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WHAT CAN THE PROTECTION AND ADVOCACY NETWORK OFFER TO OUR VETERANS?

David A. Boyer*

INTRODUCTION

The desire to compensate veterans predates the establishment of the United States (“U.S.”). In 1636, individuals with disabilities received pensions for defending the Plymouth colony against Native Americans.¹ Throughout history, this practice continued, as documented by the U.S. Department of Veterans Affairs (“VA”).² By 1930, President Herbert Hoover signed the Executive Order 5398, which created the Veterans Administration.³ Prior to President Hoover’s signing of that executive order, the available veteran services were divided by three separate governmental agencies: the Veterans’ Bureau, the Pensions Bureau, and the Soldiers’ Home.⁴ Consequently, that executive order combined all three agencies into one that concentrated and streamlined the available services for veterans.⁵ By 1988, that agency elevated to a cabinet-level position and renamed the VA.⁶ The VA is comprised of three administrations: Veterans Health Administration (“VHA”), Veterans Benefits Administration (“VBA”), and National Cemetery Administration (“NCA”).⁷ This article analyzes the VHA because it is the largest administration of the three.

Additionally, this article addresses the inadequacies of the VHA due to excessively long wait times and the neglect and abuse towards veterans. Examples will be used to show how the oversight mechanisms have failed. Lastly, this article addresses alternative solutions to ensure that veterans receive quality care through the extension of authority, which addresses the funding of the existing Protection and Advocacy system that has been effective under similar circumstances.

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¹ U.S. Dep’t of Veterans Aff., *VA History in Brief*, 3, https://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf (last visited Oct. 25, 2019).

² *VA History in Brief*, *supra* note 1.

³ *The Donnelly Collection of Presidential Executive Orders*, <https://www.conservativeusa.net/eo/1930/eo5398.htm> (last visited October 25, 2019).

⁴ *Id.*

⁵ *Id.*

⁶ 20 MARQ. BENEFITS & SOC. WELFARE L. REV. 99.

⁷ Yelena Duterte, *Decision, Appeal, Repeat How VA Can Limit Wait Times, Error, and Red Tape Through Settlements*, 68 SYRACUSE L. REV. 407, 409 (2018).

I.

VETERANS' HEALTH ADMINISTRATION

The VHA is the largest administration under the VA. As one of the largest health care providers in the U.S, it serves over nine million veterans each year.⁸ Accordingly, the VHA is divided by eighteen Veterans Integrated Service Networks (“VISN”), which are geographic administrative zones that serve as “regional systems of care working together to better meet local health needs and provides greater access to care.”⁹ The breadth of the VHA cannot be undervalued. In its own words:

The VA operates more than 1,300 sites of care including nearly 900 ambulatory care and community-based outpatient clinics, 136 nursing homes, 43 residential rehabilitation treatment programs, nearly 90 comprehensive home-care programs, and more than 200 Veterans Centers where approximately 2 million veterans have been served since the first center opened in 1979. In 2005 alone, Veterans Centers handled more than 1 million visits by nearly 133,000 veterans and members of their families.¹⁰

II.

INADEQUACIES OF THE VHA

Although the VHA’s long-standing issues extend into various contexts, this article addresses the issues of excessively long wait times and the abuse and neglect of veterans.

A.

Long Wait Times

The wait time for veterans to receive health care has been “grossly mismanaged” at various VA Health Care Systems (“VAHCS”).¹¹ In 2014, the most egregious complaints against the VAHCS centered around the massive delays to provide healthcare to veterans.¹² Such delays were reported throughout all the geographic administrative zones of the VHA. At the Phoenix VA Health Care System (“PVAHCS”), up to forty veterans died due to delays in receiving healthcare.¹³ Moreover, on May 28, 2014, a report from the VA Office of Inspector General (“VA OIG”) summarized an investigation regarding the delays.¹⁴ The investigation showed that at least 1,400 veterans were placed on an electronic waitlist at PVAHCS.¹⁵ Before being placed

⁸ U.S. Dep’t of Veterans Aff., *About VHA*, <https://www.va.gov/health/aboutvha.asp> (last visited Dec. 4, 2019).

⁹ U.S. Dep’t of Veterans Aff., *Veterans Health Admin.*, <https://www.va.gov/health/aboutvha.asp> (last visited Oct. 25, 2019).

¹⁰ *VA History in Brief*, *supra* note 1, at 33.

