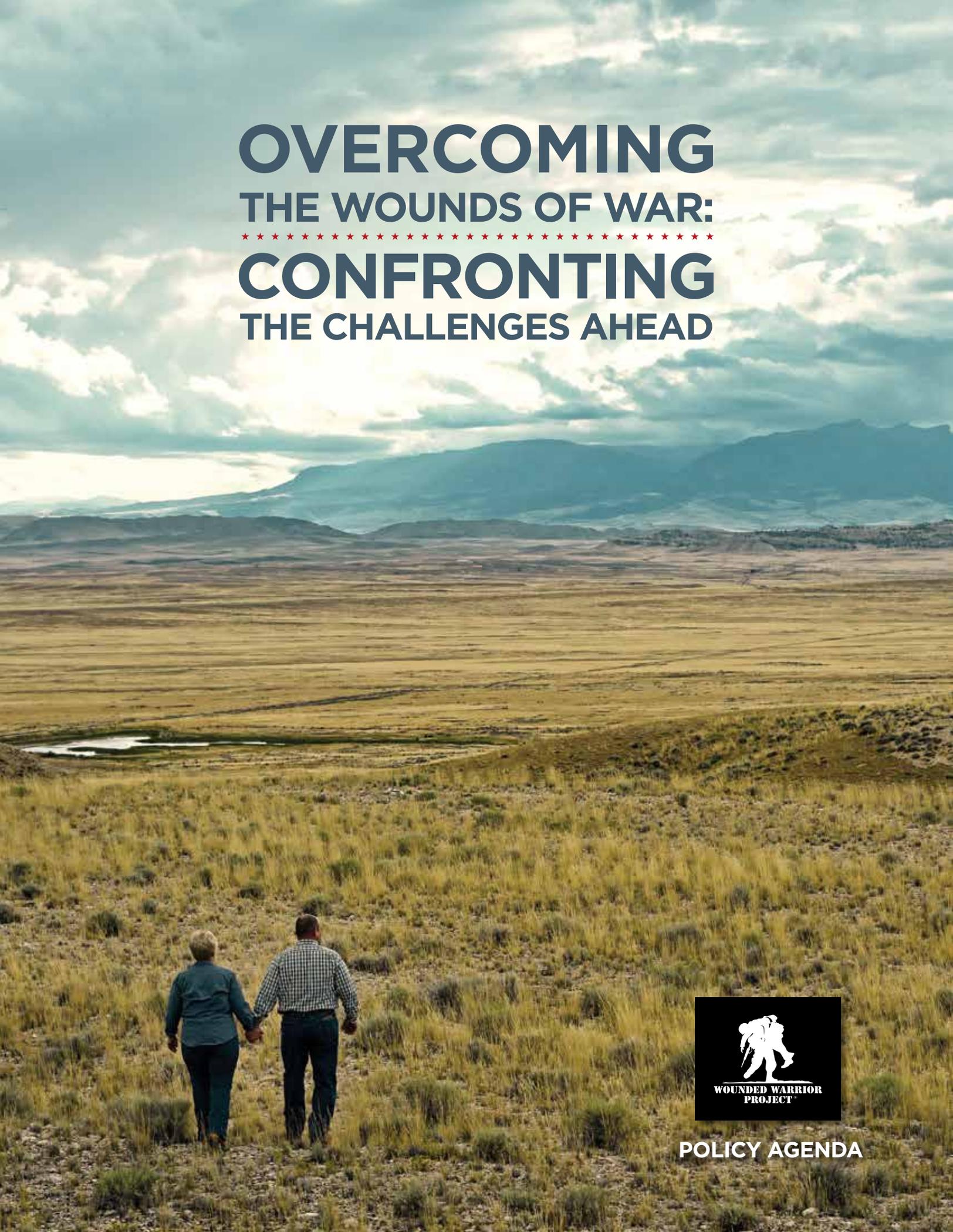


OVERCOMING THE WOUNDS OF WAR: ***** CONFRONTING THE CHALLENGES AHEAD



POLICY AGENDA



TOWARD A POLICY AGENDA FOR 2025

As Wounded Warrior Project® (WWP) transitions into its second decade, it is incumbent on us to consider what the future holds for this generation of warriors and their families. Our vision is that this will be the most successful, well-adjusted generation of injured service members in this country’s history. What progress are warriors likely to make? What problems and barriers might they face, and what support might they need? Are government programs positioned to meet their needs? Such questions guide us in formulating a policy agenda for the next decade and beyond.

As WWP anticipates the challenges warriors may encounter in the future and the direction policy should take to meet their needs, it is appropriate to reflect on the policy work the organization has accomplished and the lessons learned. With its mission of honoring and empowering Wounded Warriors, WWP has helped Americans understand the significance of the term “Wounded Warrior.” WWP has also made a concrete impact on how this country provides for those warriors by identifying gaps in government services for veterans and proposing solutions to close those gaps.

JASON EHRHART
WWP ALUMNUS
PICTURED WITH HIS MOM, PAM ESTES

WARRIORS LIKE JASON ARE OVERCOMING THE LIMITS OF THEIR INJURIES AND ACHIEVING THEIR LIFE GOALS. THEIR CONTINUED CARE, HOWEVER, OFTEN RELIES ON THE DECISIONS OF POLICYMAKERS.

THE WWP POLICY LEGACY

1 >> POLICY LEGACY

In its first major step into national policymaking, WWP saw a problem and brought Congress a solution. We identified this problem after spending time at the bedside of wounded service members and working closely with them and their families over the course of lengthy recoveries. What became evident was that many warriors and their families experienced financial instability and uprooting from their homes. The Department of Veterans Affairs (VA) disability compensation ultimately provided ongoing financial support to make up for the loss in a warrior's incoming-earning potential, but no specific benefits existed to assist the warrior and his or her caregiver with the immediate hardships resulting from his or her injuries. In pointing to a solution, WWP noted that while all service members were offered a life-insurance benefit — Servicemembers' Group Life Insurance (SGLI) — no comparable insurance protected warriors in the case of profound, disabling injury. Identifying the problem, WWP proposed establishment of a second insurance product through a parallel program — Traumatic Servicemembers' Group Life Insurance (TSGLI). As conceived by WWP and adopted by Congress, TSGLI provides automatic traumatic injury coverage of up to \$100,000 to all service members covered under the SGLI program, and retroactive coverage to those who incurred severe losses as a result of traumatic injury in Operation Enduring Freedom or Iraqi Freedom (OEF/OIF) between October 7, 2001, and December 1, 2005. The successful initiative by WWP in establishing traumatic injury insurance coverage for warriors has had a profound impact. As of October 31, 2013, more than \$817 million in TSGLI benefits have been paid to injured service members since the TSGLI program was initiated in 2005. By maintaining close ties with wounded veterans and caregivers, WWP saw how profoundly a warrior's injury can change an entire family's life. One of the many family members with whom WWP worked described it well to a congressional committee:

Confronted by severe, life-threatening injuries sustained by a spouse, fiancé, child, or other loved one, families must make sudden, life-altering changes. Family members may be forced to take extended leaves of absence or permanently leave their jobs to be at the service member's bedside, beginning a journey of what may become yearslong or even a lifetime of committed care. These are acts of love and self-sacrifice. But as the sister of a profoundly disabled veteran, and as a friend of many, many caregivers across the country, I can tell you that, while the decision to care for a loved one may come easily, caregiving can take an extraordinary toll — emotionally, physically, and economically.¹

Working daily with family members of warriors who had sustained severe or catastrophic injuries and needed ongoing care or assistance, WWP saw the profound toll on and the lack of assistance for the caregiver. Government programs and services were almost exclusively focused on recovery, rehabilitation, readjustment, and compensation for the warrior. But caregivers' needs were not addressed. WWP went to work by proposing to Congress that it enact legislation to establish a VA program to provide needed assistance to caregivers of injured veterans and service members. Our proposal highlighted that caregiving exacts an extraordinary toll on its providers, physically, emotionally, and financially. Without outside resources or relief, caregivers are sometimes forced to place young veterans in institutions for care. Our legislation proposed that VA provide support services to help shore up those vulnerabilities. Specifically, we called for a program that would provide caregivers with training, technical support, mental health counseling, healthcare coverage, respite care, and a modest financial stipend. The adoption of our legislative vision in Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, has led to more than 16,000 caregivers of OEF/OIF veterans (as of August 2014) receiving caregiver support since the law's enactment.

**MORE THAN 16,000 PEOPLE
ARE RECEIVING SUPPORT
UNDER CAREGIVER LAW.**

TODAY'S WOUNDED WARRIORS »

2 » TODAY'S WOUNDED WARRIORS

Attempting to predict the challenges and barriers injured veterans and their families might face in the future and what support they might need suggests that we establish a starting point. Fortunately, our strategic planning has given us a baseline from which to begin. A key element, our fifth annual survey² in 2014, provides a great deal of information about who our Alumni are and how they are faring in civilian life. Robust survey data provides a demographic profile showing a population that is 86% male, 71% white, 60% younger than 35 (with a mean age of 34.5), and nearly 65% married. Forty-nine percent live in the South, 24% in the West, 14% in the Midwest, and 13% in the Northeast. More than 92% were (or still are) enlisted service members, and about 94% had deployed to Iraq or Afghanistan. Eighty-two percent sustained serious injuries or health problems in Iraq or Afghanistan, with about 60% having been hospitalized as a result. More than three-fourths reported having sustained between three and eight injuries or other health conditions.

Mental health conditions were among the most frequently reported health problems, with 75% testing positive for post-traumatic stress disorder (PTSD), 67% for depression, and 64% for anxiety. Seventy-two percent reported back, neck, or shoulder problems. Forty-three percent had experienced traumatic brain injury (TBI), and more than 54% suffer from tinnitus. More than 48% have

hearing loss and more than 15% a spinal cord injury. Almost 60% of these injuries resulted from blasts, including improvised explosive devices, mortars, grenades, and bombs.

More than half of respondents rated their overall health as only fair or poor, with almost 54% stating that their health limits them a lot in undertaking vigorous activities. Twenty-eight percent said they need the aid and attendance of another person for more than 40 hours weekly because of their injuries or health problems. Military experiences are still affecting many in profoundly adverse ways. Nearly two-thirds reported having had a military experience that was so frightening, horrible, or upsetting that they had not been able to escape from the memories or effects. More than 49% reported having trouble concentrating, more than 49% had little interest or pleasure in doing things, and 76% said they had sleep problems. Overall, the survey results indicate that, for many, the effects of mental and emotional health problems are even more serious than the effects of physical problems.

Asked about other health-related matters, one in five said they used more alcohol than they meant to in the past four weeks, almost three in 10 smoke cigarettes, and about four in 10 are obese. Related health conditions, including PTSD, depression, anxiety, pain, fatigue, and limited mobility, are thought to play a role

DEMOGRAPHIC PROFILE



86% ARE MALE

71% ARE WHITE

60% ARE UNDER 35 YEARS OLD

65% ARE MARRIED



49% LIVE IN THE SOUTH

24% LIVE IN THE WEST

14% LIVE IN THE MIDWEST

13% LIVE IN THE NORTHEAST



92%

WERE (OR STILL ARE) ENLISTED SERVICE MEMBERS



94%

DEPLOYED TO AFGHANISTAN OR IRAQ



“I chose not to get the help I needed because I was afraid of losing my security clearance. I thought that once I got into the VA system, I would then get the help, but due to an overloaded system, I was forced to wait again.”

TENAY GUVENDIREN
WWP ALUMNA

in these behaviors. While the survey showed that many wounded veterans have ongoing healthcare needs, they sometimes have difficulty getting that help. Nearly 55% reported that they had seen a professional to get help with issues such as stress, substance use, emotional problems, or family problems. But about 35% did not get the care they needed. Among the reasons, 39% cited inconsistency or lapses in treatment, and 35% said they felt uncomfortable about the resources available to them through the Department of Defense (DoD) or the VA. Many did not get care because of concern about future career plans (28%), feeling that they would be considered weak (25%), and believing that they would be stigmatized by peers or family (23%). Respondents reported the top resources they had used since deployment to address their mental health problems were a VA medical center (63%), talking with another OEF/OIF veteran (59%), and prescription medication (50%).

Overall, 51% of respondents were employed full time (with 6% self-employed) and 7% part time. Despite an improving economy, among veterans in our survey, almost one in five were unemployed. Of those who were not actively looking for work, the main reason (59%) was medical/health related. Others cited many factors that made it difficult to obtain employment or change jobs, including mental health issues (31%), lack of qualifications or education (22%), physical limitations (20%), and lack of confidence (15%).

DESPITE AN IMPROVING ECONOMY, ALMOST ONE IN FIVE WARRIORS ARE UNEMPLOYED.

Among those employed, the highest proportions continue to work for the military (35%), the federal government (almost 18%), and state government (about 8%). Median income for those employed remained at \$800 each week for full-time employees; 50% of those warriors said they were satisfied, very satisfied, or totally satisfied with their jobs.

Survey findings also show that financial issues are a concern. Nearly 23% said their financial status was better than a year ago, while almost 35% said it was worse. Some of the contributing factors to a worse financial status included unemployment, no college credits, and severe mental or physical injuries.

MENTAL HEALTH CONDITIONS WERE AMONG THE MOST FREQUENTLY REPORTED HEALTH PROBLEMS, WITH 75% SCREENING POSITIVE FOR PTSD, 67% FOR DEPRESSION, AND 64% FOR ANXIETY.

3 » GOING FORWARD

GOING FORWARD»

With our annual survey findings as a baseline, we can begin to explore the question: What are the greatest problems wounded, ill, and injured warriors are likely to face a decade from now? To be clear, many warriors in this generation are thriving and we see their successes daily. There are badly wounded service members who recover and move on to mentor others. Every year, we help more warriors find new avenues and new careers that harness their battlefield-born leadership skills.

But a significant percentage is not flourishing, and it is important to assess and analyze the risks they and their families and caregivers face in the future. We begin by examining the key problems confronting warriors today and the vulnerabilities that place some at risk of those problems worsening or new problems developing. In attempting to catalogue those risks and vulnerabilities, we seek to take account of likely or potential trends — in the areas of demographics, health and health delivery, family, societal support, technology, economy, and government — that could cause new problems or compound existing ones. Insights from warriors and their family members and caregivers, WWP staff, and researchers and clinicians have contributed to the following overview of important trends:

MAJOR DEMOGRAPHIC TRENDS

The demographic changes in the military since the start of the all-volunteer force in 1973 are increasingly altering the makeup of the veteran population, whose oldest members are from a draft-era military that was overwhelmingly male and Caucasian.³ Most striking, perhaps, with women composing almost 22% of the post-9/11 population, the percentage of women in the veteran population is projected to grow from 10.3% in 2014 to 13.3% in 2024 and to 17.7% in 2040. Black, Hispanic and veterans of other racial and ethnic groups will make up greater percentages of future veteran populations, as well. VA projects that black veterans will make up 13.9% and 16.5% of the veteran population in 2024 and 2040, respectively, up from 11.9% in 2014, while the percentage of Hispanic veterans in that population will almost double, from 6.3% in 2014 to 11.4% in 2040.⁴

While the composition of the veteran population is changing, so is its size. VA projects that today's population of 22 million veterans will decline to 18.7 million in 2024 and to 14.5 million in 2040.⁵ Post-9/11 veterans will comprise a growing segment of the veteran population, projected to increase from 9.9% in 2014 to 19.2% in

2024 and to 29% in 2040.⁶ VA's projections notwithstanding, we cannot dismiss or ignore the potential for future military operations and resultant casualties. We can, however, know with certainty that the post-9/11 veteran population will have aged 10 years by 2025; based on WWP survey data, the mean age of injured service members a decade from now will be 45.⁷

Based on the WWP 2014 Alumni survey of those wounded, ill, and injured in post-9/11 service, 86% are male, 60% are younger than 35, and 65% are married. Seventy-one percent are white, 16% are Hispanic, 10% are black or African American, 4% are American Indian or Alaska Native, 3% are Asian, and 1% are Native Hawaiian or other Pacific Islander. Forty-nine percent live in the South; 24% in the West, 14% in the Midwest, and 13% in the Northeast. Two-thirds of respondents served in the Army; more than 92% were or are enlisted service members; about 60% achieved the equivalent rank of sergeant or above. Only about 6% had never deployed, while almost 33% deployed once, some 27% deployed twice, and nearly 34% deployed three or more times.⁸ A 2014 study by the think tank RAND gives a picture of the caregivers at home with this veteran population. The study found that 33% of all post-9/11 caregivers are spouses of the care recipient, 25% are the recipient's parents, and fewer than 10% are the recipient's children. Just under half of those caregivers live with the care recipient, with some 23% identifying as a friend or neighbor. RAND further reports that roughly 40% of caregivers are men.⁹

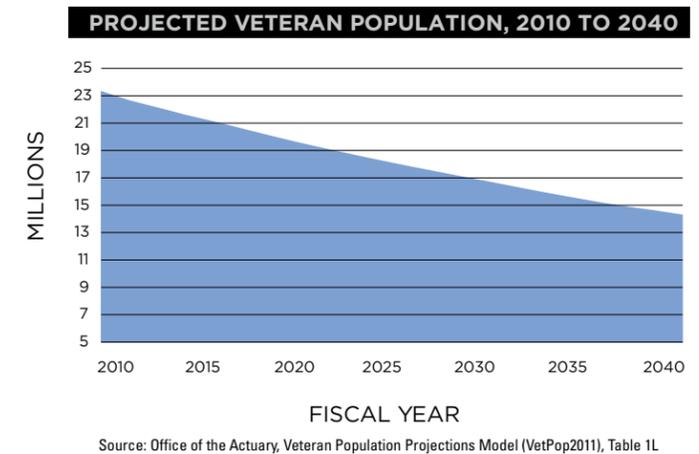
THIRTY PERCENT OF OEF/OIF VETERANS LIVE IN HIGHLY RURAL AREAS.

Where wounded, ill, and injured warriors make their homes in 2025 and beyond will affect their needs for, and access to, services. VA data found that about 30% of OEF/OIF veterans who were users of the VA healthcare system live in rural or highly rural areas,¹⁰ and that rural VA users are growing in proportion to urban VA users.¹¹ It has been observed that rural communities and small towns are sending a disproportionate share of their young adults into the military.¹² While only about one in five U.S. adults live in a rural community, an estimated 45% of armed forces personnel are from rural areas. This trend is not consistent across all states, with southern and western rural states reportedly overrepresented and

northeastern and Midwestern states underrepresented.¹³ VA data support these observations, with the department reporting that youths living in the most sparsely populated zip codes are 22% more likely to join the Army, with an opposite trend in cities. Regionally, VA reports, most enlistees come from the South (40%) and West (24%).¹⁴

It is difficult to imagine that the next decade will erase the distinct ways in which rural and urban communities differ. In particular, we can expect that residents of rural communities will generally not have the easy access to infrastructure (such as public transportation) and the institutional support that marks living in urban areas. But those rural residents will continue to be more likely to enjoy stronger social ties than those in urban areas.¹⁵ While the availability of online resources may erase some barriers to receiving services (such as applying for benefits), access to employment opportunities, healthcare, transportation, higher education, job training, and other services will likely continue to be far more challenging for those in rural America than for those in metropolitan areas.

The changing demographics in our veteran population should also be considered against the backdrop of the changing demography of the country, notably the observation that America is experiencing a rapid aging of its population, as reflected by an increasing proportion of those aged 65 and older.¹⁶ Future policy decisions relating to the aging-population trend — from decisions on the distribution of federal spending among age categories, to health policy and health spending to retirement programs — will have implications for veterans.



