Hospitals & Asylums

Battle Mountain Sanitarium at Hot Springs HA-24-7-21

By Anthony J. Sanders

Prospectus: The VA has discriminated against renovations to make Battle Mountain Sanitarium handicap and family accessible, and environmentally healthy in violation of Sec. 102 and 202 of the Americans with Disabilities Act (ADA) of 1990 under 42USC§12112 and 42USC§12132 pursuant to the Architectural Barriers Act under 42USC§4151 et seq. and 36 CFR 1191 App. C and abatement of asbestos under 40CFR§61.145 and (child dangerous) lead based paint under 40CFR§745.227 although the Secretary of Veterans Affairs has a duty under 24USC§152. $2.6 billion in un-obligated balances returned to the VA Medical Facilities budget do not meet the projected FY 22 obligation level of $9.5 billion, as the VA supposes, they are $165 million short. Including the $100 million cost of this prospectus to renovate Battle Mountain Sanitarium in Hot Springs and construct or lease a larger Multi-Specialty Outpatient Clinic in Rapid City, South Dakota, Congress must approve to add under 40USC§3307, to be mathematically and legally correct and theologically $7 billion by 42 months (Revelation 13:10). Congress is obligated to supplement the VHA facilities appropriation by $265,320,000 to $7 billion FY 22 with a commensurate reduction in medical community care appropriation pursuant to the Anti-Deficiency Act under 31USC§1341 and §1515(b)(1)(B), Sherman Anti-Trust Act under 15USC§1, *American Athletic Conference, et al v. Shawne Alston, et al* 594 U.S__(2021) and Promoting Competition in the American Economy E.O. 14036 of July 9, 2021.

Part A Prospectus

Chapter 1 Gold Standard for Coronavirus Treatment

Disciplined retreat from the completely demolished Tubercular Hospital in Fort Bayard, New Mexico to the abandoned and condemned Army and Navy General Hospital in Hot Springs, Arkansas under 24USC§18-20 to the VA Medical Center and Residential Rehabilitation Treatment Program (RRTP) at Battle Mountain Sanitarium Reserve in Hot Springs, South Dakota under 24USC§151-154 has perfected the lesson that hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus allergic rhinits. Eucalpytus or lavender cure the wet cough of influenza. The VA Black Hills Health Care System is sought to defend the national attraction of the healing waters of Battle Mountain Sanitarium to Veterans, whose outrageous in-hospital COVID-19 mortality has declined from 21% in the beginning of the pandemic to 11.9% (VHA '21: 103)(Cates et al '20). The VA must find for the United States that medicinal bathing in saline, chlorine or healing mineral water instantly cures highly contagious coronavirus allergic rhinitis, as well as topical and arthritic methicillin resistant *Staphylococcus aureus* (MRSA) pursuant to the Center for Disease Control and Prevention (CDC) justification for reopening swimming pools in 2021, 21CFR§330.10, 42USC§300u, (Gründling et al '16)(John 1: 26)(Luke 3: 7)(1 Peter 3: 21)(Mark 6: 24) and *Hot Springs Cases*, 92 US 698 (1875), with a mentholyptus cough drop or Echinacea pill for severe acute respiratory syndrome (SARS), mentholyptus drop for influenza patients and ampicillin (Principen) or Pneumovax for pneumonia.

The VA and everyone, must learn the lesson that hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus, and eucalyptus or lavender also cure influenza, to end the COVID-19 pandemic, and greatly improve the response to future SARS and influenza pandemics, vaccine monopolization of the government and news media is notoriously unsatisfactory at eliminating. Coronavirus treatment is safe and cheap. Although vaccination may cure coronavirus in two weeks and consequently reduce the risk of further severe infection and death, COVID-19 vaccination does not alleviate the need to know how to treat the contagious "Pinocchio nose" nor truly end the pandemic.

The lesson that must be learned, before the "snot nosed children" return to school is: Hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure allergic rhinitis from coronavirus. Eucalyptus or lavender also cure the wet cough of influenza. Mentholyptus cough drops are the front line treatment for both influenza and coronavirus, with a little nose washing, keep the infection out of the lungs. Medicinal bathing in saline, chlorine or medicinal mineral water, is the most effective method of curing coronavirus, submerging the head instantly cures the contagious allergic rhinitis perpetuating the COVID-19 pandemic (Mark 6: 24). Medicinal bathing, usually in an Epsom salt bath, hot-tub, chlorinated or saline swimming pool, is also the frontline daily treatment for occupational, hospital and community acquired MRSA. To end the COVID-19 pandemic the most effective strategy to achieve herd immunity is probably to place eucalyptus, lavender or peppermint soap in public restrooms, with instruction to "wash face and nose". Lysol is an effective environmental cleanser, that cures as it cleans, to overrule the new brain damaging ammonia prescribed by the EPA and CDC for school reopenings. To replace the ineffective air purifiers prescribed by CDC, schools, hospitals, intensive care units (ICUs), waiting rooms and public airspaces of all sorts may be sterilized of both influenza and coronavirus with eucalyptus scented humidifiers (diffusers) last reported to have been used by the grandmothers of snot nosed Baby Boomers in the 1950s (Sanders '21).

For Severe Acute Respiratory Syndrome (SARS), a coronavirus, the inpatient treatment with no fatalities was to ventilate the patient and medicate with the antibiotic levofloxacin (Levaquin), and corticosteroids methylprednisolone IV and then prednisone (Kit-Ying '06). However, in the FY 22 HHS budget the Agency for Healthcare Research and Quality (AHRQ) warned of the danger of "ventilator-associated pneumonia". Telemedicine, hospital admission, and intensive care unit coronavirus treatment protocol should probably be to immediately treat severely infected coronavirus patients with a mentholyptus cough drop to treat pulmonary coronavirus and/or influenza. Both staff and patients must know to wash their face and nose, and chest, if SARS, with eucalyptus, lavender or peppermint soap and water to cure highly contagious coronavirus allergic rhinitis. Ampicillin or levofloxacin (Levaquin) antibiotic is needed to treat possible pneumonia. Immersion of the whole body, especially the head and nose in a saline, chlorine or healing mineral water pool or bath to instantly cures contagious coronavirus allergic rhinitis. The coronavirus allergic rhinitis is completely and immediately cured because immersing the head is the only way to fully expose the nasal mucosa to the saline solution. When the severely ill patient is clean and dried off, hydrocortisone creme can be applied to the nose and chest. If the severely ill coronavirus patient is not completely cured, the immersion of the head in saline bath can be an extended swim, with a mentholyptus cough drop, or Echinacea pill before, and hydrocortisone creme after, can be repeated, and the patient can be given a COVID-19 vaccine. If the patients is still dying from pulmonary complications of coronavirus and/or pneumonia, they can be given intravenous methylprednisolone or dexamethasone and levofloxacin (Levaquin) and ventilated, if they cannot breath, but it would be better to cure them with alternative medicine to avoid ventilator pneumonia risk and throat damaging intubation. The basic lesson is hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus allergic rhinitis. Eucalyptus or lavender also cure influenza. Mentholyptus cough drops are the frontline treatment for influenza and keep coronavirus out of the lungs and make nose washing more successful. Echinacea pills are also a lifesaving treatment for SARS (Sanders '21).

It is extremely important that people in the United States and Europe stop getting sick and dying from "affluenza" because they are so confident in the government and news media propaganda, that expensive first world government subsidized vaccination, testing, government imposed isolation, social distancing, and protective gear and modern and medical technology will save them, and not other less

fortunate people, from certain death from the descent of coronavirus allergic rhinitis into the lungs, that they retaliate against, refuse to try for themselves and teach the lesson that hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus allergic rhinitis, and eucalyptus or lavender also cure influenza. The United States is reported to have the highest COVID-19 death rate in the world. 600,000 US fatalities out of 328 million, nearly 16% of the 3.85 million global deaths, with only 4.25% of the global population. From 2019 to 2020, the estimated age-adjusted death rate increased by 15.9%, from 715.2 to 828.7 deaths per 100,000 population. COVID-19 was reported as the underlying cause of death or a contributing cause of death for an estimated 377,883 (11.3%) of those deaths (91.5 deaths per 100,000) (Farida et al '21). Contrary to news reports, in India there have been only 345,000 deaths and in China only 4,636 died. Life expectancy in the US fell by a full year in the first half of 2020, to 77.8 years, according to a report by the Centers for Disease Control. The European Union reports 736,000 deaths out of 448 million, 19% of global COVID-19 deaths. Brazil counts 498,000 COVID-19 deaths. There is no asylum to be found in Australia and New Zealand, where the population is cured by native eucalyptus trees, and the pandemic is not bad, although the political persecution attributes their success to harsh quarantines (Baker et al '20) instead of the readily available treatment the people have not been successful at getting into the mass media, although they too have tried.

In 2020 coronavirus was the third leading cause of death in the United States overall, with only heart disease and cancer claiming more US lives. At times, most notably during the third wave of cases, it spiked higher than both heart disease and cancer. The death toll in the US is more than 10 times higher than the number of Americans who died from influenza and pneumonia the year before the pandemic. The first wave in the spring began as most of the country went into lockdown and was followed by a second albeit less severe wave in the period from late summer to early autumn, before peaking in December and January 2020-2021 (Farida et al '21). Vaccines have helped to cure many people with chronic coronavirus in two weeks, restrictions have been eased, germy masks are now optional, swimming pools are open and curing people. However, the vaccine does not truly make people immune from the contagious disease, and the pandemic rages on. Fresh masks, that do not last more than 8 hours of use before they need to be discarded or washed, are only 95% effective at preventing infection, and wearing them tends to cause a slight nasal discomfort that usually goes away when it is removed, but when exposed to a severe infection, 5% exposure is likely to result in a auto-immune allergic rhinitis unless treated. There is no reason that pandemic deaths won't spike when the children go back to school, it becomes too cold to go swimming and the American medical memory is again wiped clean. Uncounted snot nosed children are all slated to return to school in the fall, to be taught by vaccinated teachers. The vaccine is indicated for children under the age of 12 and has caused pericarditis in teenagers and young adults and is certain to cause developmental defects in small children. Children are susceptible to coronavirus, but are less prone to severe illness and only 654 are reported to have died from COVID-19 as of January 2021, however they have not been in school (Leidman et al '21). To end the pandemic, for all ages, it is medically necessary that schools be instructed in the use of eucalyptus, lavender and peppermint soaps for children to wash their face and nose in the restroom and eucalyptus humidifiers (diffusers) in classrooms.

