

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## **PTSD CLAIMS: ASSESSING WHETHER VBA IS EFFECTIVELY SERVING VETERANS**

**Tuesday, July 25, 2017**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON VETERANS' AFFAIRS,  
SUBCOMMITTEE ON DISABILITY ASSISTANCE  
AND MEMORIAL AFFAIRS,  
*Washington, D.C.*

The Subcommittee met, pursuant to notice, at 10:30 a.m., in Room 334, Cannon House Office Building, Hon. Mike Bost [Chairman of the Subcommittee] presiding.

Present: Representatives Bost, Coffman, Bergman, Esty, and Brownley.

Also Present: Representative Walz.

### **OPENING STATEMENT OF HONORABLE MIKE BOST, CHAIRMAN**

Mr. BOST. Good morning. Welcome everybody to this morning's hearing. The Subcommittee on Disability Assistance and Memorial Affairs will now come to order.

Last month the Full Committee held a hearing on treatment options for veterans who have Post Traumatic Stress Syndrome. The Subcommittee hearing will review whether the VBA compensation process for PTSD is effectively serving our veterans.

Today there are 940,000 veterans receiving disability compensation for PTSD and the number of veterans who apply for service-connected PTSD is growing. In fiscal year 2006 VA received about 100,000 PTSD claims. This number increased to 240,000 in fiscal year 2016, more than double the number of claims within ten years. One reason that more veterans are seeking benefits is probably because VA has improved its outreach to veterans who may be experiencing PTSD, which I appreciate.

VBA has also made some changes to the PTSD claim process. For example, in 2010 VA updated its regulations to make it easier for veterans who develop PTSD as a result of military sexual trauma or from a fear of hostile military or terrorism activities to prove that they had a traumatic event or stressor during their service. This change has helped many veterans receive the compensation that they are entitled to by law. But at the same time, we want to ensure that only veterans who are disabled as a result of their service are receiving compensation payments for PTSD. Unfortunately from what I read in today's written testimony, it looks like VA still has to work on better quality control.

For example, both our VSO witnesses have raised concerns about VA's use of the evaluation builder tool. I understand the purpose of the tool is to improve consistency. But each veteran is an individual and particularly with PTSD claims a one-size-fits-all approach will not work. Raters should have the flexibility to deviate from the tool if it is warranted without having to worry about being called on an error.

I am also concerned about some allegations that examiners are not sufficiently trained or may not be spending enough time with each patient to do a proper assessment.

The hearing may also turn into another issue that came up during last month's Full Committee hearing on PTSD. That was that some veterans are not seeking the health care need because they are worried that if they get better they will lose their benefits. Moreover, the average evaluation assigned to the veteran and service-connected PTSD in the last ten years has increased from 37.4 percent to 51.4 percent. I am hoping that the department can shed light on this aspect. We should encourage our veterans to get treatment and resume a normal life.

It troubles me that our current compensation benefits program may discourage veterans from seeking treatment. I am looking forward to hearing from the department and the VSO witnesses on these and other issues so that we can all be sure that veterans who have developed PTSD based on their service receive the compensation they have earned.

Again, I want to thank everyone for being here today. I now call on Ranking Member Ms. Esty for her opening statement.

**OPENING STATEMENT OF HONORABLE ELIZABETH ESTY,  
RANKING MEMBER**

Ms. ESTY. Thank you, Mr. Chairman. And thank you for holding this important hearing today. As you know, this is a subject of particular interest to me. I hear the same message over and over again from veterans in North, Northwest, and Central Connecticut, who have filed a claim for disability compensation with Post Traumatic Stress Disorder related to military service.

Now before we get going too far, I want to take time to recognize that some of the improvements over the past seven years, and recognize the importance of those, and the people who have contributed to these efforts. But Mr. Chairman, veterans in Connecticut do not understand the criteria VA uses to judge their claims. That their lives are severely impacted by PTSD as well as if their claim includes treatment. They do not believe that their rating or treatment can be determined largely based on a 15-minute interview with a doctor. They do not see that VA has a fair timeline for what will happen once they submit a claim for PTSD. And they struggle constantly on how to reconcile their courageous efforts to recover and live productive lives with the necessity of proving that they have a mental illness in order to not be downgraded for appearing too healthy, too normal.

I know that this is a difficult task for the VA and I see and respect the efforts to get on top of this. With the national work queue fully functional now, and without the requirement that DoD provide a documented combat related stressor, I think we see progress.

And these are important elements of progress and I want to acknowledge those and support those. But today I want and I believe the Chairman and I am sure our fellow colleagues want to get some answers to the questions that veterans have raised with me since I was first elected in 2012.

I want to thank the witnesses for being here today and I want to pay tribute to the veterans across the country who are struggling with the effects of Post-Traumatic Stress Disorder. PTSD is a normal, human reaction of a normal person to abnormal circumstances. For those whose PTSD is the result of military service, we owe you fair compensation in a reasonable amount of time. We owe you the chance to understand the VA process. This requires including an explanation in lay terms when a decision is made. And most importantly, we owe you an opportunity to consider your descriptions of the impact, the struggle that PTSD has on your life as evidence in this process.

Thank you, Mr. Chairman, and I yield back.

Mr. BOST. Thank you, Ms. Esty. I ask that all other Members waive their opening remarks as per the Committee's custom. And I once again welcome the witnesses seated at the table. Again, thank you for being here. Our first witness is Ronald Burke, the Assistant Deputy Under Secretary of the Office of Field Operations for VBA. Mr. Burke is accompanied by Bradley Flohr, a Senior Advisor with the Compensation Service of VBA; Patricia Murray, the Chief Officer of the Office of Disability and Medical Assistance for VHA; and Dr. Stacey Pollack, the National Director of Program Policy Implementation for the VHA. Also joining us today is Gerardo Avila, I will say it right, Avila. Got it. Okay. Who is the Deputy Director of the Medical Evaluation Board/Physical Evaluation Board/Department of Defense Correction Board for the American Legion? Finally we are also joined by Martin Caraway, who is the Associate Member and National Partner of the National Association of State Directors of Veterans Affairs. Welcome all. I want to remind all the witnesses that your complete written statement will be entered into the hearing record. Mr. Burke, you are now recognized to present the department's testimony for five minutes.

#### **STATEMENT OF RONALD S. BURKE**

Mr. BURKE. Thank you, sir. Chairman Bost, Ranking Member Esty, Members of the Subcommittee, thank you for the opportunity to discuss how the Department of Veterans Affairs manages veterans' Post Traumatic Stress Disorder disability compensation claims. My testimony will provide an overview of VA's processing of these claims, its training and quality assurance efforts, and the use of disability benefits questionnaires to capture relevant medical evidence used to evaluate PTSD claims.

With me today are Mr. Brad Flohr, the Senior Advisor for Compensation Service for VBA; Ms. Patricia Murray, Chief Officer, Office of Disability and Medical Assessment for VHA; and Dr. Stacey Pollack, National Director of Program Policy Implementation for VHA.

There are currently over 940,000 veterans who are service-connected for PTSD and receive a monthly benefit payment. This population equates to approximately 22 percent of all veterans receiv-

ing disability compensation benefits. This is a 172 percent increase compared to the end of fiscal year 2008, when approximately 345,000 veterans were service-connected for PTSD.

The increase is a result of veterans' increased awareness and understanding of PTSD and several associated changes VA has implemented. In 2010 VA took actions to make it easier for veterans to obtain disability compensation benefits associated with PTSD by placing greater evidentiary weight on lay statements to establish the required in service stressful event if related to fear of hostile military or terrorist activity. VA previously required documentary evidence from the Department of Defense or other sources to verify an in service stressful event related to the veteran's PTSD symptoms unless it was verified that the veteran engaged in combat with the enemy or was a prisoner of war, which is generally sufficient in and of itself to establish an occurrence of an in service stressful event.

For the evaluation of PTSD claims where the stressor is not combat related, or there is no initial evidence of combat participation, VBA has provided claims processing personnel with special tools to research veterans' stressor statements. A Web site has been developed that contains a database of thousands of declassified military unit histories and combat action reports from all periods of military conflict. In many cases evidence is found in these documents to support the veteran's stressor statement or confirm combat participation. Nationwide training was conducted on this database and other official Web sites that can aid with stressor corroboration. Thus VA has illustrated in various ways our commitment to understanding and assisting veterans with PTSD claims.

There are currently 16 VBA training courses focused on processing PTSD specific claims, including military sexual trauma, geared to VA claims processors, including both interactive online training sessions and classroom based instructor led courses. Additionally there are nine courses covering the topics of requesting disability medical examinations, also known as compensation and pension or C&P exams, and sufficiency of examination reports. Again, these are delivered both online and in classroom settings.

VA's challenge training for new veteran's service representatives and rating veterans service representatives including two courses regarding examination requests and examination sufficiency. There is also specific instruction on PTSD claims.

VA's national training curriculum for fiscal year 2017 requires five courses of PTSD training for VSRs and ten courses for RVSRs. Also error trend analysis drives local instructor led training on examination requests and examination sufficiency for individual stations as well as training during compensation service oversight visits. Error trend analysis has also led to the development of new national level training involving examination sufficiency that was released in the field in June of 2017.

VA reviews PTSD claims as part of its National STAR program. From the start of fiscal year 2016, which is October, 2015 through February of 2017, accuracy of processing on PTSD claims was 94.2 percent, 94.57 percent for those claims not PTSD related.

VA claims processors request disability medical examinations, or C&P exams, specific to PTSD. Trained examiners, whether at VHA



or one of VA's contract exam vendors, document the exam findings on DBQ templates, which are considered by VA claims processors in making decisions on disability compensation claims.

Running short on time, I will add my closing remarks. VA remains committed to providing high quality and timely decisions on entitlement to disability compensation benefits, with PTSD being one of the primary conditions claimed by veterans. VA will continue to update training materials, as well as the schedule for rating disabilities, regarding this condition and its impact on our Nation's heroes and their families.

This concludes my testimony and I am pleased to address any questions you or other Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF RONALD S. BURKE APPEARS IN THE APPENDIX]

Mr. BOST. Thank you, Mr. Burke. Mr. Avila, you are recognized for five minutes to give the testimony for the American Legion.

#### **STATEMENT OF GERARDO AVILA**

Mr. AVILA. Post-Traumatic Stress Disorder has been labeled as the signature wound of the conflicts in Iraq and Afghanistan. Today we meet to improve the way VA adjudicates claims for service-connection due to PTSD that ensure those suffering from this condition are properly compensated according to their symptoms. Good morning, Chairman Bost, Ranking Member Esty, and distinguished Members of the Subcommittee. On behalf of Commander Charles Schmidt and over two million members of the American Legion, we thank you and your colleagues for allowing the American Legion to present our views on the processing of PTSD claims.

The American Legion would like to acknowledge and thank VA for its July, 2010 regulation liberalizing the evidentiary standards for veterans claiming service-connection due to PTSD. Due to this change in regulation, thousands of veterans are being properly compensated and have gained access to medical treatment through the Veterans Health Administration.

Despite the change in regulation, the American Legion has the following concerns. Development of PTSD claims caused by military sexual trauma, VA reported in May, 2015 that 25 percent of female veterans and one percent of male veterans experienced MST when screened by a VA provider. Despite these percentages, American Legion service officers often submit lay statements from family members corroborating the incident only to have the statement ignored. The lay statements are crucial when there is lack of law enforcement and medical records to corroborate the incident. Failure to utilize these key documents is harmful to veterans. The American Legion has heard complaints from veterans that their compensation and pension examination lasted all of 15 minutes.

Additionally, the level of social impairment provided during the examination did not align with the level of severity reported in the disability benefit questionnaire. Conducting a proper C&P examination is critical in determining the service-connection and the correct level of disability. It is essential that C&P examiners conduct a thorough review of the record to include lay statements to establish the level of disability within the VA schedule of ratings.

Failure to recognize secondary conditions related to PTSD continues. While research exists that link exposure to trauma and poor physical health that can have a negative impact on the individual's cardiovascular, gastrointestinal, and musculoskeletal systems, sadly veterans are denied the opportunity to have a C&P examination to determine the relationship between the physical condition and PTSD. Younger veterans diagnosed with PTSD will endure years of suffering which will cause or aggravate physical conditions. The American Legion believes that determining the nexus between the physical disability and PTSD should be made by a trained medical professional and not a VBA employee.

Due to the serious effects of PTSD, unfortunately some veterans will not have the ability to gain and maintain meaningful employment. When a veteran is not able to work due to a service-connected condition, they could qualify for total disability due to individual unemployability. However, unless a veteran specifically applies for the benefit TDIU will not be granted. This was the issue in a recent case involving a Marine veteran at the Cleveland Regional Office. Despite being awarded an increase in his PTSD rating to 70 percent and providing documentation from the Social Security Administration indicating he was unable to work, TDIU was never awarded. This case highlights the importance of doing a thorough review of the records so veterans are not forced to wait to receive proper benefits.