HEALTH TRENDS AND ISSUES

The last American combat units are projected to have returned from Afghanistan by the end of 2016. Through the course of more than 15 years of overseas operations, thousands upon thousands of young men and women will have been forever changed by grievous wounds and invisible injuries and will have returned to communities across the country. Much has already been done to help them rebuild their lives, from new, expanded, and improved government programs, to the establishment and growth of programs like those offered by WWP. Our experience serving injured service members every day tells us that the job is far from done and the challenges will continue to grow as this generation of warriors ages.

Advancements in battlefield medicine and critical injury care have saved lives and allowed many to survive serious wounds that previously would have been fatal. These injuries have required extensive acute care, rehabilitation, and long-term care services. It is well understood that good health is foundational to overall well-being and is related to a person's ability to maintain employment, relationships, and general quality of life. Many warriors are currently struggling with the effects of serious physical and mental health issues, and too many are at risk of continued and even greater problems in the years ahead.

Our survey data, outlined previously, are illuminating as to the scope of health issues this generation experiences. With 75% of respondents having PTSD, 68% having moderate, severe, or very severe bodily pain, and 43% with a TBI,¹⁷ it is increasingly clear that some of the least visible wounds are having the most devastating long-term impact.

This generation of service members is also likely to begin experiencing pain management issues and chronic comorbid health problems, including diabetes, hypertension, heart disease, and obesity as they reach middle age. Other veterans who experienced TBI may develop chronic neurological degeneration or cognitive decline. A subset of warriors with mental health problems is likely to continue not to seek help until circumstances become dire, such as loss of a job, threat of a marital breakup, or criminal charges. Others will try to manage symptoms on their own or develop coping mechanisms, including substance use, smoking, and risky behavior. In addition to the challenges of treatment availability and access, warriors' focus on maintaining employment, career building, and family raising during this life phase may create further barriers to engaging in and sustaining needed healthcare, particularly as related to behavioral health.



“Military families in rural areas continue to face a battle with very few weapons or resources. We use what we have: survival instincts in an environment that does not have the resources needed to effectively heal. In a rural setting, it is difficult to find mental health professionals who know how to identify PTSD or secondary PTSD. We suffer alone, in silence, in desperation, without the tools to help understand the effect combat has on the family.”

JONA VANATA
WWP PEER MENTOR



AGING-RELATED MEDICAL CARE CHALLENGES

In the years ahead, there will be significant challenges in caring for this generation of warriors. While many will remain resilient, adapt to their injuries, and thrive in the next stages of life, others will fall through the cracks without substantial help. In the near term, studies have shown a 200% increased risk of developing an unrelated medical problem for those with PTSD in the first five years after diagnosis.¹⁸ Likewise, the five years after leaving active duty

have been identified as a time when veterans are at an increased risk of suicide.¹⁹ In the longer term, today’s veterans are likely to have similar issues as previous generations, made more complex by TBI, polytrauma, and mental health conditions.²⁰ Those who were exposed to burn pits and other environmental toxins in Iraq and Afghanistan may be at particular risk for adverse respiratory outcomes, but current understanding of the lasting effects of exposure is very limited and will require continuing follow-up to medical evaluation and treatment.²¹



The signature wounds of these wars are associated with considerable lasting difficulties and significant long-term costs; these costs typically peak 30 to 40 years after service. Fifty-six percent of those who served in OEF/OIF are now enrolled in government-provided healthcare, with almost half of those having filed for disability compensation. Currently, the most common issues of those enrolled are musculoskeletal problems, mental health issues, central nervous system and endocrine disorders, and respiratory, digestive, skin, and hearing problems.²² Added to the medical price tag, individual and societal costs of injury include lost productivity, reduced quality of life, family disruptions, homelessness, impaired health, substance abuse, and suicide. These conditions can ruin relationships, disrupt marriages, aggravate difficulties in parenting, and result in mental health problems for the families of injured service members and veterans.²³ In the government’s increasingly constrained fiscal environment, the high costs for long-term medical care and even higher costs associated with treating secondary conditions will create one of the biggest challenges in providing effective healthcare.²⁴ An additional challenge will be developing tools to identify those most at risk and providing early intervention or preventive care to help avoid some of the more disabling secondary conditions and complications. This would require better outreach, screening, education, early detection, and more effective treatments. With evidence that current programs are too often failing to provide needed care for this generation, there is work to be done in the short term to shore up services and prioritize care for primary conditions to reduce the risk of future complications. Developing a national strategy and long-term plan to address these issues would be an important first step to offset some of the most problematic lasting effects of untreated or undertreated health concerns. Treatment and rehabilitation should, at a minimum, support wounded veterans’ goals to maintain work and engage in society, and any plan to meet these needs should include healthcare, psychological services, education, career transition, and family support services.²⁵

THE LONG-TERM COSTS OF WAR PEAK 30 TO 40 YEARS AFTER SERVICE.

To develop a national strategy to address these issues, it is critical to understand the possible long-term effects of the most prevalent health issues impacting post-9/11 warriors. While each medical issue associated with service is unique and requires in-depth research and resources to improve long-term outcomes and address residual effects, there are several that particularly affect this generation. Polytrauma is the term used by VA, in response to the unique injuries incurred in Iraq and Afghanistan, to describe injuries to multiple body parts and organs occurring as a result of blast-related wounds. According to VA, a combination of disabling

conditions occur in polytrauma, such as amputation, spinal cord injury, PTSD, TBI, and other medical conditions.²⁶

AMPUTATION AND SPINAL INJURY

Those who have lost one or more limbs are at increased risk of cardiovascular disease, high blood pressure, obesity, osteoarthritis, back pain, fractures, and early mortality.²⁷ These complications can affect mobility and quality of life and lead to greater disability. Many of these conditions can be caused by reduced activity, stress, strain on the remaining limb(s), altered body mechanics, and improper prosthetic fit, while others can be caused by lifestyle factors that may be related to reduced mobility and self-medication.²⁸ People with spinal cord injury have significantly diminished life expectancy and can be at greater risk for gastrointestinal disorders, septicemia, suicide, and substance abuse.²⁹ Specific factors have been identified that place people at more risk for some of the most troubling complications. Psychosocial factors, such as being unmarried, having low income, lack of integration into the community, unemployment, and substance abuse seem to be most associated with poor outcomes.³⁰ Strikingly, many of the most negative possible outcomes would be preventable with appropriate care and more optimal conditions that include better nutrition and full community integration.³¹ The lasting health implications associated with amputation and spinal injury are considerable and call for early intervention and treatment to target prosthetic fit, alignment, gait training, and lifestyle factors that influence long-term outcomes.

LONG-TERM TBI ISSUES

Since 2000, there have been over 300,000 service members diagnosed with traumatic brain injuries. Of those, the vast majority are classified as of mild severity. About 34,000 are classified as penetrating, moderate, or severe.³² Post-9/11 warriors have experienced and survived brain trauma at greater rates than any other era’s veterans, making it a signature injury of the recent conflicts. Each TBI case is unique. Depending on the injury site and other factors, individuals may experience a wide range of residual problems, from profound neurological and cognitive deficits manifested in difficulty with speaking, vision, eating, or incontinence to considerable behavioral symptoms. Even mild TBI can result in postconcussive symptoms that may last months or years after injury.³³ In addition, any TBI increases the risk of seizure disorders, Alzheimer’s, parkinsonism, amyotrophic lateral sclerosis (ALS), ocular and visual motor degeneration, and endocrine disorders.³⁴ Not only is there a greater risk of development of Alzheimer’s and dementia, but there is also a propensity for earlier onset of these conditions.³⁵ While many individuals who have experienced a mild or moderate TBI may experience symptoms that are only temporary and eventually dissipate, others with severe TBI often face such profound cognitive and neurological impairment that they require



a lifetime of caretaking. The neuropsychiatric symptoms, such as problems with memory, attention, executive function, behavioral control, and regulation of mood, are often even more problematic than the lasting physical symptoms people experience.

VETERANS WITH SEVERE TBI OFTEN REQUIRE A LIFETIME OF CARETAKING.

Looking ahead to the challenges those with TBI may face, it is well known that brain injury places stress on many body systems, and can often co-occur with other injuries or put those afflicted more at risk for PTSD, depression, anxiety, and substance misuse.³⁶ Brain injuries can also affect balance and may leave warriors more prone to falls that cause additional injury; polypharmacy or substance use issues and sleep disorders commonly experienced by those with brain injuries may exacerbate this problem. Lack of physical activity for some of these warriors can also lead to some significant challenges — obesity, diabetes, high blood pressure, and stroke. Repetitive brain trauma can be especially problematic and can increase the risk of neurodegenerative disorders as well as suicide.³⁷ Impairments in cognition, mood, and behavior cause extensive damage to social and occupational functioning.³⁸ One especially troubling consequence of multiple brain injuries is chronic traumatic encephalopathy (CTE), which is still poorly understood, but is a condition characterized by neurologic deterioration resulting from repetitive brain trauma. Symptoms of CTE typically present in midlife, years or decades after exposure to brain trauma, and may appear unrelated to earlier levels of impairment. The most common symptoms are worsening memory, language difficulties, aggressive and irritable behavior, apathy, motor disturbance and parkinsonism, dementia, and a lack of impulse control.³⁹ While the research on CTE is still in its infancy, there is some emerging knowledge on certain risk factors beyond brain trauma that may play a role in the development of or resistance to the condition. Chronic inflammation and cognitive reserve have both been shown to influence disease progression. The recognition of cognitive reserve's role in those with brain injuries' ability to recover may mean that individuals with higher levels of educational attainment and employment in jobs with benefits have an edge in attaining successful rehabilitation outcomes, such as reemployment, over peers with similar levels of injury. In the same vein, maintaining integration and engagement in the community may lessen the risk of developing dementia. Other variables that may play a role, like trauma type and frequency, age, gender, and genetic predisposition, require further study.⁴⁰ Additionally, there is a great need for better tools to detect and treat the condition. Currently, the only way to diagnose CTE is postmortem and there are no available treatments. There is evidence, however, that early detection and treatment could be beneficial, and there has been some progress in developing treatments for other neurodegenerative disorders that can slow cognitive decline.⁴¹

There is an urgent need to recognize that patients with TBI are at significant risk of cognitive decline, developing neurodegenerative disorders, and other disabling conditions, so they can be screened by a trained practitioner and provided preventive or intervening care.⁴² While difficulties associated with TBI can persist for many years post injury, there is also evidence of the possibility of functional improvements even a decade after brain injury with proper care and rehabilitation. The converse is also true, in that those who do not receive sufficient rehabilitation can regress or deteriorate many years later.⁴³ As clinicians themselves recognize, it is difficult to predict a person's ultimate level of recovery.⁴⁴ But to be effective in helping an individual recover from a brain injury and return to a life as independent and productive as possible, rehabilitation must target the specific needs of the individual patient. This simple principle requires care that does not end after the completion of acute care and some arbitrary period of rehabilitation, but instead involves a lifelong continuum of planning and services, both medical and nonmedical, that help meet the veteran's physical and cognitive needs, as well as his or her social and life goals.

While the literature indicates that some people make a good recovery after suffering a severe TBI, many who require ongoing care have considerable difficulty accessing needed resources.⁴⁵ Others have significant challenges with community integration even after undergoing rehabilitative care, and may need further services and support.⁴⁶ Studies have found that as many as 45% of individuals with a severe TBI are poorly reintegrated into their community, and social isolation is reported as one of the most persistent issues in follow-up studies of such patients.⁴⁷ Individuals with severe TBI who have individualized plans and services to foster independent living skills and social interaction, however, are able to participate meaningfully in community settings.⁴⁸ Medical literature has documented the need to use rehabilitative therapy long after acute care ends to maintain function and quality of life.⁴⁹ While improvement may slow or plateau at a certain point in the recovery process, it is essential that progress is maintained through continued therapy and support. Variation in individuals' progress requires that rehabilitation plans be dynamic, innovative, and long-term — envisioning patient-centered planning and provision of a range of individualized services, including nonmedical services.⁵⁰

THOSE WITH TBI ARE AT SIGNIFICANT RISK OF COGNITIVE DECLINE.

It is clear that ongoing rehabilitation is often needed to maintain function, and many veterans denied maintenance therapy will regress, losing cognitive, physical, and other gains made during earlier rehabilitation.⁵¹ For this generation of young veterans,



reintegration into their communities and pursuing life goals such as meaningful employment, interpersonal relationships, marriage, and independent living may be as important as (if not more important than) their medical recovery. While improving and maintaining physical and cognitive function is paramount to social functioning, many aspects of community reintegration cannot be achieved through medical services alone. Other models of rehabilitative care provide support for community integration through such nonmedical assistance as life-skills coaching, supported employment, and community-reintegration therapy. But while such support affords opportunities for gaining greater independence, currently VA medical facilities often deny requests to provide these nonmedical services.

FORTY-FIVE PERCENT OF INDIVIDUALS WITH A SEVERE TBI ARE POORLY REINTEGRATED INTO THEIR COMMUNITY.

While current practice at VA includes dedicated rehabilitation-medicine staff, the scope of services actually provided to veterans with a severe TBI can be limited, both in duration and in the range of services VA will provide or authorize. It is all too common for families reliant on VA to help a loved one recover after sustaining a severe TBI to be told that VA can no longer provide a particular service because the veteran is no longer making sufficient progress.

Anticipating the substantial consequences and long-term residual effects of TBI, VA's proposal to reduce the funding it devotes to brain injury care under the fiscal year 2015 budget — citing a decline in the number of TBI cases — is deeply troubling and implies the limited postacute care now being furnished may be diminished further. While the number of service members who sustain new brain injuries is likely to decline with the end of combat operations, we can expect such injuries to continue to occur during training. Much of the cost associated with TBI care is incurred after the acute stage of treatment. Too many veterans are already experiencing inadequate care and rehabilitation to sustain or prevent the loss of functional gains.

VA's FY 2015 projection that it will need less funding for TBI care fails to take account of an even more fundamental point: that Congress enacted bipartisan legislation in 2012 to improve long-term VA rehabilitation of veterans with TBI.⁵² That law requires VA to put two important policies in place. First, it directs VA to provide veterans who have moderate and severe TBI with rehabilitation of ongoing duration to sustain, and prevent the loss of, functional gains. Second, it calls for VA to provide any community-based services or support that may contribute to maximizing that veteran's independence. Shortly after the law's enactment, however, VA took the position that it was already in compliance and that no further action was needed.

Following up on reports from caregivers and warriors, WWP initiated a survey in February 2014 of more than 2,000 caregivers of warriors with severe and moderate TBI. The WWP survey found no evidence that VA has implemented the TBI law or that the practice patterns that the law aimed to change have been altered to any measurable extent. In fact, one-quarter of respondents indicated they are paying out of pocket for services that VA is not providing. To be sure, the lack of services is not solely a VA issue. There are few community or private providers that offer care that effectively meet the needs of their patients with brain injury. There is a failure by the entire medical community to set up effective, accessible, and comprehensive programs to address long-term rehabilitation for TBI.⁵³

A WWP SURVEY FOUND NO EVIDENCE THAT VA HAS IMPLEMENTED THE TBI LAW.

Given current indications of VA's failure to provide or plan for the complex needs and ongoing rehabilitation of this population of injured veterans and absent significant policy change, breakthroughs in research, and advances in clinical services, warriors who have experienced brain injury will too often face some of the most troubling and disabling aftereffects of TBI. This calls for strategic and comprehensive reform to redefine how rehabilitation is provided and to promote understanding, improve knowledge, and enhance screening tools and early intervention to improve outcomes for those with TBI.



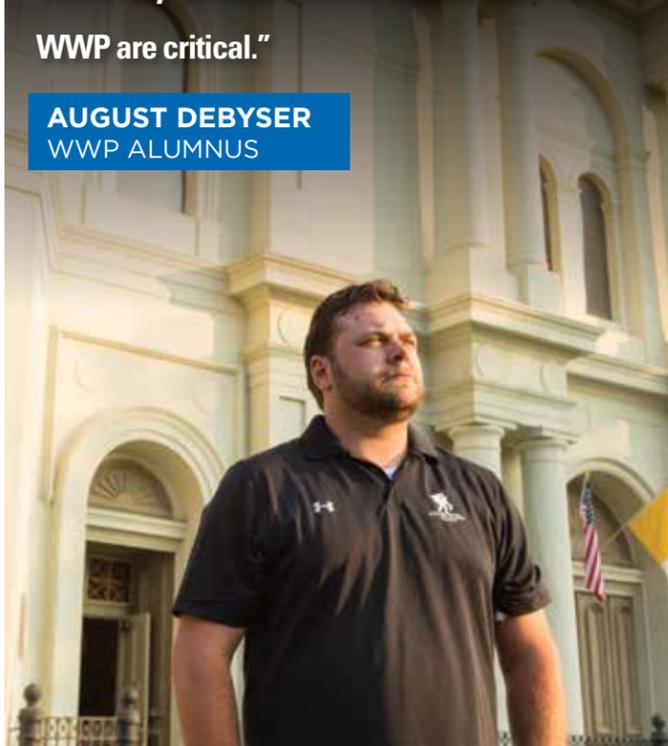
“When chronic pain becomes unmanageable, it sets back my treatment and compromises my recovery. Pain needs to be managed before anything else can be addressed.”

JOSH RENSCHLER
WWP ALUMNUS



“There’s a lot of paperwork involved when you out-process from the Army. With no plain language, or any idea how to interpret the forms, you really need someone to bridge the gap. That’s why benefits liaisons like the ones from WWP are critical.”

AUGUST DEBYSER
WWP ALUMNUS



There are important advances being made in clinical services and TBI research that — with ongoing support — will go a long way toward warding off some of the most debilitating lasting consequences of TBI. WWP itself has gone an extraordinary distance to demonstrate the kinds of assistance warriors with severe TBI should be receiving to achieve maximum independence. With that goal, WWP created the Independence Program, which in 2014 assisted about 150 warriors and which is slated to more than double that number by the end of 2015. The Independence Program is a team effort that includes family members and caregivers, medical providers and treatment teams, community support professionals, and WWP staff. A full assessment of an individual’s needs and interests is conducted and results in a personalized plan to enlist the support of community resources and move the warrior on the road to recovery. Through this program, WWP is helping severely injured veterans — who might otherwise simply stay home, with a risk of social isolation and inactivity — achieve

real community reintegration. As warriors and their families in the Independence Program will attest, recovery is possible with sufficient support, and enlisting community resources is often a critical step to sustaining success.

In the area of research, President Obama in 2013 announced the Brain Research through Advancing Innovative Neurotechnologies Initiative, or BRAIN Initiative, with the goals of advancing science to better understand how the brain works and accelerating the development of effective treatments for brain disorders, including TBI. This is an important first step in shoring up resources to support research in this area, but when the National Institutes of Health offered a realistic appraisal of the funds needed to realize the project’s goals, they found a need for three to five times the currently allocated funds.⁵⁴ While there are some bright spots on the front of TBI research, care, and rehabilitation, there are also clear challenges in the years ahead to improve the outlook and meet the needs of this population of warriors.