¹¹ VA Off. of Inspector Gen., *Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System* (May 28, 2014), <https://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf>.

¹² German Lopez, *The VA Scandal of 2014, Explained* (May 13, 2015), <https://www.vox.com/2014/9/26/18080592/va-scandal-explained>.

¹³ Scott Bronstein & Drew Griffin, *A Fatal Wait: Veterans Languish and Die on a VA Hospital’s Secret List* (Apr. 23, 2014), <https://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/index.html>.

¹⁴ VA Off. of Inspector Gen., *supra* note 11.

¹⁵ *Id.*

on the electronic waitlist, 1,700 veterans were forced to wait to receive initial appointments.¹⁶ Consequently, such delays caused a dual effect of underestimating wait times and depriving veterans of receiving necessary medical appointments.

Moreover, VA OIG reported that the PVAHCS grossly underreported its average initial wait times for veterans.¹⁷ The daily average wait time was not twenty-four hours as initially reported; instead, it was 115 days long.¹⁸ By 2002, over 300,000 veterans were either placed on waitlists or forced to wait over six months to make an appointment at the VHA.¹⁹

Based on the VA OIG report, the then-VA Secretary Eric Shinseki recommended that VHA doctors see new patients within fourteen days.²⁰ However, as an attempt to lower the apparent long wait times, employees strategically avoided the new waitlist requirement by engaging in “gaming strategies.”²¹ On the outset, VHA employees maintained two separate patient lists: one to show VHA officials and one kept internally at respective VHA locations.²² The first demonstrated that veterans were provided with timely appointments.²³ However, the second confirmed that veterans waited for more than a year to receive treatment.²⁴

The increase in long wait times reflected the increase in veterans brought to the VHA after returning from recent conflicts. In 2001, the VHA reported that 482,448 veterans had a fifty percent or higher rate of being disabled.²⁵ From 2007 to 2013, the average caseload of the VHA increased dramatically due to the rapid influx of veterans returning from Iraq and Afghanistan.²⁶ By 2017, the number of veteran disabilities soared to over two million.²⁷ The overwhelming increase of caseloads in the VHA has burdened the system’s efficiency.²⁸ The system just cannot keep up with the demand, and further resources are nowhere in sight.²⁹

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ VA Off. of Inspector Gen., *supra* note 11.

²⁰ *Id.*

²¹ *Id.*; see, e.g. Dep’t of Veterans Aff., Inappropriate Scheduling Procedures (Apr. 26, 2010), <https://www.legion.org/documents/pdf/gamingthesysystem2010%20memo.pdf>.

²² *Id.*

²³ VA Off. of Inspector Gen., *supra* note 10.

²⁴ *Id.*

²⁵ U.S. Dep’t of Veterans Aff., *Veterans Health Admin. of Off. of Policy and Planning*, https://www.va.gov/vetdata/docs/Utilization/Number_of_Veteran_Patients_by_HC_Priority_Groups_2000_2017.pdf (last visited Jan. 24, 2018).

²⁶ Sidath Viranga Panangala, *Veterans’ Med. Care: FY2015 Appropriations* (Oct. 9, 2014), <https://fas.org/sgp/crs/misc/R43547.pdf>.

²⁷ *Id.*

²⁸ *Id.*

²⁹ German Lopez, *Vox*, *The VA Scandal of 2014, Explained* (May 13, 2015, 3:34 PM), <https://www.vox.com/2014/9/26/18080592/va-scandal-explained>.

B.

Abuse and Neglect of Veterans

Veterans, in or out of any VHA facility, represent a population that is vulnerable to abuse and neglect. Veterans should receive protections equal to civilians. Veterans are more susceptible to abuse and neglect as compared to civilians because veterans experience higher occurrences of poor physical and psychological health, functional and cognitive impairment, and isolation from the general population.³⁰ At a VHA nursing facility in Los Angeles, California, a study of 575 veterans found that within three years of a patient's stay, approximately 5.4% of its patients experienced abuse or neglect.³¹ Unfortunately, much of this abuse and neglect goes unreported.³² Therefore, the data on abuse and neglect against veterans remains limited.³³

Although the data regarding abuse and neglect is limited, the general public and media continue to criticize the quality of care provided at VHA facilities. In 2017, USA Today and the Boston Globe exposed that VHA facilities compiled statistics on patient quality, but kept them hidden from the public.³⁴ Accordingly, an investigation into the VHA facilities revealed that VHA facilities "scored worse on average than [civilian facilities] on nine of eleven key indicators."³⁵ Moreover, nearly half of the VHA facilities received one-star ratings.³⁶ Even today, veterans remain a vulnerable target for abuse and neglect. It is important to ensure that VHA facilities provide quality care and safe places for veterans.