Vaccines may be helpful for hospitals and clinics to effectively cure staff and patients with severe coronavirus, in two weeks to a month, and should be integrated into the clinical and hospital treatment of coronavirus. However, COVID-19 vaccines were not designed around allergic rhinitis and the official list of symptoms, compiled by sheepish World Health Organization (WHO) workers with dangerously contagious “Pinocchio noses”, actually describes the wet cough, fever and fatigue of influenza, and vaccines do not confer any long lasting immunity, without regular involuntary exposure

to sinus clearing pseudo-ephedrine brain shrink, reserved for the scientists, public health officials and journalists whose brain damaged propaganda preceded and fuels the pandemic. To compound this confusion FDA approved combination tests test positive for COVID-19, whether coronavirus or influenza; the frontline treatment for both of which is a mentholyptus cough drop to cure the wet cough of influenza and severe acute respiratory syndrome (SARS) from coronavirus, however instead of curative treatment people who test positive are persecuted with isolation, quarantine and possible death untreated. COVID-19 vaccination does cure immediately, nor confer a lasting immunity, they absolutely do not alleviate the need for everyone to know how to treat coronavirus allergic rhinitis to prevent further infection, and patients must be trained that hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus allergic rhinitis. The good news is that the COVID-19 vaccine works better than the seasonal influenza vaccine, the COVID-19 vaccine cures coronavirus in two weeks, but does not confer any long lasting immunity after a month, whereas the seasonal influenza vaccine is believed to be completely placebo. The similarity of the two unfairly advertised vaccines can be found in the pseudo-science they have developed regarding resistant mutations, when in fact they don't work at all. Systematic review of 51 studies found no evidence that the flu vaccine is any more effective than a placebo in children (Smith et al ’08). Studies published in 2008 found that influenza vaccination was not associated with a reduced risk of pneumonia in older people (Jackson et al ’08)(Eurich et al ’08). In the winter flu season of 2012-2013 the flu vaccine was said to be only 8% effective (Fiore '09). Statistical reductions in COVID-19 deaths in long-term care facilities for the elderly indicate that the vaccines are effective, although this could also be due to unsaid improvements in hygiene, diagnosis and medical treatment, the effectiveness of vaccines is not to be disregarded by adult at risk and medically incompetent populations, it is not allowed for children under the age of 12 (Baden et al '20). All COVID-19 vaccines available in the United States typically take about 2 weeks for the body to build protection after vaccination, so that after the second dose a complete cure is effected. A two-dose regimen was found to be safe and 95% effective against Covid-19. The vaccine met both primary efficacy end points, with more than a 99.99% probability of a true vaccine efficacy greater than 30%, and greatly exceeded the minimum FDA criteria for authorization (Polack et al '20). The transient benefit of COVID-19 vaccines is that they effect a complete cure about two weeks after the first shot, that is reinforced with the second shot, that medically incompetent populations might otherwise never achieve, and once being completely cured, dramatically improves the body's ability to fight off minor infections, and reduces the risk of severe illness and death, for a while.

It has long been held, certain essential oils used in aromatherapy can treat and cure allergy and asthma symptoms where conventional medicine has failed – essential oils of lavender, peppermint and eucalyptus are particularly curative of allergic rhinitis (Sapeika '63). In response to the COVID-19 pandemic a number of in vitro studies have supported eucalyptus, echinacea, lavender, mint and menthol remedies, over less effective remedies, however instead of giving over-the-counter natural medicine vendors clinical trials of their claims to cure coronavirus pursuant to 21CFR§330.10 the FDA is reported to have pseudo-scientifically threatened them with injunctions under 21USC§331 et seq. (Asif et al '20)(da Silva et al '20)(Patne et al '20). Echinacea is also a highly effective natural remedy for coronavirus (Aucoin et al '20)(Signeur et al '20) however it typically comes in pill form and is most effective as a life-saving treatment for SARS. Eucalyptol (1,8 cineole) from eucalyptus essential oil is probably the most highly recommended coronavirus treatment (Sharma et al '20a)(Sharma et al '20b). At the beginning of the pandemic even the FDA approved Lysol, active ingredient eucalyptol, it cures as it cleans, and the brain damaging ammonia smell from the lengthy EPA list of cleansing products accompanying the CDCs new guidance for reopening schools, that omits FDA approved Lysol, must be overruled, in favor of Lysol. Lavender, mint and menthol, made from mint, are also proven to cure

coronavirus, but are not so highly acclaimed as eucalyptus (Asif et al '20)(da Silva et al '20)(Patne et al '20). While Hall's menthol cough drops, probably work, it is better to make sure to purchase mentholyptus cough drops that contain eucalyptus flavor, to be doubly sure to cure coronavirus and influenza.

The testing bias in the CDC guidelines for the return to school also needs to be checked for allergic rhinitis to prevent the contagion from being spread by unwitting vaccinated persons and people who have been previously tested, who have been wrongfully exempted from discriminatory testing. CDC normally receives funding from CMS to pay for childhood vaccines, health professionals routinely, cruelly, refuse to report adverse reactions about to the Vaccine Injury Compensation Fund, and CDC is believed to receive money from Congress to distribute COVID-19 vaccines, and behaves with an extraordinarily unscientific, legislative propaganda reinforced, bias for the COVID-19 vaccine (two week cure) also seen in the anti-competitive advertisement of the completely placebo influenza vaccine. To complicate matters infinitely the CDC Injury Prevention and Control program has conspired with the Department of Justice to distribute, without spending limits, terrorist Office of National Drug Control Program (ONDCP) grants to rob marijuana to push methamphetamine, that have been expelled from the White House by the Trump Administration, except a small office to intoxicate the President. It is necessary to repeal ONDCP intoxication under 21USC§1701 *et seq*. The legal, health, scientific and journalist sectors are rife with exposure to "two bag meth" - sinus clearing pseudo-ephedrine brain shrink and TMJ causing anti-depressant that causes a violent withdrawal – to explain the illiterate COVID-19 propaganda and censorship and retaliation against the OTC coronavirus treatment that must be prescribed by public health authorities in the mass media to end the global pandemic, by the global public health authorities and mass media, hell-bent on eliminating "vaccine hesitancy". To prevent perpetuation of either abusive or negligent political persecution in regards to COVID-19 the purpose of the testing must be to test before and after administering curative and harmless over-the-counter coronavirus remedies – medicinal bathing submersing head in saline, chlorine or healing mineral water, washing the face and nose with eucalyptus, lavender or peppermint soap, echinacea pills, mentholyptus cough drops etc. before resorting to a fews dabs of hydrocortisone creme to the nose and chest.

Social and chain smoking menthol tobacco may be most effective remedy for coronavirus on the street because it sterilizes the environment. The July 2021 outbreak of coronavirus is almost certain to have occurred because the FDA Center for Tobacco Products and Secretary of Health and Human Services conspired to withdraw menthol tobacco from the market and adulterated a large market sector of the menthol additive in tobacco products in sealed packages on store shelves in flagrant violation of 21USC§387b. They were racially motivated by lung cancer in African-Americans, but were in fact suppressing information that menthol tobacco cures coronavirus and hydrocortisone creme cures carcinogenic pulmonary aspergillosis in one blow of their "Pinocchio nose" - hate crime. There was an immediate outbreak of coronavirus in Washington DC probably because the African-American majority smoke a lot of menthol tobacco, and were specifically targeted in this terrorist attack. By June, HHS had adulterated a majority of the market share of menthol tobacco in many states. Adulterating the menthol tobacco additive, with neurotoxic mullein extract, aspergillus mold etc., made the coronavirus remedy ineffective. Nearly 10% of the population either smoke menthol or got their coronavirus cure from secondhand menthol tobacco smoke. They quickly became as contagious as those vaccinated people who still don't know how to treat their allergic rhinitis because they are COVID-19 vaccine and symptom propaganda [sic]. The menthol injunction threat is overturned. The uncited Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol versus Non-

Menthol Cigarettes by the Tobacco Product Scientific Advisory Committee of March 23, 2011 held, the weight of evidence supports the conclusion that menthol in cigarettes is not associated with an increase in disease risk to the user. Extraneous tobacco definitions need to be repealed from 21USC§321(rr) para. 2-4.

The FDA Center for Tobacco Products (CTP) tobacco adulteration research and teenage rebellion propaganda is fined $100 million of their $763 million FDA revenues FY 22; CTP spending, considered to be abolished entirely, Secretary of HHS considered for impeachment, for felony monopolization in violation of the Sherman Anti-Trust Act under 15USC§2. $5,000 fine should be paid to sponsor clinical trials of each natural coronavirus cure that was threatened with an injunction pursuant to the Clayton Anti-Trust Act under 15USC§13a up to $15,000 compensation for personal suits for injury under 15USC§15. $10 million for the Alcohol, Tobacco, Tax and Trade Bureau to redress tobacco product adulteration in violation 21USC§387b. $20 million for the postal service to redress the speedy delivery of online pharmaceuticals that have been counterfeited in violation of 21USC§331 and 39USC§101 pursuant to 21USC§381(u) that needs to be repealed. The remaining $70 million should be used by the FDA to secure clinical trials of over-the-counter coronavirus cures against the FDA's biased record of political persecution, pursuant for $5,000 to $15,000 under 15USC§13a and §15. Clinical trials should test for coronavirus before and after treatment, tabulate results and follow-up until the patient is cured and trained in the various methods of treating coronavirus allergic rhinitis and/or severe acute respiratory syndrome (SARS). The VA is highly encouraged to improve their outrageous 11.9% in-hospital COVID-19 mortality with clinical trials pursuant to procedures for classifying over-the-counter remedies safe and effective under 21CFR§330.10. The basic lesson is hydrocortisone, eucalyptus (echinacea), lavender, peppermint or salt helps water cure coronavirus allergic rhinitis. Eucalyptus or lavender also cure the wet cough of influenza. The most effective and immediate cure for coronavirus allergic rhinitis is immersion of the head in saline or chlorine water, eg. Swimming. A mentholyptus cough drop and/or echinacea pill may be necessary to treat severe acute respiratory syndrome (SARS). One of the most important clinical trials, to ensure a sterile work environment in hospitals, especially intensive care units and waiting rooms, with particular concern regarding a coronavirus free return to school in September 2021, are clinical trials of eucalyptus humidifiers (diffusers).