MENTAL HEALTH

After more than a decade of combat operations marked by multiple deployments, some of the most prevalent causes of disability are mental health-related conditions. Long after the physical wounds of war have healed, many still struggle with invisible injuries that contribute to physical, social, and occupational difficulties. WWP survey data, media reports, and research have made it clear that the systems dedicated to providing mental healthcare to service members and veterans are still struggling to meet their missions and are still not reaching large numbers of returning veterans, with high percentages either never accessing or dropping out of treatment.⁵⁵

There are serious and long-term repercussions of mental health conditions going untreated. Those with PTSD, in particular, are at higher risk of cardiovascular disease, diabetes, gastrointestinal disease, fibromyalgia, chronic fatigue syndrome, musculoskeletal disorders, and autoimmune diseases.⁵⁶ Substance abuse, depression, homelessness, and suicide are also associated with traumatic exposure and PTSD.⁵⁷ While mental health conditions alone are enough to present significant challenges to warriors’ recovery outlook, many in this generation are beset with comorbid conditions, especially TBI and chronic pain. Pain can be especially problematic as a co-occurring condition and can lead to higher levels of maladaptive coping strategies, poorer outcomes, and greater difficulty with treatment adherence.⁵⁸

In the years ahead, this generation of warriors is likely to experience issues similar to those veterans of other eras have faced, although there are marked differences that may increase the risk of some significant challenges. Compared to earlier conflicts, a higher proportion of OEF/OIF veterans experienced combat, deployed



multiple times, and survived injuries, which are all associated with adverse mental health outcomes.⁵⁹

It bears emphasizing that PTSD and other war-related mental health conditions can be successfully treated — and in many cases, VA clinicians and Vet Center counselors are helping veterans recover and thrive. But these problems have their origin in service, and more can and must be done both to prevent and to treat behavioral health problems at the earliest point. That will require not only overcoming issues of stigma and barriers to care, but also reducing negative perceptions among service members about mental healthcare that may keep them from engaging or continuing in treatment.⁶⁰

The failure to meet veterans’ mental health needs effectively today will undoubtedly compound the challenges they face tomorrow. Despite the spotlight on long waits veterans have experienced in attempting to schedule VA appointments, lack of timely care is only one facet of the problem. WWP survey data suggests that veterans at many VA facilities may not be getting the kind of mental healthcare they need or the appropriate intensity of care. About 35% of respondents reported difficulties in obtaining effective mental healthcare, with Alumni reporting inconsistent treatment (e.g., canceled appointments, having to switch providers, lapses in between sessions, etc.) and not being comfortable with existing resources at VA.⁶¹ Some report that VA is quick to provide medications,⁶² and others identify the limited types of treatment available as potential barriers. VA is pressing clinicians to employ exposure-based therapies that — without adequate support — may be too intense for some veterans, with the result that many drop out of treatment altogether.

While VA has made outreach efforts, they have not had an effective impact on large numbers of returning veterans. As described by one of the leading researchers on the mental health toll of the conflict in Afghanistan and Iraq, Dr. Charles W. Hoge:

... veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out ... With only 50% of veterans seeking care and a 40% recovery rate, current strategies will effectively reach no more than 20% of all veterans needing PTSD treatment.⁶³

Those with mental health conditions other than PTSD are even less likely to receive effective care.⁶⁴ Without access to or adequate care, one apparent consequence of so few veterans receiving sufficient treatment is a disturbing rise in the number of suicides. Recent data have only begun to describe the issue.⁶⁵ There is an urgent need for intervention that improves engagement and retention in treatment, and there is an ongoing issue of identifying and tracking the scope of the problems.⁶⁶ While access to care is

the first step in preventing suicide, identifying the factors that lead injured service members to drop out of therapy is a critical factor in reversing this troubling trend.

ONE APPARENT CONSEQUENCE OF SO FEW VETERANS RECEIVING SUFFICIENT TREATMENT IS A DISTURBING RISE IN THE NUMBER OF SUICIDES.

Early evidence-based treatment has been shown to be essential to preventing chronic PTSD and resulting challenges. However, at least one large study found that relatively few received the care they needed, and only a very small number received adequate care early after diagnosis.⁶⁷ For those who do receive care, most receive treatment of unknown efficacy.⁶⁸ There are multiple variables that become barriers to care for those who need it most. The symptoms of PTSD alone, especially avoidance, can make it more difficult to engage in care. Treatment adherence can also be compromised by competing priorities, like employment, family, and school. During midlife these factors can be especially powerful.⁶⁹ And while PTSD is strongly associated with relationship distress and instability, many veterans would prefer family-based interventions and treatments that target interpersonal issues, but few are able to access such resources.⁷⁰ Additionally, social support has been shown to be extremely significant in improving outcomes for those with PTSD, highlighting the importance of developing effective family interventions.⁷¹ While stigma and organizational barriers to care are often cited as explanations for why only a small proportion of service members with psychological problems seek professional help, negative perceptions about the utility of mental healthcare may be even stronger deterrents.⁷² To reach these warriors, there would be merit in a strategy of expanding the reach of treatment, to include greater engagement, increased family-based interventions, understanding the reasons for negative perceptions of mental healthcare, and “meeting veterans where they are.”⁷³ Peer support is one area that could be better utilized to increase engagement in mental healthcare. Underscoring the benefit of warriors reaching out to other warriors, our 2014 survey found that 59% identified talking with another OEF/OIF veteran as a top resource for coping with stress.⁷⁴ Importantly, current law requires VA medical facilities to employ and train warriors to conduct outreach to engage peers in behavioral healthcare.⁷⁵ Early reports from warriors point to the success of this initiative and suggest value in expanding the program to reach more veterans. Also, with many warriors responding well to engagement with peers, group therapy can be an important tool, whether in combination with individual psychotherapy or as a supportive treatment in itself.

Advancements in the provision of mental healthcare will need to focus on leveraging available tools (such as peer support) to



improve engagement and retention in treatment. There would be particular value in exploring promising therapies to complement the treatment of PTSD and other behavioral health conditions and the management of comorbid conditions to help improve overall wellness of injured service members, veterans, and their family members. These are areas where many warriors see a need for more therapeutic options than conventional healthcare offers. Research demonstrates that complementary and alternative medicine (CAM) treatments, like acupuncture, relaxation, and meditation, hold promise as adjuncts to traditional therapies and may reduce the need for medications whose long-term use may be detrimental or associated with significant complications. These treatments have been shown to be particularly helpful in addition to other treatments or as a gateway to evidence-based services to engage those veterans who might otherwise not take part in other approaches.⁷⁶ Beyond expanding or better integrating current proven therapies, emerging research on PTSD and mental health conditions points to the role of biology in many of the symptoms of these issues and the great need for new assessment tools and treatments that also target biophysiological processes that contribute to the disorder or hinder treatment and recovery.⁷⁷

The VA has certainly taken significant steps over the years to improve veterans' access to mental healthcare. DoD has also taken action to address service members' behavioral health, including increasing its mental health workforce by 35% over the past several years and placing mental health providers in primary care clinics.⁷⁸ But for all the positive action taken, too many warriors still do not receive timely and effective treatment. In short, and as WWP has testified,⁷⁹ wide gaps remain between well-intentioned policies and on-the-ground practices, with more work needed to improve access and to provide effective screening and appropriate, sensitive care for those seeking treatment for mental health conditions.

THE NUMBER OF HOMELESS VETERANS WILL LIKELY PEAK MORE THAN 10 YEARS AFTER DISCHARGE.

Anticipating the considerable challenges those with invisible injuries may confront over the years ahead, there are several issues that will require strategic planning to address. Homelessness has been a notorious scourge within the veteran population, particularly for those with mental health conditions. The number of homeless veterans of any generation has typically peaked more than 10 years post discharge, highlighting the need for early risk assessment and intervention to prevent long-term difficulties.⁸⁰ Research has identified variables that influence risk in addition to combat exposure and mental health conditions, such as ethnicity, age, unemployment, being unmarried, substance use, physical

health problems, and social isolation.⁸¹ A history of incarceration is also strongly associated with homelessness risk, highlighting the need for expanded use of veterans' treatment courts, which have been shown to successfully divert warriors with behavioral health problems from the criminal justice system into treatment and rehabilitation.⁸² Women veterans, especially those who have experienced sexual assault during service or who are in poor health, have been found to be particularly at risk compared to their civilian peers. One study found that 40% of homeless women veterans had experienced military sexual trauma (MST).⁸³ While there are many programs targeting homelessness in the veteran population, very few offer adequate facilities and resources to meet women's unique needs, especially for those who may have children.⁸⁴ Given the high incidence of risk factors, it is clear that this generation of warriors experiences significant challenges that put them at higher risk of not having regular, secure, adequate, or safe housing. While VA has expressed its commitment to ending homelessness among veterans and provided substantial funding toward that end, there is still much work to be done to develop effective early intervention programs that provide trauma-informed care, administer holistic treatments, and target the factors that place veterans most at risk of homelessness before they get to the breaking point.

Another area of needed engagement is mental health treatment for victims of MST. As a form of high betrayal trauma that can result in long-lasting physical and psychological problems, there is a great need for better preventive care and risk assessment to avoid the most negative long-term effects associated with in-service assault.⁸⁵ Researchers report that MST is an even stronger predictor of PTSD than combat.⁸⁶ But while victims' reluctance to report these traumatic incidents is well documented, many also delay seeking treatment for conditions relating to that experience.⁸⁷ Where veterans do seek treatment, research has shown there are few resources available, and those that are may have significant barriers relating to types of treatment offered, or because of confidentiality concerns.⁸⁸ With VA reporting that one in four women and one in 100 men seen in its medical system responded "yes" when screened for MST⁸⁹ and DoD reporting that 26,000 active duty service members experienced a sexual assault in 2012,⁹⁰ it is clear that there is a great need for resources, support, and effective treatment for those who are coping with health issues as a result of an in-service assault. While researchers cite the importance of screening for MST and associated referral for mental healthcare, many victims do not currently seek VA care. Indeed, researchers have noted frequent lack of knowledge on the part of women veterans regarding eligibility for and access to VA care, with many mistakenly believing eligibility is linked to establishing a connection to service for a condition.⁹¹ In-service sexual assaults have long-term health implications, including debilitating physical conditions like cardiovascular disease, diabetes, chronic pain, and gynecological and gastrointestinal problems.⁹² There is also



an increased risk of PTSD, suicide, major depression, and alcohol or drug abuse, and without outreach to engage victims of MST on needed care, the long-term impact may be intensified.⁹³ A comprehensive review of individuals seeking VA care found that those who experienced MST were three times more likely to receive a mental health diagnosis of some type, almost nine times more likely to be diagnosed with PTSD, and twice as likely to be diagnosed with a substance abuse issue.⁹⁴ While women are more likely to be assaulted in service and have been generally found to be more susceptible to developing PTSD after trauma,⁹⁵ male victims of MST have been found to be particularly at risk of having more severe symptoms and longer-lasting effects relating to in-service assault, which points to the need for specific guidance and training for providers relating to patient gender.⁹⁶

ONE IN FOUR WOMEN AND ONE IN 100 MEN SEEN BY VA REPORTED EXPERIENCING MST.

As DoD has stated unequivocally, military sexual assault is a crime that may forever change the life of its victims.⁹⁷ Yet it is also a significantly underreported crime. DoD reports that only about 14% of the estimated number of incidents of unwanted sexual contact in 2012 were reported to a military authority.⁹⁸ It also acknowledges that victims commonly believe that nothing will be done after an assault is reported.⁹⁹ Such impressions, and the resultant reluctance to report MST, are reinforced by experience. Despite reported improvements in holding the perpetrators of MST accountable, recent data still describe a troubling climate where too many are not held responsible for victimizing their fellow service members.¹⁰⁰ DoD has certainly attempted to institute prevention strategies and improve response mechanisms, and has reported some encouraging progress.¹⁰¹ However, as Congress recognized in imposing wide-ranging new measures through the NDAA for fiscal year 2014,¹⁰² DoD has not gone far enough.

A 2014 survey of WWP Alumni further demonstrates the great challenges in getting needed treatment for warriors affected by MST. Almost half of survey respondents indicated that accessing care through VA for MST-related conditions was "very difficult." Of those who did not seek VA care, 41% did not know they were eligible for such care. It is clear there is still a lot of work to do to improve care and treatment for veterans with MST-related conditions.

ABOUT 50% SAID ACCESSING VA CARE FOR MST WAS "VERY DIFFICULT."

Congressional testimony in 2013 also provided strong evidence that both DoD and VA are failing to provide adequate mental health services for veterans who had been assaulted by fellow service members. Veterans detailed troubling and similar experiences relating not only to access to VA care, but also to inadequate screening, providers who were either insensitive or lacked needed expertise, and facilities ill equipped to appropriately care for MST survivors.¹⁰³

Particularly at risk for adverse outcomes are those with other than honorable discharges, or "bad paper." These can stem from sometimes questionable diagnoses, such as personality disorder or adjustment disorder. Substance abuse or conduct that may be related to service-incurred conditions can also result in loss of earned benefits and being denied unemployment compensation.¹⁰⁴ These individuals are also at high risk of unemployment, incarceration, substance abuse, and homelessness, and without access to needed resources, their prospects can be especially grim.¹⁰⁵ With estimates that thousands of OEF/OIF warriors may have been administratively discharged inappropriately, the scale of the problem has not been well defined, and each passing year compounds the problems for those affected.¹⁰⁶ DoD has tightened some rules regarding these types of discharges, but little has been done to provide retrospective remedial action. And with reports that increases in bad paper discharges have mirrored upticks in the overall numbers of wounded, and investigations questioning DoD's ability to ensure discharge requirements were followed, there is a real concern that many warriors suffering from the wounds of war are falling through the cracks and are in need of a correction to their discharge status.¹⁰⁷

Barring significant changes that engage and retain in treatment those needing mental healthcare, warriors bearing the scars of years of combat will be at risk of lasting negative outcomes. So it is critical that VA make system-wide improvement of mental healthcare a singular priority. VA leaders, citing steps the department has taken, have for years assured Congress that such indeed is the case. But as the damning findings of a four-year Institute of Medicine (IOM) assessment of PTSD care highlight, "[a]lthough the VA central office has established policies on minimum care requirements and guidance on PTSD treatment, it is unclear whether VA leaders adhere to the policies, encourage staff to follow the guidance, or use the limited outcome data available ... to improve PTSD management."¹⁰⁸ IOM also observed that while VA (as well as DoD) increased mental health staffing, including increasing purchased care, those "staffing increases do not appear to have kept pace with the demand for PTSD services."¹⁰⁹ IOM's findings give context to the systemic problems in VA appointment scheduling (involving both primary care and mental healthcare) unearthed in 2014. With profoundly disturbing findings of veterans encountering dangerously lengthy delays in being scheduled for care, that tumultuous scandal aptly sparked both a departmental and congressional laser focus on improving



access to care. Particularly in the context of mental healthcare, however, improving access to care does not ensure that an individual will receive effective care. Moreover, veterans report that to meet VA performance requirements on timeliness, some facilities provide an initial assessment within required time limits, but that actual treatment may be long delayed, compromising the effectiveness of treatment.

For many warriors whose training is to “soldier on” and “tough it out,” asking for help — especially mental healthcare — is a long-delayed last step. When warriors who are at the end of their rope finally seek help at a VA medical center and are “seen” within a reasonable time frame but told they must wait six weeks or longer to actually begin therapy, one should not be surprised if they experience deep frustration or even despair. Such deferred treatment can set the stage for potentially tragic outcomes. These problems are multilayered and require ongoing oversight and comprehensive solutions. There remain facilities that need additional mental health staff. Others are also plagued by so basic a problem as a lack of treatment rooms in which to meet privately with patients. VA has some mental-health performance metrics, but they don’t ensure that patients are actually getting better, since none measure mental health patient outcomes. Similar to concerns raised by IOM, it is not just good enough to say that VA is “seeing” high percentages of veterans for mental health conditions when treatment is sporadic or is limited to provision of medications — as it is for too many injured service members. The issue is not just access to treatment, but access to timely, effective treatment. Among the requirements by which VA assesses facility performance is the percentage of veterans with a primary diagnosis of PTSD who receive eight sessions of evidence-based psychotherapy over a 14-week period. But warriors with comorbid conditions or who have witnessed events such as the death of a battle buddy are not likely to have profound trauma erased by just eight treatment sessions. Yet VA clinicians report that their facilities are not staffed to provide for these veterans’ continued mental health treatment needs. Ultimately, if veterans are to overcome combat-related mental health issues and thrive, VA and DoD must close critical gaps in their respective mental healthcare systems and work together seamlessly.

SINCE VA MENTAL HEALTH PERFORMANCE METRICS DON’T MEASURE OUTCOMES, THEY DON’T ENSURE PATIENTS ARE ACTUALLY GETTING BETTER.

It is evident the healthcare needs of this generation of veterans will continue to grow in the coming years and decades. While current challenges are likely to persist or even worsen over time, there are encouraging advances being made, and developments in the provision of mental and physical healthcare will greatly affect the experience of warriors confronting some of the most trying health outcomes.

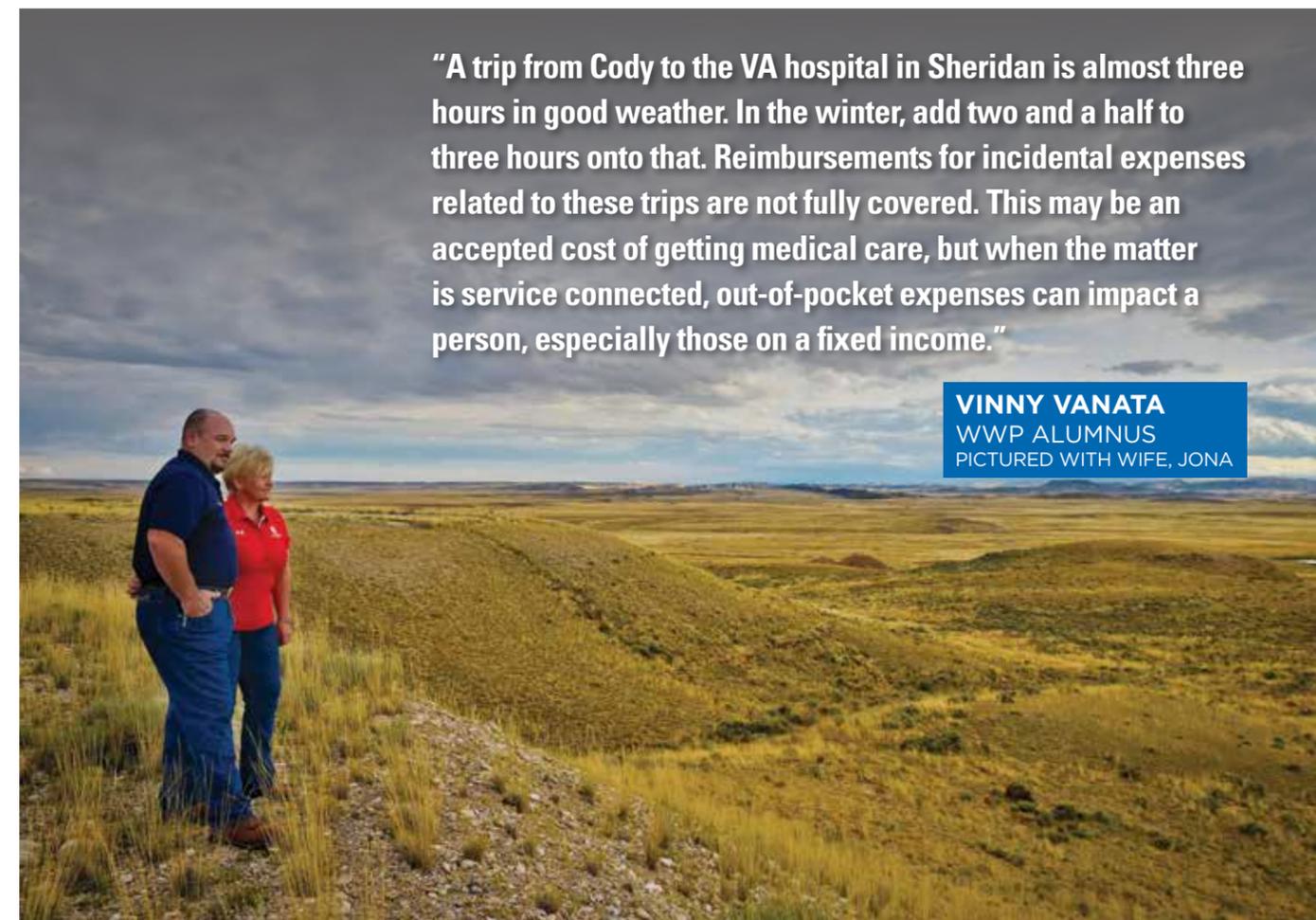
TRENDS IN HEALTHCARE DELIVERY

The next decade can be expected to bring sweeping change in healthcare. The nature of medical care, how it is furnished, where, and by whom, will likely all look very different from what patients experience today. Some of these trends are already evident; others will likely emerge.