VBA created their evaluation tool to develop uniform decisions across all regional offices. A rater at one regional office should in theory reach a similar decision as all other regional offices. Caution should be used not to solely depend on the tool. The American Legion understands that pertinent information that can be crucial to establish a claim, such as lay statements, continuity of symptoms, and outside privileged evidence, is not considered. While we believe that the tool can be a great asset in assisting raters, flexibility and consideration must be given to the entire record.

We would like to thank you and the Committee once again for the opportunity to testify on this important topic. I would be happy to answer any questions.

[THE PREPARED STATEMENT OF GERARDO AVILA APPEARS IN THE APPENDIX]

Mr. BOST. Thank you, Mr. Avila. I see that Ranking Member Walz has joined us. I want to ask unanimous consent that Ranking Member Walz be allowed to sit on the dais and ask questions. Hearing no objections, so ordered.

Mr. Caraway, you are now recognized for five minutes to give the testimony for the National Association of State Directors of Veterans Affairs.

#### **STATEMENT OF MARTIN CARAWAY**

Mr. CARAWAY. Thank you, sir. Chairman Bost, Ranking Member Esty, and Members of the Committee, I am honored to be here on behalf of NASDVA President Randy Reeves and the State Directors from across the Nation. Accompanying me today is Texas Commission and NASDVA District Vice President Colonel (Retired) Tom Palladino.

State Directors, their staff, and veteran's service officers at the county and local level are literally on the front line serving veterans every day. As a county veteran's service officer, I assist veterans in the PTSD claims process daily. I witness the pain in the veterans' faces and sometimes the tears in their eyes as we discuss the stressors that affect their ability to carry on their daily life. I hope our conversation will help continue improvement of the process for these veterans.

The process for an initial PTSD claim can be quite cumbersome, especially if the veteran's DD Form 214, their discharge from military service, does not indicate a combat award. The law allows for VA examiners to determine the diagnosis and whether in their professional medical opinion the stressors the veteran presented were in fact congruent with the time, place, and scope of the veteran's military service. When the examiner renders a supporting opinion, VA should rate the case in favor of the veteran. But we are finding many times in these cases that the VA instead of issuing that decision will develop the case for more evidence by sending the veteran a VA Form 21-0781, a statement in support of a claim for service-connection for PTSD so they may utilize their internal systems to attempt to verify the stressors from DoD. This actually removes a veteran's claim from the fully developed claims process, delaying the benefit.

Veterans often feel discarded and frustrated when they receive this document because they have gone through the initial PTSD examination where they have provided the exact same information. A potential best practice to resolve this is currently being performed by the Texas Veterans Commission. With every claim for PTSD where the veteran does not have a combat award documented on their DD-214, the TVC is assisting the veteran in completion of the VA form 21-0781. This does not completely prevent the feeling of duplication from the veteran's point of view, but it will keep the claim in the FDC process for faster adjudication of the claim.

The disability benefits questionnaires, DBQs, allow for streamlined examination directly touching pertinent information that will impact the rating of the claim. VA utilizes a DSM-5 DBQ for PTSD claims for increases or reevaluation of the disability. If the veteran wishes to obtain a private examination at their own expense, only the DSM-4 DBQ is made publicly available for use by private physicians and providers. Releasing the DSM-5 DBQ for PTSD so it can be used by private physicians and providers would greatly benefit the veteran claimants in the submission of evidence that could impact the claim to their benefit.

Veterans that continuously seek care at the VA for PTSD that are also going through the claims process are more times than not rejected when they ask their provider to assist in the completion of a DBQ. Providers routinely cite time and conflict of interest as their reasoning to decline. When considering a diagnosis such as PTSD and quantifying the symptoms to align with the VA rating criteria is to say the least a difficult task. Instructing these providers to complete a DBQ would allow for the opinions of a medical professional with intimate knowledge of the impacts of the diag-

nosis to be weighed in the rating process and that would greatly enhance the process for the veteran.

To answer the bottom line question is VA handling PTSD claims in the best way possible? I would argue they are not, only because the apparent conflict between 38 C.F.R. and the M-21 manual in the concession of PTSD stressors.

Mr. Chairman and distinguished Members of the Committee, NASDVA and its partners deeply respect and appreciate the important work you are doing to ensure America's veterans receive the service, care, and compensation they have earned through their sacrifice. Working together with VA and all stakeholders, we can improve this process and define a culture that is committed to providing due process of the law to those men and women that have served, protected, and defended this Nation.

My written testimony goes into much more detail than time will allow here and I do look forward to answering any questions you may have.

[THE PREPARED STATEMENT OF MARTIN CARAWAY APPEARS IN THE APPENDIX]

Mr. BOST. Thank you, Mr. Caraway. And we are going to go on with questioning and I am going to recognize myself first for five minutes. Mr. Burke, during the, and let me tell you that I was shocked when this actually came out. But during the June 7, 2017 hearing of the Full Committee, a veteran by the name of Brendan O'Byrne testified that his PTSD improved with treatment. But when he had contacted the VA to ask that his disability rating be reduced, and I have never heard of that before, he was told that VA could not reduce his payment at his request. Now we are dealing with a unique situation, the fact that many disabilities, if a person has the loss of a limb, loss of hearing, loss of eyesight, it will only get worse with time. We hope that with this, that it would get better in time. So my question is, and my staff, you know, we have since learned that the only way for a veteran that can be diagnosed with a disability compensation, the only way they can have it reduced is totally ignore it and say, never mind, I do not want to receive it at all. Can you verify, you or Mr. Flohr, confirm whether now the VA has a process to lower the disability rating on a veteran's request if they claim their condition has improved?

Mr. BURKE. Yes, sir. Thank you for that question, and also thank you for your interest in this matter. We are as deeply committed and interested in the topic of PTSD as everyone in this room.

There are actually several different ways that a veteran can have their evaluation reduced. One is a renouncement of benefits, which is basically when a veteran comes in and renounces the entire benefit. They cannot renounce parts of it. They have to renounce the entire benefit. The other is to come in and actually ask for a re-evaluation if they consider their condition has improved. In that instance we would either look at the available medical evidence or schedule an examination to ascertain the current level of disability and then make a disability determination commensurate to what the evidence shows.

In many cases on the initial grant of service-connection for PTSD we set a veteran up for what is called a routine future examina-

tion. That is to ascertain where we think there may be a likelihood of improvement, we will set an examination for three years in the future, schedule that veteran for an examination, call him or her in, do another reevaluation, and see if the evidence does show that the disability has improved through treatment or other means. Again, in that instance, sir, we would take a look at the evidence from that new examination and render a new disability determination.

Mr. BOST. Okay. The concern I have is to see if you are looking into any other possibilities. Because I see the concern of, okay, if all of a sudden a veteran does not renounce, but knows they still need a little help, and maybe they realize they do not need that level. But then coming before a hearing could be reduced to a level that is lower than what they feel they should receive. Do you think that would discourage them from coming in?

Mr. BURKE. I think we are doing a lot now, sir, to educate veterans, and stakeholders for that matter, on the entire process. The examination is not a 'gotcha' process. It is a vehicle to allow us, in addition to other medical evidence, it is a vehicle that allows us to ascertain the current level of severity. And in some cases, a veteran may think he or she, you know, warrants a disability evaluation lower than what the medical evidence shows. It is not meant to persuade anyone from coming in to get a reevaluation.

Mr. BOST. Okay. Also I want to ask you, are you confident VSRs and the RVSRs are always identifying PTSD examination results that are not adequate for rating purposes?

Mr. BURKE. So VA does place focus and importance on training our individuals to look at the adequacy of examinations. In fact when a rating specialist or a veterans service representative denotes an examination that is not adequate for rating purposes, we do have a process and a vehicle to return those inadequate examinations to the, whether it is VHA or a contract provider. That is an example when we do find some of those. It is a perfect example of some of the checks and balances that we have in the system working. So any instance that we do see an examination that is inadequate, our claims processors will reach out to the provider of that exam, whether it is asking for clarification or filling in something that is missing. We do have that opportunity.

Mr. BOST. And that gives you the confidence you feel that there does not need to be any changes or retraining or anything like that?

Mr. BURKE. Well, sir, I think we constantly look for ways to improve our process. While the processing of PTSD claims accuracy is at 94.2 percent, we are not content with that. We think the process is working but as with everything else we are in the business of doing the best for our veterans that they deserve and this is one we continually look for ways to improve our quality of processing.

Mr. BOST. One more quick question. I know I am close on, or actually out of time, but I really do want to know this. How often do claims processors ask for clarification of the PTSD exams that are not adequate for rating purposes? Did you understand that while I stuttered it out?

Mr. BURKE. Yes, sir. I think I have your question. So I have some numbers from fiscal year 2016. Basically the amount of claims that

our rating veterans service representatives, or VSRs, sent back to a provider for clarification of an examination was about one percent or less. But again, that is a good example of the checks and balances, whether they are detected by our claims processors or even by our VSO partners as well.

Mr. BOST. Thank you. I will turn the questioning over to Ms. Esty for five minutes.

Ms. ESTY. I would defer and allow the Ranking Member to go ahead of me, since I will be staying through the duration. Ranking Member Walz, are you ready to go?

Mr. BOST. Are you—

Mr. WALZ. I'll pass.

Ms. ESTY. Oh, all right. Well then I will proceed. Thank you very much. Let me get my papers here. Just a second. I want to return to some of this question about the exams themselves. Because I am finding from the veterans I represent, they are often confused by the notices. So they go in, they know they have an exam, they assume it is going to be PTSD. They are finally ready to tell their story. They go in, they tell their story, and halfway through they get shut down because actually they are seeing a podiatrist who is asking about their good. This seems like something we can address because in fact if we do not address this you are going to have an appeal based on that exam. Which if we have greater clarity about what is the purpose of this exam, so that a veteran knows going in you are being examined for PTSD or not as part of this particular exam. So I would ask, you know, that is one issue I would like you all to talk about. Because I can tell you for sure we are not doing a good enough job because people tell me about their frustration. And feeling disrespected when they actually tell their story and they are shut down. So we need to do a better job of explaining what is happening with exams. So I would like, I would like to at least have you all answer that. If you think we are doing a good job or what can we do better on that front?

Mr. BURKE. Thank you for that question, ma'am, and certainly I will ask my partners at the table to jump in as well. It is an area that we can do better in. In fact, over the past year or so VA has been asking veterans for their feedback after they have gone through the examination process and we are gleaning some information from there. It lets us know that while in many cases veterans are satisfied with the process, there are areas that need improvement.

As part of VA's modernization plan, one of the things that we are gearing up to do with the help of our stakeholders is to refine the way that we collect and analyze that feedback. And that is going more direct to the source, getting more accurate feedback from them. But I think we are doing a good job. I also think there is room for improvement. And I will ask anybody from the panel to jump in as well.

Ms. MURRAY. Sure. So again, thank you for that question. We do monitor the satisfaction of our veterans on a biweekly basis. We are sending out questionnaires every two weeks, those that have come in over that period of time, to ask them about their satisfaction in the clinic, what things we can improve, what areas of concerns they have. And so we get a lot of feedback from our veterans.

And we trend that data. We look at it across the system. If we see something specific at a facility we will contact that facility and ask them to look at it. So we follow up very closely on our satisfaction survey data.

Ms. ESTY. I would appreciate it if you could show me what some of those notices look like to see if we need to work with our VSOs or if in fact we could have greater clarity. Because, again, we know that the amount of money and time that goes into reviewing claims when we would all like to see help being given to our veterans. So if we can reduce unnecessary appeals that would be good for everybody and would reduce time. So I would like your commitment on that.

I want to follow up a little bit on what Chairman Bost asked about reducing rating but with perhaps a slightly different take. What I hear are two different concerns. One is people are being coached that they actually have to look physically a wreck before they can go in for PTSD and they are encouraged not to bathe, not to shave, to really, not to sleep so that they can establish that physically they are looking that bad. And that is not a good situation, I think we can agree, if that is what our VSOs are coaching the folks I represent. So that is one piece.

And the other is, what do we do about a situation in which there is a belief, and it may be founded, that if they do not get a sufficient rating, they will lose access to treatment? Our goal should be getting our veterans back on their feet and productive members of society. So there is an inherent tension that I think we are somewhat papering over, particularly on PTSD, in terms of if you believe and if you need to get a high rating of disability in order to get treatment, we are setting up a no end scenario for our veterans. And I believe that to be the case for some of the veterans I represent. That is the way they see it. They see it that they will lose access to treatment unless they prove they are not doing well and not getting better. And we have got to address that. And I see you nodding your head a little bit, Mr. Avila, so if you have got thoughts on this from the perspective of the Legion I would appreciate your weighing in. Thank you.

Mr. AVILA. So you are correct and there has been a debate whether the percentage of disability, the veterans are afraid they might lose their benefit if they get better. So that has always been a concern. But even if it goes, as long as they still have the service-connection, and they have that access to the health care, they should not fear of losing that. Yes, on the monetary side they can be reduced a couple of dollars. But hopefully the condition still stays as recognized as service-connected and that will still get them access into the health care system so they can continue receiving the treatment.