Chapter 2 Discrimination against Disability

To make a long nose short, for a long time the VA has engaged in a pattern of discrimination against disability, in regards to not paying for necessary repairs to make Battle Mountain Sanitarium handicap and family accessible, in violation of Sec. 102 and 202 of the Americans with Disabilities Act (ADA)of 1990 under 42USC§12112 and 42USC§12132 pursuant to the Architectural Barriers Act under 42USC§4151 et seq. and 36 CFR 1191 App. C and asbestos and (child dangerous) lead based paint abatement under 40CFR§61.145 and 40CFR§745.227 respectively, to perfect *bona fide* claims of the VA to own the land at Battle Mountain Sanitarium Reserve under 24USC§153. Although ramps improved accessibility they do not meet ADA standards (Lyle '07)(Julin '08: 70). The facilities at Hot Springs were constructed as early as 1907 and would need significant renovation to meet the ADA guidelines and VA’s Barrier Free Design Guide. The 2015 Facility Condition Assessment of the Hot Springs Campus identified 15 conditions specifically related to accessibility estimated to cost $15.2 million. The 2015 Facility Condition Assessment for Hot Springs identified an additional $33,972,546 required to correct deficiencies in the architectural, electrical, mechanical, plumbing, steam generation/distribution, structural, transport, information technology, and hazardous materials (asbestos

and lead paint) systems of the campus buildings; and site work relating to parking lots, roads, and other items. The total cost to address all facility condition deficiencies at Hot Springs was estimated to be $49,190,661. A separate study in 2012, "Analysis of VA Cost Options for VA Facilities with Status Quo Option; Updated with Input from Historic Architect" reported overall 30-year costs of needed non-recurring renovations and capital life-cycle costs at $63,184,331 (BHHCS '16: 12-13). A third price quote by contractors prepared to do the job are likely to be even less. A $50 million balance should be made available to afford renovation obligations for disability accessibility and environmental health.

Accessibility Deficiencies at VA Hospital Medical Center, 2015

Cost	B. No.	Building Name	Accessibility Issue
$63,325	10	Catholic Chapel, Electric Room	Rework ramps to provide accessible route.Replace door knobs with lever hardware along accessible routes. Renovate public and staff toilets to comply.
$18,697	11	Auditorium, Library	Small diameter (1-inch) handrails at connector do not meet criteria and should be replaced.
$987,222	12	Hospital	Many public and staff toilets do not comply or partially comply. Accessible toilets are limited to Ground and 1st Floor but not on the upper floors. Remodel to provide accessible facilities where required. Replace door knobs with lever hardware along accessible routes (approx 25 percent of doors).
$8,414	14	Facilities Management, MAS	Interior accessible routes and public and staff toilets on Floor 1 partially comply. Floor 2 Offices not accessible (less than 2,000 sf, no action recommended). Replace door knobs with lever hardware on Floor 1. Install lever faucets and grab bars at Floor 1 toilet.
$560,922	2	Dom Kitchen, EMS	Renovate public and staff toilets. Replace door knobs with lever hardware along accessible routes.
$137,114	20	Day Care / Quarters	Exterior entrances, interior accessible routes and stairs, and toilets partially comply with criteria. Ground Floor: accessible from rear. Construct ramps and landings for accessible entries to Floor 1. Renovate at least one (1) toilet for accessibility on Floor 1. Replace door knobs with lever handles along accessible routes.
$249,298	21	Apartments	Exterior entrances and interior accessible routes and stairs do not comply with criteria. Replace door knobs with lever hardware along accessible routes. Provide ramps to Ground and Floor 1. Renovate at least one (1) Apartment Unit for accessibility.
$2,056,713	3	Dom Quarters, AMMS,	Interior accessible routes and ramps, public and staff toilets, Dom resident rooms, toilets and bathing facilities do not comply with criteria. Renovate resident rooms, toilets and bathing facilities to

		Fiscal	meet accessibility criteria. Ramps from Arcade are up to 1:6 slope. Rework ramp from B to C Levels. Install elevator to provide access to all floors. Replace door knobs with lever hardware throughout.
$2,461,823	5	Dom Quarters, Canteen	Interior accessible routes and ramps do not comply. Ramps from Arcade are up to 1:6 slope. Rework ramp from B to C levels and install elevator to provide access to all floors. A Level Domiciliary resident rooms and A and B Level resident toilets and bathing facilities do not meet accessibility criteria. C Level public and staff toilets do not comply and should be renovated. Replace door knobs with lever hardware on approx. 50 percent of all doors.
$24,930	53	Nutrition Food Svc., Eye, Podiatry	Public and staff toilets partially comply; remodel toilets and showers to meet criteria. Replace door knobs with lever hardware along accessible routes (Basement toilets and locker costs included with Interior Finish / Door).
$2,337,173	6	Dom Quarters, Warehouse	Interior accessible routs and ramps do not comply. Ramps from Arcade are up to 1:6 slope. Rework ramp from B to C levels and instal elevator to provide access to all floors. Domiciliary resident rooms and toilets and bathing facilities do not comply. Renovate resident rooms toilets and bathing facilities to meet accessibility criteria. Replace door knobs with lever hardware throughout building.
$31,162	66	Fire & Security	Replace door knobs with lever hardware. Renovate public (office toilet to meet criteria.
$3,116,231	7	Dom Quarters, Arts & Crafts	Interior accessible routes and ramps do not comply. Ramps from Arcade are up to 1:6 slope. Rework ramp from B to C Levels, and install elevator to provide access to all floors. Domiciliary resident rooms, and toilets and bathing facilities do not comply. Renovate resident rooms, toilets and bathing facilities to meet accessibility criteria. Replace door knobs with lever hardware throughout.
$3,116,231	8	Dom Quarters, Recreation	Interior accessible routs and ramps do not comply. Ramps from Arcade are up to 1:6 slope. Rework ramp from B to C Levels, and install elevator to provide access to all floors. Replace door knobs with lever hardware throughout. Domiciliary resident rooms, and toilets and bathing facilities do not comply. Renovate resident rooms, toilets and bathing facilities to meet accessibility criteria.
$49,860	9	Protestant Chapel	Rework ramps to provide accessible route. Replace door knobs with lever hardware along accessible routes. Renovate public and staff toilets to comply.
$15,218,115			TOTAL

Source. Table 1-3 pg. 14

The current Hot Springs Campus domiciliary layout, including open-bay sleeping and communal bathrooms, does not meet current VA standards for delivery of Mental Health Residential

Rehabilitation Treatment Program (MH RRTP). No accommodations for single- parent Veterans. Small town setting offers limited opportunities for employment, housing, and permanent re-integration. Resident rooms are institutional in character. Living, dining, limited kitchen, laundry facilities are shared by 8 to 16 residents. Public transportation, housing and work opportunities are very limited. Discharge planning can be extremely challenging for those with a history of homelessness, co-occurring mental health disorders that impact independence, and lack of income. This results in extended length of stays for those Veterans (BHHCS '16: 18). On the flipped out side, there are few opportunities to buy illicit drugs in Hot Springs and when the corner store menthol tobacco products are adulterated by the Secretary of Health and Human Services, in a fit of rage that menthol tobacco is a more effective cure for coronavirus than his beloved vaccine monopoly, there is no tobacconist to buy well-regulated tobacco from, so one out of three quits, nor are there bars for the so-called social drinker. Point being, the paucity of economic opportunity to buy illicit drugs in rural care may be helpful for detox, and the VA should not excessively discriminate against the rural economy.

Non-recurring maintenance (NRM) program funds additions, alterations, and modifications to land, buildings, other structures, nonstructural improvements of land, and fixed equipment (when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure) to maintain and modernize existing campus facilities, buildings, and building systems; replace existing building system components; provide for adequate future functional building system capacity without constructing any new building square footage for functional program space; and/or provide for environmental remediation and abatement, and building demolition. VHA uses the NRM program as its primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments. These assessments are performed at each facility every three years and highlight a building's most pressing and mission critical repair and maintenance needs. VHA specifically supports research and development infrastructure projects by ensuring that the Office of Research and Development is involved in the identification of gaps to support the Strategic Capital Investment Planning (SCIP) process. This inclusion ensures a research focus for mitigation within a ten-year window of identified research infrastructure deficiencies (VHA '21: 382). While not specifically mentioned in the Budget Submission, the 2015 Facility Condition Assessment does estimate the costs of the ADA compliance. It is possible that the VA Budget Submission needs to specifically recognize NRM responsibility for ADA compliance to better prohibit retaliation and coercion pursuant to Sec. 503 of the Americans with Disabilities Act under 42USC§12203.