Current trends in clinical practice and medical technology development have led some to project that in twenty years we will be able to manage most cancers as chronic diseases, to perform most surgeries noninvasively, and to realize still unforeseen medical advances.¹¹⁰ Research on neuroprosthetics points to new ways of regaining lost functioning as well as new modes of disease treatment.¹¹¹ One of the most promising fields is in nanotechnology, the science of manipulating submicroscopic structures and properties.¹¹² Nanotechnology promises a range of medical applications, to include delivering drugs to cancer cell nuclei, synthesizing drugs within the body, and developing nanofibers that can be used in surgical dressings, implants, and tissue or organ repair.¹¹³

Tiny cameras implanted in a patient’s glasses that can capture images, which, in turn, can be converted into electrical impulses and wirelessly transmitted to an antenna in a retinal implant point the way toward a means of restoring some level of sight.¹¹⁴ Gene therapy, involving the reengineering of genes to fight disease, has already shown promise in treating leukemia, while immunotherapy — spurring the body’s immune system to treat cancer — is already seen as a breakthrough,¹¹⁵ and much work is being done toward genomic-based testing.

Complex, futuristic treatments and applications will likely be centered in major medical centers. But more routine care and care that might today often be delivered on an inpatient basis will likely become more community- and home-based. A “hospital-at-home” demonstration model in which acutely ill elderly patients received timely, efficacious hospital-level care at home¹¹⁶ could become a standard of care in the future. With successful treatment of many chronic conditions hinging on patient compliance, some also see the application of wireless technologies as a key for clinicians to better manage chronic disease and illness prevention.¹¹⁷ Technology from smartphones to sensors will likely also arm



“A trip from Cody to the VA hospital in Sheridan is almost three hours in good weather. In the winter, add two and a half to three hours onto that. Reimbursements for incidental expenses related to these trips are not fully covered. This may be an accepted cost of getting medical care, but when the matter is service connected, out-of-pocket expenses can impact a person, especially those on a fixed income.”

VINNY VANATA
WWP ALUMNUS
PICTURED WITH WIFE, JONA

patients themselves with the means of monitoring their health. Going a step further, a telehealth platform and a highly monitored home environment could serve as an adjunct to traditional health services and enable people to be cared for in their homes instead of in a hospital.¹¹⁸ Developing some or all of these approaches could result in as much as 50% of healthcare moving from hospitals and clinics to homes and communities as we move to a “healthcare is everywhere” approach.¹¹⁹

Hospitals and medical centers will surely also evolve, not simply incorporating new technologies but changing in scale and scope. While relatively routine care continues to move to more affordable retail clinics, observers see a trend in major employers’ contracting directly with big-name high-performance health networks for costly, complicated procedures.¹²⁰ Facing increased competition, rising costs, and changing business models, hospitals and hospital systems have already seen mergers and acquisitions. Health industry consolidation reportedly increased by more than 50% since 2009, and this trend is expected to continue.¹²¹ One can reasonably

anticipate that forces driving containment of healthcare costs will result in both system reengineering¹²² and further consolidation of the infrastructure for financing and managing patient care.¹²³ The Affordable Care Act (ACA) encourages the development of new models of care delivery that would provide financial incentives aimed at reducing costs and improving quality. Accountable Care Organizations (ACOs), under the ACA, generally involve restructuring a clinical organization and integrating care among individual physicians, hospitals, and other healthcare providers.¹²⁴ (ACOs are seen as having significant implications for rural areas as well.)¹²⁵

While it is early to speculate on whether the accountable care organization concept will thrive or not, increasing pressures to lower cost and improve efficiency will likely also result in more mergers among hospitals, health systems, pharmaceutical companies, and payers, leading to more megasystems.¹²⁶ Those same drivers will likely lead institutions to create nontraditional strategic partnerships with industries in wide-ranging fields, from biotechnology to information technology and beyond.¹²⁷



With such growth on the part of already large, sophisticated metropolitan medical centers, the future of small community hospitals that are not otherwise acquisition targets and cannot easily adapt to change seems troubled. As large institutions get larger and more complex and inpatient care grows more costly, care can increasingly be expected to move to the patient. Yet with megasystems growing in market power, it is said that “the day of the independent practitioner and stand-alone hospital will come to an end.”¹²⁸ The changes ahead in the healthcare marketplace dictate the importance of adapting to those changes, but the formidable costs associated with instituting those changes, it’s warned, mean that small community hospitals and the safety net of not-for-profit care will struggle to remain intact, with those declining roles leaving heightened gaps in rural access and for those dependent on charity care.¹²⁹

With dramatic change affecting rural as well as urban healthcare, there has been real concern regarding closures of rural community hospitals, as the hospital has been the focus of healthcare delivery in rural communities and closures have had a devastating effect on people’s health status.¹³⁰ With such closures, one can also foresee the closing or relocation of associated medical providers and support services such as laboratories and ambulances. Some believe closures will continue, along with cuts in reimbursement rates, with a resultant growing problem of “medical deserts.”¹³¹

Against the backdrop of this dramatically changing landscape is the question: how can our healthcare system ensure that there are enough health professionals in the future with the right skills to care for all who need care in the right place at the right time?¹³² While job growth in the healthcare industry will likely continue to rise, we do not yet have comprehensive and comparable workforce data across a broad range of health professions, or even reliable workforce-forecasting models.¹³³ Experts acknowledge that there are great challenges in projecting future supply and demand.¹³⁴ To illustrate, while one study projected a need for another 52,000 primary care physicians in this country by 2025,¹³⁵ another showed that primary care physicians practicing in teams and delegating tasks to nonphysicians to the maximum extent appropriate could manage roughly twice as many patients as those working under a traditional practice model,¹³⁶ a finding with clear implications for workforce projections. Yet another commentator opined that with not many medical students choosing primary care as their career path and older ones retiring early or seeking hospital employment, the field is shrinking at a time when it should be growing, given millions of previously uninsured Americans enrolling for care under the ACA.¹³⁷

Many factors contribute to uncertainty regarding future workforce supply and demand, including changes in the healthcare system itself. While nonphysician providers will likely fill some gaps, and

expanded use of telehealth may help reach underserved areas, one cannot lightly ignore the chilling warning — focused at 2025 — that “[u]nder any set of plausible assumptions, the United States is likely to face a growing shortage of physicians.”¹³⁸ Meeting the need for primary care providers represents a particular challenge. One 2013 federal study projects a shortage of some 20,400 primary care physicians by 2020, based on current utilization patterns, though it suggests that increased use of nurse practitioners and physician assistants could somewhat alleviate that shortage and new ACA programs and policies that invest in health workforce training could further ease the shortages.¹³⁹

TRENDS SHOW A PHYSICIAN SHORTAGE AHEAD, WHEN THE U.S. ALREADY LACKS AN ADEQUATE BEHAVIORAL HEALTHCARE WORKFORCE.

Having an adequate supply of physicians is more than a matter of achieving a raw number. In addition to the challenge of ensuring that providers have the training and skills to provide clinically competent care, there has long been concern about the lack of cultural diversity among physicians. The challenge of ensuring that clinicians are able to provide culturally competent care is particularly relevant to providing effective behavioral healthcare to wounded veterans.¹⁴⁰

Even assuming that needed growth in the size of the physician workforce is realized, geographic disparities can be expected to continue.¹⁴¹ It is reasonable to assume that rural areas will continue to be among those experiencing disparities given that primary care in rural areas has been described as in crisis, with 77% of rural counties deemed primary care shortage areas and an aging rural primary care workforce.¹⁴²

While there is real concern regarding a future shortage of physicians, the country is already experiencing shortages in the behavioral health workforce, and has been for some time. The shortage is not evenly distributed, with a 2007 study indicating that 55% of U.S. counties — all rural — have no practicing psychiatrists, psychologists, or social workers.¹⁴³ Another study found that 77% of U.S. counties had a severe shortage of mental health workers, both prescribers and nonprescribers.¹⁴⁴ Moreover, the mental health workforce is aging, with the median age of psychiatrists 55.7; nearly half are 65 or older.¹⁴⁵ While there has been growth in the number of both psychologists and social workers for many years, the number of psychiatrists has been stable and has not kept up with population growth.¹⁴⁶ We see no evidence that the next decade will bring a meaningful increase in the number of psychiatrists or in their geographic distribution.



FAMILY ISSUES AND THE WARRIOR

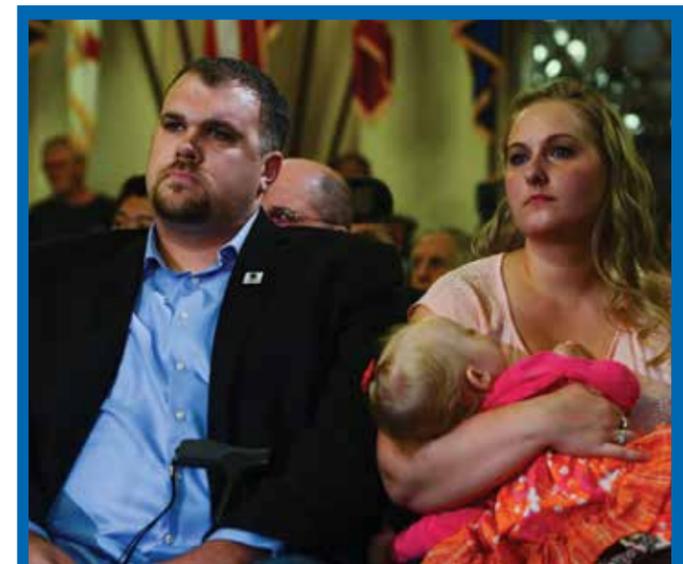
Interpersonal relationships are a source of pleasure in our lives, and they support our well-being. Those relationships are seen as buffering us from stress, and as playing a role in preventing psychological and somatic disorders.¹⁵²

Families play a critical role in wounded veterans’ reintegration, recovery, and rehabilitation. Military families have a unique culture, and families learn to live with the shared sacrifices that come with military service.¹⁵³ Despite a core of resilience, more than a decade of deployments and redeployments — compounded by often untreated PTSD and other co-occurring problems — have had damaging and potentially long-term effects on some military families and marriages. Left to fester, those “family wounds” may ultimately weaken critical sources of support some warriors need as they confront inevitable challenges ahead.

The current behavioral health workforce shortage in rural America does not differ markedly from that described more than a decade ago by a presidential commission on mental health, which found that rural areas suffer from chronic shortages of mental health professionals and need improved access to mental health services.¹⁴⁷ Since then, the enactment of the ACA, under which mental health services are a covered benefit, is expected to expand the numbers of people who will seek mental healthcare,¹⁴⁸ though we have not seen an increase in the behavioral health workforce. The ACA may lead to changes in the care setting in which behavioral healthcare is provided — with more care likely to be furnished in primary care settings and, potentially, also in new integrated care structures that make greater use of team-based care. Caring for newly insured individuals will require an expanded behavioral health workforce.¹⁴⁹ Telepsychiatry is seen as a way to stretch the mental health workforce to better meet needs in shortage areas, but, as one scholar observed, “[t]elepsychiatry redistributes resources, but does not necessarily create them.”¹⁵⁰ In other words, there remains a problem of provider supply.” As explained, “[t]elepsychiatry programs within organizations and academic centers start out very successful, with clinical champions, usually providers, quickly establishing clinical practices themselves or with a colleague. Clinical time, however, is rapidly saturated. Recruiting additional providers to serve rural areas, full or part time, puts them in competition with existing organizational psychiatry resources. Additionally, unless the leadership in the organization or government is committed to the prospects of changing the way they deliver mental healthcare and reallocating resources, they are doomed to limited success at best.”¹⁵¹

Behavioral healthcare providers have a critical role to play in treating the invisible wounds of two wars — including PTSD and other mental health conditions, TBI, pain, and substance abuse and dependence. The next decade will likely see changes in the way mental healthcare is delivered, with the potential for greater collaboration and integration between behavioral and primary healthcare. This is subject to the adoption of changes in reimbursement advancement, which do not currently support this model. While collaborative care holds the promise of providing more efficient and effective care, troubling shortages in the mental health workforce, particularly among psychiatrists and particularly in rural areas, pose high risk of those needing services experiencing great disparities in access and quality of mental health.

With a large proportion of post-9/11 wounded veterans living in rural areas, evidence suggesting a growing urban/rural divide in access to both tertiary medical care and behavioral healthcare is cause for concern.



“A strong family relationship is crucial for a veteran’s recovery from PTSD or other debilitating injury, but it takes a lot of effort to reengage with your family. It’s easier to isolate yourself. Nevertheless, it’s critical for them and others with close relationships to be a part of the healing process.”

JOSH RENSCHLER
WWP ALUMNUS
PICTURED WITH HIS WIFE, NICHOLE, AND DAUGHTER



While career military families are generally perceived to be steeled to the stresses of frequent relocation, long absences, and deployments, the circumstances of military operations since September 11, 2001, have had a profound impact on many families. U.S. military operations after 9/11 were characterized by unprecedented levels of deployment tempo and heavy reliance on National Guard and Reserve troops. Some 40% were deployed to a combat zone more than once. Not since the Vietnam War have so many U.S. military families been affected by deployment-related family separation, combat injury, and death.¹⁵⁴

While deployment itself can be traumatic, reintegrating into family life — particularly after the initial euphoria of return from the war zone — can sometimes be more emotionally taxing than deployment itself, and can take a toll on both the mental health and relational health of military members.¹⁵⁵

REINTEGRATING INTO FAMILY LIFE CAN BE MORE EMOTIONALLY TAXING THAN DEPLOYMENT ITSELF.

With the extraordinary operational tempo experienced by this generation of warriors, the process of reintegrating — that is, reentering daily life as experienced before the deployment — was for many also a period of predeployment, or preparing for another deployment.¹⁵⁶ Further research will surely provide more insight into the degree to which family resilience has been protective, and the extent to which some families have experienced resultant long-lasting psychological wounds.

It has been widely assumed that being deployed increases the risk of divorce, but there is little consistent evidence yet to support that belief.¹⁵⁷ One study that tested that assumption — analyzing divorces during the first three years of the conflicts among service members who had married after 9/11 — found that most military couples separated by deployment are actually at decreased risk of marriage dissolution.¹⁵⁸ (The study did find, however, that female service members — across all services and in the National Guard — were at significantly greater risk of experiencing marital dissolution than males.)¹⁵⁹ While the analysis did not find the predicted effect on marriage in the short term, the study authors acknowledge that the predicted effect of deployment on divorce might yet emerge.¹⁶⁰ Among soldiers surveyed before and after deployment to Iraq, deployment appeared to be associated with decreased marital satisfaction, increased intention to divorce, and increased self-reported spouse abuse, particularly at the 12-month postdeployment point.¹⁶¹

It is clear that mental health problems in those returning from Iraq and Afghanistan are stressors for families that compound the stress of deployment itself. With symptoms including emotional numbing; irritability, anger, and aggression; and withdrawal from social, work, and family activities, PTSD is known to cause difficulty in maintaining stable family relationships. Research has demonstrated strong associations between PTSD and low marital satisfaction and the likelihood of divorce,¹⁶² and when a marriage is strained, the veteran lacks the social support needed to overcome some of the very mental health problems that are exacerbating the marital discord.¹⁶³ More troubling still, veteran status has been associated with three times the rate of intimate partner violence than among nonveterans, and veterans are reportedly more likely than nonveterans to cause significant injury to their spouses.¹⁶⁴ Domestic violence within military families has been attributed to particular symptoms, such as anger and impulsivity, that can be associated with PTSD and prior history of trauma, and comorbidities of PTSD. Depression, substance abuse, relationship distress, and impaired problem-solving are also seen as increasing the risk for domestic violence.¹⁶⁵

Also troubling is a growing body of research on the effects of deployment and reintegration on children. A parent's deployment to a combat zone may be one of the most stressful experiences a child faces.¹⁶⁶ And the reintegration phase, acknowledged to be a turbulent time for the family, can actually persist for years.¹⁶⁷

There is an acknowledged need for more research to understand the long-term impact of deployments on children.¹⁶⁸ While evidence indicates that many demonstrate remarkable resilience during deployment and reintegration,¹⁶⁹ there is also considerable agreement that some children are especially vulnerable.¹⁷⁰ Several studies suggest that boys and younger children may be more at risk for negative outcomes. One study of children between the ages of 5 and 12 whose parents had deployed after 9/11 found that one-third were at high risk for psychosocial morbidity. Some factors that have been found to play a role in potential risk of developing psychosocial symptoms are younger parental age, shorter duration of marriage, and lower socioeconomic status.¹⁷¹ One longitudinal study of youth in military families who participated in a camp program to assess their coping with parental deployment found that children and their nondeployed caregivers confronted significant challenges to their emotional well-being and functioning. Length of deployment, National Guard or Reserve status, and caregiver emotional well-being were found to be strongly associated with greater youth difficulties.¹⁷² Another study that examined the prevalence and severity of adjustment problems among school-age children found that one-third of the children of both deployed and recently returned parents demonstrated clinically significant symptoms of anxiety.¹⁷³ Compounding the effects of deployments, studies suggest that children of parents with PTSD have higher risk of emotional, behavioral, academic, and interpersonal problems.¹⁷⁴



SOCIETAL SUPPORT FOR WOUNDED VETERANS AND CAREGIVERS

Given the bedrock importance of family, we are left to speculate as to what the next decade holds for these families. While there is limited research on the long-term effects of war on military families, one can reasonably anticipate that the cumulative effect of deployment, redeployment, injury, and PTSD will have done lasting damage to some percentage of our warriors' families. Families can represent a vital source of support for recovering warriors, or relationships strained by deployment and PTSD can become yet another source of stress. The passage of a decade will certainly bring marked change beyond the immediate sphere of the nuclear family. For warriors whose parents have been caregivers or who otherwise provided support, that decade will likely irreversibly alter those relationships. Aging parents may no longer be able to sustain caregiving. Many of our warriors will have moved into a "sandwich generation" phase of life marked by competing roles — at once a parent and a caregiver to those aging parents.

While changing family dynamics over time are inherent in our lives' journeys, such changes will likely have greatest impact on warriors who continue to struggle with PTSD and who are severely disabled as a result of TBI. In both instances, family support and other interpersonal relationships are likely to be important for many in recovery, rehabilitation, or simply in managing day to day. Yet behaviors associated with both conditions can be profoundly challenging, and without therapeutic help, can prove corrosive. With often deep-seated negative attitudes about seeking help,¹⁷⁵ many are likely to continue to avoid seeking help; others simply may not find effective care. There are many warriors whose well-being may depend on support, companionship, and interpersonal engagement. Without a dramatic reversal of trends, it seems likely that these warriors in particular will, because of common PTSD symptoms, either isolate themselves or find themselves isolated from others.