Mr. BOST. Thank you, Ms. Esty. And I now recognize Mr. Coffman for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman. First of all, just from a veteran perspective, I am concerned about the nature of the treatment, modality of treatment that we offer our veterans, our combat veterans. It seems to be that it is kind of, that it is drug centric and that is not helping anybody get better. It seems like

they, that people get worse that go into treatment than better. And can somebody address that concern?

Ms. POLLACK. Certainly. Thank you for the question. Certainly drugs are one treatment for Post-Traumatic Stress Disorder but we really use the clinical practice guidelines developed by VA and DoD for treatment of PTSD. And the first line treatments for Post-Traumatic Stress Disorder are actually prolonged exposure as well as cognitive processing therapy, which are two talk based therapies. We also in recent years have implemented a variety of complementary and alternative treatments for PTSD. Lots of veterans have not wanted to participate in those types of treatments due to the fact that they involve exposure to one's trauma and one of the hallmark symptoms of PTSD is avoidance of trauma or avoidance of what reminds you of the trauma. So things like yoga, mindfulness based stress reduction, all sorts of other things. So drugs are only one part of the treatment.

Mr. COFFMAN. This is more of a Department of Defense question. I am Subcommittee Chairman for Military Personnel on the Armed Services Committee. And we are not going to go back to the selective service system. We are ultimately going to do away with it. So our backup reserve, so to speak, is going to be those who are discharged from active duty and still have a remaining commitment up to eight years. And I think that certainly the Marine Corps, I know, was heavily reliant upon going into their inactive reserves during the height of the Iraq and Afghanistan Wars. If somebody receives a permanent disability for PTSD, whether it is ten percent or it is 100 percent, are they exempt from further military service? And I know you are more on the VA side. Maybe the American Legion might know the answer to that.

Mr. AVILA. Mr. Coffman, so this is an area that we have done some work. So you can have a disability and still continue your service in whatever branch as long as you meet the medical standards of the respective branch. Whenever you have, you can even have a permanent disability but when it becomes a red flag, is this disability impacting or having a negative ability to complete your job or to do your duties in the military? Then there can be a concern that maybe you are not fit to continue your service. And that is when it kind of raises the issue and to maybe be separated through a med board process.

Mr. COFFMAN. Well I think that is why we need to focus more on treatment as a country. And I think we have an obligation to our veterans, and from a national security standpoint. I was an infantry officer in the United States Marine Corps, and I can tell you that if somebody is so traumatized by combat that they are going to have a percentage of disability, they are not going back into the fight. That is all there is to it. And that compromises the national security of this country given the fact that we are not going to go back to the selective service system and we are going to rely on those inactive reserve forces. And so I think we, the VA has to do a better job about treatment. And I yield back.

Mr. BOST. Thank you, Mr. Coffman. And Members need to be advised, I think we are going to go to a second round. So if you want to stay around for other questions. With that, Mr. Bergman, you are recognized for five minutes.



Mr. BERGMAN. Thank you, Mr. Chairman. I see some familiar faces at the table. I would like a show of hands how many of you at the table feel a sense of urgency in this? Good, at least we are getting 100 percent on this hearing.

Mr. Flohr, in 2010 the VA lowered the standard approved for some veterans who file claims for PTSD. The lower standard is intended to make it easier for some of those veterans, such as those who have experienced fear of a terrorist attack or hostile military activity, to receive benefits even though the incident was not documented in their records. What safeguards are in place to basically make sure that, you know, the pendulum has not swung and we have people gaming the system?

Mr. FLOHR. Thank you, sir, for that question. We did that as a result of a belief by Secretary Shinseki at the time and Under Secretary Admiral Dunn that there were veterans who were serving, or servicemembers serving in Iraq and Afghanistan that were not combatants but yet who feared potential injury or death due to terrorist activity. And DSM-4 changed the criteria for PTSD from being exposed to a stressor that would cause symptoms in almost anyone to a more individual based stressor, recognizing that individuals react differently to stress. So we gathered actually a lot of people in the Secretary's office on three occasions from DoD, private providers, and talked about this. And we determined this was the right thing to do, was to recognize that if somebody developed PTSD diagnosed by a clinician and the stressor was fear of hostile military or terrorist activity, that we should take action to grant that claim.

We as far as making sure that it is not, someone is not gaming the system, of course we review all the evidence we have. If there should be a reason to question someone's statement, we would follow up on that if we felt—

Mr. BERGMAN. Okay. I am going to cut you off here. Because I want to get to another question.

Mr. FLOHR. Okay.

Mr. BERGMAN. But thank you. Thank you. Does the VA maintain data on what you have been accumulating over the suitability if you will of people for service, especially either after a traumatic event that has potentially caused PTSD, or fear of a traumatic event that has caused it? It does not make any difference what the cause is. But does the VA maintain data, not necessarily by individual name, but data that would suggest solutions going forward? As you heard Mr. Coffman say we are going away from the selective service system eventually. But as we look at comparing data that exists based upon 15 years at war to apply to future selection criteria, if you will, or evaluating criteria for enlistment. When we had the selective, we still do, you could go 1A or down to 4F, with a lot of other classifications in between. But does the VA have a database that says, here we are, and here is how we might compare this to what we might be looking at on the front end for understanding the young men and women who really have the best chance of being successful in in this case military service?

Mr. BURKE. So sir, I will take that one. I do not know that we have the data teased out for future, you know, for modeling if you

will for future considerations. But if you will allow us to take that back, we can get back to you on that one, sir.

Mr. BERGMAN. Yes, well you know even if you do not have it modeled out at this point, if the cases that you are dealing with are being recorded, again nameless because we are not trying to assign a name to this, but so that we know here we are in the 21st Century. We know that we are going to need strong, mentally strong, physically strong men and women to serve our country in many different forms. So that is where I am driving with this. So if you have that, I believe we can take a next step. Yes, doctor?

Ms. POLLACK. Well some of the information that we do have, it is not specific data, but there has been a lot of research done into what sort of causes Post Traumatic Stress Disorder. And we really do not know why one person develops PTSD and one person does not. Two people can be exposed to the same trauma, one may develop Post Traumatic Stress Disorder, one may not. But we do know there are certain risk factors. The number of traumas an individual is exposed to, PTSD is more common in women than in men, we know that social support is really important, you know, someone who does not have that social support as they are going through traumatic event will be more likely to develop PTSD. So there is research out there looking at those risk factors.

Mr. BERGMAN. Okay, thank you. Thank you, Mr. Chairman. My time is expired, I see.

Mr. BOST. Thank you, Mr. Bergman. Going around on our second questions here, Mr. Avila, based on your experience, do you believe that the raters have the capability to review the evaluations and then properly assign a rating based off of the examiner's description of symptoms? And then also, are the raters sending back questionable exams when necessary?

Mr. AVILA. So we do believe they do have the ability, the capability to do it. I guess the question would be how often do they do it? From our experience in visiting the VA regional offices, if an examiner indicates a specific box on the DBQ, the rater more or less just concurs with that decision. So if this is the case, then essentially the examiners are adjudicating the claims if the rater is not questioning the decision. We have seen cases where a veteran presents symptoms, severe symptoms such as suicide ideology, which is a key component of a 70 percent rating and he is only given maybe a 30 or a 50 percent. And the raters do have the ability to send back an examination for clarification. But once again from our experience, this does not happen a lot. So essentially and if it does happen you can also be dealing with long years dealing with an appeal.

Mr. BOST. Mr. Caraway, do you have anything to add to that?

Mr. CARAWAY. Yes, sir. I think the raters when they are using the rating tool, they have the ability to go one rating higher or lower than the appropriate, well then the median result that comes out of the rating tool. So in the case of a suicide ideation, while that could be a 70 percent, the rating tool also allowed the rater a 50 percent evaluation or a 30 percent evaluation depending, and it will say that this is a suggestion only. And so what we are finding is that the raters are going to go down the middle of the road to prevent any error codes coming up later down the road. And us

as state and CVSOs and VSOs at the regional offices, we are going to submit an appeal on that and based off of the rater's decision or their inability or lack of desire to go out and err on the side of the veteran based off of that C&P examination.

Mr. BOST. Okay. And staying with that line of questioning, with you, Mr. Caraway, please if you can so can you go into detail why NASDVA is concerned with the quality of disability examinations on this particular issue?

Mr. CARAWAY. Yes, sir. Thank you for that question. The state directors, and I am a county veteran's service officer so I work in partnership with the state directors across the Nation. And the reason why we are concerned about this is because veterans will come into their examinations expecting, the Ranking Member said, to tell their story. Well if you show up at a 1:00 appointment you are probably not going to be seen until 1:30, and presumably because the examiner is evaluating and going over your C file. But then you are going to go in at 1:30, when you are called in, you are going to have 15 minutes to tell your story. And those boxes, what is happening is the examiners are skimming over and going through as quickly as they can so then they have time to dictate that examination to get it back to the VA so they have a timely examination.

Mr. BOST. Mr. Avila, would you like to expand on, comment on that as well?

Mr. AVILA. So I think the biggest issue, sir, is, or the biggest concern we have is the review of the records. And some of these records can be quite extensive. So as a matter of fact, my colleague just put it the other day saying if you show up and the examiner has not reviewed the record, it is like showing up to class and you have not done your reading. You are kind of a little behind the power curve. So it does not give a full picture of the whole situation and that just can be based on the disability benefit questionnaire or on that short appointment during the C&P.

Mr. BOST. Okay. Because I am down to one minute here on my own self, would someone from the VA please try to explain to me how you verify these medical experts and spending all this time trying to figure out how to check boxes and not actually listening to the individual? And I mentioned that in my opening statement, to the individual on their own case and their own situation. And I know we try to put it in a uniform box with a check. But how do you allow for something like this not to be heard out on an individual case?

Mr. BURKE. So thank you for that and I am going to ask my friends from VHA to jump in when I am finished as well. But we believe that whether it is VHA or a contract vehicle, that adequate time is allotted for these exams. It should be differentiated that the initial PTSD exam is typically longer than a claim for increase based on the amount of gathering of evidence.

I do want to make one point very clear for VBA. When we rate it is on the totality of evidence, it is not just the information from the VA examination. So whether it is private statements, outpatient treatment records, or any other evidence submitted, the VA exam is but one piece of what is reviewed and used in the overall

determination. So I want to ask if VHA wants to add anything to that at all?

Ms. POLLACK. The only thing I would add is that these examinations are being done by psychiatrists and psychologists who have extensive obviously mental health training in the provision of those assessments and care. And I know myself, as someone who did C&P exams for many years, at the beginning of any examination we spend time talking to that veteran about what that examination would entail and that while we were going to be asking questions about trauma, there may be times also that we would redirect the veteran for a variety of reasons that we do not need to get into every nitty-gritty detail of everything that happened because this is not a treatment assessment. It is really an assessment to make sure that we get the information that is needed so that VBA can make, can adjudicate their claim. And I think, you know, examiners, and maybe we need to be doing a better job training examiners to make sure that they really are starting all of the examinations as we talked about, letting the veterans know what to expect. Because I think if someone understands to expect that I am not going to be asking you every detail and here is why, I think they are okay with that.

Mr. BOST. Okay. I am way over on my time. Mr. Ranking Member, would you—okay. Ms. Esty? You are recognized.

Ms. ESTY. Thank you, Mr. Chairman. I think I am going to probably pick up with that. But I do want to quickly flag how important this hearing is but we are scratching the surface of some really important issues. Given that the number one clinical, the only clinical priority of our new Secretary is reducing military and veteran suicide, we have not talked about that. We have not talked about other than honorable discharge. So I hope we can have an opportunity, have a separate hearing on those critically important issues. Because I think those are incredibly important and intimately related. But I am not going to go there now because I think we need to focus on what has, we have plenty of things already on the table.

A couple of thoughts, Dr. Pollack, I think what you just said about laying the table for the veteran is tremendously important. I would hope that that is part of the training and that people are actually evaluated on that. Because I think, again, it is really important. Because, you know, for a veteran who is suffering with this, that is going to be a really hard distinction? And I think that needs to be made early and often, up front, this is not a treatment interview. Really, we are trying to determine a level of disability for this piece. There is a different piece and all of this material is going to be relevant for that. So that is one.

The second was the issue several of you have raised about on the adequacy of the exam. It is not just the time with the patient. Is there time to do the homework? Is there time to review the file in full? And how, that has to do with the time pressures. And I am particularly concerned for people doing this under contract. Are they under such time pressure that in fact they are not given the time to properly review the file? Because, again, if they are not given the time to review the file, we should not be surprised if they are not doing it. If that is the incentive, that they have no time to

review the file, we should not be surprised that they then review. And I will just say with a little window into this on the treatment side, I have a brother-in-law who was a contract physician through Kaiser for the VA. And he was given 15 minutes to do treatment, ten minutes to do treatment. You are not doing talking treatment when you are doing ten minutes. You are prescribing drugs and you are sending them right out the door. I want to make sure that in the concern about moving people through the system, we are not doing them a disservice and ensuring they are going to be right back in the door. So I put a bunch of things out and I appreciate your comments. Thank you.

Mr. BURKE. So again, thank you for your concern, ma'am. All valid points, all things that we continue to focus on. To your issue of the Secretary's goal of veteran suicides, reducing will not be good enough for us. It is eliminating. A very, very sensitive topic for all of us in this room, including all of our stakeholders.