The purpose of VA's proposal to reconfigure health care services in the BHHCS is to provide high-quality, safe, and "accessible" health care for Veterans well into the twenty-first century. The VA is advancing dangerous rhetoric that Veterans currently face long distances, extended travel times, and travel costs to access primary and secondary care. This is dangerous rhetoric because hyperinflation in excess of 20% annually, to finance lower quality community care, close to home (invasion), has been the primary driver of the VA budget 10% hyperinflation, since its inception in FY 17 all the while refusing to pay for handicap "accessible" repairs. The Government Accountability Office, Veterans Community Care Program *Improvements Needed to Help Ensure Timely Access to Care* report found that almost all VA health care facilities were able to schedule appointments within 30 days 80 to 100 percent of the time, depending on the location, however wait for community care were often more than a 100 days (GAO '20). This hyperinflation to provide eligible Veterans access to health care close to home, seems to hypocritically come at the expense of disability accessibility reconstruction at Battle Mountain Sanitarium and referral to and upkeep of VA medical centers and clinics everywhere. Travel distance may become more of an issue if services are relocated to Rapid City and/or Fort Meade, which

is approximately 1.5 hours from Hot Springs. With respect to travel assistance, VA BHHCS offers transportation through the Veteran Transportation System (VTS) (e.g., the DAV and community Volunteer Transportation Network, government-owned vehicles, and VTS wheelchair-equipped vans) throughout the health care system to all Veterans with a VA-approved appointment without regard to beneficiary travel eligibility (BHHCS '16: 45).

Instead of paying for the non-recurring cost of disability, environmental abatement and family accessibility renovations, cuts in VA appropriations were noted, before the VA reconfiguration scheme was released in 2016. BHHCS budget for Fiscal Year (FY) 2010 was $142 million. The FY 2011 budget was $147 million, an increase of approximately $5 million. The FY 2011 appropriations are as follows: medical received $113.5 million, facility received $25.8 million, and administration received $17.6 million. The FY 2012 budget was $142.5 million, a decrease of approximately $4.5 million. The FY 2012 appropriations are as follows: medical received $99.9 million, facility received $22.1 million, and administration received $14.1 million. The VA BHHCS received supplemental funds from the Veterans Integrated Service Network (VISN) in FY 2010 for $1.7 million, $4.8 million for FY 2011 and is believed to have received $6.4 million FY 2012. A Freedom of Information Act (FOIA) request has been made for BHHCS 2011-2021 financial reports pursuant to the Anti-Deficiency Act. These cuts in 2012, and their micro-economic mathematical tricks, clearly indicate that the VA has utilized standards, criteria, or methods of administration, that have the effect of discrimination (in regards to not funding non-recurring maintenance and cutting basic funding, in a way that is detrimental to employment) on the basis of disability; and perpetuates the discrimination of others who are subject to common administrative control (that deprives them of ADA access to asbestos and lead free campus, etc.) in violation of Sec. 102 of the ADA under 42USC§12112(a)(b)(3). No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity pursuant to Sec. 202 of the ADA under 42USC§12132.

VA falsely accuses BHHCS of having the highest cost per unique patient among VISN 23 health care systems, many of which have facilities that offer more costly and more highly complex medical services compared to those available in VA BHHCS. Based on FY 2014 data, VA BHHCS's cost per unique patient was approximately $9,404 and was $8,960 and $8,958 in FY 2013 and FY 2012, respectively. In FY 2011, the last year for which data is available, BHHCS saw 20,421 unique veterans and had a budget of $147 million, a per capita cost of $7,199. The VA estimates FY 2014 cost was approximately 22 percent higher than the next highest cost (VA Minneapolis Health Care System at $7,713) and 23 to 65 percent higher than the other health care systems VISN-wide, whose costs per unique Veteran ranged from $5,690 to $7,670 in FY 2014. It would seem that the accusation that costs are higher in BHHCS are false. The VA admits a contributing factor to the relatively high costs within VA BHHCS, which was formed in 1996 through the merger of the Fort Meade and Hot Springs VA Medical Centers, is the increasing age and cost of operating, maintaining, and improving buildings that range from 40 to over 100 years old. VA BHHCS maintains 464,000 square feet and 77 acres of property at Hot Springs and 820,000 square feet and 220 acres at Fort Meade. Both of these campuses must maintain a full suite of site services (fire department, security, laboratory, nutrition and food, radiology, and others) serving a total of more than 1.2 million square feet of space. Maintaining this costly infrastructure diverts financial resources from direct patient care. For example, the VA staffed police and fire protection units at Hot Springs alone requires over $3.5 million annually for maintenance (BHHCS '16: 20). It is true, if one adds the $50 million cost of renovations at the Hot Springs campus, the total budget for FY 2011 would have been $197 million, and per capita cost

$9,733. However, the VA did not pay for the renovations and falsely accused BHHCS of these costs.

The VHA needs to both stop falsely accusing the victim of budget cuts of high costs and sustain growth in the regular budget while paying for non-recurring maintenance (NRM) of the facilities. The VHA must stabilize BHHCS regular costs at 3% inflation from $147 million FY 2011, $197 million FY 2022, this should be enough to afford 50 new personnel at a Rapid City, when that scheme to discriminate against disability turns into anti-trust settlement. Additionally, the VHA must pay for the $50 million cost of repairs at the Hot Springs Campus, and another $50 million for the proposed MSOC in Rapid City, with VHA non-recurring maintenance funds. VHA facilities budget cuts are obviously a major problem that impairs the judgment of the Assets and Infrastructure Review Committee. Non-recurring maintenance and construction costs should not distort local agency budgets. Major and minor construction projects, should be budgeted, painlessly, via 3% inflation to the VHA facilities budget. Unfortunately medical facilities finance a significant proportion of their costs with un-obligated funds from the previous year, and this is a behavioral problem, because not fulfilling the obligations they budget for, and like to retaliate against prospective beneficiaries for, is a major source of revenue, for the extremely budget cut compromised VHA facilities budget that will have lingered between $6 and $7 billion for longer than 42 months (Revelation 13:10) mid-year FY 22. To bring an end to this cruel and unusual treatment, of expensive construction and rehabilitation, non-recurring maintenance jobs, VHA should take in stride, it is legally necessary that the VHA facilities budget be increased to at least $7 billion FY 22 and grow 3% annually every year thereafter.

VA is not requesting additional discretionary resources for Medical Facilities above the enacted 2022 Advance Appropriation of $6.735 billion, although by the middle of FY 22 this would extend the length of time the VHA facilities budget has fluctuated between $6 and $7 billion, beginning with a cut in FY 19, beyond the 42 months allowed such persecutions (Revelation 13:10). In 2022, VA projects obligating $2.6 billion out of unobligated balances provided by sections 8002 of the American Rescue Plan Act for activities traditionally funded by the Medical Facilities discretionary appropriation, as authorized in the Act. When these resources are combined with available transfers, reimbursements, and other net unobligated balances, Medical Facilities will not meet the projected 2022 obligation level of $9.5 billion, as the VA supposes, they are $165 million short. Including the $100 million cost of this prospectus to renovate Battle Mountain Sanitarium in Hot Springs and construct or lease a larger Multi-Specialty Outpatient Clinic in Rapid City, South Dakota, Congress must approve to add to the list of major construction projects under 40USC§3307, to be mathematically and legally correct and theologically $7 billion by 42 months. Congress is obligated to supplement the VHA facilities appropriation by $265 million to $7 billion FY 22 pursuant to the Anti-Deficiency Act under 31USC§1341 and 31USC§1515.

With a long history of 10% annual agency hyperinflation continuing into FY 22, and budget cuts at Hot Springs campus since at least FY 11, the VA is too rich to argue that their account does not have budget authority sufficient to cover the total cost of their obligation to the VA Medical Center at Battle Mountain Sanitarium Reserve at the time the obligation is incurred, to prevent Veteran health care from being diverted to higher cost and lower quality commercial health care providers, abusing the same pursuit of the Anti-Deficiency Act under 31USC§1341. The United States currently operates on the basis of the Federal Reserve “buying” rather than selling debt incurred counterfeiting currency to pay for deficits in excess of 3% of GDP under 31USC§5153. There is no need to panic or cut federal agency budgets because when and if the United States is ever convicted of counterfeiting more than $3.3 trillion they will only need to devaluate the US dollar somewhat more than 16% pursuant to the

Marshall Lerner Condition under 19USC§4421, 22USC§5301 *et seq*. and 2020 Revised estimates: effect of changes in rates of exchange and inflation Report of the Secretary-General A/74/585 of 11 December 2019. Due the length of this work it seems unlikely that the annual federal budget review will be entirely completed before the new fiscal year, and the exact amount of devaluation will instead be estimated by the December deadline set by the calendar year. If the VA does not agree to settle, this Sherman Anti-Trust and Anti-Deficiency Act case may be reviewed by the local US District Court pursuant to the Administrative Procedures Act under 5USC§706, *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U. S. 402, 410 (1971) and *Grayned v. City of Rockford* 408 US 104 (1972).

Chapter 3 Hot Springs Medical Center Campus

The Hot Springs Campus occupies the buildings constructed in 1907 as part of the Battle Mountain Branch of the National Home for Disabled Volunteer Soldiers, the first to serve entirely as a medical center. The Battle Mountain Sanitarium was recognized as a National Historic Landmark in 2011. The property also is a contributing element to the Hot Springs Historic District, a property listed in the National Register of Historic Places. Services provided at the VA Hot Springs Campus include primary care, urgent care, pharmacy services, outpatient surgery, inpatient care (10 beds), dialysis, x-ray and mobile imaging, specialty care, laboratory services, mental health, and a call center. There are also seven beds for long-term care in a Community Living Center (nursing home) and 100 beds for the RRTP that serves homeless Veterans and provides mental health services for post-traumatic stress, substance abuse, alcohol abuse, and other conditions (BHHCS '16: 185). The Hot Springs Campus has a low acute inpatient census, averaging five patients in the 10 available beds. When alcohol detoxification, which is provided on an outpatient basis in most treatment settings, is subtracted, the average acute inpatient daily census decreases to less than four patients (BHHCS '16: 9). At Battle Mountain Sanitarium the greatest number of patient encounters is associated with monthly care in the RRTP. These Veterans come from all over the United States, with just over 40 percent living within the BHHCS service area and only approximately 25 percent of the total residing in Fall River and Pennington Counties (BHHCS '16: 27). While not entirely competitive with urban public transport in Rapid City, rural public transit services are available in Hot Springs and Fall River County. Prairie Hills Transit, a non-profit organization, provides public transportation within Hot Springs and service to Rapid City, Custer, and Edgemont via disability accessible vehicles. The transportation service is available Monday through Friday from 7:00 a.m. to 4:00 p.m. with a 24-hour advance request. Bicycle and pedestrian routes in the Hot Springs area include the Freedom Trail that parallels Fall River through the city, the George S. Mickelson Trail that crosses the western part of Fall River County (BHHCS '16: 202) and the Centennial Trail that runs from Wind Caves National Park to Sturgis.