An extensive array of warrior-focused programs has helped empower this generation of returning warriors. Yet there remains "a long road ahead — of recovery, of returning to normal, of reconnecting as a family, and of reintegrating into society — for wounded veterans and their families."¹⁷⁶ That road of recovery must also take account of the needs of the caregivers — needs highlighted by a 2014 RAND Corporation study, "Military Caregivers: Who are they? And who is supporting them?" (carried out in partnership with the Elizabeth Dole Foundation and with WWP funding).¹⁷⁷ WWP has long been committed to supporting these caregivers through advocacy and programs, including a coordinated effort that won enactment of the Caregiver Assistance Law of 2010, which provides vital support for family caregivers. That work is not over.

The broad support with which America has embraced service members and wounded veterans has been a prominent dimension of the country's sustained overseas engagements and the governmental support afforded the veterans of those engagements. What is less clear, however, is the extent to which these veterans will continue to enjoy that support in the future. Indeed, even though Americans have demonstrated gratitude and empathy for our warriors, very few can understand and appreciate what the warriors endured and how that experience has changed their lives. Sober thinking must take into account the possibility that empathy and support may recede over time as memories of U.S. operations in Iraq and Afghanistan fade and as people not directly touched by war come to experience warriors' problems as "old news." Yet several current trends in public opinion are likely to persist and to influence future levels of support. These include views regarding the wars in Iraq and Afghanistan; feelings about the veterans of those operations; and the relatively wide gulf between the civilian, military, and veteran populations. Indications that we may see at least some decline in the public's interest and support for wounded veterans over the next decade has implications for the government's strategy to partner with community and nonprofit entities to provide support for programs that serve injured veterans and their families.

POLICY CHANGES COULD WEAKEN CHARITABLE GIVING, JUST AS GOVERNMENT SUPPORT FOR INJURED WARRIORS IS DIMINISHING.

Polling data suggests that public interest in media coverage of the wars in Iraq and Afghanistan has ebbed.¹⁷⁸ By 2010, reports about the war in Afghanistan accounted for only 4% of the nation's news coverage in major outlets in America.¹⁷⁹ By 2011, that percentage dropped further, to approximately 2%.¹⁸⁰ The Pew Research Center identified 2013 as reflecting the highest, most sustained "isolationist sentiments" since the 1960s. The trend suggests that "Americans want to mind their own business."¹⁸¹ Further, public opinion polling in 2014 indicated the unpopularity of U.S. foreign and defense policies of the past 13 years.¹⁸² These patterns suggest a society that wants to forget the "War on Terror" and "the long war"¹⁸³ as things of the past — sentiments likely to continue into the next decade.¹⁸⁴

In contrast, however, veterans of Iraq and Afghanistan enjoy a special status in American society today, in stark contrast to the experience of returning Vietnam War veterans in the 1960s and 1970s. This generation of veterans is unique for at least two reasons: (1) the Iraq and Afghan



“I’m usually the only person who has served in the military that my friends know.”

TENAY GUVENDIREN
WWP ALUMNA



campaigns represent the first protracted, large-scale conflicts since our Revolutionary War fought entirely by volunteers, and (2) no major war in our history has been fought with a smaller percentage — one-half of one percent¹⁸⁵ — of this country’s citizens in uniform full-time. Literally thousands of organizations hold themselves out as serving veterans today, though the extent of the services provided varies greatly.¹⁸⁶ Just as the years may dim the public’s level of appreciation for our warriors,¹⁸⁷ the veteran-support infrastructure will also likely shrink.

The passage of time also seems likely to widen our society’s well-documented civilian-military divide.¹⁸⁸ With each passing decade, fewer and fewer Americans know someone with military experience in their family or social circle. In 1988, about 40% of 18-year-olds had a veteran parent. By 2000, the percentage had dropped to 18%, and is projected to fall below 10% in the future.¹⁸⁹ Further magnifying that divide, DoD basing changes have moved a significant percentage of military posts to just five states: Texas, Washington, Georgia, Kentucky, and North Carolina. For environmental and budgetary reasons, many military facilities in the Northeast and on the West Coast have been shut down, leaving a void of relationships and understanding of the armed forces in their wake.¹⁹⁰ This process, coupled with nationwide demographic shifts in the veteran population, has effectively moved our nation’s veterans south and west in the United States¹⁹¹ and virtually out of urban and affluent areas.¹⁹²

Prominent scholars further observe, “[T]he U.S. military’s domestic bases are the nation’s most exclusive gated communities ... The geographic isolation of military bases further divides the services from society.”¹⁹³ The military’s self-imposed isolation does not

encourage civilian understanding, and it makes it difficult for veterans and their families to navigate the outside world. After spending years in geographic and cultural isolation, military members and their families who leave active duty lose their support system and community ties that sustained them. They become veterans transitioning into a brave new civilian world.¹⁹⁴

What is less obvious and nonetheless significant is a divide separating the active military and veteran communities. DoD strives “to provide the military forces needed to deter war and to protect the security of our country.”¹⁹⁵ The VA aims “to fulfill President Lincoln’s promise ‘to care for him who shall have borne the battle, and for his widow, and his orphan’ by serving and honoring the men and women who are America’s veterans.”¹⁹⁶ These different missions require different priorities,¹⁹⁷ focal points for policy and budget resource allocations,¹⁹⁸ and contribute to a structural military-veteran divide. While that is not a new phenomenon, it highlights the challenges with which The President’s Commission on Care for America’s Returning Wounded Warriors (the Dole-Shalala Commission) grappled. Notwithstanding the extensive work that has been done since to realize the goal of a seamless transition for returning service members, that multipronged effort remains a work in progress.

At a time when DoD’s priorities and budget constraints are likely to shift more responsibility for injured service members to VA, that department is admitting that it cannot take care of all veterans, their families, or caregivers alone.¹⁹⁹ VA is placing new emphasis on fostering strategic partnerships to meet veterans’ needs.

AT A TIME WHEN DOD’S PRIORITIES AND BUDGET CONSTRAINTS ARE LIKELY TO SHIFT MORE RESPONSIBILITY FOR INJURED SERVICE MEMBER PROGRAMS TO VA, THAT DEPARTMENT IS ADMITTING THAT IT CANNOT TAKE CARE OF ALL VETERANS, THEIR FAMILIES, OR CAREGIVERS ALONE.

The wars in Iraq and Afghanistan did spark the development of a new “ecosystem of nonprofit organizations,” established with the goal of serving veterans and their families.²⁰⁰ In 2014, there were approximately 40,000 nonprofit organizations with an expressed aim of helping veterans.²⁰¹ To varying degrees, organizations within this sector, along with many local communities, have made a real difference to injured service members and their families over the past decade. But the economic recession has taken a toll on many



of those organizations.²⁰² Economic pressures could cause some to abandon efforts to assist veterans and concentrate their efforts on core missions. An even graver risk is that state and federal policymakers could further weaken the fabric of charitable giving in either ill-advised reform efforts or changes in tax policy that might shrink national giving.

Policy changes over the next decade could profoundly weaken the nation’s long tradition of charitable giving. Such changes, while certainly not targeting veterans, could nevertheless tragically diminish the capacity of not-for-profit service providers to assist wounded veterans and their families at the very time that government’s role may be declining.

THE ROAD TO ECONOMIC EMPOWERMENT

Employment is a fundamental component of quality of life and self-esteem, providing identity and social status, and a sense of achievement.²⁰³ Unemployment, on the other hand, is associated with poor health status, and in particular an increased risk of poor mental health.²⁰⁴ And long-term unemployment has large negative effects on mental health.²⁰⁵ With military careers often cut short by life-altering injuries, this generation of wounded veterans has faced often-stark employment challenges as warriors attempt to reintegrate into their communities and rebuild their lives. Hundreds of thousands more are likely to be diagnosed with PTSD and TBI in the years ahead.²⁰⁶ Absent marked changes in policy, the related economic and social costs — including loss of wages due to medical needs and lack of labor force participation — will continue to rise.²⁰⁷

Most post-9/11 veterans returned home to a sluggish economy followed by one of the most severe recessions since the Great Depression. Veterans of this generation are also more likely to have experienced difficulties in readjusting to civilian life and higher levels of unemployment than veterans of other eras and other labor force participants.²⁰⁸ As discussed earlier, high percentages of the all-volunteer armed forces have come from and are returning to rural and small communities. Veterans in these communities, and particularly younger veterans, are experiencing higher rates of unemployment than other veterans across the country.²⁰⁹ But even before the recession, unemployment rates among all veterans were higher in rural than urban areas.²¹⁰ This may reflect local economies’ frequent reliance on a single industry and the prevalence of low-skill jobs in these areas.²¹¹ Rural communities and areas often have limited access to well-paying jobs with benefits, require longer travel to employment, lack public transportation options, have fewer educational and social resources, and have fewer options for child care.²¹² While there has been high awareness of unemployment among post-9/11 veterans generally, women veterans have higher rates of postservice

unemployment than their male counterparts, and black veterans have higher overall unemployment than white veterans.²¹³

Several factors contribute to post-9/11 veterans’ high unemployment rates and associated difficulty in transitioning. For one, recent veterans tend to be younger and less educated than the general working-age population; younger and less educated workers tend to have higher unemployment rates.²¹⁴ The Georgetown Center on Education and the Workforce found that college graduates earn nearly twice as much as those with just a high school diploma.²¹⁵ In our 2014 Alumni Survey, 24% of respondents had a bachelor’s degree or higher; almost 40% had some college credit, but no degree.²¹⁶ According to a Pew Research Study, post-9/11 veterans who were commissioned officers and those who had graduated from college are more likely to have an easier time readjusting than enlisted service members and those who are high school graduates.²¹⁷ Also, it has been suggested that military experience is transferable to only a select number of particular tasks and occupations.²¹⁸ One study found that a high percentage of veterans tend to work in construction, manufacturing, transportation, and utilities, all industries that had weak growth during the recession.²¹⁹ Manufacturing, construction, and other low-skilled occupations have declined markedly over the past several years, and most analysts expect this trend to continue and to see future employers demand more specialized skills, particularly technological skills.²²⁰ Those who are unskilled or underskilled and lack technical or higher education are likely to be at a severe competitive disadvantage in the workplace and at risk of marginal employment, underemployment, or even unemployment.

Despite our successes in helping wounded, ill, and injured warriors enter the labor market, injury, illness, or disability compounds the difficulty veterans experience in finding employment and making the transition from military to civilian life. Veterans who reported an emotionally traumatic experience or a serious service-related injury were significantly more likely to have encountered problems with their transition.²²¹ Wounded veterans face many employment-related challenges once they decide to return to work. Those wounded between 2001 and 2006 are estimated to have experienced an aggregate earnings loss of \$556 million through 2010.²²² Among the challenges facing these wounded veterans are those related to their age, as most are young.²²³ Typically, the military represents their first work experience and they have no other history of employment; many may leave the military without being properly equipped to participate in the workforce.²²⁴ Other challenges include the difficulties in translating military experiences to civilian job duties, feeling overwhelmed by less-structured work environments, lack of necessary accommodations for a disability, and being unaware of vocational assistance that may be available.²²⁵



While many veterans overcome their injuries and thrive in the workplace, disability appears likely to continue to have a powerful influence. One study found that in the civilian populations with chronic mental illness and PTSD, having PTSD leads to lower rates of competitive employment, fewer hours worked, and less wages earned.²²⁶ Another found that for women veterans, more severe PTSD was associated with poor occupational outcomes and that depression was significantly linked with current employment status, with each increase in depression symptoms reducing the odds of working by about 35%.²²⁷ But while veteran status and female gender do increase the chances of being unemployed, disability is a “consistently stronger” influence.²²⁸

The close linkage between career and identity also makes the transition more difficult.²²⁹ Many wounded veterans had anticipated a military career, and when a life-changing injury derailed that plan, the transition was all the more challenging. For individuals whose sense of self is strongly informed by their career, the termination of that career threatens self-identity and generates feelings of hopelessness, alienation, and fear.²³⁰ One study found that those who are able to reestablish assumptions of the world and self are better positioned to pursue their passion through their careers and link their past career and coping competencies with their future.²³¹ Conversely, those who have yet to establish such foundational assumptions continue to feel vulnerable, and think more about “superficial mismatches” between prior competences and those required for a new career.²³² It would appear to follow that there would be great value in wounded veterans seeking vocational assistance as early as possible so as to begin rebuilding their career identity foundations. But a life-altering injury or illness may make it impossible to begin that process early. In a study of veterans with mental health or substance abuse issues, on average, it took them almost two years to recognize their need for vocational assistance.²³³ The study further found that it took these veterans another three years to move from recognizing this need to seeking assistance.²³⁴

THOSE WHO ARE UNDERSKILLED OR LACK DESIRED SKILLS AND TECHNICAL OR HIGHER EDUCATION ARE LIKELY TO BE AT A SEVERE COMPETITIVE DISADVANTAGE IN THE WORKPLACE.

Employer perceptions and their practices have an important impact on overall hiring of veterans with disabilities. Despite much work to educate employers and hiring managers about the value of hiring veterans and veterans with disabilities, there remains considerable stigma among employers regarding the signature

wounds of the Iraq and Afghanistan wars. Misperceptions continue to cloud employers’ views of PTSD and TBI,²³⁵ posing significant barriers to the hiring of veterans and discouraging the veteran-employee from asking for accommodations or to have other needs met.²³⁶ In a study of human resources professionals aimed at understanding if employers are ready to hire, accommodate, and retain post-9/11 veterans with disabilities, researchers found that although employers believed employing veterans with disabilities would add value to their organization, they are largely unaware of and don’t use resources to find, recruit, and hire them.²³⁷ Additionally, the employer respondents in the study had significant knowledge gaps regarding how to create effective employment practices for individuals with PTSD and TBI.²³⁸ As an example, 70% of these employers responded that they couldn’t identify any possible accommodations needed by employees with TBI.²³⁹ Veterans with disabilities generally and those with PTSD and TBI specifically can certainly succeed in the workforce, and their chances of success increase greatly when employers provide proper accommodations. For example, veterans with PTSD might require flexible work schedules, schedule reminders, rest breaks, checklists, and a low-noise environment.²⁴⁰ But while employers play a role in an individual’s employment success, the responsibility of career success and job retention tends to be on the individual to be willing, for example, to seek out needed resources and, where indicated, to disclose his or her disability.²⁴¹ These are not solely issues confronting veterans with invisible wounds.

Looking ahead to assess opportunities as well as perils that may face wounded veterans, the next decade is likely to bring further evolution and globalization in the U.S. economy, changes in demographic patterns, and still-unforeseen technological changes.²⁴² While the workforce can be expected to grow, some believe it will be at a much slower rate.²⁴³ We are likely, though, to witness a shift in workforce composition toward a more balanced distribution by age, sex, and race/ethnicity.²⁴⁴ By 2030, more than 20% of Americans are expected to be 65 and older, compared with 13% in 2010 and almost 10% in 1970.²⁴⁵ By 2050, it is projected that there will be three working-age adults per elderly person in the U.S., compared with two in the UK, France, and Germany, and 1.4 in Japan, Spain, and Italy.²⁴⁶ Given economic incentives, older workers may be more motivated to stay in the workforce past retirement age.²⁴⁷ Older workers may also need workplace accommodation due to age-related disability,²⁴⁸ making such workplace adaptations/modifications more commonplace.

People with disabilities will likely occupy a more prominent place in the workforce as well. Generally, economic growth is dependent on a growing labor force or increases in worker productivity.²⁴⁹ But with some anticipating slow growth of the workforce, firms could face more difficulty in recruiting and hiring workers.²⁵⁰ We anticipate this could lead employers to increasingly value the leadership



skills and experience of former service members with disabilities, thereby providing more job opportunities. The opportunity to recruit more employees with disabilities will expand with technological and medical advances, as with increased reliance on telework.²⁵¹ Future medical and prosthetic advances that improve and expand functioning and mobility, for example, could open new avenues to individuals with disabilities. New and improved technologies in such areas as speech recognition, screen reader software, transcription, and alternative pointing-and-clicking devices will increase the scope of workplace accommodations, allowing disabled individuals to perform a wider range of tasks.²⁵² With continued technological advances supporting higher productivity growth, we can also expect to see further changes in business organization and employment relationships.²⁵³ Some expect a shift away from permanent jobs toward nonstandard employment relationships and arrangements. Already, about one in every four workers in the country are in some nontraditional employment relationship, such as self-employment, contract work, or telework.²⁵⁴ This trend will continue to grow, creating potentially attractive opportunities for wounded veterans and others seeking to balance work and family.

With the pace of technological change — through advances in such areas as information technology, biotechnology, and nanotechnology accelerating over the next 10 to 15 years — the economy will likely experience a continued decline in low-skilled jobs, especially in manufacturing, and a sharp increase in demand for a highly skilled workforce.²⁵⁵ And in a globally competitive marketplace that is highly sensitive to technological change, more emphasis will likely be placed on training and retraining well past entry into the labor force.²⁵⁶

EDUCATION AND TRAINING WILL BE KEY TO AN INDIVIDUAL’S SUCCESS IN THE WORKPLACE.

Today, as well as in the years ahead, education and training will be key to an individual’s success in the workplace. We anticipate that that will be true for veterans, and particularly true for wounded veterans. Student veterans generally, compared with their nonveteran peers, are older, with an average age of 33, and more likely to be the first in their families to attend a college or university.²⁵⁷ A third of the warriors who responded to our 2014 survey were enrolled in school.²⁵⁸ Of those enrolled, nearly two-thirds were pursuing a bachelor’s degree or higher, 24% an associate degree, and 7% a technical degree or certificate. But even when enrolled in school, wounded veterans face hurdles. They report difficulty assimilating on campus and adapting to student life, insufficient or nonexistent accommodations to their disabilities, and lack of understanding on the part of faculty and

SEVENTY PERCENT OF EMPLOYERS COULDN’T IDENTIFY ANY POSSIBLE ACCOMMODATIONS NEEDED BY EMPLOYEES WITH TBI.

fellows students of needs arising from PTSD and TBI. Family issues, finances, and health problems often compound these school-related stresses.

In the first study of its kind, the Student Veterans of America assessed the postsecondary outcomes of this generation’s veterans by examining the academic records of nearly one million student veterans using Montgomery and Post-9/11 GI Bill benefits between 2002 and 2010.²⁵⁹ While the initial results showed strong outcomes for post-9/11 student veterans — almost 52% had earned a postsecondary degree or certificate — the average time for completion for student veterans who first earned a bachelor’s degree was a little more than six years.²⁶⁰



“Guys don’t know how to navigate the system and can be skeptical about being helped. It’s important for veterans who have been there and experienced these issues firsthand to help other combat disabled veterans through the process by educating them and hooking them up with needed resources.”

AUGUST DEBYSER
WWP ALUMNUS



More granular studies highlight the challenges for student veterans. One study found that the “average” student-veteran experienced moderate anxiety, moderately severe depression, significant symptoms of PTSD, and rates of suicidal ideation at 46%.²⁶¹ Nearly 46% of the sample experienced “significant symptoms of PTSD,”²⁶² almost 35% suffered from severe anxiety, and nearly 24% had severe depression.²⁶³ Another study, in which researchers conducted interviews, focus groups, and surveys of student veterans and student service members on their experiences using the Post-9/11 GI Bill, found that most of these survey and focus group participants encountered substantial transition challenges while adapting to life on campus.²⁶⁴ Among these students, one of the most frequently discussed challenges was coping with service-related disabilities and PTSD.²⁶⁵ Overall, about 68% of survey respondents rated the extent to which they had to cope with such disabilities, and of those, 55% reported it as a moderate or major challenge.²⁶⁶ Participants cited such difficulties as being unable to move quickly from one class to the next across campus, hyperalertness and anxiety caused by PTSD, difficulty concentrating due to TBI, and difficulty relating to other students.