We continue to take a look at the feedback we are getting from the veterans that go through these examinations, feedback from our stakeholders, our partners. And as we go to modernize VA, we want to make sure that we are putting our veterans first and making sure that we are taking their feedback as to what they need instead of us determining what we think they need. It is kind of the bid push. Our Secretary is determined to make sure that we are putting the needs of the veterans first and the exam process is huge. The examination process touches the bulk of our pending claims. And so for us to get that right is extremely important and we are committed to doing that.

Mr. CARAWAY. I wanted to touch again on the examinations. When veterans walk into the C&P examination, while they expect to tell their story to some degree one of the things, and it also will revert back to a statement that you made earlier about VSOs coaching veterans before the C&P examination. One, we are not allowed to coach. That is against the law. And if people are doing that, they should be ashamed of themselves. But we do educate. And what I will say is you are going to walk into an examiner and you have months or years of dealing with your symptoms and you have one chance to meet with this examiner. I mean, think about how you go into your doctor. Your doctor has learned over a period of time how a diagnosis is impacting your life as they move into treatment. When you walk into this appointment the veterans need to be told that you need to bring it to the third and fourth appointment immediately. You take off the uniform, put your pride aside, and you are going to have to open up and explain how this is actually impacting your day to day life. And I thought that I would make that point known. Because we do not ever allow or teach coaching but we do have to educate the veterans on what to expect in those examinations and to bring themselves to a level where they can be able to explain how the diagnosis is impacting them.

Ms. ESTY. Just a quick question, how do you do that? Because I think there is the human need to, you know, how do you get to the third visit when it is the first visit? I mean, let us think realistically. How does a human being who has been, had this bottled up, how do they do that? And are we doing an adequate job, all of us, doing an adequate job to recognize someone is going to have to

go, you cannot jump over those phases, right? So are we doing what we need to be doing to get at least the preliminary work done so that someone can adequately present their appropriate case when they are in that C&P exam?

Mr. CARAWAY. And thank you for that. Because one of the easiest ways is to try to allow time for the treating providers at the VA medical centers or contracted providers if veterans are going outside in community care to fill out those DBQs. But because they cite the time limits, when I talk to medical professionals at a CBOC they will tell us, well, if you are going to tell VA to create 27 hours in a day for me, I will be more than happy to do a DBQ. And so that is a concern for me. Because you are taking the treating provider's opinion out of the equation, when they know more intimately about how the diagnosis is affecting them. So how do we do it? And is the veteran really able to come to the third appointment on the first time? No. But at least they can recognize that they have to try.

Ms. POLLACK. And from a clinical perspective I think again it is important to recognize so much of this comes into play in sort of the introduction of the purpose of the evaluation, why you are here, that we need to get to this information, and really just recognizing how hard it is to talk about these issues, you know, how hard it is to build rapport and to differentiate, again, that this is different than if I was in a clinical evaluation, where we would be spending weeks getting to know each other. This is a one-time evaluation and really I need a lot of information in a short time. I recognize it is going to be difficult for you to share that with me. But I think, you know, over the years clinicians learn techniques to work with veterans who are often sort of resistant to share what is often very difficult personal information. I can use as an example, lots of time saying to a veteran who has PTSD, my guess is you find it very difficult to go out to a restaurant and when you do you need to sit with your back to a wall? And all of a sudden just by saying that simple statement, I cannot tell you how many veterans that I have worked with said, how do you know that? How do you know me? And I think that really sort of helps in terms of that rapport. Being able to say I understand PTSD. I understand what you are going through. And we can work together to make this evaluation as comfortable for you as possible.

Mr. BOST. Okay. With that, we have pretty well run through this. But one thing I do want to do is I want to thank everybody for being here. But I do want to let the Ranking Member have any closing remarks that she might want to make at this time, and then before we close this out.

Ms. ESTY. Well again, I want to thank you for joining us here today and let me be very clear. I know everyone is trying to get to the same place. Everybody's heart is in the right place. And people have jobs to do and they have time pressures and a lot of veterans to serve. And I know everyone is well intentioned. I think we are just trying to figure out how we can do our job in Congress to provide you the resources but also the incentives and the clarity.

So for example, I want to follow up with you, Mr. Caraway, you noted that there is some inconsistency out there with forms being

present or not present. That creates confusion. We want to do everything we can to make this simple.

Dr. Pollack, you clearly are an experienced, caring professional. But we have people doing contract work. We have people who are fresh to this. I worry about how someone new to this is going to be able to appropriately evaluate, put a veteran at ease in their C&P exam. And I worry a lot about that. And we have seen a tremendous number of increase because we are doing outreach but we also know from the tale that it tends to peak about six years after exposure, which is no surprise why we are seeing those numbers going up now. So we, it does make me worry about adequate preparation for the people doing the exams. Where if you are not experienced, you may not be doing right by the veterans in front of you. And they do not deserve to be the training wheels for a new examiner. And so, again, thoughts on what we can better do with that.

Because, again, I want to say I know people are trying hard. But each and every veteran, for them the only exam, the only treatment that matters is what they get. And that is as it should be. And we want to make sure that that experience is a good one, an accurate one, and we are providing the care that our veterans need and the accuracy that the public demands.

So again, I want to thank you for your service and your ongoing commitment. And thanks again the Chairman for his holding this important hearing. Thank you very much, and I yield back.

Mr. BOST. And thank, I want to thank the Ranking Member for what she said earlier, which is we were just scratching the surface here. And early on in this process I said that as with any other disability, you can truly identify it. That does not mean it is not difficult, and each person deals with that, does have a difficult job. But when we are dealing with a human mind that has been damaged by some really, really bad experiences, to be able to analyze that and do it in a way, that is why it makes it so difficult. But we have got to do the best job we can.

I believe everybody in this room wants to do that, whether it is the VSOs, or the agency. I believe that our veterans are, we are trying. But each one of us as Members know this. When we are back in our district, we hear from them on a regular basis. Concerns from both sides, hey, I feel like somebody is trying to push me to say I have got it. And hey, I have got this issue, and doggone it, they are not listening. And so somewhere in there is that balance that we can truly take those individuals and, you know, they truly are our heroes. They have served us. They have stepped out into the fire for us. And so we are going to keep working on this.

But I do want to thank all the witnesses again for being here today. And as I said at the very beginning of the hearing, the complete written statement of today's witnesses will be entered into the hearing record. I ask unanimous consent that any written statement provided for the record will be placed into the hearing record. I also ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material. Hearing no objections, so ordered. With that, this hearing is now adjourned.

[Whereupon, at 11:33 a.m., the Subcommittee was adjourned.]

# A P P E N D I X

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## Prepared Statement of Ronald Burke

### Opening Remarks

Chairman Bost, Ranking Member Esty, and Members of the Subcommittee, thank you for the opportunity to discuss how the Department of Veterans Affairs (VA) manages Veterans' post-traumatic stress disorder (PTSD) disability compensation claims. My testimony will provide an overview of VA's processing of these claims, its training and quality assurance efforts, and the use of Disability Benefits Questionnaires (DBQs) to capture relevant medical evidence used to evaluate PTSD claims. With me today are Mr. Brad Flohr, Senior Advisor for Compensation Service, VBA; Ms. Patricia Murray, Chief Officer, Office of Disability and Medical Assessment, VHA; and Dr. Stacey Pollack, National Director, Program Policy Implementation, VHA.

### PTSD Claims Processing

There are currently over 940,000 Veterans who are service connected for PTSD and receive a monthly benefit payment. This population equates to approximately 22 percent of all Veterans receiving disability compensation benefits. This is a 172-percent increase compared to the end of fiscal year (FY) 2008, when approximately 345,000 Veterans were service connected for PTSD. The increase is a result of the veterans increased awareness and understanding of PTSD and several associated changes VA has implemented. In 2010, VA took actions to make it easier for Veterans to obtain disability compensation benefits associated with PTSD by placing greater evidentiary weight on lay statements to establish the required in-service stressful event if related to fear of hostile military or terrorist activity. VA previously required documentary evidence from the Department of Defense or other sources to verify an in-service stressful event related to the Veteran's PTSD symptoms, unless it was verified that the Veteran engaged in combat with the enemy or was a Prisoner of War, which was generally sufficient in itself to establish occurrence of an in-service stressful event.

For the evaluation of PTSD claims where the stressor is not combat-related or there is no initial evidence of combat participation, VBA has provided claims processing personnel with special tools to research Veterans' stressor statements. A website was developed that contains a database of thousands of declassified military unit histories and combat action reports from all periods of military conflict. In many cases, evidence is found in these documents to support the Veteran's stressor statement or confirm combat participation. Nationwide training was conducted on this database and other official websites that can aid with stressor corroboration. Thus, VA has illustrated in various ways its commitment to understanding and assisting Veterans with PTSD claims.

### Training

There are currently 16 VBA training courses focused on processing PTSD specific claims (including Military Sexual Trauma) geared to VA claims processors, including both interactive online lessons and classroom-based, instructor-led courses. Additionally, there are nine courses covering the topics of requesting disability medical examinations-also known as Compensation and Pension or C&P examinations-and sufficiency of examination reports. Again, these are delivered in both online and classroom settings.

VA's Challenge Training for new Veteran Service Representatives (VSRs) and Rating Veteran Service Representatives (RVSRs) includes two courses regarding examination requests and examination sufficiency. There is also specific instruction on PTSD claims.

VA's National Training Curriculum for FY 2017 requires five courses of PTSD training for VSRs and 10 courses for RVSRs. Also, error-trend analysis drives local instructor-led training on examination requests and examination sufficiency for indi-



vidual stations as well as training during Compensation Service oversight visits. Error-trend analysis has also led to the development of new national-level training involving examination sufficiency that was released to the field in June 2017.

#### **Quality Assurance**

VA reviews PTSD claims as part of its national Systematic Technical Accuracy Review (STAR) program. From the start of FY 2016 (October 2015) through February 2017, accuracy of processing on PTSD claims was 94.2 percent, which is comparable to VA's overall 12-month issue-based accuracy of 94.57 percent through April 2017.

PTSD claims are reviewed under the same criteria as all rating claims through the STAR program. This includes a review for appropriate development of the claim; whether the grant or denial of issues was correct; whether the appropriate evaluation was assigned; and whether the effective dates and payment rates were correct. It also considers whether appropriate notification, both of VA's duty to assist and the decision, were provided to the Veteran and representative. Finally, it considers whether appropriate medical examinations and opinions were requested and conducted where necessary. This review does not differentiate claims based upon the stressor type (combat, military sexual trauma, etc.).

#### **DBQs**

VA claims processors request disability medical examinations, or C&P examinations, specific to PTSD. Trained examiners, whether at Veterans Health Administration or at one of VA's contracted examination vendors, document the exam findings on DBQ templates, which are considered by VA claims processors in making decisions on disability compensation claims. It is important to note that DBQs are intended to capture information necessary to evaluation of a claimed condition under the VA Rating Schedule for Disabilities; thus, DBQs are a tool designed to support a forensic assessment of a Veteran's claimed condition, not for treatment purposes. The initial examination for PTSD, where a diagnosis is made, must be conducted by a psychiatrist or psychologist.

#### **Closing Remarks**

VA remains committed to providing high quality and timely decisions on entitlement to disability compensation benefits, with PTSD being one of the primary conditions claimed by Veterans. VA will continue to update training materials and the Schedule for Rating Disabilities regarding this condition and its impact on our Nation's heroes and their families.

This concludes my testimony. I am pleased to address any questions you or other Members of the Subcommittee may have.

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#### **Prepared Statement of Gerardo Avila**

The Department of Veterans Affairs (VA) National Center for Post-Traumatic Stress Disorder (PTSD) defines PTSD as "a mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident, or sexual assault."<sup>1</sup> "The nature of serving in the armed forces is inherently dangerous; fear of hostility, combat operations, military sexual trauma (MST), and the dangers of training operations are only some of the causes that could eventually lead to a PTSD diagnosis.

PTSD affects each generation of veterans. The National Center for PTSD estimates 11–20 percent of veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) suffer from the condition; an estimated 12 percent of Operation Desert Storm veterans have PTSD, and 15 percent of Vietnam War veterans also suffer from PTSD, according to the most recent VA study conducted in the late 1980s. VA estimates that 30 percent of Vietnam War veterans have suffered from PTSD at some point during their life<sup>2</sup>.

Chairman Bost, Ranking Member Esty, and distinguished members of the Subcommittee on Disability Assistance and Memorial Affairs (DAMA), on behalf of National Commander Charles E. Schmidt and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to testify regarding The American Le-

<sup>1</sup>National Center for PTSD

<sup>2</sup>PTSD: National Center for PTSD

gion's position on "VBA's Processing of Claims for Benefits Based on Post-Traumatic Stress Disorder".

### **Background**

In July 2010, VA took significant strides towards assisting veterans suffering from PTSD. The liberalization of regulations relaxed the need for veterans to provide proof of a PTSD stressor; instead, veterans only needed to prove a "fear of hostility." Former VA Secretary Eric Shinseki recognized the importance of the liberalization and added, "This final regulation goes a long way to ensure that veterans receive the benefits and services they need." The American Legion concurred with the former Secretary and lauded the efforts to streamline the access to benefits.