Hot Springs Campus has insufficient patient volume to support services or specialties in addition to those currently provided. In fact, some of the services currently provided are not adequately supported. For any particular health service, a certain patient volume is required for a facility to responsibly offer that service, medically and financially. In 2010, VA completed a nationwide review of surgical facilities and classified each one to ensure that scheduled (non-emergency) surgical procedures do not exceed the infrastructure capabilities. Each inpatient surgical program was assigned a "surgical complexity" level of *standard* (such as an appendectomy), *intermediate* (such as a shoulder joint reconstruction), or *complex* (such as coronary artery bypass surgery); and each ambulatory (outpatient only) surgery center was assigned a surgical complexity level of either *basic* (for example, surgical removal of a skin cancer) or *advanced* (such as laparoscopic gallbladder removal) (BHHCS '16: 10) for gallstone patients not treated with Stonebreaker (Chanca piedra) that eliminates both urinary and gall-

stones overnight. In 2010, the Hot Springs Campus was designated as a basic-level ambulatory surgical facility. VA BHHCS had been discontinuing providing certain medical services at the Hot Springs Campus at points when the infrastructure (as described in the discussion of critical mass of patients below) was determined to no longer safely support that service or type of care. This prospective mitigation of risk was to specifically prevent an increased rate of unfavorable medical events. The availability of a surgeon and other health care providers after a surgery in the case of post-operative complications; the last operating room procedure was performed in Hot Springs in April 2011 (BHHCS '16: 9). Between 2012 and 2015 the Ft. Meade campus constructed a two story addition to house a surgery department (BHHCS '16: 4).

Surgical outcomes are significantly improved by seeking treatment in hospitals that frequently perform the procedure (Sweeney ’03: 43). As technology-enabled trends in U.S. Medicine [sic], and especially precision medicine that takes into consideration safe and effective generic, natural and over-the-counter remedies, are integrated into medical knowledge, bringing care closer to individuals and communities, there is less demand for prodigious, sprawling campuses and more emphasis on ambulatory facilities and virtual care. Many surgical, medical and diagnostic procedures that once required a hospital stay are now safely performed in the outpatient setting, and telehealth and teleservice delivery bring expertise to a patient’s own home. This evolving landscape requires VA to rebalance and recapitalize its infrastructure to optimize the mix of traditional inpatient hospitals with outpatient hospitals, multi-specialty Community Based Outpatient Clinics, single specialty Community Based Outpatient Clinics and virtual care (VHA '21: 16). The reconfiguration study proposes national Pharmacy call center would provide approximately an additional 120 new jobs (BHHCS '16: 385). The VA should be honored that Battle Mountain Sanitarium upholds the Hippocratic Oath to not use the knife, even on those with stone, because they know to cure urinary and gallstones with Stonebreaker (Chanca piedra).

At the 2011 State Convention, The American Legion Department of South Dakota passed a resolution that the VA Medical Center and Domiciliary continue to remain in Hot Springs. The department has never received an answer from VA as to the cost to bring the facility into compliance with the ADA standards. Other concerns voiced were, about the privatization of health care for veterans, local medical facilities not being familiar with veterans; the veteran becoming just a number, questions about the quality of care for veterans under this plan and the distance to travel for health care and neighboring states wanting to use the Hot Springs VA. VA staff and local businesses have considerable concerns of job retention. At a population of only 4,000, the medical center provides significant economic stability to the Hot Springs Community. Staff and other community member’s home values may decline. School District’s staff may suffer job retention and funding may decline. Since constructed in 1907, concerns of its historic preservation are in question. The local hospital may not be able to meet the needs of these veterans from Hot Springs.

National American Legion Recommendations are that VA should not relocate and/or close medical services until a new facility is in place in order to accommodate the health care needs of the veterans in

the Hot Springs catchment and/or surrounding areas. VA should maintain the same level of care and/or services, and provide equal understanding of veteran's health care needs, if contracted to non-VA medical facilities. If the VA Medical Center was to be closed, VA should plan to open a super CBOC to provide both primary and specialty care services. VA should keep the domiciliary on the Hot Springs Campus to provide longterm/extended care to meet veteran's long term care needs. The VAMC should search for opportunities to make use of the State Veterans Home in Hot Springs. Future plans should reflect necessary services that veterans in the Hot Spring's catchment and surrounding areas need. Without viewing a finalized contract with the local hospital in Hot Springs, The American Legion at this time cannot ensure reconfiguration of inpatient services will provide the same quality of care that veterans are currently receiving at the Hot Springs Campus. Due to the widespread attention generated by VA's proposal to vacate the Hot Springs Campus, VA agreed to evaluate alternatives offered by the public (BHHCS '16: 37). Neither American Legion nor VA should mistake the high cost of commercial health care in the United States, with the high quality of free VA care, whereas three recent studies published in prominent medical journals confirm VA outcomes are superior to the private sector across a broad range of measures (DeLancey et al '17)(Price et al '18)(Weeks et al '18).

In 2014 VA notified the Advisory Council on Historic Preservation (ACHP), the State Historic Preservation Office (SHPO), the National Park Service (NPS), as the steward of National Historic Landmarks (NHL) and Tribal Historic Preservation Officers of federally-recognized tribes with geographic or cultural ties to the Black Hills pursuant to Sec. 106 of the National Historic Preservation Act. Four parties objected to substitution of the National Environmental Policy Act (NEPA) for the National Historic Preservation Act (NHPA). Section 110 of the National Historic Preservation Act requires that prior to acquiring, constructing, or leasing buildings for purposes of carrying out agency responsibilities, each federal agency shall use, to the maximum extent feasible, historic properties available to the agency in accordance with Executive Order No. 13006 *Locating Federal Facilities on Historic Properties in our Nation's Central Cities* (BHHCS '16: 31-32). The public scoping period was open for 90 days from May 16 through August 16, 2014. The scoping process provided sufficient opportunity for stakeholders to express their comments and provide meaningful input to the integrated NEPA/NHPA process. There were 386 written comments received, 159 verbal comments made during the scoping meetings, and a form letter submitted by 138 individuals. The comments focused generally on the purpose, need, and alternatives for the reconfiguration; potential effects to local social and economic conditions, community services, and utilities; the National Historic Landmark (NHL) status of the VA Hot Springs Campus and potential adverse effects to historic properties and cultural resources; integration of NHPA consultation with the NEPA process; and implementation of the NEPA process (BHHCS '16: 422).

After annoying NEPA in daylight hours, although sued under the ADA, the plan to mothball NHPA is that following publication of the Record of Decision (ROD), and until portions of the Hot Springs campus are transferred to another entity or the campus buildings are preserved in accordance with the comprehensive preservation plan, VA shall make available to a local group or organization the greenhouse, so that group may determine if it is feasible to reactivate, operate and maintain it, and to use it to grow vegetation (medical marijuana) for the campus or town landscape. VA shall support the Hot Springs Historic Preservation Commission to complete an application for the Preserve America program for the town of Hot Springs. This support may include, but is not limited to, technical assistance, staff support, shipping fees, copy fees, and photography. VA shall host an annual reunion for patients, staff, and other community residents to commemorate the history of the Battle Mountain Sanitarium and celebrate the service of the residents of Hot Springs to our nation and our nation's

Veterans. During this reunion, VA shall establish an oral history booth/tent so participants may record oral histories. Within applicable laws and regulations, VA shall produce or contract for the production of, a book about the historical significance of the Battle Mountain Sanitarium/VA Hot Springs campus, the Hot Springs Historic District, and the spirit of service to country in Hot Springs. This book shall be authored by a professional writer with experience writing commemorative history books; it shall not exceed 300 pages. This book shall contain photos of the Battle Mountain Sanitarium prior to implementing any mothballing plan. At least one chapter of the book will be devoted to the National Homes for Disabled Volunteer Soldiers. This book shall include information gathered from the oral history project established at the annual Battle Mountain Sanitarium/VA Hot Springs reunions. VA shall develop a mobile application ("app") to memorialize the Battle Mountain Sanitarium (BHHCS '16: 410-411).

Battle Mountain Sanitarium challenges are said to be: Declining veteran population. Only 39 percent of enrolled veterans reside within 60 miles of the medical center. However, 60 percent of Battle Mountain Sanitarium patients come from outside the BHHCS service area entirely, due to the national attraction of the National Historic Landmark. Hot Springs Domiciliary is not compliant with Americans with Disabilities Act (ADA). The building is not completely handicapped accessible with limited elevators, ramps steeper than mandates, and bathroom accessibility. This building should be completely handicapped accessible for disabled veterans. However, instead of paying for residential treatment to comply with the ADA, the VA has proposed to close the Hot Springs campus entirely, construct two new facilities in Hot Springs and Rapid City, at great cost, and pay for it by cutting total staff. Low average of five hospital inpatients daily which is insufficient to maintain medical staff specialization. Limited specialty care and surgical procedures due to insufficient veteran case load. Costly maintenance of infrastructure requires diverting resources from direct care. However, instead of paying to comply with disability accessibility and environmental health regulations, at Battle Mountain Sanitarium Reserve, VA has discriminatorily proposed a reconfiguration of the services provided within the catchment area of the VA Black Hills Health Care System (BHHCS). The reconfiguration would call for the closing of the VA Medical Center in Hot Springs, opening a new Community Based Outpatient Clinic (CBOC) in Hot Springs, transferring some services to Rapid City, and using Fee Basis at Fall River Hospital. Effort must be made to ensure that the alteration of a property, including restoration, rehabilitation, repair, maintenance, stabilization, hazardous material remediation, and provision of handicapped access, is consistent with the Secretary's *Standards for the Treatment of Historic Properties* (36 CFR 68) and applicable guidelines.