WITH MANY EDUCATIONAL INSTITUTIONS FACING PRESSURE TO CONTAIN COSTS, SUPPORT AND FUNDING FOR SPECIAL VETERANS’ INITIATIVES MAY WANE AS THE WARS FADE FROM PUBLIC CONSCIOUSNESS.

Our warriors’ experiences provide vivid snapshots of the kind of challenges student veterans face in higher education. More than half of those WWP Alumni surveyed in 2014 reported that emotional problems had interfered with work or regular activities during the previous four weeks.²⁶⁷ Fifty percent and nearly 61% of those survey respondents reported that physical and emotional problems, respectively, interfered with their normal social activity during the prior four weeks — an important component of overall academic success.²⁶⁸ Wounded veterans entering schools are not simply grappling with adjustment to the demands of higher education. Many are also having difficulties relating to their nonveteran peers. Staff and faculty are typically unaware of their challenges with PTSD, TBI, and other often-severe disabilities. With these issues, wounded veterans face a steeper climb than their fellow students.²⁶⁹

Still other disability-related issues affect warriors on campus. Some may not understand how their injuries affect their learning, and may be unaware what accommodations they need (and might

be able to receive) to be successful.²⁷⁰ While a report found that a growing number of colleges have instituted some type of programs and services for veterans — 62% in 2012, up from 57% in 2009 — there is great diversity in how these institutions serve veterans and in the variety of their programs and services.²⁷¹ Some institutions of higher education have offered particularly meaningful assistance. Examples include providing accessible on-campus mental health staff trained in military culture, counseling, and tutoring services for student-warriors, full-time staff to assist student-warriors, training for faculty on TBI and PTSD, and peer support services. But model programs represent the exception, not the norm. With many educational institutions facing pressures to contain costs, support and funding for special veterans’ initiatives may wane as the wars fade from public consciousness.

The structure, financing, and even missions of higher education will likely continue to evolve, but its cost will continue to be a concern. The cost of a college education has risen much faster than inflation for decades, and this trend is likely to continue. With college costs rising at a rate of roughly 7% for decades,²⁷² one researcher projected the cost for public in-state tuition would be almost \$58,000 a year, while a private school’s tuition would soar to more than \$130,000 a year by 2030.²⁷³ Most Americans realize that a college degree is necessary for upward mobility, yet cost will likely put that degree out of many Americans’ reach.²⁷⁴ A study found that the earnings gap between today’s young adults, or millennials, with bachelor’s degrees and those with just a high school diploma is wider than it was for prior generations. Today, those with only a high school education earn 62% of what the typical college graduate earns.²⁷⁵ The four-year degree has become the one that matters: a graduate with a two-year associate degree can expect only 29% more in annual income than a high school graduate.²⁷⁶

One can foresee that a conflict between demand for higher education and a shortage of affordable options will lead to sweeping changes in higher education.²⁷⁷ Some who simply cannot afford college will look to lower-cost alternatives, or turn to massive open online courses (MOOCs), YouTube for lectures, and other affordable online opportunities.²⁷⁸ Competitors are already exploring markets that aren’t served by the traditional college model, focusing on working adults who want to enhance their skills and lower-income students who are looking for less-costly degree programs.²⁷⁹

The future of higher education, both in terms of its cost and its structure, will have a tremendous impact on veterans looking to further their education. With projections that, by 2020, two-thirds of all jobs will require education beyond a high school degree (up from roughly one-quarter 40 years ago)²⁸⁰ and expectations of continued increases in the cost of education, colleges and universities will be under increased pressure to change. Many see the trend toward online education growing rapidly in both scale and scope. In a Pew



Research Center survey of college presidents, half predict that in 10 years, a majority of undergraduate students will be taking a class online.²⁸¹ Some versions of online learning will replace face-to-face learning in entirety, with other versions supplementing time in the classroom. Tomorrow’s student population is also likely to look much different, as the average age of students can be expected to keep trending higher and the makeup of student bodies is likely to be increasingly made up of minority students.²⁸² Students’ interest in convenience in education will likely be a major driver. Online education and associated technologies offer advantages to older, nontraditional students, enabling students to learn at their own pace, allowing course content to be presented in an array of engaging formats, and permitting students to draw on course materials from schools across the country — not just a single professor or textbook.²⁸³ Some see the for-profit sector and community college models continuing to grow stronger, as they are more nimble and tend to cater to older students who don’t have time for or necessarily want the traditional college experience.²⁸⁴

But the for-profit college industry must do much more to ensure that it is serving veterans rather than being served by Post-9/11 GI Bill funding. As documented in a 2014 report by the Senate Committee on Health, Education, Labor, and Pensions (HELP Committee), for-profit colleges accounted for 31% of students in higher education in this country in 2012, but received \$1.7 billion — almost as much as the total cost of the Post-9/11 GI Bill program in 2009.²⁸⁵ The HELP Committee also found that taxpayers spend more than twice as much to train veterans at for-profit colleges as at public colleges.²⁸⁶ There are for-profit schools that are seen as having solid credentials and a history of success for their graduates. Overall, however, studies have questioned the relative value of a degree or certificate from for-profit institutions. One study found higher rates of unemployment and lower earnings among students who attend for-profit colleges than comparable students from other types of colleges.²⁸⁷ Another study found better benefits for students in associate degree programs at public and not-for-profit institutions.²⁸⁸ Of particular significance to WWP, for-profit schools often lack the academic and counseling support services that many injured service members need to thrive while undertaking higher education. Additional student loans and GI Bill money is typically spent on programs that don’t provide job skills or classroom credits that other schools recognize. This current model will not foster the well-adjusted, economically successful generation of veterans that WWP pursues and in which our nation is investing.

For veterans pursuing postsecondary education using the Post-9/11 GI Bill or other government education benefits, the rising costs of higher education would certainly impact them in their choice of school. The Post-9/11 GI Bill will cover up to 36 months of in-state tuition at all public schools.²⁸⁹ Congress passed legislation

in July 2014 requiring public universities to limit tuition costs for Post-9/11 GI bill beneficiaries to in-state tuition rates.²⁹⁰ There remains a financial cap on Post-9/11 GI Bill tuition for private schools.²⁹¹ When the average time for completion of requirements for a bachelor’s degree for a student veteran is six years, the rising costs of a college education become a severe problem. Because of this, some veterans may look to more affordable options. Reliance on distance or online learning may be especially attractive to veterans because of its affordability and flexibility. But for those having trouble reintegrating back into their communities or on campus, the choice of an online learning environment runs the risk of social isolation and difficulties assimilating to life as a student.

TECHNOLOGY TRENDS

Reflecting on the past decade, and the importance of technological advances to economic growth and global competitiveness, we can feel confident that the next decade will bring unforeseeable scientific breakthroughs and new technologies. Innovation and broader dissemination of existing and new technologies will surely be powerful forces in shaping the future. The more apparent of these coming advances, however, will likely build on many of the far-reaching technological developments and applications of the past decade. These developments include broadband connectivity, mobile devices, and social media, each of which sets a foundation for future inventiveness and entrepreneurship that will likely influence and shape the years ahead.²⁹² Importantly, however, these technologies have blurred the lines between private and public lives, between home and work, and between being a consumer and a producer of information.²⁹³

Broadband connections have brought increased information-sharing capabilities to millions of people at faster speeds than ever. Once connected via broadband services, people began doing more online, from creating videos to developing online platforms and broadcasting forums (YouTube, Facebook, Twitter, LinkedIn, Pinterest, etc.). With the boost in internet speeds and usage from broadband, mobile devices have become ubiquitous. Faster speeds from broadband, coupled with interconnectedness through mobile devices, have paved the way for new social media platforms and social networking. Real-time connectivity, now possible through multiple platforms, is changing the way people interact. In 2014, nearly 73% of internet users used social media in some form.²⁹⁴

While these technologies appear to be here to stay, their proliferation and further technological advancement through the next decade will likely occur at an unforeseeable rate and scale. Already, technological advances in cloud services and computing, mobile devices and applications, and big data analytics have changed society in significant ways. More advances are likely on the horizon, increasing concerns about cybersecurity, especially as the government adopts new technologies into its standard practices.



Cloud services and computing: Cloud services technology is the process of storing and accessing data and programs over the internet instead of on a computer hard drive.²⁹⁵ This technology synchronizes data, improves data storage reliability and scalability, and increases the ease of integrated, anytime-anywhere access to applications and collaborative services. Over the next decade, mobile and cloud computing will likely converge to create a new platform, one with the potential to provide unlimited computing resources. This third platform would release existing restrictions on mobile devices by increasing their memory, processing power, and battery life.²⁹⁶

Mobile devices and applications: Mobile devices and applications surround us. As of 2014, approximately 98% of Americans use cellphones, 78% use laptop computers, 58% use smartphones, 35% use tablets, and 32% use e-readers.²⁹⁷ At the end of 2013, there were over one million applications (apps) available for download.²⁹⁸ Mobile technology is connecting people and things in myriad ways, converging the physical and digital worlds,²⁹⁹ a trend likely to continue.

Big data and analytics: The proliferation of mobile devices, apps, cloud data storage, and online accounts has created enormous amounts of data. While some argue that the technology world does not have the ability to put the massive amounts of data gathered into meaningful perspective³⁰⁰ and others see frightening invasions and loss of personal privacy, another view sees benefit:

Smartphones contain a rich record of people’s activities, including who they know (contact lists, social networking apps), who they talk to (call logs, text logs, emails, etc.), where they go (GPS, Wi-Fi, and geo-tagged photos, etc.) and what they do (apps we use, accelerometer data, etc.). Using this data and specialized machine-learning algorithms, detailed and predictive models about people and their behaviors can be built to help with urban planning, personalized medicine, sustainability, and medical diagnosis.³⁰¹

Less expensive, more agile, more collaborative, and adaptive methods for analytics and data sharing are likely to lead to predictive apps able to respond in real time, anticipate user actions, and meet users in their moment of need.³⁰²

Cybersecurity: Although social networks, interconnectivity, and real-time predictability bring numerous advantages, there are also considerable cybersecurity and privacy concerns as a result of these advancements. Criminality in the form of cybertheft, cyberfraud, and personal identity security is very likely to continue to prey on vulnerable systems and individuals.³⁰³ An already robust cybersecurity industry is likely to grow further.

E-government: Technology’s convenience, utility, efficiency, cost savings, universal application, and reach has moved us into electronic government: the use of information and communication technology (ICT) to provide and improve government services, transactions, and interactions with citizens, businesses, and other arms of government.³⁰⁴ This trend appears irreversible, with implications for veterans.

We expect the next decade to see further shifting from traditional modes of delivering services toward online service delivery, with efficiency and cost-cutting likely trumping quality of service delivery. Already this shift is evident in education, benefits-delivery platforms, and certain areas of medical care.

Where once a veteran might have been able to rely on a conversation with a VA employee to understand the range of benefits to which he or she is entitled, today that veteran is more likely to be directed to VA’s website. The road map of that formidable website, its site index, includes, as of April 2014, a list of 115 high-level pages. VA also maintains a robust presence on social media platforms, with official accounts on Facebook, Twitter, Flickr, and YouTube, and an online blog, “VAntage Point.” In addition to already-available mobile applications for smartphones and tablets, VA plans to create a VA App Store, where one will be able to download those and forthcoming VA Mobile Health Apps.³⁰⁵ Similarly, DoD maintains well over 600 official websites, and social media accounts on all of the aforementioned platforms.³⁰⁶ DoD is partnering with vendors so that as its cloud services develop, its programs can be accessed from mobile devices.³⁰⁷ In January 2014, DoD’s mobile device program supported 16 apps and was in the process of screening more than 90 others.³⁰⁸

Today’s VA emphasizes technology and online service delivery at unprecedented levels. VA’s IT budget request doubled between 2008 and 2014,³⁰⁹ demonstrating a commitment to bringing VA “into the 21st century.”³¹⁰ Within this focus on technology, VA’s Innovation Initiative has aimed at automating GI Bill benefits; attacking the claims backlog by, among other means, making records electronic;³¹¹ and developing a virtual lifetime electronic record for each service member.³¹² The movement to online service delivery, or “paper war,”³¹³ is intended to streamline benefits and claims processing and wait times, improve processing accuracy, and save money.³¹⁴

Presently, veterans conduct education benefits applications and transactions almost exclusively online. This has resulted in faster processing of benefits claims³¹⁵ and cost savings.³¹⁶ We anticipate that VA will continue to administer these benefits online and that the robust industry of online classes will continue to thrive and reach veterans into the next decade.³¹⁷



Despite a decade of cost overruns and delays,³¹⁸ it seems likely that, in the next decade, VA will continue to develop online medical care delivery through My HealthVet,³¹⁹ and DoD will advance its VistA Evolution platform. Eventually, the two departments will implement the long-delayed, interoperable³²⁰ individual electronic health record (iEHR)³²¹ and realize their goal to “facilitate health information exchanges between DoD and VA health facilities to have service members’ and veterans’ health information available throughout their lifetime, while maintaining privacy and security of that information.”³²² Further expansion of the use of electronic medical records will likely pave the way for greater health information exchanges, care coordination, and patient mobility between the DoD and VA healthcare systems as well as those in the private sector that provide healthcare to veterans.

With many veterans having dual and greater healthcare eligibility (VA and Medicare, for example), and in many cases utilizing VA medical facilities for only certain healthcare needs,³²³ it seems likely that concerns regarding care coordination and cost containment will ultimately lead to electronic connectivity between VA and community facilities as well. Such connectivity or connectivity potential might ultimately facilitate degrees of integration between VA and community healthcare facilities, or conversely, steps toward such integration may be a catalyst toward developing such electronic connectivity. Telehealth, already vibrantly deployed in VA, may be one dimension of greater connectivity between VA and non-VA healthcare, but is certainly one aspect of service delivery that is likely to continue to grow and flourish in the next decade.³²⁴

From the joint VA-DoD eBenefits web portal³²⁵ to the Veterans On-Line Application (VONAPP)³²⁶ to an integrated, one-stop online employment center for transitioning veterans,³²⁷ benefits delivery is going digital. Going from paper to digital³²⁸ is the primary means by which VA intends to combat the disability benefits claims backlog. The over two million veterans of the wars in Iraq and Afghanistan, coupled with an unanticipated number of Vietnam veterans, have generated unprecedented levels of veterans disability benefits claims in the last decade. As of April 2014, the number of disability claims in pending status for more than 125 days — the benchmark for the claims backlog — was 319,363, with more than 596,000 veterans awaiting VA adjudication.³²⁹

To eliminate the disability claims backlog and process all claims in 125 days with 98% accuracy by 2015,³³⁰ VA is feverishly working to digitize all benefits claims.³³¹ In 2010, VA began to develop the Veterans Benefits Management System (VBMS), a paperless claims processing system intended to convert existing paper-based claims folders into electronic claims folders and allow VA employees electronic access to claims and evidence. While

technical challenges have delayed launch of VBMS nationally, WWP anticipates that VBMS will significantly advance in the next decade.

WWP recognizes and appreciates the advances technology can bring to service delivery and claims adjudication. But as VA and DoD continue to build out streamlined, technologically based systems and capabilities, they must also be mindful of those they serve. VA’s troubled experience with a longstanding claims backlog is an inescapable reminder of the need for change. The backlog highlights both inefficiencies in the system and opportunities for shrinking that backlog through smart use of technology and streamlining. Fundamentally, this system must serve veterans who have incurred disability in service. Some wounded veterans do not have access to this technology, some may not be computer literate, and some may be anxious about or otherwise uncomfortable with using these technologies. It may not optimize efficiency, but VA and DoD must accommodate this population, not the other way around.³³²

VA’S TROUBLED EXPERIENCE WITH A LONGSTANDING CLAIMS BACKLOG IS AN INESCAPABLE REMINDER OF THE NEED FOR CHANGE.

Overall, online services lead to increased access to services, greater transparency, and cost savings.³³³ But, with more than 700 websites to choose from, it is easy to imagine a new veteran becoming lost in a sea of online information. We should also anticipate that technological challenges like information security³³⁴ will continue to be a concern for injured service members moving into the next decade and beyond.³³⁵

While it is hard today to imagine a world without online-only exchanges, mobile apps, smartphones, cloud services, or a world before omnipresent social media, we must recall that some of these concepts were budding ideas only a decade ago. Not long ago, a firm handshake, good eye contact, and one’s solemn word opened doors for advancement for many in America. Now, however, the proliferation of technology and our country’s growing reliance on email, text messages, and computers have made it much more difficult to directly interact and communicate with others. In some cases, technology obviates the need for in-person interaction. This trend appears irreversible. Projecting ahead, tech savviness will no longer be simply an asset, but an economic, governmental, civic, and social necessity.



In the next 10 years, we will also likely see diminishing in-person interactions as online social networks grow and technology permeates business, government, and other services. Already evident in 2014, computer screens will increasingly become another barrier between those seeking and those providing services, information, or human interactions. As a provider of benefits and services, it will be particularly important for VA to prevent technology from creating a less compassionate workforce as staff have less and less personal interaction with veterans. While interconnectivity and the accessibility inherent in online services and exchanges can be empowering, some wounded veterans will likely not see these benefits. For example, some who live with invisible wounds, such as TBI and PTSD, may have comprehension difficulty, or experience a high degree of frustration or heightened concern over the perceived loss of privacy associated with certain technologies.³³⁶ With the growing importance of these technologies, veterans whose injuries preclude them from participating online may encounter real barriers to full reintegration, potentially shutting off avenues to social discourse, education, healthcare, and more.

Finally, technological advances have for years led to ever-greater automation of work and to elimination of blue-collar jobs. That trend will likely not abate, with significant implications for those who, without a college education or technical skills, might in the past have gravitated to and found blue-collar jobs or similar entry-level positions.³³⁷

CHANGING GOVERNMENT POLICIES AND PROGRAMS

Even as the government continues to embrace technological solutions, we anticipate that the next decade will bring significant changes in government policies and programs, with potentially far-reaching impact on injured veterans and their families and caregivers.

The past decade illustrates the point. Recognizing the needs of injured veterans and their caregivers, Congress established major new programs, including the Post-9/11 GI Bill, which expands opportunities for warriors to obtain higher education or to transfer entitlement to family members, the TSGLI program, and a comprehensive caregiver-assistance program. We should anticipate policy changes of no less magnitude over the course of the next decade. At the same time, the federal government between 2009 and 2012 recorded the largest budget deficits relative to the size of the economy since 1946, according to the Congressional Budget Office (CBO),³³⁸ causing federal debt to soar and sparking wide-ranging efforts to rein in federal spending.