While The American Legion acknowledges advancements in this area, we also know there is significant room for improvement. From development of PTSD claims, through compensation and pension (C&P) examinations, to ultimate adjudication, American Legion accredited representatives routinely see errors throughout the process. Furthermore, if a veteran seeks service connection for a physical condition that manifested secondary or was aggravated by PTSD, veterans routinely are faced with a difficult journey.

### **Development of PTSD Claims**

Improvement in the development of PTSD claims improved significantly following the July 2010 liberalization and has led to greater uniformity in relating PTSD to being deployed to hostile areas. VA's veterans service representatives are more likely to request C&P examinations, leading veterans to not receive VA disability compensation but gain access to VA healthcare.

The July 2010 liberalization was not the first instance of relaxing standards for PTSD. VA relaxed the standard for gaining service connection for PTSD related to military sexual trauma (MST) in 2002. The frequency and impact of MST among servicemembers and veterans is intolerable. VA reported in May 2015 that 25 percent of female veterans and one percent of male veterans experienced military sexual trauma when screened by a VA provider<sup>3</sup>.

Though VA relaxed MST-related PTSD claims, the implementation and effectiveness of that relaxation has not been enjoyed in the same manner as combat related PTSD claims. Recent reports have highlighted the complications regarding reports associated with MST. Command cover-up, lack of military or civilian law enforcement records, and lack of medical records are some of the myriad reasons why claimants are unsuccessful in gaining service connection.

It is extremely frustrating to veterans that experience such degradation by fellow servicemembers and then receive a denial of benefits post-service. American Legion service officers often submit lay statements from family members or friends that corroborate the incident, only to have the lay statements ignored or disputed. PTSD caused by MST often can only be corroborated by family members or friends, and VA's failure to regularly utilize these key documents is harmful to veterans.

### **C&P Examinations**

The PTSD disability benefits questionnaire (DBQ) has created a uniform examination process that provides medical professionals with a list of symptoms and severity of symptoms experienced by the veteran. DBQs have proven a useful way to providing a uniform method of providing the necessary questions and ensuring the appropriate information is transferred to the Veterans Benefits Administration (VBA) for establishing the level of service connection. In theory, the veteran in Los Angeles should be receiving the same C&P examination for PTSD as the veteran in Atlanta.

Complaints pertaining to C&P examinations from veterans do not generally surround the DBQ; it surrounds the manner and method the examinations are conducted. Veterans have complained of C&P examinations that last 10–15 minutes and examiners that question the veracity of their symptoms or severity. Additionally, examiners have detailed significant and severe symptoms; however, when evaluating the level of occupational and social impairment provide a response that do not align with the level of severity reported in the DBQ.

A recent issue has developed regarding C&P examinations provided by VBA contracted examinations. Within the last six months, American Legion service officers have noted the quality of re-examinations for PTSD. Despite having months of continual treatment by VA for the condition with records indicating the severity of the condition, some contracted examiners indicate the veteran's symptoms are signifi-

<sup>3</sup>Military Sexual Trauma

cantly less severe than indicated by VA treatment records. Ironically post-C&P examination, VA treatment records continue to show the previously indicated more severe symptoms.

The impact of C&P exams are highly critical in determining service connection and the level of disability. Symptoms experienced and the severity of the symptoms are the foundation of establishing the level of disability within the VA Schedule for Rating Disabilities. Due to this fact, it is absolutely essential that C&P examiners conduct a thorough review of records, to include lay statements, to ensure veterans' conditions are properly evaluated.

### **Secondary Conditions Related to PTSD**

The National Center for PTSD published an article by Kay Jankowski, Ph.D., regarding the impact of PTSD upon physical health. Dr. Jankowski acknowledged "a growing body of literature has found a link between exposure to trauma and poor physical health" and added research exists regarding the relationship between PTSD and cardiovascular, gastrointestinal, and musculoskeletal conditions.<sup>4</sup>

Veterans are often diagnosed with PTSD at a relatively young age. Years of suffering with the condition could cause or aggravate physical conditions, as suggested by Dr. Jankowski. Unfortunately, veterans are often denied or not even provided the opportunity to have a C&P examination to determine the relationship between the physical condition and PTSD.

Sadly, some within VBA do not believe that a relationship exists, despite the fact that VA has published articles suggesting the existence of the relationship. In 2015, The American Legion met with senior leaders at a VA regional office (VARO). The topic of the relationship between cardiovascular health and PTSD was discussed, as we noticed frequent remands from the Board of Veterans' Appeals regarding this issue. The veterans service center manager declared no relationship exists and added that her husband was unsuccessful at connecting the two conditions for his VA claim. Perhaps he should have enlisted the help of an American Legion service officer.

When further pressed on the issue, she demanded to produce a medical study discussing the relationship. The American Legion immediately provided a study suggesting the relationship issued by VA's Published International Literature on Traumatic Stress. We realize that each case is different; we realize that medical professionals may have different opinions. However, we believe a trained medical professional should make that determination and not a VBA employee.

### **PTSD and Total Disability Due to Individual Unemployability**

An unfortunate impact of PTSD is that it can eventually lead to a veteran's inability to gain and sustain meaningful employment. This leads to the veteran qualifying for total disability due to individual unemployability (TDIU) benefits. Unfortunately, unless the veteran specifically applies for this benefit, TDIU may not be awarded.

Annually, The American Legion conducts VARO visits as part our Regional Office Action Review (ROAR) program. In March 2016, The American Legion visited the Cleveland VARO to review recently adjudicated appealed claims.

During the visit, we reviewed a claim of a Marine veteran that filed to increase his 50 percent PTSD disability rating in March 2010 and stated he could not work due to PTSD. His wife provided a letter in May 2010 indicating the veteran's inability to work due to PTSD and documentation from the Social Security Administration (SSA) indicating he is unable to work due to a psychiatric disorder. Eleven months later, the veteran received a rating decision stating, "Social Security records dated February 3, 2010 noted your isolation and irritability. The examiner on your Mental Residual Functional Capacity Assessment provided that you are unable to work in proximity to other people due to extensive social discomfort and you are unable to complete work behaviors in a typical work environment due to your psychiatric conditions. You are currently receiving Social Security for your affective disorders and your anxiety related disorders."

In March 2012, the veteran filed a notice of disagreement, and nearly four years later, in February 2016, he received a decision increasing his disability rating for PTSD to 70 percent. Unfortunately, the veteran still was not receiving TDIU; however, he continued to receive social security disability benefits.

The American Legion reviewed the appeal in March 2016. The veteran's documentation strongly suggested consideration for TDIU existed, and we demanded VA to take action. VA conducted a C&P examination in April 2016, and the examiner

<sup>4</sup>National Center for PTSD

agreed with SSA and opined the veteran's PTSD caused unemployability. The American Legion's questions combined with a positive opinion indicating the veteran's PTSD caused unemployability led to an eventual grant of the benefit. VA did retroactively award the benefit to May 2010 and received a retroactive award in excess of \$96,000.

Had The American Legion's ROAR team not visited this location and reviewed the appeal, this veteran may have never received TDIU, and if he did, it is uncertain if he would have received the same effective date. This case serves as an example of the need for VBA employees and C&P examiners to perform a careful and thorough review of the record. This veteran should not have had to wait four years to have an appeal adjudicated, and he certainly should not have had to wait six years for the proper awarding of his TDIU benefits.

### **Evaluation Builder Tool**

The creation and implementation of VBA's Evaluation Builder tool has also led to improper denials or an under evaluation of claims. VBA created the tool to develop uniform decisions; a rater at one VARO should have similar decisions as a rater at a different VARO. Unfortunately, nearly whole dependence on the tool has created missed opportunities.

In 2017, The American Legion has asked VBA employees during ROAR visits about the tool. Raters have the capability to disregard the tool's suggestion; however, the local quality review team is notified, and many fear reprisal if they continually challenge the tool's suggestion. Quite simply, they do not want a label of being a difficult employee.

No concern would exist if the tool were 100 percent effective. The American Legion understands that not all information receives consideration in the tool. Lay statements, continuity of symptoms, or outside private medical evidence may not be considered and significantly influence a decision.

The American Legion believes the Evaluation Builder tool could greatly assist raters. However, there requires flexibility. Raters should be encouraged to challenge the tool and not fear reprisal. In fact, challenges to the tool's system would lead to better development of the product; VA should welcome this input. Finally, the decisions should not solely reflect the suggestion of the tool; it is essential consideration of all pertinent records occur.

### **Conclusion:**

The American Legion has long recognized the impact of PTSD within the veterans' community. We have worked with those that have been affected by horrors of combat and MST. During our 96th National Convention in 2014, we resolved to, "Urge the VA to review military personnel files in all MST claims and apply reduced criteria to MST-related PTSD to match that of combat-related PTSD"<sup>5</sup>. VA has taken significant strides in improving its recognition of veterans deployed to hostile lands; however, VA still needs improvement in MST-related PTSD claims, C&P examinations, and evaluations of disabilities. The American Legion thanks this committee for their diligence and commitment to our nation's veterans on this topic. Questions concerning this testimony can be directed to Derek Fronabarger Deputy Director in The American Legion Legislative Division (202) 861-2700 or at [dfronabarger@legion.org](mailto:dfronabarger@legion.org).

### **Prepared Statement of Martin "Marty" Caraway**

Mr. Chairman and distinguished members of the committee, my name is Martin Caraway. I am an Associate Member of the National Association of State Directors of Veterans Affairs (NASDVA) and I am here at the request of and on behalf of NASDVA President, Randy Reeves and NASDVA's Executive Committee. I currently serve as the Redwood County Veteran Service Officer in southwestern Minnesota and am also honored to serve as the 1st Vice President of the National Association of County Veterans Service Officers. The strong relationships and partnerships we, as County Veteran Service Officers, have with our individual State Directors across the Nation is a force multiplier and enabler for service and care to our Veterans. Here with me today is Colonel (retired) Thomas Palladino, Executive Director, Texas Veterans Commission and NASDVA Southwest District Vice President.

<sup>5</sup>American Legion Resolution No. 67: (2014): Military Sexual Trauma

State, County and National Veteran Service Officers assist Veterans every day who suffer from Post-Traumatic Stress Disorder (PTSD). We not only see their needs and the difficulties they may encounter with daily life, we also see the frustration and confusion they sometimes feel in dealing with the VA claims process. I sincerely hope the “ground level” perspective I present will be helpful in improving the process for our Veterans.

Specifically:

**1. VA’s accuracy in processing PTSD claims (including those with an exception to the requirement of a verified stressor).**

It is our general observation that VA employees (VSR/RVSR) are, for the most part, doing a good job in handling the complex claims of service connection for PTSD. However, there are parts of the process that require review (and correction). For example, 38 CFR 3.304 (f)(3) states “... If a stressor claimed by a veteran is related to the veteran’s fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of post-traumatic stress disorder and that the veteran’s symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary, and provided the claimed stressor is consistent with the places, types, and circumstances of the veteran’s service, the veteran’s lay testimony alone may establish the occurrence of the claimed in-service stressor...”. Even though the guidance appears to be clear, in these cases VA is still sending a VA Form 21–0781 Statement in Support of Claim for Service Connection for post-traumatic stress disorder. The employees are following the M21 4.i.i.d, Claims for Service Connection for Post-Traumatic Stress Disorder, which states “...service connection (SC) for posttraumatic stress disorder (PTSD) associated with an in-service stressor requires credible supporting evidence that the claimed in-service stressor actually occurred...” Given that information, the VA VSR’s and RVSR’s are adequately performing their jobs per VA guidance. The M21 is requiring the credible supporting evidence, i.e. the VA Form 21–0781. When this process takes place it is considered further development and the veteran’s case is removed from the Fully Developed Claim process, and then placing more burden of proof on the veteran. We have heard from VA staff that if a 21–0781 is not received, they will not grant service connection for the claim, despite 38 CFR guidance. Failure(s), like this, to follow prescribed guidance and apparent disparities between law and VA guidance must be addressed and steps must be taken to ensure the process is consistent for all our Veterans.

We further observe that the Department of Veterans Affairs (VA) does not distinguish between drill-down for numbers on individual conditions like PTSD. A “best practice” example can be seen in Texas, where the VA Regional Offices are working with the Texas Veterans Commission (TVC) Strike Force Teams to ensure a VA Form 21–0781 (Statement in Support of Claim for Service Connection for PTSD) is completed for the PTSD stressor or the combat related stressors are verified on the DD 214s (Purple Heart or Meals w/ V Device, etc.).

**2. Efficacy of DBQs used to evaluate PTSD claims (ability of DBQs to produce intended result).**

The VA does not use DBQs on initial examinations for PTSD. They can however, use them on claims for increases or routine future examinations. In many instances, VA physicians refuse to fill out DBQ’s because they believe it is a “conflict of interest”. The veteran, of course, can take the DBQ to a private physician if they wish, but feedback from many veterans is that the cost is exorbitant. Sadly, based on individual veterans’ financial situations, “exorbitant” or cost-prohibitive can be reality, therefore disadvantaging some veterans based on their ability to pay.