C.

The Current Oversight Scheme

Four government authorities conduct oversight of the VHA: Congress, the VA OIG, the Government Accountability Office ("GAO"), and the newly-created VA Office of Accountability and Whistleblower Protection ("OAWP"). The VHA believes that this level of oversight is adequate, not excessive.³⁷ For instance, concerning a call for increased oversight of the modernization of electronic health records, a VHA spokesperson stated, "there are already multiple avenues for robust Congressional oversight, including regular briefings and Congressional hearings . . . engagement with GAO, regular statutory reporting requirements, and responses to Congressional inquiries."³⁸ Despite this seemingly adequate oversight, scandals

³⁰ LK Makaroun et al., *Veterans Experiencing Elder Abuse: Improving Care of a High-Risk Population About Which Little Is Known*, J. AM GERIATRICS SOC. (2017).

³¹ Ailee Moon et al., *Elder Abuse and Neglect Among Veterans in Greater Los Angeles*, 46 J. OF GERONTOLOGICAL SOC. WORK 187 (2008).

³² *Id.*

³³ Lidia Vognar et al., *The Impact of Elder Abuse on a Growing Senior Veteran Population*. FED. PRAC. 33(8), 22–26 (2016).

³⁴ *Secret VA nursing home ratings hide poor quality care from the public*, USA TODAY (June 17, 2018, 8:08 PM), <https://www.usatoday.com/story/news/politics/2018/06/17/secret-va-nursing-home-ratings-hide-poor-quality-care/674829002/>.

³⁵ *Id.*

³⁶ *Id.*

³⁷ Kate Monica, *VA Opposes 11-Member EHR Modernization Oversight Committee*, EHR INTELLIGENCE (May 28, 2019) <https://ehrintelligence.com/news/va-opposes-11-member-ehr-modernization-oversight-committee>.

³⁸ *Id.*

continue to plague the VHA.³⁹ Before turning to an alternative oversight scheme, I will describe the one currently in place.

Congress's strong oversight authority over the VHA has been described as "indeed co-extensive with the power to legislate."⁴⁰ Douglas Kriner concludes in his evaluation of Congressional oversight that "[w]hile oversight is a potentially important tool of legislative influence; it is not one that Congress employs uniformly."⁴¹ Kriner argues that Congressional oversight is driven by partisanship and tempered by political ambition.⁴² Those ambitions limit the ability of Congress to regulate the VHA meaningfully.

The VA OIG also exerts oversight authority over the VHA. VA OIG is among seventy-three separate inspector general offices in the federal government that operate under the mission of "investigating agency mismanagement, waste, fraud, and abuse, and providing recommendations to improve federal programs and the work of federal agencies."⁴³ Unfortunately, funding challenges make the VA OIG a less effective oversight entity. Budget woes plague inspector generals and are one of the most substantial constraints on the ability to exert oversight.⁴⁴ Funding is dependent on the federal budget and the politics surrounding this process.⁴⁵ The Trump administration's most recent budget forecasts a dramatic decrease in funding for several OIGs.⁴⁶ VA OIG responded that the proposed budget "presents a shortfall that will undermine progress achieved to 'right size' the OIG oversight capacity to the growth and demands of VA's new initiatives, increased funding environment, and ongoing work on behalf of veterans."⁴⁷ The proposed budget by the Trump administration would require the VA OIG to cut its staff by 30 employees.⁴⁸

The third government agency that exerts oversight authority over the VHA is the GAO. According to the GAO, the agency "is an independent, nonpartisan agency that works for Congress. Often called the 'congressional watchdog,' GAO examines how taxpayer dollars are spent and provides Congress and federal agencies with objective, reliable information to help the

³⁹ Barbara Romzek, *The Veterans Affairs scandal reflects the tangled web of accountability in U.S. government* (May 29, 2014), <https://blogs.lse.ac.uk/usappblog/2014/05/29/the-veterans-administration-scandal-reflects-the-tangled-web-of-accountability-in-u-s-government>.

⁴⁰ *McGrain v. Daugherty*, 273 U.S. 135, 175 (1927).