Future federal budgets will substantially influence and potentially even limit the assistance, support, and opportunities afforded to warriors and their families and caregivers in the future. The budget trajectories for the coming decade are unlikely to mirror the trend lines of the preceding 10 years. For example, budget laws have capped funding for national defense through 2021 to a degree some have characterized as “crippling,”³³⁹ and led the defense secretary to characterize them as leading to “tough, tough choices.”³⁴⁰ In this fiscal climate, programmatic areas that do not directly support DoD’s primary war-fighting mission, such as healthcare and transition assistance, will surely face fiscal scrutiny and potential elimination. To illustrate, the CBO, which provides Congress options for reducing federal spending, reported earlier this year that DoD’s cost of providing healthcare (\$52 billion in 2012) has increased rapidly as a share of the defense budget over the past decade. CBO described that increase as outpacing three measures: growth in the economy, growth in per-capita U.S. healthcare spending, and funding for DoD’s base budget.³⁴¹ CBO observed that war-related funding may continue into future years, but represents a small fraction of defense health spending and is not likely to contribute to future growth.³⁴² Rather, CBO attributes most of the rapid growth in military health costs to new and expanded TRICARE benefits and increased utilization of those services.³⁴³ Warning that continued military healthcare costs could force DoD to cut spending in such areas as force structure, readiness, and weapons modernization, CBO suggests that, of the options it has examined, only increased cost sharing for retirees who use TRICARE can generate significant savings. But with skepticism in some quarters that such cuts could be realized, other areas of DoD health spending may be vulnerable. CBO’s view that DoD could “administer the military healthcare system more effectively” assumes that “DoD could alter its operations without affecting patients directly.”³⁴⁴ Its suggestion that DoD could, for example, reduce spending on military medical education by closing the Uniformed Services University of the Health Sciences and expand its scholarship program³⁴⁵ hints at the potential that budget cutting would lead to shedding unique assets and programs that contribute to excellence in military medicine, including programs that have supported injured veterans’ rehabilitation.

The likelihood of a diminished future DoD role in support of warriors and caregivers should not be considered in isolation. Departments that have supported warriors, caregivers, and veterans generally in partnership or in parallel with DoD are likely to face budgetary storms of their own. Not only VA, but the Department of Labor, the Department of Housing and Urban Development, and the Substance Abuse and Mental Health Services Administration have all supported important veterans programming, and are all heading into a tighter budget environment under discretionary budget caps.



VA’s role is certainly critical. As with Congress’ expanding TRICARE benefits, enactment of a 1996 VA eligibility-reform law sparked a rapid climb in the number of veterans VA treated, from 2.9 million in fiscal year 1995 to 4.5 million in 2003.³⁴⁶ While VA has enjoyed significant budget increases during the course of U.S. overseas military operations, particularly for its healthcare system, discretionary budget caps could certainly lead to a change in VA’s budget trajectory.

Congress has long been protective of veterans’ benefits, and over the course of the wars in Iraq and Afghanistan, VA has generally seen annual increases in funding for its major programs. But history suggests a degree of ebb and flow. Budget reconciliation acts in the 1990s, for example, saw cuts in veterans’ benefits.³⁴⁷ Relatively tight VA funding during the 1990s led to what one commentator described as healthcare rationing, explaining that:

*Over a nine-year period from 1990 to 1999 ... incidences of chronically ill veterans increased dramatically nationwide because many did not receive [VA] medical services for their ailments. The failure of Congress and the president to increase appropriations to the department greatly contributed to the situation.*³⁴⁸

Budget caps will increase VA’s vulnerability to cuts in funding, or at least to straight-lined budgets that will not support prior-year program service levels (with longer waits for services, reemergence of adjudication backlogs, etc.). This type of budgetary environment could play out in many ways, from apportioning cuts by a fixed percentage across the board to more targeted measures that seek to insulate, to as great an extent as possible, direct services to veterans at the expense of less visible spending (facility maintenance and construction, employee travel, training, etc.).

THE NEXT DECADE WILL BRING SIGNIFICANT CHANGES IN GOVERNMENT POLICIES AND PROGRAMS, WITH POTENTIALLY FAR-REACHING IMPACT ON INJURED VETERANS AND THEIR FAMILIES AND CAREGIVERS.

Were VA to face still tighter budgets, the CBO has proposals on hand for more dramatically lowering VA spending. Among its menu of discretionary spending budget reduction options, CBO includes, for example, ending VA enrollment of veterans in the two lowest priority-enrollment groups. These groups, higher-income veterans and those who have no special eligibility, are projected to cost the VA more than \$4 billion annually, or about 8% of total medical care spending.³⁴⁹ It bears noting that several programs with high priority for injured warriors and their families, including VA mental health services, TBI rehabilitation, and the comprehensive caregiver assistance program, have no dedicated budget lines, and, as such, are vulnerable to across-the-board cuts.

CBO also includes several proposals for cutting mandatory spending, such as Congress has carried out in earlier budget reconciliation acts. Among these are eliminating concurrent receipt of military retirement pay and disability compensation for a 10-year savings of \$108 billion.³⁵⁰ There’s also the consideration of narrowing eligibility for veterans disability compensation by excluding conditions unrelated to military duties such as multiple sclerosis. This could result in 10-year savings of more than \$20 billion.³⁵¹

Health and budget analysts have certainly examined utilization patterns of veterans enrolled in VA’s healthcare system as well as other federal healthcare programs (Medicare, Medicaid, and TRICARE). VA analysis of 6.5 million veterans who received healthcare coverage under VA, Medicare, or Medicaid in fiscal year 2006 found that approximately one-third used more than one system of care.³⁵² Some have observed that using multiple systems raises concerns regarding fragmentation of care and may contribute to diminished quality of care. But another argument is that the inherent inefficiency of such a system is an incentive for veterans to adhere to a single federal benefit. The suggestion is that cost savings could be achieved if veterans could be induced to use either Veterans Health Administration (VHA) or non-VHA care. This could be accomplished by either reducing VA’s attractiveness or increasing the rewards of an alternative like Medicare by waiving annual copayment requirements or monthly subscription fees.³⁵³

While it is difficult to imagine Congress directly cutting veteran benefits, numerous factors could influence funding declines and healthcare delivery practices. Some examples include a declining veteran population, aging VA infrastructure, changing expectations about benefits and service delivery, and the end of military operations in Afghanistan. To illustrate, the president’s FY 2015 Budget for VA reflected the first indication that the war’s wind down would bring funding cuts, with VA proposing to cut funding for TBI care. Under questioning, VA’s undersecretary for health characterized the cut as “good news,” citing a decline in numbers of new cases of severe TBI.³⁵⁴



Potentially still more far reaching, the veteran population is shrinking. A population of some 22 million today will decline to a projected 18.7 million in 2024, and to 14.5 million in 2040. Vietnam-era veterans, the largest cohort today at 33.4%, will decline to 8.9% in 2040. Gulf War veterans, inclusive of post-9/11 veterans, will represent the largest proportion of veterans in the next decade, with 44%, climbing to a projected 55% by 2040. That steady decline raises the question: can VA's healthcare system maintain a patient population of sufficient size to remain viable over the long term? The ACA imposes no obligations on veterans who have enrolled for VA healthcare services, but does expand insurance coverage options available to many VA healthcare enrollees.³⁵⁵ Under the ACA, a veteran who is eligible for VA coverage may choose between enrolling in VA coverage or enrolling in coverage through a healthcare exchange and, if eligible, receiving a tax credit that reduces the monthly premium of a health insurance plan purchased through that exchange.³⁵⁶ Analyzing the potential impact of the ACA on veterans, former Undersecretary for Health Dr. Ken Kizer observed that VA enrollees with non-VA health insurance are



“Who wants to travel three hours to a VA medical center, to wait two hours, only to be seen for 20 minutes?”

JASON JOHNS
WWP ALUMNUS

known to use less VA care than those having only VA coverage, so expanding health coverage for veterans may decrease use of VA facilities.³⁵⁷ Currently, most veterans do not get their care through VA. As one might expect, convenience plays a role in veterans' choice of VA care, with one analysis showing that veterans living more than an hour from a VA hospital were more than four times as likely to use a non-VA hospital than those living closer. Veterans who have coverage options other than VA are reported to use VA care for a much smaller portion of their care than those who do not.³⁵⁸ Such data leads some to project that VHA utilization may decline somewhat in the future, assuming younger veterans will get coverage through ACA.³⁵⁹ However, VA officials have projected a net gain of 66,000 new VA enrollees.³⁶⁰

CAN THE VA HEALTHCARE SYSTEM REMAIN VIABLE OVER THE LONG TERM?

While the VA healthcare system has expanded its reach over the course of nearly 20 years by establishing primary-care clinics across the country, VA's medical centers — more than 100 of which are sites of research and education as well as patient care — remain in many respects the heart of the system. Yet even VA's undersecretary for health acknowledged in 2013 that “on average, VA-owned assets are more than 60 years old,” and described the challenges of planning for VA's “aging infrastructure.”³⁶¹ According to Jim Sullivan, director of VA's Office of Asset Enterprise Management, the implications of failing to fund VA's construction budget adequately are that “VA's aged infrastructure will continue to degrade, facilities will become more obsolete as technology and healthcare and benefits modes of delivery evolve and change, [and] improvements to safety, security, access, space realignment will be hampered.”³⁶² Sullivan indicated that VA's 2014 Strategic Capital Investment Plan had identified \$54 billion in capital needs. Sullivan conceded that assuming continued funding at the level requested for FY 2014, VA would not realize the needed funding for more than 22 years, a projection that did not take account of the further degradation that would occur in VA's aging infrastructure.³⁶³ With VA construction budgets (in the words of the 2015 Independent Budget report) “falling behind” in meeting known safety, utilization, and access needs,³⁶⁴ one sees little evidence of a vision for meeting those needs. The department's current strategic plan sets goals that include improving veteran access to VA services, but its only apparent strategy for achieving that goal is to increase the efficiency and effectiveness of virtual access to care.³⁶⁵ That step alone, while a reasonable component of a strategic plan, especially with a significant population residing in rural areas and distant from VA medical facilities, does not appear to offer a comprehensive answer as long as modern healthcare facilities continue to play a prominent role in healthcare



delivery. With VA's statutory responsibility “to provide a complete medical and hospital service for the medical care and treatment of veterans,”³⁶⁶ the department surely needs to develop a more broad-based strategy than just expanding virtual care. Despite the troubling implications of these intermediate and longer-range concerns, they have evoked little, if any, evident handwringing.

What does appear to be a significant development is a VA strategy to enhance VA partnerships with federal, state, private-sector, and academic affiliates, and veteran service organizations and nonprofit organizations. As described in VA's strategic plan that identifies enhancing and developing trusted partnerships as one of three strategic goals for FY 2014-2020, the department:

*[W]ill leverage responsible and productive partnership opportunities that can supplement VA services and help fill urgent or emergent gaps in services. We will pursue opportunities for partnering with organizations that can best provide what we cannot or should not.*³⁶⁷

VA states that such partnerships will “augment VA care, services, and benefits” and “will fill new, emerging, and unmet needs of veterans when and where services are not available.”³⁶⁸ It is not clear whether VA's objective is solely to fill gaps that lie outside the scope of VA's responsibility, or whether it represents an implicit acknowledgement that the department cannot provide all eligible veterans all the services those veterans may need in all places. That is a reality and, as evidence has confirmed, veterans already experience some degree of rationing of services today, whether in the form of long wait times for primary and specialty medical appointments, long delays in adjudication of claims, or lack of access to community-based TBI rehabilitative supports. A period of constrained budgets would almost certainly widen such gaps and at the same time heighten the importance of identifying partners who could step in and either help VA carry out its mission or fill a void that VA may be leaving in particular communities or areas.

VHA took a promising first step in 2013 in mounting a series of community “mental health summits,” which were described as an initiative “to help build or sustain collaborative efforts with community providers to enhance mental health and well-being for veterans and their families.”³⁶⁹ While these summits were initiated with considerable fanfare, VA medical centers were, unfortunately, given neither direction on how or whether to follow up on that initial effort, nor funding with which to build on its overture. With no evidence that the seeds of those initial summits have taken root, it is difficult to assess what a full-throttled effort to enhance partnerships might yield. One could imagine, for example, VA building closer partnerships with affiliated healthcare teaching institutions and with other institutions of higher education in proximity to VA facilities, and potentially even a network of collaborative symbiotic partners in certain metropolitan

areas. The opportunity for VA to develop rich, robust partnerships that can fill gaps and provide services and supports would seem to vary widely from community to community with the availability of local resources. With some of the widest gaps facing veterans who live in rural areas, which often are not resource- or potential-partner rich, one could question the extent to which fostering partnerships can be an effective national strategy.

Overall, one can foresee tension in the coming years between the promises that have been made to the country's 22 million veterans and the deficit-reduction-focused budgetary machinery and resultant limitations in programmatic resources. Those budgetary forces are likely to frustrate some of those expectations, and might ultimately lead or contribute to far-reaching structural changes, programmatic downsizing, or even changes in eligibility for some veterans or retiree programs. Other unforeseen trends over the course of the next decade — technological, medical, economic, or societal, for example — could conceivably alter more fundamentally the structures or mechanisms through which government supports veterans and their families. While the course of a decade will necessarily bring far-reaching changes, we can anticipate at least one constant: this country's obligation to those wounded, ill, and injured in post-9/11 service, and their families and caregivers.

OVERALL, ONE CAN FORESEE TENSION IN THE COMING YEARS BETWEEN THE PROMISES THAT HAVE BEEN MADE TO THE COUNTRY'S 22 MILLION VETERANS AND THE DEFICIT-REDUCTION-FOCUSED BUDGETARY MACHINERY AND RESULTANT LIMITATIONS IN PROGRAMMATIC RESOURCES.

4 » CHALLENGES AHEAD

CHALLENGES AHEAD »

Attempting to look ahead a decade, and taking account of heightened risk factors as well as the insights of warriors and caregivers themselves, we anticipate profound needs and challenges that compel this organization's and policymakers' attention. While WWP and its programs will undoubtedly help thousands of injured service members excel and thrive — and many of those warriors will help more of their peers do the same — still others seem likely to face serious, even grave problems.

For a generation of combat veterans, many of whom experienced more than one deployment, the passage of a decade will bring early onset of chronic health conditions. Some conditions are due simply to aging, but others, including diabetes, cardiovascular disease, and traumatic arthritis, are secondary to service-incurred conditions. There is also the risk of illness associated with war-related toxic exposures.

For some, the largely invisible wounds of war seem likely to have deeper, more insidious, and more long-lasting effects on the warriors and their families than even the horrific physical injuries so many have suffered. Our experience is that warriors have generally overcome or learned to live with loss of limbs or other devastating physical injuries. But those with invisible wounds, often co-occurring chronic PTSD and other war-related mental health conditions, TBI, chronic pain, and substance abuse or dependence, are at far greater risk of chronic, downward-spiraling problems.

We know that early treatment of one of the most common residuals of war, PTSD, can be effective in overcoming that condition. But approximately one in two OEF/OIF veterans have not pursued much-needed treatment and many drop out of treatment.³⁷⁰ We see no evidence to suggest major changes in those trends. Often, substance use and abuse become substitutes for treatment and exacerbate rather than relieve problems. Chronic pain and TBI, widely prevalent among injured veterans, not only compound the problem, but complicate treatment. Yet without effective treatment, there is a high risk of PTSD and other conditions worsening and potentially becoming chronic. This can contribute to other adverse health outcomes, impair social relationships and fracture family bonds, lead to unemployment, and heighten the risk for homelessness.



“In addition to relearning motor skills, it’s equally critical for those with severe brain injuries to successfully reintegrate into the community. Restoration of impulse control, judgment, and mood stabilization are just some of the key behaviors that need to be addressed for them to ‘fit in’ socially.”

PAM ESTES
CAREGIVER
PICTURED WITH HER SON, JASON EHRHART

For those who have suffered polytrauma, we may look back after a decade to mark the success of rehabilitative medicine on restoration of lost function. But for veterans who have sustained severe brain injuries, current trends also suggest that rehabilitative medicine will not have invested significant effort toward stabilizing behavioral functioning and will not approach the degree of improvement achieved in restoring biomechanical capabilities. Yet for those with severe brain injuries, restoration of impulse control, judgment, mood stabilization, and other dimensions of social living are at least as critical to successful community reintegration as relearning motor skills. Most are not getting help with those behavioral issues, and

FIFTY PERCENT OF OEF/OIF VETERANS HAVE NOT PURSUED NEEDED MENTAL HEALTH TREATMENT; OTHERS ARE LEAVING TREATMENT PREMATURELY.



“Plateaued?’ I don’t listen to that. What kind of guy wants to hear he’s plateaued? Not me. I think everybody should [have aspirations to move forward].”

JASON EHRHART
WWP ALUMNUS



there is little to suggest a course change in the years ahead. Absent such a change, most veterans with severe brain injury will continue to need near-full-time caregiver support. The demands of such caregiving will likely continue to take a toll on families, a toll that will only grow over a decade.

A WWP-won change in law³⁷¹ calls for VA to provide veterans who have sustained severe brain injuries all possible means to achieve their fullest potential through support for rehabilitation and the kind of community-based supports the WWP Independence Program provides. Through the WWP Independence Program, warriors are provided an individualized plan that focuses on their goals for the future and draws on community resources, including rehabilitation and life coaches, to make that plan a reality. But VA’s failure to implement that law, and clinicians continuing to curtail further rehabilitative services when a warrior is perceived to have “plateaued,” may continue to thwart warriors with further rehabilitation potential.

Many of our warriors have not only experienced injury, wounds, and illness, but also lost their sense of purpose after their military careers unexpectedly ended. For many, the promise of seamless transition has been empty, reintegration has remained elusive, and their lives have lacked clear direction. Some have encountered difficulty in finding jobs or have found work with only minimal reward or satisfaction. Generous education programs and vocational rehabilitation programs have offered paths forward, and some have taken those paths and experienced success. Warriors pursuing those programs have also encountered barriers, failed to gain the accommodations or support they may have needed, or simply haven’t been ready or willing to pursue those avenues. It’s likely that future economic success will require workers to

continue to learn new job skills to keep pace with an increasingly complex and demanding labor market. This places a subset of injured veterans at risk of being without optimal or even necessary skills, thereby experiencing even higher levels of unemployment or employment at a job below their skill level.

Many veterans are realizing and will continue to realize a successful reintegration. However, we can anticipate that, without major intervention and course correction, a decade from now, journalists will likely be writing about a cohort of “lost warriors.” Even as WWP works successfully with growing numbers of wounded veterans, some remain disengaged or continue to struggle. Mindful of the obligation we owe them, the country must take steps to reverse foreseeable trends. Absent such steps, we can expect to see a cohort of veterans who never regain a sense of purpose after injury, who sustain themselves on disability compensation or marginal work, whose war demons lead them to lives of isolation, and who age too quickly as a result of untreated war-related health problems.

WITHOUT MAJOR INTERVENTION AND COURSE CORRECTION, A DECADE FROM NOW JOURNALISTS WILL LIKELY BE WRITING ABOUT A COHORT OF “LOST WARRIORS.”

5 » GUIDING PRINCIPLES

PRINCIPLES TO GUIDE POLICY FORMULATION »

Many among this generation of injured veterans are resilient and will continue to thrive, but policymakers must take account of strong evidence that many post-9/11 veterans will continue to experience, or will develop, serious problems that are linked to their service-incurred wounds, illnesses, and injuries. We can anticipate that some will need ongoing support to overcome the residual effects of injury, to realize their goals for recovery, and to discover and forge new life paths. As other problems may not fully emerge for years or may elude early resolution, there may be too many variables and uncertainties to permit policymakers or advocacy organizations to craft specific forward-looking proposals with any confidence that they will reach the target. But it is not too soon to formulate principles that should guide policymakers as they anticipate veterans' needs a decade from now.