For the sake of the VHA facilities management budget it seems important to emphasize just how many expenses, other than non-recurring maintenance, they are obligated to pay. The Medical Facilities appropriation supports the operation and maintenance of Department of Veterans Affairs (VA) hospitals, community-based outpatient clinics (CBOCs), community living centers, domiciliary facilities, Vet Centers, and the health care corporate offices. The appropriation also supports the administrative expenses of planning, designing, and executing construction or renovation projects at these facilities. The staff and associated funding supported by this appropriation are responsible for: keeping the VA hospitals and clinics climate controlled; maintaining a clean and germ- and pest- free environment; sanitizing and washing hospital linens, surgical scrubs, and clinical coats; cleaning and sterilizing the medical equipment; keeping the hospital signage clear and current; maintaining the trucks, buses and cars in good operating condition; ensuring the parking lots and walk ways are sanded and free of snow and ice; cutting the grass; keeping the boiler plants and air conditioning units operating effectively; and undertaking certain repairs and alterations to the buildings to keep them in

good condition. Construction of new or replacement facilities are paid for under the Non-recurring Major Construction or Minor Construction appropriations (VHA '21: 378-379). VA must request authorization from Congress to spend funds on major medical facility construction projects exceeding $20 million and lease projects with annual rent exceeding $1 million. VA must provide prospectuses for major construction and major lease projects to support the authorization requests. Design and planning funds do not require authorization (VACLRCPA '21: i-7).

Medical waste is routinely generated through operations at both the Hot Springs Campus and the Rapid City CBOC. Medical waste is collected by a third party and transferred to Stericycle in Dacono, CO, where wastes are treated for ultimate disposal. In FY 2013, the Hot Springs Campus generated 12,754 pounds of medical waste and the Rapid City CBOC generated 806 pounds of medical waste. The Hot Springs Campus is classified as a RCRA Conditionally Exempt Small Quantity Generator (CESQG) of hazardous waste. CESQGs generate 100 kilograms (220 pounds) per month) or less of hazardous waste or 1 kilogram (2.2 pounds) per month or less of acutely hazardous waste. Additionally, CESQGs may not accumulate more than 1,000 kilograms (2,200 pounds) of hazardous waste at any time. During FY 2014, the Hot Springs Campus generated 603 pounds of hazardous waste, including 4 pounds of acutely hazardous waste (VA 2014b). All generated hazardous waste is contracted for transportation and disposal at authorized facilities. The Hot Springs Campus stores some hazardous materials in ASTs; no USTs are present at the site. Three ASTs (39,590 gallons each) store #2 diesel fuel oil for site heating purposes. Twelve additional ASTs (ranging from 40 gallons to 2,000 gallons) store #1 and #2 diesel fuel, gasoline, hydraulic oil, cylinder oil, and compressor oil. ASTs at the site are located within secondary containment and are managed in accordance with the site Spill Prevention, Control, and Countermeasures Plan. Rapid City CBOC operations do not utilize any ASTs or USTs. Radioactive materials are used in medical operations within the VA BHHCS. The BHHCS radioactive material management program effectively tracks and manages radioactive sources while onsite, where they naturally decay and are eventually disposed in accordance with solid waste regulations. Many uses of asbestos-containing materials were phased out or banned in a series of federal regulations from 1973 to 1990. Lead-based paint was used in many structures built or repainted before 1978. Due to the age of the facilities at the Hot Springs Campus, asbestos-containing materials and lead-based paint are present in facility building materials. The VA BHHCS Industrial Hygiene group maintains an inventory of facilities where asbestos-containing materials and lead-based paint are present. Underground storage tanks at the Hot Springs Campus were removed more than 15 years ago, and subsequent groundwater monitoring was completed without identifying residual contamination (BHHCS '16: 198-200).

Water is supplied to the Hot Springs Campus from a natural spring located approximately one-half mile northwest of the campus campus. Water is diverted from the spring to a cistern located at the campus Boiler Plant (Building 18) through a buried eight-inch diameter pipe via gravity. Water is pumped from the cistern via two pumps to two water towers (980,000 gallons total capacity) through buried eight-inch and six-inch diameter pipe. Typically, one pump is operated at a time, but both pumps can be operated if necessary. Water is treated for potable use with gaseous chlorine. Water uses at the campus include potable use, heating, fire protection, and landscape irrigation. Water diverted to the cistern in excess of campus demand is discharged to Fall River. South Dakota administers water rights under the Doctrine of Prior Appropriation, where the priority of each water right is established based on the date of filing an application (priority date) – older rights are senior to more recent rights. VA holds two water rights licenses authorizing its use of the spring water supply. Vested Right Water License No. 2420-2 appropriates 1.56 cubic feet per second (700 gallons per minute) of water from the spring. This water right has a priority date of January 1, 1907 (SD 1999). Water License No. 2421-2 appropriates an

additional 1.23 cubic feet per second (551 gallons per minute) of water from the spring. This water right has a priority date of March 17, 1999 (SD 2011). The Hot Springs Campus is also connected to the Hot Springs municipal water system for backup supply. The Hot Springs Campus reported a total water consumption of 24,284,000 gallons in FY 2013 and 26,103,000 gallons in FY 2014, with greater consumption during the summer months when landscape irrigation is required (BHHCS '16: 213-214).

The Hot Springs Wastewater Treatment Plant treats wastewater generated throughout Hot Springs, including wastewater generated at the Hot Springs Campus. The treatment facility design flow is 700,000 gallons per day (EPA 2014a), and the average facility flow is 350,000 gallons per day (Bastian 2014). Treated water is discharged to Fall River. Wastewater generation from the Hot Springs Campus is metered at two locations where wastewater is discharged to the city wastewater collection and treatment system. The Hot Springs Campus reported a total wastewater generation of approximately 13,200,000 gallons in FY 2013 and approximately 10,100,000 gallons in FY 2014 (VA 2015), or approximately nine percent of the Hot Springs Wastewater Treatment Plant average facility flow. According to the City of Hot Springs, flow reductions from the campus to the wastewater treatment plant in recent years has affected wastewater revenue for the city, which dropped 36% between 2007 ($41,340) and 2014 ($26,470), despite a 15% rate increase over that period. Electricity service at both the Hot Springs Campus and the Rapid City CBOC is provided by Black Hills Power, a subsidiary of Black Hills Corporation. The Hot Springs Campus consumed 6,409,513 kilowatt-hours in FY 2013 and 6,275,920 kilowatt- hours in FY 2014. The Hot Springs Campus operates three 500-horsepower steam boilers to provide facility heating. The boilers utilize #2 fuel oil supplied by Harm's Oil in Aberdeen, SD. Fuel oil is stored in three 39,590-gallon ASTs. The Hot Springs Campus consumed 397,444 gallons of #2 fuel oil for steam generation in FY 2013 and 438,765 gallons in FY 2014. The Hot Springs Campus currently receives telephone, television, and internet service from Golden West Telecommunications (BHHCS '16: 216-218).

Hot Springs is a city in and county seat of Fall River County, South Dakota, United States. The City of Hot Springs sits in the canyon of Fall River at the base of Battle Mountain to the east, Seven Sisters Range to the south, and Hot Brook and Cold Brook canyons to the north-northwest. The visual appeal of the city is the surrounding sandstone cliffs and evergreen forests. Most of the oldest part of the city is designated as a historic district and maintains many of the original buildings constructed to support the city's early days as a resort destination for the therapeutic warm waters in the area. The historic River Street business area is characterized by Richardsonian Romanesque buildings constructed of pink sandstone from Fall River County quarries. The newer areas of Hot Springs are typical of more modern buildings and houses. Sources of nighttime light throughout the city include street lights and security lights for buildings and parking lots (BHHCS '16: 85). Hot Springs area is primarily urban with little to no agricultural activity. No land within the city limits is designated as prime farmland. In 1980, about 12,000 acres in Fall River County, or about 1 percent of the total acreage, met the requirements for prime farmland. All of this acreage was used for irrigated crops, mainly corn and alfalfa (USDA 1982) (BHHCS '16: `128). With about 354 employees Battle Mountain branch of the VA Black Hills Health Care System employs more than 10% of the population of Hot Springs.

It seems better to dismiss the felony arson conspiracy with the National Park Service to discriminate against the Veteran's Town, on an aggravated identity theft case by case basis, as an unlawful intrusion, violation of the rules and regulations under 24USC§154 caused by the repeal of the Organic Act in 2014, that needs to be restored, not our good friend the armed park Ranger at Wind Caves National Park *ultra vires* 16USC§1a-7b that needs to be demoted to the end of the chapter on obstruction of

lawful hunt at 16USC§5208, and treated at some 159 miles of subterranean length, with tea tree oil for white nose syndrome (WNS) in hibernating bats (Rogawansamy et al '15). It is noted, as the first national Veterans care center to serve as an independent medical facility, the Battle Mountain Sanitarium is a place of long-established health care for Veterans. During public scoping meetings and consultation with consulting parties, the Battle Mountain Sanitarium was identified as a traditional place of care for the Veteran community. Additionally, the presence of the Battle Mountain Sanitarium is part of what leads the City of Hot Springs to self-identify as "The Veterans Town". The VA goes on to discriminate against two possible (American) communities that have been explored as cultures that could consider the Battle Mountain Sanitarium campus a Traditional Cultural Property (TCP): Veterans who receive or have received health care at the facility, and the Hot Springs community. According to National Park Service (NPS) guidance, "a 'traditional' community is a one that has beliefs, customs, and practices that have continued over time, been passed down through the generations, are shared, and help to define the traditions of the community" (NPS Bulletin 38, revised 1998) (BHHCS '16: 116). The VA does justify a part of Battle Mountain Sanitarium being leased to the Bureau of Indian Affairs and/or Indian Health Service Black Hill headquarters to settle, once and for all tribes, *United States v. Sioux Nation of Indians*, 448 U.S. 371 (1980)(BHHCS '16: 121-122, 426-427). VA shall develop a vigorous process to identify possible redevelopment partners for the unused portion of the Battle Mountain Sanitarium campus. This process will include alternative VA uses, other federal agency uses, state or local government uses, Native American uses, and private developer projects, as well as mixed use or multiuser coalitions (BHHCS '16: 418).