DBQ’s are designed to streamline the examination process, allowing examiners to ask pointed questions that specifically address symptomology and severity of those symptoms. Without question, a claim for service connection for PTSD is complex. VA is attempting to draw out what the individual veteran fights daily to suppress. Examiners, more specifically those whom are contracted and not employed by VA, seem to have a tendency to “skim” through the DBQ form. There are many potential reasons for this, but it appears it is to see as many patients as possible throughout the day. Reports back from veterans are eerily similar, in that the exams start later than the scheduled time (most likely because the examiner is reviewing the claims folder) and conclude well before the scheduled appointment is scheduled to end (most likely to complete the dictation of DBQ). Most PTSD appointments are scheduled for one hour, with (generally) a mere 15 minutes of face to face time between the veteran and provider. The pressure of trying to accurately gauge the effect of

PTSD on someone's life in that short time (15 minutes) is not in the veteran's best interest nor frankly in the best interest of VA and the integrity of the system. Veterans tend to walk away feeling like they had little or no opportunity to really discuss how their life is impacted. Reading hundreds (even thousands) of these examinations, they all read very similar; examiners are capturing one or two quotes from the veteran and inserting them into the dictations to present a (seemingly) thorough examination that is then used to rate the case.

VA and VA contracted providers are given DSM V DBQ's to complete for PTSD claims. Private mental health providers are restricted to only filing out DSM IV DBQ's if the veteran wanted or needed to appeal the initial decision, based on a poor or incomplete examination. This inconsistency often questions the integrity of the private examination. To expand: VA examiners are taking the aforementioned time (1 hour total) to review the veteran's claim file, where in contrast the private examiner may have spent multiple sessions with the veteran and often has intimate knowledge of the impact of the diagnosis on the veteran's life. If the veteran goes through a FOIA request for a copy of their claims file for the private examiner to review, they run a significant risk of missing critical deadlines due to VA's untimely turnaround time on FOIA requests. If the private evaluation does not cite the claims file, the VA RVSR's and DRO's give relative equipoise to the internal examiner solely based on review of the C-file.

### 3. VA's quality review measures.

There is a six-page Rating Veterans Service Representative (RVSR) quality checklist that is followed for quality review measures. Two key points on the checklist are: error description on exams; and medical opinions. One of the most common disability claims is PTSD. Due to the large number of claims, that allows for a larger number of errors in quality.

Examples of errors in quality:

- Insufficient examination dealing with the issue of nexus.
- Effective date assigned.
- All needed evidence not on record when the exam was ordered.

For the last couple of years, since the VA has allowed for internal Quality Review Teams (QRT), we are finding QRT personnel utilizing the rating builder's disclaimer, "The mental calculator produces a suggestion only, based on the data entered. However, this suggestion is not meant to replace the judgement of the decision maker and a review and weighing of the evidence is required." This vividly highlights the subjectivity individual raters and, in these cases, the veterans' representative/VSO is usually told to appeal the case instead of VA correcting the decision at the local level. This is counterproductive, adds to the time the veteran waits for a decision and, functionally, shifts the workload from claims to appeals; this is inefficient if the aim is to decide/solve cases at the lowest possible level.

Since VA is now relying heavily upon contracted C&P examiners we believe there should be more oversight on these contractors. To illustrate this point: extensive review of multiple DBQ's, from multiple examiners (and on different veterans), look like the (multiple) DBQ's completed on that these veterans were the exact same person, written by the same provider. It is alarming when we see these "boiler-plate" DBQ's completed so similarly and yet face time with the veteran is continuously shortened by the examiners. This needs critical review.

### 4. Guidance and Training for VSRs and RVSRs to identify PTSD examination results.

The VA provides compensation templates to assist raters in evaluations. Upon review of claims, it has been discovered that the templates are not being utilized. It appears underutilization of this tool may be the leading cause of errors in quality. We believe it can be argued that if these templates were used during evaluation of PTSD examination results and in preparation of rating decisions, the number of decisions in favor of veterans would increase.

We contend it should be standard practice for VA employees to resolve in favor of the veteran in cases of conflict; especially when "higher level" guidance (i.e. 38 CFR) exists. Specifically, VA's directive(s) outlined in the M21 Manual seem to directly contradict the proper application of the legal provision(s) of 38 CFR as it relates to utilizing exception to the requirement of a verified stressor. VA should not negatively scrutinize VSR's and RVSR's who resolve doubt in favor of the veteran by carrying out 38 CFR 3.304(f) in lieu of following the M-21 Manual and subsequently issuing the VA Form 21-0781, which may or may not come back as a verifiable stressor by citing 38 CFR 3.102-Reasonable Doubt.

Mr. Chairman and distinguished Members of the House Subcommittee on Disability, Assistance and Memorial Affairs, NASDVA and its partners deeply respect and appreciate the important work you are doing to ensure America's Veterans receive the service, care and compensation they have earned. Working together, with VA and all stakeholders, we can make this process better.

Thank you for including NASDVA in this very important hearing.

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### Statement For The Record

#### JOHN TOWLES

##### MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to offer our perspective on whether or not the Department of Veterans Affairs' (VA) Veterans Benefits Administration (VBA) is effectively processing claims for Post-Traumatic Stress Disorder (PTSD).

War is as old as civilization itself, as are the stories describing the mental wounds incurred by men and women who fought in those wars. Not only do these wounds take a toll on those who served in one form or another, they impact those who are the closest to them - their friends and families.

It goes without saying that combat changes you. Everyone is affected to some degree, whether they realize it or not. While some who serve in combat are able to return home and cope with their experiences with little to no assistance, there are a large number who cannot, and truly need access to assistance as soon as possible. With that said, it is important to understand that not all people or experiences are the same, and as such, we need an emphasis on approaches to treatment that are tailored for an individual's needs and what will work best for him or her.

VA is the largest integrated health care system in the United States with specialized treatment for PTSD. The number of veterans seeking treatment at VA for PTSD has continued to increase as more veterans from the wars in Iraq and Afghanistan leave the military and transition to civilian life, and it is expected that these numbers will continue to grow.

With 14 of the 20 veterans who die by suicide every day not seeking care at VA, the VFW believes VA must see to it that every one of these brave men and women has access the services they need to overcome these difficulties, easing the transition into civilian life and becoming as whole as possible. Sixty-five percent of veterans who die from suicide are 50 years old or older. No veteran should suffer untreated for what happened to him or her while serving this nation.

#### **Claims Processing -**

Over the past seven years, VA has undergone sweeping reforms meant to ensure veterans from every generation have access to the best services and resources available to identify, diagnose, and treat PTSD for those who were deployed to combat environments. While these reforms were instrumental in providing help to veterans who present with uncomplicated cases, there are still numerous shortfalls for those who have other conditions as a result of their service, such as Traumatic Brain Injuries (TBI), which often exacerbate PTSD symptoms; and PTSD as a result of Military Sexual Trauma (MST).

According to DOD's Defense and Veterans Brain Injury Center, more than 330,000 service members have been diagnosed with TBI between 2000 and 2015. VA has made significant progress in diagnosing and treating TBI related conditions since the start of the wars in Iraq and Afghanistan. VA reports nearly 80,000 veterans were treated by its integrated Polytrauma System of Care in 2015, and estimates a more than 30-percent increase in demand within two years. VA must continue to expand its services to ensure veterans who suffer from conditions associated with TBI are identified as soon as possible, and afforded the specialized care they need.

With regards to MST, the VFW has testified before this committee numerous time in the past that MST claims have not been properly adjudicated. Despite VA relaxing the burden of proof for service members filing a claim for MST almost 15 years ago, there has been little done in the way of ensuring that those claims have been standardized across the administration.

Furthermore, while there are now special considerations and relaxed standards regarding the burden of proof needed to substantiate sexual assault resulting in

PTSD, there are still unique barriers or challenges. Female veterans of OEF/OIF are experiencing conflict and situations at a pace that no other previous generation of women veterans have faced.

#### **Examinations -**

The VFW supports timely and accurately performed exams. VA must provide quality, mandatory training to contract examiners, Ratings Veterans Service Representatives (RVSR), and Veterans Service Representatives (VSR) in order to accurately rate these claims and Congress should continue to exercise its oversight authority in VA reporting completion of prescribed training.

VA uses third party examinations in order to speed up the process for an initial claim, or an appeal, to ensure veterans receive timely decisions. While we feel as though contracted exams are a good stop gap for VA given the current circumstances, it should be noted that there is much to be desired regarding third party examinations and we would go so far as to caution against the full outsourcing of C&P exams.

Like a regular VA facilities, contractors must utilize a standardized Disability Benefits Questionnaire (DBQ) for claims; however; there is little consistency from site to site with regards to the quality of the examination and final disposition. Examples of this can be seen in everything ranging from the type and nature of questions that are being asked during the interview, to the amount of time that is spent talking to veterans about the severity of their diagnoses.

In light of this, if VA were able to ensure consistency in how it conducts contracted C&P examinations, we feel as though this could exponentially speed up the process in which claims are adjudicated.

Mental health examinations are increasing every day, and VA insisting on patients seeing only VA doctors for these examinations is increasing the burden on its compensation and pension examinations system. Yet, VA does not enable veterans to seek initial C&P exams from contracted C&P examiners. Mental health examinations for initial and supplemental claims must be added to the type of services offered by contracted C&P examiners.

While VA accepts private medical evidence for veterans who are applying for disability compensation for physical disabilities, it does not accept private medical evidence for mental health claims. The VFW urges VA to expand the use of private medical evidence to include mental health claims.

Veterans should not have to see a VA doctor in order to validate their private sector doctors' findings. Requiring redundant examinations only adds to more confusion and clogs up the system. VA should accept evidence from competent, credible physicians and not force veterans to seek a second opinion from a VA physician. The VFW urges Congress to make VA's private medical evidence authority permanent.

It is because of this that the VFW also supports the use of private medical evidence to review and adjudicate claims, as it significantly expedites the timeline for veterans with complex co-morbidities.

#### **Conclusion -**

Overall, the biggest complaint comes from inconsistencies within the system as a whole. The VFW has long sought to ensure that the men and women who have served our country honorably receive the care and benefits they have earned. While we recognize that VA has taken significant steps in the past seven years towards fulfilling this goal, more must be done to standardize the processes among all who are responsible for conducting C&P exams and, more importantly, with those responsible for adjudicating claims across all VA regional offices.

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### **Questions For The Record**

#### **Letter from Chairman Mike Bost to: U.S. Department of Veterans Affairs**

The Honorable David J. Shulkin, M.D.  
Secretary  
U.S. Department of Veterans Affairs  
810 Vermont Ave, NW  
Washington, D.C. 20420

Dear Secretary Shulkin:

Thank you for the testimony provided by the Department of Veterans Affairs for the July 25, 2017, Subcommittee on Disability Assistance and Memorial Affairs



hearing entitled "PTSD Claims: Assessing Whether VBA is Effectively Serving Veterans."

I would appreciate receiving your answers to the hearing questions below by 5:00 P.M. on September 5, 2017:

1. Is VA planning to revise its policy to allow for a veteran's disability rating to be lowered, at the veteran's request, if the veteran claims his or her condition has improved? If so, please describe the application process for such a request.

2. Please provide a detailed description of the Department's plans, including training initiatives, to improve the ability for VSRs and RVSRs to identify PTSD examination results that are not adequate for ratings purposes?

a. What percentage of PTSD exams conducted by VHA examiners requires additional clarification or supplementation because the initial results are not adequate for ratings purposes?

b. What percentage of PTSD exams conducted by contract examiners requires additional clarification or supplementation because the initial results are not adequate for ratings purposes?

3. Please provide a detailed description of the Department's plans to improve the quality of disability examinations for PTSD?

4. Please describe the measures VA has in place to verify that medical experts are spending sufficient time during disability examinations to thoroughly and accurately assess and analyze a veteran's claim for PTSD, including but not limited to the following requirements for PTSD claims:

a. If there is credible evidence that the claimed in-service stressor occurred?

b. Is there a nexus between the veteran's PTSD and service?

c. Any other factor that would tend to support a claim for service-connection for PTSD?

5. Is it mandatory for raters to use the evaluation builder tool?

a. If yes, how does VA ensure that raters are using the evaluation builder?

b. If no, why not?

6. Please describe the general impact of the 2010 regulatory changes for PTSD claims?

a. Additionally, what safeguards are in place to ensure that VA is devoting its resources to veterans who have earned compensation because they have developed service-connected PTSD?

7. Please describe the specific steps VA is taking to encourage veterans who are awarded compensation benefits for PTSD to continue receiving medical treatment?

8. Please describe the training provided to disability examiners on how to determine whether the veteran's service is consistent with the claimed stressor, when that information is not well-documented.

a. How does VA ensure that the examiner takes the necessary time to conduct such a thorough review?