⁴¹ Douglas Kriner, *Can Enhanced Oversight Repair "The Broken Branch"?*, 89 B.U. L. Rev. 765, 791 (2009).

⁴² *Id.*

⁴³ See Liz Hempowicz et al., *The Watchdogs After Forty Years: Recommendations for Our Nation's Federal Inspectors General*, PROJECT ON GOV'T OVERSIGHT, (July 9, 2018), <https://www.pogo.org/report/2018/07/watchdogs-after-forty-years-recommendations-for-our-nations-federal-inspectors-general/>.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Jory Heckman, *Inspectors general fear staff cuts, less oversight under Trump budget plan*, FEDERAL NEWS NETWORK (Aug. 17, 2018, 5:02 pm), <https://federalnewsnetwork.com/budget/2018/08/inspectors-general-fear-staff-cuts-less-oversight-under-trump-budget-plan/>.

⁴⁷ *Id.*

⁴⁸ *Id.*

government save money and work more efficiently.”⁴⁹ In 2015, the GAO placed the VHA on high-risk status⁵⁰ for the following reasons: ambiguous policies and inconsistent processes, inadequate oversight and accountability, information technology challenges, inadequate training for VA staff, and unclear resource needs and allocation priorities.⁵¹ The VHA acknowledges that: “At any given time, there are [eighty] to 100 open recommendations about VA health care. Overall, VA has succeeded in closing approximately 377 recommendations since 2009, and is committed to closing as quickly as possible all [twenty-two] recommendations that GAO has identified as high priority.”⁵² Moreover, the GAO continues to press for more oversight and accountability over the VHA.⁵³ However, the GAO is limited in its power because it merely communicates its findings to Congress – it has no power to enforce its recommendations.⁵⁴

The last of these oversight authorities is the OAWP. Created by Executive Order in 2017, the OAWP is a mechanism for VHA employees to report a potential violation of any law, rule or regulation, gross mismanagement or gross waste of funds, abuse of authority, or substantial and specific danger to public health or safety. The office was intended to provide oversight of employee complaints, as well as complaints about inadequate patient care. Unfortunately, the success of the OAWP is in question. Critics of the program raise concerns about the 2,558 employees that were terminated in the first year.⁵⁵ Efforts to repeal the bill have bipartisan support in Congress, with one group stating that the VHA has failed to “demonstrate in any way that implementation has been consistent, fair, and appropriate.”⁵⁶ While the VHA emphasizes the importance of the OAWP, the OAWP has not accomplished its intended goals.

Each of the existing mechanisms of oversight of the VHA is severely limited. The common factor among them is that they derive from the federal government. Absent from this scheme is an independent oversight authority empowered with enforcement mechanisms.

⁴⁹ U.S. GOV’T ACCOUNTABILITY OFF., About GAO, <https://www.gao.gov/about/> (last visited Oct. 30, 2019).

⁵⁰ The GAO considers a program to be high risk if it has “vulnerabilities to fraud, waste, abuse, and mismanagement, or that need transformation.”

⁵¹ *Id.*

⁵² *VA Takes Decisive Actions to Move off GAO High-Risk List*, U.S. DEPARTMENT OF VETERANS AFFAIRS (Apr. 16, 2018, 10:30 AM), <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4038>.

⁵³ *Veterans Health Administration: Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities*, U.S. GOV’T ACCOUNTABILITY OFF. (June 19, 2019), https://www.gao.gov/products/GAO-19-462?mobile_opt_out=1, hereinafter [Regional Networks].

⁵⁴ Kriner, *supra* note 41.

⁵⁵ J. David Cox Sr., *Accounting for bad management: The VA Accountability Act turns one*, THE HILL (July 23, 2018, 8:45 AM), <https://thehill.com/blogs/congress-blog/healthcare/398315-accounting-for-bad-management-the-va-accountability-act-turns>.

⁵⁶ *Tester, Blumenthal, Baldwin, Brown Call for Investigation into VA’s Implementation of Accountability Bill*, U.S. SENATE COMMITTEE ON VETERANS’ AFFAIRS (June 18, 2018), <https://www.veterans.senate.gov/newsroom/minority-news/tester-blumenthal-baldwin-brown-call-for-investigation-into-vas-implementation-of-accountability-bill>.