As of the 2010 census, the city population was 3,711. The current 2020 population is estimated at 3,486. Hot Springs is currently declining at a rate of -0.23% annually and its population has decreased by -6.06% since the most recent census, which recorded a population of 3,711 in 2010. Hot Springs reached it's highest population of 5,030 in 1950. Spanning over 4 square miles, Hot Springs has a population density of 803 people per square mile. The average household income in Hot Springs is $56,929 with a poverty rate of 15.42%. The median rental costs in recent years comes to $584 per month, and the median house value is $118,100. The median age in Hot Springs is 52.6 years, 46 years for males, and 54.7 years for females. According to the 2019 American Community Survey (ACS), the racial composition of Hot Springs was: White: 79.99% Native American: 11.09%. Two or more races: 5.04%. Asian: 2.88%. Other race: 1.00%. Black or African American: 0.00% or recently 0.01% with at least one long term African-American employee and several apartment lessors. Native Hawaiian or Pacific Islander: 0.00%. Latin American ethnicity: 5.2%. There are 3,009 adults, 985 (33%) of whom are seniors, in Hot Springs. There are 485 Veterans, 16.1% of the adult population, 301 are over the age of 65, 135 were 75 or older, 166 were 65 to 74, 76 were 55 to 65, 74 were 35 to 54 and 34 were 18 to 34. 195 were Vietnam Veterans, 64 Korean, 42 World War II, 34 Second Gulf War, 33 First Gulf War and 117 other career soldiers. There is no military recruitment office in Hot Springs. 457 of Veterans are White (94%), 41 Hispanic (8%) and 28 Native American (6%). The Veteran disability rate is 56.38% and poverty rate is 9.95%. 9.7% of Veterans had an education level of 9thgrade or less, 46% high school graduate, 31.5% some college and 12.8% Bachelor degree or greater.

For the City of Hot Springs, the total labor force dropped slightly between 2010 and 2014, from 1685 to 1649, with a peak high of 1764 in 2011, while the total number of workers employed rose slightly during this period from 1539 in 2010 to 1608 in 2014. This resulted in a 4.4% decline in the labor force between 2010 and 2014 (compared to 20.7% decline in Fall River County); and a 4.4% increase in total number employed (compared to a 20% decline in Fall River County) (Census 2016). Private industry in Fall River County employed approximately one-third more persons (1,351) than did the government

(local, state, and federal) sector (1,040), yet accounted for approximately $7 million less in total wages ($34.8 to $41.8 million) in 2014. The highest average wage in Fall River County was in the natural resources/mining sector ($41,348) and the lowest was in the leisure/hospitality sector ($12,759). The construction sector was very small with only 81 employees earning an average wage of $27,181. The education/health services sector was larger with 24 establishments supporting 323 employees earning an average wage of $34,243. In 2015 VA BHHCS employed 1,103 people (1,021 full-time and 82 part-time) in FY 2014. This equates to 1,069 full-time equivalent employees (FTEEs) assigned to the VA facilities in Hot Springs (357 FTEEs), Rapid City (30 FTEEs), and Fort Meade (682 FTEEs). The average total wage for VA BHHCS FTE within the total area is nearly $66,000 and the average total wage for a VA BHHCS FTE working at the Hot Springs Campus and residing in Fall River County is just over $61,500. This compares to a median income in Fall River County $43,239 in 2014 (Census 2016). There are a total of 100,948 people in Pennington County compared with 7,094 in Fall River County (BHHCS '16: 222). Office of Management and Budget February 2021 economic projections to assume that the unemployment rates will decline from 7.3% in FY 2020 to 3.9% in FY 2023 (VHA '21: 427).

There are nine volunteer fire department (VFD) response areas in Fall River County, of which Hot Springs is one. Hot Springs Volunteer VFD has over 30 volunteers, of which approximately 20 are active firefighters providing fire suppression within and surrounding the city. The City of Hot Springs provided approximately $85,000 from the general (tax) fund for fire department operations (Hot Springs 2013). The fire station is located on Garden Street, approximately one mile south of the VA Hot Springs Campus. Wildland fire suppression in Fall River County is provided by VFDs, the State of South Dakota, and the U.S. Forest Service. Because local fire departments are staffed by volunteers, the status and response capability to wildland fires may vary. Hot Springs is considered a "community at risk" due to the moderate level of wildland fire susceptibility. VA BHHCS Fire Department (FD) is a federally funded department that provides fire response services for VA facilities in Hot Springs and Fort Meade. The fire department on the VA Hot Springs Campus is staffed 24 hours a day with a total staffing level of 13 firefighters who operate two fire engines and one brush truck. A mutual aid agreement was executed between the VA Hot Springs FD and the Hot Springs VFD in June 1998 to provide firefighting assistance (personnel and apparatus) to one another (VA 1998). Although there is no written mutual aid agreement with another federal agency for wildland firefighting assistance, the VA Hot Springs FD would provide appropriate assistance to the Forest Service if requested (BHHCS '16: 188).

VA Hot Springs FD and medical center do not provide ambulance transport for emergency medical response, although the urgent care clinic accepts ambulance transport vehicles. Hot Springs Ambulance Service provides basic and advanced life support service throughout Fall River and Custer Counties using volunteer and paid personnel (emergency medical technicians and paramedics) from Hot Springs and surrounding communities. Fall River Health Services operates the Fall River Hospital, Rural Health Clinic, and Seven Sisters Living Center in Hot Springs. The hospital is designated by the U.S. Department of Health and Human Services as a critical access hospital. The hospital has 25 inpatient beds and provides services for acute (urgent) and emergency care, laboratory, medical imaging, ultrasound, physical therapy and rehabilitation, surgery, orthopedics, podiatry, and sleep studies. Fall River Hospital employees two physicians and two nurse practitioners; contracts four emergency medicine physicians and four outreach specialty physicians; and has additional nursing, patient care, and service and facility support staff (Fall River Health Services 2013). Hot Springs Regional Medical Clinic operates Monday through Friday from 9:00 a.m. to 4:00 p.m. It offers family

and internal medicine services and specialties in audiology, counseling, endocrinology, nephrology, urology, and surgical practices (BHHCS '16: 188).

VA BHHCS maintains a police and security unit to provide law enforcement and security services for the safety and well-being of patients, staff, and visitors at VA facilities. VA Hot Springs Police Department (PD) is staffed by 10 police officers and a supervisor with a minimum of two officers patrolling the VA Hot Springs Campus 24 hours a day. Police protection and law enforcement within the City of Hot Springs is provided by the Hot Springs PD with a staff of 10 people (Hot Springs 2015). The City of Hot Springs provided approximately $577,000 from the general (tax) fund for police department operations (Hot Springs 2013). The area surrounding the city (outside the corporate limits) is served by the Fall River County Sheriff's Office with a staff of 19 people. There are three public school districts in Fall River County serving pre-kindergarten through grade 12: Hot Springs, Edgemont, and Oelrichs. Hot Springs School District covers part of Custer County. Student enrollment has decreased slightly in Hot Springs, from 840 in 2010 to 802 in 2014, and Oelrichs, from 126 in 2010 to 123 in 2014, and has increased in Edgemont, from 150 in 2010 to 163 in 2014, while expenditure per student has increased at the three school districts. Expenditures per student for the 2014 school year for Hot Springs ($7,559), Edgemont ($11,312), and Oelrichs ($16,019) ranked 115, 24, and 4, respectively, out of the 151 districts in the state (BHHCS '16: 188-189).

The decision-making process failed to make plans for the proposed national Pharmacy call center would provide approximately an additional 120 new jobs (BHHCS '16: 385) or indeed do anything but discriminate against disability in regards to fulfilling their obligations to sustain a reasonable level of inflation for existing programs and pay for necessary renovations at the Hot Springs Campus. VA plan A-1 and A-2 for a new Community Based Outpatient Clinic (CBOC) in Hot Springs that would be staffed with 67 FTEEs, would result in a reduction of 290 FTEEs from the FY 2014 total of 357 FTEEs and complete or partial closure and mothballing of Battle Mountain Sanitarium. If all of the FTEEs on the Hot Springs Campus lived in the City of Hot Springs, this would represent a decrease of 13.1 percent in employment for the local Hot Springs community. There would be a similar increase in the unemployment rate in Fall River County from 4.6 to 11.8 percent if all 216 FTEEs became unemployed and remained in the labor force (and an increase in unemployment in Hot Springs from 2.1% in 2014 to 15.2%). This change in Fall River County and local Hot Springs employment levels assumes none of the 216 FTEE reductions would occur via retirement, early retirement, buy-out, or a transfer to another position within the VA BHHCS service area. Such a reduction in employment and an increase in the unemployment rate would be adverse, and potentially significantly adverse, on the local community of Hot Springs. However, VA has stated that no VA employees would lose VA employment, even though they may need to fill a different job with retraining as needed. More than half of the FTEE reduction (116 of 216) could occur through retirement, with an overall decrease in Fall River County employment of 3.5 percent. There would be a similar increase in the unemployment rate from 4.6 to 7.9 percent if the other 100 FTEEs (216 minus 116) became unemployed and remained in the labor force. The reduction of 216 FTEEs would decrease the occupancy rate by 5.2 percentage points from 78.1 percent to 72.9 percent. The reduction could be less (2.4 percentage points) if those FTEEs eligible for retirement remained in Fall River County. The reduction of $14.25 million in VA wages would represent a decrease of 18.6 percent in the total wages of $76.7 million for Fall River County. The total reduction with retirements could be as high as $6.6 million, which represents a decrease of 8.6 percent in total county wages. VA Plan A-1 and A-2 for a new Multi-Specialty Outpatient Clinic (MSOC) and Residential Rehabilitation Treatment Program (RRTP) in Rapid City would be staffed with 128 FTEEs, which would result in an additional 98 FTEEs from the FY 2014 total of 30 FTEEs. The 53 FTEEs

residing in Pennington County over the five-year implementation time period would represent a negligible change (0.1 percent increase) in employment in Pennington County (BHHCS '16: 314, 328).