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, would appreciate your answer provided consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Maria Tripplaar, Staff Director and Counsel of the Subcommittee on Disability Assistance and Memorial Affairs, at [Mar ia ri pp l aar@ mail .hou se.gov](mailto:Mar ia ri pp l aar@ mail .hou se.gov). Please also send a courtesy copy to Ms. Alissa Strawcutter at [ali ssa .strawcutter@rmail.hou se.gov](mailto:ali ssa .strawcutter@rmail.hou se.gov). If you have any questions, please call Ms. Tripplaar at (202) 225-9164.

Sincerely,

Mike Bost

Chairman

Subcommittee on Disability Assistance and Memorial Affairs

cc: The Honorable Elizabeth H. Esty, Ranking Member, Subcommittee on Disability Assistance and Memorial Affairs

MB/aks

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## HVAC MINORITY

**Question 1:** What community education has the Department of Veterans' Affairs done (including with partner organizations, the Department of Defense, and Veterans Service Organizations) to explain the new Disability Benefits Questionnaire and the examination process to veterans and service members?

**VA Response 1:** The Veterans Benefits Administration (VBA) conducted community education and outreach during FY 2017, highlighting different parts of the Disability Benefits Questionnaire and the examination process. This outreach included quarterly Veterans Service Officer (VSO) Meetings, VSO National Conventions, quarterly community outreach events with VA's Center for Faith Based and Neighborhood Partnerships (CFBNP), partnership with the American Kidney Foundation, various Health Fairs, VA Resource Exhibits, Veteran Summits, VA Benefit Briefings for Veterans, dependents and beneficiaries. Additionally, during the Transition Assistance Program (TAP), briefers explain the VA examination process to Servicemembers.

VBA has updated factsheets, claim, and examination letters based on Veteran feedback. Print information has been reformatted and includes easily understood language explaining the process from start-to-finish. Veterans may also visit the Compensation & Pension Exam Webpage - <http://www.benefits.va.gov/compensation/claimexam.asp> to review additional information on the examination process, informational videos, frequently asked questions, and fact sheets.

Disability Benefit Questionnaires (DBQs) were created to allow Veterans increased control over the disability claims process and present the option of visiting a private health care provider or a VA facility. In support of VA's Fully Developed Claims (FDC) and Decision Ready Claims (DRC) programs, more than 70 DBQs are currently available on VA's external facing Disability Benefit Questionnaire Webpage - <http://www.benefits.va.gov/COMPENSATION/dbq-disabilityexams.asp>.

**Question 2:** How often does VBA update its schedule for disabilities? When is the next update for PTSD due out?

**VA Response 2:** In 2009, VBA's Under Secretary for Benefits (USB), on behalf of the Secretary for Veterans Affairs (VA), directed the revision and update of the 15 body systems that are contained in the VA Schedule for Rating Disabilities (VASRD).

VBA is committed to publishing final rulemakings to update all VASRD body systems by the end of 2018. Thereafter, VA will place each VASRD body system into a 5-year cycle of staggered reviews. This strategy is based on recommendations from a 2007 Institute of Medicine (IOM) report. In that report, IOM proposes a series of corrections to the existing schedule for rating disabilities and guidance designed to improve Veterans benefits in the 21st century.

VA is working diligently to update the mental disorders body system, which includes the evaluation criteria for post-traumatic stress disorder (PTSD). This rule-making is a high priority for the Secretary and although it is a lengthy and complex process, VA will make every effort to get the proposed and final rules published as soon as possible.

**Question 3:** Can you describe how a Veteran's rating due to PTSD can be reduced? How does this happen if the medications have not changed, or the symptoms being experienced by the Veteran?

**VA Response 3:** If a PTSD disability evaluation is reduced, it generally results from either a (1) mandatory review examination process or (2) claim for higher evaluation.

A review examination is typically scheduled if VA grants service connection for PTSD and the evidence of record shows the disability may improve. In such situations, a review examination will be scheduled three years after the date of the initial grant of service connection for PTSD. The evaluation may be reduced if the examination, as well as all other relevant evidence of record, shows material improvement. Also, the evaluation may be reduced if a Veteran files a claim for increased evaluation for PTSD, even during the initial rating period, if the examination and other relevant evidence shows material improvement. If in either case the examination findings reveal that the Veteran's symptoms have not changed, then the evaluation will not be reduced.

VA may not reduce a disability evaluation, to include a PTSD evaluation, without affording the Veteran administrative due process under the law. VA will issue a proposed rating decision that provides the Veteran notice of the proposed reduction and

the opportunity to submit additional evidence as well as request a hearing to demonstrate why the proposed reduction should not be effectuated. VA will only implement the proposed reduction if it concludes that assignment of a reduced evaluation is still warranted after considering all evidence and /or testimony presented by the Veteran.

**Question 4:** In his testimony, Mr. Caraway describes an example of how a Veteran's claim cannot be granted service connection if a VA Form 21-0871 is not received despite the fact that there is an apparent disparity between the law and VA guidance as to whether it is necessary. What is VA doing to clarify this discrepancy and when?

**VA Response 4:** Under VA regulations, service connection for PTSD is established when there is a current diagnosis of PTSD, credible supporting evidence of the occurrence of an in-service stressor, and a medical association between the diagnosis and in-service stressor. As the occurrence of an in-service stressor must be established to support service connection for PTSD, VA may request information from the Veteran regarding his or her stressor through a VA Form 21-0871, Statement in Support of Claim for Service Connection for Post-Traumatic Stress Disorder (PTSD).

VA often does not have to request stressor information from the Veteran because the record already contains sufficient evidence to concede that the claimed in-service stressor occurred. This is also the case if PTSD was initially diagnosed in service or the claimed stressor is related to (1) verified combat or former POW service, and consistent with the circumstances, condition, or hardships of such service, or (2) fear of hostile military or terrorist activity, or drone aircraft crew member duties, and consistent with the places, types, and circumstances of the Veteran's service.

However, in the absence of any of the aforementioned fact patterns, VA will send VA Form 21-0871 to solicit specific details of the claimed in-service stressor, such as the date and place of the incident, detailed description of the incident, unit or assignment at the time of the incident, medals or citations received as a result of the incident, and names and other identifying information concerning any other individuals involved in the incident, if appropriate. Upon receipt of VA Form 21-0871, VA will further review the record and may be required to request additional information from the service department to determine if there is credible evidence that the claimed in-service stressor occurred.

The above guidance has been communicated to field stations through training materials and in VA's Adjudication Procedures Manual.

**Question 5:** What is VA's oversight over examiners contracted outside of VA to do disability exams? Is any oversight conducted on site at the physician's office? How often does VA audit the contracts?

**VA Response 5:** The VBA medical disability examination contracts include specific training requirements for all contracted medical examiners. The vendors are required to provide confirmation of training and are regularly tasked to conduct additional training as deemed necessary by VA.

VBA conducts both scheduled and surprise site visits at vendor locations.

The medical disability examination contracts are audited through a third party vendor. The financial audit contract is expected to be re-awarded by September 2017. The audit of each of the contract examination vendors is done quarterly.

**Question 6:** How many VBA applicants had Other than Honorable discharges per year since 2001? What are the statistics per year for determined Honorable for VA purposes, determined dishonorable for VA purposes for regulatory bars, determined dishonorable for VA purposes for statutory bars, and no determination? How many of the claimants per year claimed traumatic brain injury, post-traumatic stress, military sexual trauma, or other mental health condition? Can you break them down by discharge determination? And provide the grant rates?

**VA Response 6:** We are able to provide data for the number of character of service (COS) determinations made by VBA upon receiving an application for benefits or health care from 2010 through 2017 fiscal year to date (FYTD). We are unable to provide 2001-2009 data as we did not begin capturing this data element until 2010.

VA issues character of service determinations for former Servicemembers with a period of service resulting in (1) an administrative discharge under conditions other than honorable, (2) bad conduct discharge, (3) an uncharacterized discharge due to void enlistment or dropped from the rolls, and (4) a dishonorable discharge.

There are three potential outcomes of a character of service administrative decision:

- **Honorable for VA Purposes:** Establishes basic eligibility to all benefits administered by VA, provided all other requirements for eligibility are satisfied.
- **Health Care Eligible:** Establishes eligibility for specialized health care for service-connected disabilities, provided requirements for service connection are satisfied.
- **Dishonorable for VA Purposes (Health Care Ineligible):** Bars all VA benefits and services.

Decision Outcome	2010	2011	2012	2013	2014	2015	2016	FYTD 2017
Honorable for VA Purposes	1,094 (21.2%)	700 (16.9%)	551 (14.3%)	680 (12.2%)	551 (13.8%)	962 (16.9%)	1,462 (21.4%)	1,167 (22.6%)
Health Care Eligible	2,487 (48.3%)	2,099 (50.9%)	1,846 (51.8%)	3,144 (56.2%)	2,200 (55%)	2,989 (52.7%)	3,389 (49.7%)	2,433 (47.2%)
Dishonorable for VA Purposes (Health Care Ineligible)	1,571 (30.5%)	1,321 (32.1%)	1,170 (32.8%)	1,772 (31.7%)	1,251 (31.2%)	1,717 (30.3%)	1,974 (28.9%)	1,560 (30.2%)
<b>Total Decisions</b>	<b>5,152</b>	<b>4,120</b>	<b>3,567</b>	<b>5,596</b>	<b>4,002</b>	<b>5,668</b>	<b>6,825</b>	<b>5,160</b>

VBA does not track whether a dishonorable determination was based on statutory or regulatory bar. Historically, 16 percent of VBA's character of discharge determinations result in a Veteran being found honorable for VA purposes, 53 percent result in the Veteran being found eligible only for VA health care, and 31 percent result in the Veteran being found dishonorable for VA purposes.

VBA does not track disability data with COS determinations. Therefore, this data is unavailable.

**Question 7a:** What is the process for receiving a discharge determination if a veteran presents at a VA facility to submit a claim with an Other than Honorable discharge on their DD214? How does a veteran initiate it? What is the timeline?

**VA Response 7a:** In order to initiate the discharge determination process when a former Servicemember has an Other than Honorable discharge, the individual would need to seek treatment for a condition at a VA Medical Center or file a claim for benefits-VA Form 21-526ez, Application for Disability Compensation and Related Compensation Benefits. In both scenarios, VA sends the claimant a notice that a COS determination is necessary and requests all active duty and personnel records. After the records have been received and the time limit for evidence submission has elapsed, VA makes a decision on whether or not the individual's service is honorable or dishonorable for VA purposes.

VBA provides oversight and prioritization of eligibility decisions, specifically Character of Discharge Determinations, controlled under an EP290 at the national level. As of April 9, 2017, all Regional Offices receive a daily distribution of actionable due process eligibility decision work that is either priority - homeless, terminally ill, etc. - or our oldest pending claims. Nationally, Regional Offices are held to a standard that appropriate action should be taken on a claim within five days of it being distributed to their office. Regional and District Office leadership, as well as the Office of Field Operations, routinely monitor stations' performance related to the five day Time In Queue (TIQ) standard. Since NWQ began managing distribution of EP290s, timeliness of Eligibility Determinations has improved by 81 days.

VBA will continue to monitor the improvements in EP 290 timeliness and make prioritization adjustments as necessary.

**Question 7b:** Does VA provide an exam for traumatic brain injury, military sexual trauma, post-traumatic stress disorder, or other mental health condition? Is there a process, training, or guidance for this given to the VA employees doing the determinations?

**VA Response 7b:** Upon initial receipt of an eligibility determination request from the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) will gather all relevant service treatment and personnel records in order to prepare an administrative decision as to whether the character of the former Servicemember's service was honorable or dishonorable for the purposes of establishing eligibility to disability compensation and/or health care benefits.

If, upon review of facts and circumstances, the service is deemed honorable for VA purposes, VBA personnel will assess any claimed conditions by reviewing in-service and post-service medical evidence, as well as any available lay testimony, to determine if it demonstrates a(n) 1) event, injury, or disease in service, 2) current

diagnosed disability or persistent/recurrent symptoms of disability, and 3) an indication of association between the current symptoms/condition and the in-service event. If those criteria are met, claims developers will request an examination (and, in most cases, medical opinion) to determine the condition's current degree of severity and ascertain its relationship to the Veteran's service, if any.

If the service is deemed dishonorable for VA purposes, but is of a nature that allows eligibility to health care benefits for conditions determined to be related to service, VBA personnel will perform the same functions described in the paragraph above, but will, when warranted, request only a medical opinion concerning the condition's etiology. No examination will be requested, as a detailed account of the disability's symptoms does not meaningfully inform the establishment of eligibility to medical care in this scenario.

If the service is deemed wholly dishonorable (i.e. eligible for neither disability compensation nor medical care), no examination or medical opinion will be requested, as no benefit entitlement, monetary or otherwise, may be legally established.

Procedural guidance on this process is published in the M21-1 Adjudication Procedures Manual; relevant provisions are found in M21-1, Part III, Subpart v, Chapter 7, Section A, Topic 7, Block d (III.v.7.A.7.d) and IX.ii.2.4, and are available to all VBA claims processing personnel.

**Question 7c:** What training does VA provide frontline employees on OTH discharges? Specifically, on what benefits veterans with OTH are eligible for?