III. THE PROTECTION AND ADVOCACY NETWORK PRESENTS ONE SOLUTION

If the current system of oversight is not effective, what might be a possible solution? The Protection and Advocacy network presents a possible solution to the VHA's oversight problem. I propose that an existing system of oversight could be the way to ensure that the VHA provides safe and effective treatment for our Veterans.

Although public outrage over conditions in VA facilities is relatively recent, shocking conditions in other types of facilities is nothing new. In the 1960's, attention focused on the horrible abuses in large institutions for individuals with mental illness and developmental disabilities. One example is Willowbrook State School, a New York run institution for individuals with intellectual and developmental disabilities.⁵⁷ Willowbrook was home to widespread abuse and neglect, including forcing residents to participate in a study on hepatitis.⁵⁸ By the middle of the 1960s, the census at the facility was approximately double its actual capacity.⁵⁹ Residents were crammed into squalid conditions with a nearly 50:1 resident to attendant ratio.⁶⁰ In 1965, New York Senator Robert Kennedy demanded reform as he described Willowbrook as a "snake pit."⁶¹

That reform did not occur, and a young Geraldo Rivera, working as an investigative reporter, reported on the conditions in 1972.⁶² Increased oversight is often the result of moral or legal wrongs that lead to public outrage.⁶³ Rivera's coverage of the atrocities at Willowbrook sparked public outrage and led to Congressional investigations that confirmed the worst suspicions.⁶⁴ Individuals with disabilities were being warehoused in large state institutions and subjected to deprivations of basic human rights through abuse and neglect.⁶⁵ The 1975 amendments to the Developmental Disabilities Assistance and Bill of Rights Act created a Protection and Advocacy System ("P&A") with authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of individuals . . . with developmental disabilities."⁶⁶ Under the legislation, the governor of each state and territory had

⁵⁷ Saul Krugman, *The Willowbrook Hepatitis Studies Revisited: Ethical Aspects*, 8 REVS. INFECTIOUS DISEASES 157 (JAN. – FEB. 1986), https://www.gvsu.edu/cms4/asset/F51281F0-00AF-E25A-5BF632E8D4A243C7/willowbrook_hepatitis_studies.pdf.

⁵⁸ *Id.* at 158.

⁵⁹ Heard on The Bryant Park Project, *Remembering an Infamous New York Institution*, NPR (Mar. 7, 2008, 7:00 AM), <https://www.npr.org/templates/story/story.php?storyId=87975196>.

⁶⁰ *Id.*

⁶¹ Dalton Brown, *The horrifying truth uncovered: Willowbrook State School*, ROOTED RIGHTS (Oct. 15, 2014), <https://rootedinrights.org/the-horrifying-truth-uncovered-willowbrook-state-school/>.

⁶² *Id.*

⁶³ Hugo van Driel, *Financial fraud, scandals, and regulation: A conceptual framework and literature review*, BUS. HIST. (2018), <https://doi.org/10.1080/00076791.2018.1519026>.

⁶⁴ *Regional Networks*, *supra* note 53.

⁶⁵ See, e.g., *Care of Institutionalized Mentally Disabled Persons: Joint Hearings on Examining the Issues Related to the Care and Treatment of the Nation's Institutionalized Mentally Disabled Persons: Joint Hearings Before the Subcomm. on the Handicapped of the Comm. on Labor and Human Res. and the Subcomm. on Labor, Health and Human Servs., Educ. and Related Agencies of the Comm. on Appropriations*, 99th Cong. (1985) (pt. II).

⁶⁶ Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15043(a) (2004).

to appoint an organization to serve as the P&A.⁶⁷ Notably, however, the P&A could be a private, not-for-profit, or state agency, but would remain independent of the state and any treatment providers.⁶⁸ Today, most P&As are private, not-for-profit agencies.

The P&A system has grown since 1975 to encompass an ever-increasing array of disability sub-groups and issues. The success of the system is evidenced by the continued congressional expansion of the number of P&A programs to monitor conditions and investigate abuse and neglect. The current programs that fall under the P&A rubric are as follows: Protection and Advocacy for Individuals with Developmental Disabilities (PADD);⁶⁹ Protection and Advocacy for Individuals with Mental Illness (PAIMI);⁷⁰ Protection and Advocacy for Individuals with Traumatic Brain Injuries (PATBI);⁷¹ Protection and Advocacy for Individual Rights (PAIR);⁷² Protection and Advocacy for Beneficiaries with Representative Payees (PABRP);⁷³ Protection and Advocacy for Beneficiaries of Social Security (PABSS);⁷⁴ Protection and Advocacy Vote Act (PAVA);⁷⁵ Protection and Advocacy for Assistive Technologies (PAAT);⁷⁶ and Client Advocacy Program (CAP).⁷⁷