Principles are themselves statements of values. We look, therefore, to the WWP core values; its ethos of one warrior carrying another; and its strategic plan as starting points for our search. Extended and deep dialogue with our warriors and caregivers—our most important stakeholders—has contributed greatly to this document and its articulation of values. We recognize in this inquiry that we cannot predict the future other than to acknowledge that change will be a given. Given that, we do not cling to a vision of immutable government programs, structures, or benefit systems. To insist on ensuring the permanence of today's system architecture and programs in the face of surrounding dynamic change would be irresponsible. It would also be to ignore the limitations and inefficiencies of some of those systems and programs. Rather, we seek to identify the principles that should govern how those changes occur, with the objective of ensuring that this country meets its obligations to wounded, ill, and injured veterans and achieves this organization's vision. We look to the following principles to guide us toward that goal:

GOVERNMENT PERFORMANCE

While it is important to measure and evaluate the performance of government programs, the most relevant measure of performance with respect to assisting our wounded, ill, and injured veterans must be based on the primary objective: the success those veterans have in reintegrating successfully into the community.

Helping service-disabled veterans reintegrate into the community with maximum independence and a rekindled sense of purpose will require a coordinated, integrated delivery of services to meet individual needs. These services include health, education, vocational, housing, peer support, and compensation benefits.

HEALTH

Rehabilitation and timely, effective treatment of service-connected injury or illness is a critical first step to successful reintegration, and particularly in the case of a very serious brain injury, rehabilitation should be understood as an ongoing process that only really begins upon return to the community, and that necessarily requires provision of community-based services and support to achieve individual goals.

The seamless transition of case management for a service-disabled veteran moving from DoD to VA is necessary to keeping the veteran on an upward reintegration track.

Service-connected injuries are often complex, and successful treatment may require an innovative, integrated, and multidisciplinary approach to health and wellness.

An innovative approach to health requires a flexible and responsive healthcare system, which purchases services not available in-house from the best-qualified industry providers. Promoting increased focus on behavioral health, rehabilitation, pain management and prosthetics will encourage treatment advancements that will meet the specialized needs of service-disabled veterans.

Service-disabled veterans suffering from PTSD require holistic treatment for the physical, mental, and spiritual effects of trauma. Veterans require varied treatment options to find the right mix and delivery of services that meet their individual needs.

Some service-disabled veterans will require long-term support to realize their recovery goals from injuries and to forge new life paths, a journey that should include ongoing case management, as needed, to achieve individual goals.

COMMUNITY

Community services and support are essential for disabled veterans, especially those with severe injuries, to achieve individual goals.

Peer mentoring and peer support are vital to the successful reintegration of service-disabled veterans.

6 » MEETING THE CHALLENGE

MOBILIZING TODAY TO MEET TOMORROW'S CHALLENGES »

JUST AS IT IS TIMELY TO ESTABLISH PRINCIPLES THAT SHOULD GUIDE THE DEVELOPMENT OF FUTURE POLICY, IT IS NOT TOO EARLY TO TAKE STEPS TO AVERT FORESEEABLE TRAGEDIES. ACCORDINGLY, WE CALL ON VA, DOD, THE WHITE HOUSE, CONGRESS, THE BUSINESS COMMUNITY, SCHOOLS OF MEDICINE AND ALLIED HEALTH, AND COMMUNITIES ACROSS THE COUNTRY TO TAKE ACTION ON A SET OF SPECIFIC MEASURES (BELOW). THESE COMPLEMENT PROPOSALS WE HAVE BROUGHT TO CONGRESS AND REITERATE IN THE APPENDIX.

WE CALL ON VA TO:

- ★ **Prioritize and Treat Wounded Veterans:** From its infancy, this country has provided for those disabled in war. Today, with the Department of Veterans Affairs having many programmatic responsibilities and sometimes competing priorities, we call on the department to reaffirm and reinforce its founding mission of caring for those wounded in battle. Meeting the treatment and rehabilitation needs of veterans who have been injured or developed illnesses in service must be VA's top priority. Consistent with that fundamental mission, and with increasing evidence that VA healthcare funding will not likely keep pace with demand for VA healthcare services, we call on VA to: (1) give demonstrable priority in both healthcare scheduling and programmatic policy to the treatment and rehabilitation of service-connected veterans, and (2) establish funding priority for such programming as well as for deployment health-related programs and caregiver support.
- ★ **Build a 21st-Century VA:** With today's brick-and-mortar-based VA healthcare system at risk of becoming obsolete because of the age and location of its facilities with respect to veteran demographics, a changing healthcare landscape, and changing expectations of veterans, we call on VA to begin now to plan for fundamentally restructuring that system in a manner that retains its unique capabilities while enabling those wounded, ill, or injured in service access to optimal care, whether directly or through contract arrangements.
- ★ **Expand Long-Term TBI Rehabilitation Care:** VA's failure to implement a law aimed at improving long-term rehabilitation of veterans with traumatic brain injury and in 2014, for the first time, proposing to shrink funding for traumatic brain injury care are sentinel events. Together, they show insensitivity to the potential for veterans with TBI to continue to make rehabilitative gains toward maximizing their independence, a potential being realized daily by veterans participating in the WWP Independence Program. The nation owes those with service-incurred TBI

every opportunity to return to a life as independent and productive as possible. With studies having found that as many as 45% of individuals with a severe TBI are poorly integrated into their community, and with social isolation a persistent problem, rehabilitative services must be far more encompassing than a focus on regaining lost physical functioning. We call on VA to expand the scope of long-term rehabilitation programming for TBI to include behavioral and vocational functioning and successful community living, and to make such expansion a department priority.

- ★ **Increase PTSD, TBI, and Prosthetic Research:** This generation of OIF/OEF veterans have used VA care at double the rate of prior era cohorts³⁷² and exhibit unprecedented rates of PTSD. While VA has seen substantial increases in mental health staffing, its healthcare system has not been able to keep up with demand for PTSD care or ensure provision of effective care for PTSD and often concurring conditions. Moreover, VA lacks a strategic plan for dealing with the surge of PTSD. This carries immediate and long-term consequences. We call on the secretary of Veterans Affairs to make marked improvement of PTSD care a specific, sustained, major VA initiative with the same high degree of priority as has been given to eliminating veteran homelessness. As part of that initiative, we urge that VA provide for a holistic approach to treatment, including addressing the physical, mental, and spiritual effects of trauma; and that it ensure veterans are afforded varied treatment options to meet their individual needs, including providing family members needed mental health services.
- ★ **Require Cultural Competence Training of Mental Health Professionals:** Recognizing that (1) large numbers of warriors need mental healthcare but are reluctant, or find it inconvenient, to go to VA, and (2) community providers and even some VA clinicians often lack sufficient understanding of military culture to relate effectively to combat veterans, we call on VA to offer "cultural competence" training for community mental health providers and require such training for physicians who are doing clinical rotations at VA medical facilities.

- ★ **Expand Peer Mentoring and Peer Support Programs:** Peer mentoring and peer support are vitally important to successful rehabilitation and reintegration of injured warriors, though the full potential of such support has only begun to be realized. We call on VA both to expand the number of trained peer specialists deployed as members of mental health treatment teams and to build on that model by incorporating peer mentorship into other programs to help warriors develop self-direction and achieve economic empowerment.

- ★ **Institute a Comprehensive Women Veteran's Health Initiative:** With the number of women serving in the military continuing to grow and the percentage of women in the veteran population projected to almost double by 2040, VA has made concerted efforts to develop or improve VA programs for female veterans. Nevertheless, gender remains a significant factor in healthcare access and long-term health outcomes. Women veterans are more likely to wait longer for care and to be referred outside the VA system than male veterans. They are also at greater risk than civilian females of being prescribed medications that can cause birth defects³⁷³ or that have clinical guidelines warning against their use.³⁷⁴ Perceived lack of availability or adequacy of services based on lack of outreach also contributes barriers to engagement of female veterans.³⁷⁵ There are also higher reported rates of mental health problems among this generation of women than their male peers.³⁷⁶

Additionally, women are at increased risk for MST, which is associated with lasting physical and psychological effects. While researchers cite the importance of screening for MST and associated referral for mental healthcare, many victims do not seek VA care. Women veterans are frequently unaware of their eligibility for and access to VA care, with many mistakenly believing eligibility is linked to establishing a condition's connection to service.³⁷⁷ Yet a 2013 report showed that victims of MST have a higher burden than other cohorts of veterans seeking to establish PTSD's connection to service.³⁷⁸ Those data (obtained through a FOIA request) showed that during fiscal year 2012, VA approved only 56.8% of MST-based claims compared to an approval rate of 73.3% of all other PTSD claims for those years.³⁷⁹ Given this troubling picture, we call on VA to institute a comprehensive approach to serving women veterans, especially in terms of their unique healthcare needs and barriers to care. Such a women veterans' initiative should include substantially improved outreach, reassessment of care delivery, removing the VA's requirement of corroborative evidence of a military sexual assault,³⁸⁰ starting research on gender differences in barriers to care, and ongoing evaluation of efforts to improve services for this population.

WE CALL ON CONGRESS TO:

- ★ **Invest in Veterans' Long-Term Planning:** Consistent with the obligations owed those whose service-connected conditions are either severely disabling or place them at risk of chronic, worsening health or other problems, and the importance of developing an integrated approach to ameliorating those problems, we call on Congress to direct that such veterans be afforded (1) assistance in developing an individualized life plan to guide their rehabilitation and empowerment; (2) help in revising that plan from time to time, as necessary; and (3) all needed support to realize the plan's goals (including ongoing case management).³⁸¹
- ★ **Invest in PTSD, TBI, and Prosthetic Research:** Despite a pressing need for better treatments for PTSD, VA's PTSD research budget has remained static.³⁸² We call on Congress to substantially increase funding for VA research on PTSD, and to improve as quickly as feasible the treatments available for PTSD, with particular emphasis on treatment-resistant patients and those with comorbid conditions.
- ★ **Invest in Civil-Military-Veterans Community Programs:** Communities can play a critically important role in supporting veterans and their families and caregivers, and with appropriate incentives and technical support, communities could not only mount and operate programs that help injured veterans reintegrate, but also could establish best-practice models. We call on Congress to establish and fund a modest grant program for communities with significant concentrations of injured veterans. These grants would be used to foster the development of programming that meets community-specific warrior and family needs. With appropriate incentives and technical support, communities can be partners in mounting and operating programs that help injured veterans reintegrate.³⁸³
- ★ **Establish a National Center for TBI Community Support:** Though many veterans with severe or even moderate brain injuries have had relatively successful physical recoveries, brain injuries often rob their survivors of the ability to sustain relationships or function effectively in social groups. The profound behavioral changes that many experience compound and sometimes even frustrate their return to successful community and family living. With often very limited or no community support, all but the strongest families experience relational strains, in some cases ultimately shattering marriages or kinship bonds, and often leading to lengthy, very costly rehospitalizations. We call on Congress to enact legislation directing that VA establish a National Center for TBI Community Support to (1) advance the successful reintegration of veterans with moderate to severe TBI through research, development of models of effective community support, education and training, and workforce



“There are a lot of veterans who transition out of the military and create a normal and balanced life. But there are also an overwhelming number who are having a hard time integrating into the civilian world, and much of the time it’s because they have given up and isolated themselves. When they do that, they’re going to fall through the cracks and never receive the help they deserve.”

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development; and (2) develop programs to educate, train, and credential paraprofessionals and other individuals to be life skills counselors and behavior coaches (to assist warriors with TBI in relearning relational skills).

★ **Correct “Bad Paper” Discharge:** Thousands of service members have been separated from service since 9/11 on the basis of sometimes questionable diagnoses of a preexisting personality disorder or adjustment disorder. An administrative discharge on that basis leaves a service member without eligibility for VA compensation or disability retirement pay and can impair that individual’s ability to find employment. While DoD has taken steps to tighten its rules regarding such administrative discharges, it is not clear they are being enforced and the department has not taken any retrospective³⁸⁴ remedial action. We call on Congress to direct the Government Accountability Office (GAO) to conduct an analysis of a sample of administrative discharge cases prior to 2008. This analysis can be used to develop projections of the number of post-9/11-deployed service members who were subsequently separated with a questionable diagnosis of personality disorder or adjustment disorder and to identify any patterns associated with questionable diagnoses.³⁸⁵

WE CALL ON THE WHITE HOUSE TO:

★ **Correct “Bad Paper” Discharge:** With regard to the considerable number of service members discharged based on questionable diagnoses of preexisting conditions (as described earlier), we call on the White House to issue an executive order directing the defense secretary to establish a special discharge review program. Such program should provide for special boards of review that include at least one psychiatrist or psychologist who is not an officer or employee of DoD. These boards should review and, when indicated, correct the military records and award back pay and other benefits to which the individual would have been entitled. Staffing for such program should take account of GAO’s findings (see the above call for congressional action).

★ **Develop a National Plan for the Behavioral Health Workforce of the Future:** A continuing shortage of psychiatrists and other mental health professionals, particularly in rural America, threatens veterans’ growing need for behavioral health services. We call on the White House to develop a national plan to address this gap by consulting medical schools and working with the departments of Veterans Affairs and Health and Human Services.



WE CALL ON DoD TO:

★ **Improve Transition and Reintegration Outcomes for Injured Warriors:** As the sole source of veterans in America, DoD has an inherent obligation to improve transition and reintegration outcomes for those who have borne the burden of service to our nation. We call on DoD to improve transition and reintegration programs across the entire department, including within each service. Measurements of successful transition, currently defined as civilian readiness standards, should include more robust measures of outcomes, including meaningful employment, effective use of GI Bill opportunities, absence of homelessness, and reductions in criminal justice involvement.

WE CALL ON COMMUNITIES TO:

★ **Help Bridge the Civil-Military Divide:** Many veterans leave military service fully prepared to apply their military-acquired leadership experience and skills, and to contribute to their communities. Others require more assistance because they are still recovering from injury or illness, or they lack education or skills. But all return to their communities, not to the VA or some other federal program. Moreover, even though the VA can ultimately offer services, it is increasingly looking for partners to fill service gaps and supplement its services. Therefore, we call on communities to take an active, two-pronged role to support returning veterans.

First, we call on communities to expand the awareness of, reach, and scope of local programs and services that help returning veterans become valuable contributory members of the community. In addition, we call on communities to convene not only those who serve veterans and military families, but also all potential partners, both public and private. Together, they can develop collaborative networks that can ensure warm handoffs and a holistic approach to needed assistance in such areas as education, meaningful employment, and access to well-being services.

WE CALL ON MEDICAL SCHOOLS AND SCHOOLS OF ALLIED HEALTH TO:

★ **Plan for and Treat Veterans:** We call on the nation’s medical schools and schools of allied medicine to ensure that the education and training of the nation’s clinical workforce takes account of and is aligned with the long-term health and rehabilitative needs of wounded ill and injured veterans. Behavioral health, rehabilitation, pain management, and prosthetics must be principal areas of focus, as well as meeting workforce needs in rural America and other underserved areas.

WE CALL ON THE BUSINESS COMMUNITY TO:

★ **Hire, Train, or Retrain Veterans:** Although many in the business community have stepped up and instituted programs to hire veterans, there are opportunities to tap and build on that experience. More can still be done, and we call on the business community, with an eye to the importance of ever-increasing technological advances, (1) to adopt culturally sensitive hiring practices and training programs designed to help wounded veterans return to the workforce with competence in technologies required for 21st-century jobs; (2) to develop, and offer wounded veterans the opportunity to participate in education and retraining programs as a continuous process well past initial entry into the labor force; and (3) to examine best practices within the business and nonprofit communities, such as the Transition Training Academy offered by WWP, as examples of partnerships that empower injured servicemen and women to enter the workforce with marketable skills that lead to rewarding employment.

APPENDIX: 2015 POLICY PRIORITIES »

Wounded Warrior Project has set out to develop a strategic policy agenda focused a decade ahead. While there has been progress toward realizing policy goals set in earlier years, much remains to be done. Just as many warriors are still on a road to recovery, policymakers in Congress and Executive departments have to close gaps and topple barriers that impede recovery and reintegration. Reflecting the experience of injured veterans and their caregivers, WWP will continue to focus on four key objectives:

1. Closing gaps and eliminating barriers to improved mental health of warriors, their families, and caregivers.
2. Fostering the economic empowerment of wounded, ill, and injured veterans by eliminating educational and employment barriers.
3. Helping ensure access to optimal long-term rehabilitative care for wounded, ill, and injured veterans and support for their caregivers.
4. Improving the effectiveness of government programs that were established to help warriors and their families transition from active duty to successful community reintegration.

Within that framework, WWP has identified and will continue to advocate for 2015 policy objectives, which include:

1. Mental Health:

- a. Increasing emphasis on effectively engaging warriors to enter into and continue treatment for behavioral health conditions, with particular emphasis on war-related conditions and those associated with military sexual trauma.
- b. Improving the access, timeliness, and effectiveness of care for the invisible wounds of war, including PTSD, depression, and anxiety; TBI; substance use conditions; and chronic pain, through programmatic change, continued oversight, and legislation.
- c. Increasing veterans' and service members' access to Vet Center services by adding new facilities and increasing staffing.
- d. Providing alternatives to trauma-focused psychotherapy, including supportive group therapy, for veterans who wish to avoid revisiting trauma.
- e. Fostering the development of more effective VA procedures to evaluate, and more appropriate and equitable criteria to rate, disability due to mental health conditions.
- f. Furthering efforts to prevent military sexual trauma and easing the evidentiary burden on warriors of establishing service-incurred trauma.
- g. Providing grant support for the development of veterans treatment courts to foster diversion of warriors who have

behavioral health problems from the criminal justice system into treatment and rehabilitation programs.

2. Economic Empowerment:

- a. Improving the effectiveness of VA's Vocational Rehabilitation & Employment program.
- b. Expanding the availability of campus-support services for wounded student-warriors using the Post-9/11 GI Bill.
- c. Eliminating a barrier to severely disabled veterans' pursuit of gainful employment when they are rated 100% service-connected disabled by reason of individual unemployability.

3. Long-Term Rehabilitation:

- a. Achieving full implementation of law requiring VA to provide veterans who have severe TBI with rehabilitative services and support to realize and sustain functional gains while achieving maximum community independence.
- b. Ensuring continued robust provision of residential rehabilitative care for veterans with TBI as instituted under VA's assisted-living pilot program.
- c. Achieving full implementation of the Caregiver Assistance Law of 2010; expanding that law to provide improved respite options and meet other caregiver needs; and eliminating excessive, duplicative oversight of caregivers who are also fiduciaries for their warriors.
- d. Improving the effectiveness of VA amputee care.
- e. Revising current law to provide VA coverage of services to overcome a veteran's inability to have children due to traumatic injury.
- f. Substantially increasing funding for research on long-term rehabilitation needs to improve available treatments, with particular emphasis on treatment-resistant patients and those with comorbid conditions.

4. Improve Injured Warrior Programs:

- a. Improving the operation, efficiency, and effectiveness of the medical retirement process and DoD-VA coordination in the evaluation of disability.
- b. Enacting legislation to ensure mental-health-informed review of administrative discharges where a character-of-service determination may have failed to take account of a service-incurred mental health condition.
- c. Revising current law that subjects the most severely injured veterans to loss of TRICARE coverage if they opt out of purchasing Medicare supplementary insurance.

ENDNOTES »

8 » ENDNOTES

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- 385 *Id.* An individual who has a personality disorder can also have co-occurring PTSD, and the symptoms of the two conditions can overlap. *Id.*



"Any good citizen of the USA is willing to support the troops returning home. But their ability to show this support is limited to volunteering, saying thank you, or writing a check. You as a policymaker have the rare opportunity to affect the lives of millions of veterans through legislative action, agency revisions, and ensuring proper funding for our much-needed veteran resources and benefits. This is an opportunity, no, a responsibility, that I ask you to not take lightly."

JASON JOHNS
WWP ALUMNUS



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