**VA Response 7c:** Compensation Service has several courses that include training for Other than Honorable (OTH) discharge during Challenge training (all employees):

- VSR Overview-Establish Veterans Status Module TMS# 3733279, Character of Discharge, provided via Web-Based Training
- Character of Discharge (COD) Web-Based Training (WBT) TMS 3825367
- VSR Compensation: Initial Actions TMS 3843741

The following courses are After Challenge Courses:

- Character of Discharge (COD) TMS 4179795
- Claims Establishment for Character of Discharge Determinations TMS 4300970
- TMS course 3843741 and 4179795 include training for both the VSRs and the RVSRs and are used as refresher training

All of these courses cover eligibility determinations for Veterans with OTH discharges.

**Question 7d:** DoD has issued guidance (and it was codified in the FY2017 NDAA) to give liberal consideration to Veterans with evidence of TBI or PTSD resulting from combat or MST. Does VA use the same liberal consideration when determining if service is honorable for VA purposes? If so, when was this guidance issued? And was there a change in the characterizations determined honorable from before the guidance to after? If so, was there a statistically significant change in the number of claims approved for PTSD for veterans with OTH discharges?

**VA Response 7d:** The guidance to give liberal consideration to a Veteran's TBI or PTSD, as referred to in the NDAA 2017, relates to DoD's upgrade of characterization of discharges. As VA has a longstanding practice of giving similar consideration to mitigating factors when making a character of discharge (COD) determination for purposes of establishing eligibility for VA benefits, additional guidance was not issued.

In cases where a former Servicemember receives an "other-than-honorable" (OTH) discharge, VA considers all facts and circumstances surrounding the COD. This includes reviewing any lay statements from the former Servicemember or other individuals, service treatment records (for any medical conditions), personnel records, post-service records, etc. Once VA considers all available evidence, a formal determination is rendered. Any reasonable doubt is resolved in favor of the claimant. This longstanding practice was clarified in a March 2016 update to the M21-1 Adjudication Manual Part III, Subpart v, Chapter 1, Section B.

As there were no changes in VA's guidance, there were no significant changes in COD determinations.

**Question 8:** Does VA do any outreach to veterans with OTH discharges on what services and benefits they may be eligible for? Specifically with respect to veterans with PTSD, TBIs, MST, or other mental health conditions?

**VA Response 8:** VBA does not conduct outreach specifically targeted at reaching Veterans with OTH discharges; however, VBA does conduct targeted outreach in an

effort to educate and provide mental health care access to eligible Veterans. During FY 2016, VBA completed 132,000 hours of outreach at 69,000 events and engaged more than 1.8 million attendees during outreach events.

VBA employees have provided outreach at a number of diverse events nationwide during FY 2017 that include: Health Fairs, VA Resource Exhibits, Veteran Summits, VA Benefit Briefings, and PTSD Awareness Programs.

- In partnership with VHA, VBA attends mental health summits open to Servicemembers and Veterans where benefit briefings are provided.
- VBA has established partnerships with the United States Marine Corps and the National Guard to provide military sexual trauma (MST) training to DoD employees. Topics include claims processing and eligibility for VA healthcare.
- Information about VA's MST related services is included as part of the course curriculum for the Transition Assistance Program (TAP).
- VBA created a Distressed Veteran Standard Operating Procedures that was introduced VBA wide in May 2017 and serves as a reference point for all employees encountering Veterans experiencing distress in the following categories: Special Emphasis (Homeless Veterans & Elderly Veterans), Financial Distress, Mental Distress, Physical Distress, & Natural Disasters.

**Question 9:** Is the mitigating effect of mental health conditions during a period of service considered for every Other than Honorably discharged PTSD claimant when doing discharge characterization determinations?

**VA Response 9:** When making a formal COD determination, VA takes into account all facts and circumstances surrounding the reasons for the OTH discharge. The specific reasons and bases for each individual case can be found in the formal determination located in the Veteran's electronic claims record. VBA is reviewing its regulation in the Code of Federal Regulations (38 C.F.R. § 3.12) to determine if clarification is needed for (1) character of discharge criteria, (2) the circumstances in which an Other than Honorable administrative discharge will be found to be disqualifying for VA benefits purposes, and (3) mitigating circumstances, such as mental health issues.

**Question 10:** Do you have data at the original claims level that might show how mental health is taken into account when deciding OTH eligibility in mental health compensation claims?

**VA Response 10:** VA does not track at the corporate level all of the various factors considered in OTH determinations. Therefore, aggregate data on numbers of cases where mental health was a factor in OTH discharges is not obtainable.

**Question 11:** Can you provide a citation to any VA Regulation, any section of the VBA Benefits Adjudication Manual, and any VA Fast Letter or Training Letter, that instructs adjudicators to consider PTSD, TBI, and Adjustment/Personality disorder diagnoses when considering whether conduct in service should be disqualifying?

**VA Response 11:** Claims processors are instructed to follow guidance in VBA Benefits Adjudication Manual, M21-1, Part III, Subpart V, Chapter 1, Sections B and E. Section B provides instructions on where claims are to be routed, while section E contains information on the effect of insanity on administrative decisions. Section E states:

If a Veteran was determined to be insane at the time of the commission of the act or acts that would otherwise result in an adverse character of discharge, line-of-duty or willful misconduct determination, hold that the Veteran

- was without fault, and
- is not precluded from any Department of Veterans Affairs (VA) benefits.

Section B states that claims for PTSD should go to the Core Lane for development activity, unless they are based on military sexual trauma, in which case they would go to the Spec Ops Lane for determination.

**Question 12:** With the Secretary's announcement that veterans in crisis will be granted emergency access on a 90 day timeline, is VA tracking utilization by discharge status and outcomes? Is VA tracking utilization of other VA and community care assets, like Vet Centers or the Veteran Crisis Line and emergency rooms or community providers, by veterans that present to the VA requesting emergency access?

**VA Response 12:** VHA is establishing processes for monitoring emergency access services by those with Other than Honorable discharges. Information Technology efforts are focused on building a reporting mechanism within the current electronic

health record (EHR), which will provide a local mechanism for monitoring the 90-day episode of care. Additionally, the Office of Mental Health and Suicide Prevention are coordinating efforts with the Health Eligibility Center (HEC) to establish the protocol for monitoring national utilization.

**Question 12a:** What metrics is VA tracking and utilizing to determine the effectiveness of the emergency access program, specifically related to reducing suicidal ideations, suicide attempts, and deaths by suicide?

**VA Response 12a:** Given complexity in measurement, initial effectiveness will focus on qualitative analysis of submitted Issue Briefs concerning adverse outcomes related to suicide ideation, attempts and deaths.

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### HVAC MAJORITY

**1. Is VA planning to revise its policy to allow for a veteran's disability rating to be lowered, at the veteran's request, if the veteran claims his or her condition has improved? If so, please describe the application process for such a request.**

**VA Response:** VA does not plan to revise this policy. A Veteran has the right to either renounce the compensation benefit in whole or request a reevaluation of the condition if he or she feels the condition has improved or worsened. The Veterans Benefits Administration (VBA) relies upon medical evidence to determine the level of severity of a service-connected condition. Therefore, it is not advisable to develop a policy to allow decision makers to reduce the percentage of disability based on a Veteran's lay statement alone.

**2. Please provide a detailed description of the Department's plans, including training initiatives, to improve the ability for VSRs and RVSRs to identify PTSD examination results that are not adequate for rating purposes?**

**a. What percentage of PTSD exams conducted by VHA examiners requires additional clarification or supplementation because the initial results are not adequate for rating purposes?**

**b. What percentage of PTSD exams conducted by contract examiners requires additional clarification or supplementation because the initial results are not adequate for rating purposes?**

**VA Response:** VA utilizes several avenues to ensure claim processors identify post-traumatic stress disorder (PTSD) examination reports that are not adequate for rating purposes. In a general sense, adjudicators are taught from the beginning that examinations must include all findings necessary to adequately rate the case in accordance with the specific regulatory criteria. VA addresses this in its centralized training program, Challenge, through classroom and computerized courses. VA has also included detailed guidance on this matter in the Adjudication Operations Manual. Finally, VA conducts reviews of cases as part of its national quality program. The results of these reviews are used to conduct training and further clarify examination procedures. During fiscal year 2016, less than 1 percent of VA examination reports (from both VHA and contract vendors) were returned as inadequate.

**3. Please provide a detailed description of the Department's plans to improve the quality of disability examinations for PTSD.**

**VA Response:** The office of Disability and Medical Assessment (DMA) conducts monthly ratability quality evaluations of a random sample of disability examinations that would include PTSD exams. These reviews ensure that the Disability Benefits Questionnaires (DBQ) are suitable for rating purposes. DMA also updates training courses to ensure the inclusion of the latest diagnostic criteria is used and that the current regulations are applied. For VHA clinicians who complete compensation and pension examinations, the clinical quality of their work is reviewed during an Ongoing Professional Practice Evaluation (OPPE) at the local medical center.

**4. Please describe the measures VA has in place to verify that medical experts are spending sufficient time during disability examinations to thoroughly and accurately assess and analyze a veteran's claim for PTSD, including but not limited to the following requirements for PTSD claims:**

**a. If there is credible evidence that the claimed in-service stressor occurred?**

**b. Is there a nexus between the veteran's PTSD and service?**

**c. Any other factor that would tend to support a claim for service connection for PTSD?**

**VA Response:** Initial PTSD evaluations are conducted by either psychiatrist or psychologists who have been trained in graduate school/medical school to conduct thorough clinical assessments for PTSD. In order to conduct a PTSD Compensation and Pension evaluation, an examiner would need to assess whether or not the Veteran reports experiencing a traumatic event and if so, whether the Veteran meets the rest of the diagnostic criteria for PTSD. The examiner would need to document both the traumatic event as well as all of the symptoms of PTSD in the DBQ. As part of the Compensation and Pension (C&P) evaluation, the examiner is instructed to review records provided by VBA within the compensation file (c-file) or the Veterans Benefit Management System (VBMS). These records often contain the Veteran's DD214 as well as other documentation that may support whether the claimed in-service stressor occurred. Of note, it is not the role of the examiner to determine whether the stressor occurred, as that is the role of claims adjudicators in VBA. During the evaluation, the examiner would need to assess and document whether there is a nexus between the Veteran's diagnosed condition and service. In cases of PTSD secondary to Military Sexual Trauma (MST), the examiner would review the c-file or VBMS and determine whether or not there are any "markers" of MST. Markers may include things such as: sick call visits; changes in performance; visits to mental health clinics; reports to police, etc. Without adequate time, a clinician would not be able to provide a quality examination. VHA C&P clinics are careful to provide mental health clinicians with appropriate scheduled time for both examination and medical records review.

**5. Is it mandatory for raters to use the evaluation builder tool?**

**a. If yes, how does VA ensure that raters are using the evaluation builder?**

**b. If no, why not?**

**VA Response:** Yes, it is mandatory that raters use the evaluation builder when determining the evaluation level of PTSD. This function is embedded in the rating application, Veterans Benefits Management System - Rating. For purposes of accountability, VA conducts local and national quality reviews of claims to ensure adjudicators are following the proper policies and procedures.

**6. Please describe the general impact of the 2010 regulatory change for PTSD claims?**

**a. Additionally, what safeguards are in place to ensure that VA is devoting its resources to veterans who have earned compensation because they have developed service-connected PTSD?**

**VA Response:** The regulatory change in 2010 facilitated a more streamlined adjudicative process for certain PTSD claims. The change allowed VA to accept lay statements from claimants to verify in-service stressors, if such stressors are related to fear of hostile military or terrorist activity. This relaxed standard has contributed to the increased population of Veterans receiving compensation for PTSD. As mentioned in the hearing testimony, the number of Veterans on the compensation rolls for PTSD has increased from 345,000 in 2008 to over 940,000 currently.

Regarding measures to ensure VA allocates sufficient resources for PTSD claims, VA utilizes a well-established resource allocation model to determine the level of full time employees necessary for adjudicators in the regional offices. This allows VA to balance the hiring of claim processors (VSRs) and decision makers (RVSRs) to ensure claims are addressed in a timely manner.

**7. Please describe the specific steps VA is taking to encourage veterans who are awarded compensation benefits for PTSD to continue receiving medical treatment?**

**VA Response:** When awarding service connection, VBA notifies the Veteran of his or her right to free medical treatment for the service-connected condition. VA has utilized various outreach and campaign efforts to raise awareness, encourage treatment, and break down the stigma of PTSD. Additionally, individual VHA exam-



iners may discuss the benefit of seeking medical or mental health follow up when appropriate.

**8. Please describe the training provided to disability examiners on how to determine whether the veteran's service is consistent with the claimed stressor, when that information is not well-documented.**

**a. How does VA ensure that the examiner takes the necessary time to conduct such a thorough review?**

**VA Response:** C&P clinics are careful to provide mental health clinicians with appropriate scheduled time for both examination and medical records review. The service chiefs are responsible for allocating time slots for various disability exams on requests received from VBA to schedule exams. The C&P examiners are bound by ethics to conduct a thorough medical record review and the disability examination, and document both on the Disability Benefits Questionnaires.