In addition to advocacy and legal representation, P&As exercise special oversight tools granted by several statutes.⁷⁸ Specifically, a P&A has wide-ranging authority to access locations within its state where individuals with disabilities are receiving care or treatment.⁷⁹ This access authority includes records and extends to (1) investigations triggered by a report or a determination of probable cause, and (2) monitoring visits to ensure compliance with respect to the rights and safety of individuals with disabilities.⁸⁰

P&A authority extends to various groups of individuals with disabilities, to various settings, and various issues. However, various statutes drive P&A work by funding specific groups or issues. For instance, the PADD program only funds work with individuals with developmental disabilities, and the PAAT funds work with individuals that have assistive technology. P&As have limited resources and are required to develop their priorities and objectives based on their funding.

While P&As can (and do) work with Veterans, they are not granted specific funding for VHA work. Currently, several federal legislators are pressing for a bill that would mandate P&A

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ 42 U.S.C. §§ 10801-10807 (2019).

⁷¹ 42 U.S.C. §§ 300d-53 (2019).

⁷² 29 U.S.C. § 794e (2019).

⁷³ 42 U.S.C. § 405(j)(6) (2019).

⁷⁴ 42 U.S.C. §§ 1320b-21 (2019).

⁷⁵ 42 U.S.C. §§ 15461-62 (2019).

⁷⁶ 29 U.S.C. § 3004 (2019).

⁷⁷ 29 U.S.C. § 732 (2019).

⁷⁸ Access authority is specifically granted in the following programs: PAIR, PAIMI, PADD, PATBI, and PABRP.

⁷⁹ 42 U.S.C. § 10805(a)(3) (2019).

⁸⁰ 42 C.F.R. § 51.42(b)-(c) (2019).

oversight in the VA system.⁸¹ A specific funding source from Congress would send a signal that P&As have an important role in monitoring the VHA, and P&As would be able to allocate additional resources for increased monitoring and oversight of VHA facilities and programs.

IV. PROTECTION AND ADVOCACY FOR VETERANS ACT

It is evident that increased oversight of the VHA is necessary. The current oversight scheme is effective but limited. The VHA continues to experience scandal within its organization that depletes its ability to complete its mission: “[t]o care for him who shall have borne the battle, and for his widow, and his orphan[.]”⁸² Unfortunately, our Veterans are receiving sub-optimal care and are too often the victims of abuse and neglect.

Given this need for oversight and accountability, Congress has suggested the P&A network as a monitoring arm for the VHA. A bill introduced in recent sessions of Congress – the Protection and Advocacy for Veterans Act – proposed provision for the necessary protections for our Veteran population.⁸³

The bill includes a five-year pilot program that would place the P&A network as a primary means of oversight for the VHA.⁸⁴ It provides funding for four P&As (selected by the VA Secretary) to carry out a demonstration project to investigate and monitor the care of Veterans at VHA facilities.⁸⁵ The project focuses on two very important recent concerns of Veterans: substance abuse and mental health.

Most importantly, the bill provides the same access authorities as the P&A possesses under the PAIMI Act.⁸⁶ That is, the P&A would have reasonable unaccompanied access to VHA facilities for the purposes of monitoring compliance with rights and safety, as well as investigating possible instances of abuse and neglect. This authority would provide the most powerful tools in a P&A’s repertoire, to efficiently and effectively provide oversight of the VHA programs and services.

CONCLUSION

The U.S. has always been a country that believes that its Veterans should be provided quality healthcare and benefits after their service is complete. Recently, the VHA has experienced several scandals involving long wait-lists, inadequate treatment, and abuse and neglect. While some oversight exists, it is limited by funding, authority, and political agendas. The Protection and Advocacy for Veterans Act proposes harnessing the long-standing success and power of the P&A network to provide the necessary oversight for our Veterans.

⁸¹ See H.R. 1712, 115th Cong. (2017).

⁸² *About VA*, U.S. DEP’T OF VETERAN AFF., https://www.va.gov/ABOUT_VA/index.asp, (last visited June 21, 2019).

⁸³ 42 U.S.C. § 10805(a)(3) (2019).

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ See 42 U.S.C. §§ 10801-10807 (2019).