The local community of Hot Springs, organized against the reconfiguration proposal and developed a detailed alternative, Plan E, proposing, an expanded campus in Hot Springs would be staffed with 492 FTEEs, which would result in an additional 135 FTEEs from the FY 2014 total of 357 FTEEs. There would be an increase of 100 FTEEs residing in Fall River County over the five-year implementation time period. This would represent an increase of 3.5 percent in employment in Fall River County, which would be a small to moderate impact. The increase in FTEEs could have an effect on available housing and occupancy. The increase of 100 FTEEs in Fall River County would increase the occupancy rate by 2.4 percentage points from 78.1 percent to 80.5 percent (BHHCS '16: 328, 385). Alternative F. Buildings on the VA Hot Springs Campus would be renovated and modified to maintain clinical standards. VA would make effort to maintain the current type and level of health care services, depending on the ability to meet building renovation requirements based on budget and schedule limitations. Renovations would be scheduled under the routine budget process. The annual average of 38 to 51 construction workers would add approximately 1.6 percent to the 2014 employment numbers for Fall River County. There could be short-term impacts to employment, housing, and the local economy primarily connected to the number of construction workers. Erroneously, no construction or renovations are proposed for the CBOC in Rapid City under this alternative (BHHCS '16: 330). VA BHHCS would employ similar levels of personnel under Alternative F as presently, approximately 357 FTEEs in Hot Springs and 30 FTEEs in Rapid City (BHHCS '16: 71). Depending on whether the 120 FTEs for the VA National Pharmacy Call Center and other programs, decide to locate at Battle Mountain Sanitarium, the settlement is either Plan E or modified Plan F whereby both Battle Mountain Sanitarium is renovated and the MSOC in Rapid City expanded.

Chapter 4 Black Hills Health Care System

The Department of Veterans Affairs (VA), Black Hills Health Care System (BHHCS), was established in 1996 through the combination of the Fort Meade and Hot Springs, VA Medical Centers, approximately 90 miles a part. VA BHHCS consists of two medical centers, 11 community-based outpatient clinics (CBOCs), and six Compensated Work Therapy (CWT) locations (BHHCS '16: 3). There is a VA-staffed Multi-Specialty Outpatient Clinic located in Rapid City. Contract Community Clinics are located in Pierre, Winner and Mission, South Dakota, and Gordon and Scottsbluff, Nebraska. There is also a contract with Prairie Community Health which has clinics available to Veterans in Eagle Butte, Isabel, and Faith, South Dakota. The BHHCS operates Outpatient Clinics in Pine Ridge, South Dakota and Newcastle, Wyoming. There are also Compensated Work Therapy (CWT) programs in McLaughlin, Eagle Butte, and Pine Ridge, South Dakota, serving Veterans on the Standing Rock, Cheyenne River and Pine Ridge Indian Reservations. BHHCS provides primary and secondary medical and surgical care, along with residential rehabilitation treatment program (RRTP) services, extended nursing home care and tertiary psychiatric inpatient care services for veterans that reside in South Dakota, portions of Nebraska, North Dakota, Wyoming, and Montana. The VA BHHCS services Veterans residing in a rural market spanning over 100,000 square miles of Western South Dakota, northwestern Nebraska and eastern Wyoming, within VISN 23 (Midwest Health Care Network) (BHHCS '16: xix). The 34 counties in the VA BHHCS catchment area were home to over 35,000 Veterans in fiscal year (FY) 2014. Approximately 60 percent (21,000) percent of these Veterans were both eligible for and had enrolled to receive care at a VA facility. The BHHCS has 2,944 Operation Enduring Freedom (OEF), Operation Iraqi freedom (OIF), and Operation New Dawn

(OND) veterans that are enrolled. The VA BHHCS is a part of the VA Midwest Health Care Network (Veterans Integrated Service Network 23), which includes facilities in South Dakota, North Dakota, Minnesota, Nebraska and Iowa.

At the end of FY 2014, VA BHHCS employed 1,103 individuals, with 1,021 full-time and 82 part-time. The workforce represented a total of 1,069 full-time equivalent employees. The staff included 42 physicians, 271 nurses, and 29 physician assistants and nurse practitioners. Other employees included ancillary medical, housekeeping, administrative, and facilities management staff. There were also 301 volunteers that provided transportation; served in the Honor Guard; visited patients; and provided information desk, clerical, and other services (BHHCS '16: 8). VA BHHCS has active education affiliations with the Sanford School of Medicine, with several staff members holding faculty appointments to the University. Approximately 200 residents, interns and students are trained at the VA BHHCS each year. There is a current nursing student affiliation with the South Dakota State University, University of South Dakota, Oglala Lakota College, National American University, Western Dakota Technical Institute, and South Dakota Job Corps. There are affiliations involving pharmacology, social work, psychology, optometry, medical technology, physical therapy, occupational therapy, counseling, health service administration, physician assistant, recreation therapeutics, certified nursing assistants, painters, and environmental management-housekeeping with the other agencies and institutes. The BHHCS continues to actively participate in Research programs, and was awarded a full three-year re-accreditation from the Association for the Accreditation of Human Research Protection Programs (AAHRPP) in December 2009.

The Department of Veterans Affairs (VA) Black Hills Health Care System (BHHCS) is committed to providing high-quality, safe and accessible health care to the Veterans in western South Dakota and the bordering states of Nebraska and Wyoming. The BHHCS provides primary, surgical, behavioral health, Community Living centers and domiciliary (residential rehabilitation treatment program) care. Services offered within the BHHCS include the following: Inpatient Primary Care, Inpatient Surgery, ICU (4 beds), Inpatient Psychiatry, Community Living Center, Emergency Care, Primary Care, Ambulatory Surgery, Urology, Orthopedics, Ophthalmology, ENT, Endoscopy, Audiology, Optometry, Podiatry, Dental, Neurology, Pulmonary Medicine, Nephrology, Medical Oncology, Rehab Medicine (Psychiatry), and Outpatient Mental Health. The services that the CBOCs offer are: primary care/case management, mental health/counseling, telehealth. In FY 2011, BHHCS CBOCs had 44,161 visits to their CBOCs. The BHHCS has a combination of full-time, fee basis and contract providers working in the Compensation and Pension (C&P) Department. In FY 2011, the medical center completed 1,855 C&P examinations. The average processing days (APD) to complete a C&P exam is less than 30 days most months. During FY 2011, the Average Length of Stay (ALOS) for in-patients was 10.96 days, including the Community Living Center (CLC), and 63 days in the Residential Treatment Program. For FY 2012 first quarter, the Length of Stay for the in-patients beds was 5.3 days, CLC beds was 4.2 days, and 78 days for the domiciliary beds. In 2011, the system had 1,063 total employees, including 374 employees who work at the Hot Springs campus. The BHHCS Mental Health department has 60 employees at the Hot Springs campus. The Medical Center has ten acute medical beds and seven Community Living Center (CLC) beds on campus. The medical center has rooms dedicated for bariatric, respite, hospice, and palliative care within their facility. The Hot Springs campus currently has a part-time hospice and palliative care, and accepts veterans needing hospice care to any of the open beds. The medical center offers veteran's hospice services through available VA purchased home hospice, or community hospice care. In FY11, there were 1,621 unique patients including 229 women veterans that were seen for mental healthcare services on an outpatient basis at the Hot Springs campus.

During the 4th quarter of FY11 the facility increased their Post-Traumatic Stress Disorder Cohort by 12 beds.

FY 2011 there were approximately 31,000 veterans in the BHHCS catchment area which includes Ft. Meade and Hot Springs. There are 1,171 veterans in the Fall River County/Hot Springs catchment area. In FY 2011, the BHHCS has seen 20,421 unique veterans, and had 239,297 outpatient visits. In FY 2011, the BHHCS-Hot Springs campus had 77,626 outpatient visits, 670 inpatient admissions, and had 3,127 primary care veteran enrollees. The periods of services for the medical center were as follows: World War II (282), Pre-Korean War (12), Korean War (326), Post Korean War (246), Vietnam Era (1,207), Post Vietnam Era (314), Persian Gulf War (465), and other conflicts (17). Between FY 2012 and FY 2014, of the 22,334 Veterans served, approximately 74 percent (16,470) were from the 34 counties that comprise the VA BHHCS service area. South Dakota represents the largest concentration of Veterans (inside and outside the service area) served by VA BHHCS. Veterans from 41 different states and territories received service, with Colorado and North Dakota the residence of the largest number of Veterans outside the service area at 592 and 528, respectively (BHHCS '16: 27). At Battle Mountain Sanitarium the greatest number of patient encounters is associated with monthly care in the RRTP. These Veterans come from all over the United States, with just over 40 percent living within the BHHCS service area and only approximately 25 percent of the total residing in Fall River and Pennington Counties (BHHCS '16: 27). In terms of where the Veterans live, population data show that, for FY 2012 through FY 2013, VA BHHCS health care facilities served 983 unique patients residing in Fall River County (where the Hot Springs Campus is located), compared to 5,928 unique patients from Pennington County (where the Rapid City CBOC is located). VA data show the Veteran population in Pennington County rising the most, at 4.3% to nearly 13,000 in 2030, and the Veteran population in Fall River County declining the most, at 12.9%, to just under 900 Veterans, in 2030. Nonetheless, in FY 14 the majority (52.1 percent) of all PCEs occurred at the Fort Meade facility and 34.1 percent occurred at the Hot Springs facility. In addition to the 362,272 PCEs (65.7 percent) that occurred at VA BHHCS facilities, another 189,254 encounters (34.3 percent) occurred at non-VA facilities for a total 551,526 encounters during FY 2014 (BHHCS '16: 21, 24, 25).

All veterans are screened in Primary Care for depression, Post Traumatic Stress Disorder (PTSD), alcohol misuse, and suicidality. There has been one completed suicide in FY11 that was attached to the Hot Springs campus. The BHHCS has 500 homeless veterans within their catchment area. The BHHCS currently has drop in centers, and women veteran's center located in Rapid City, South Dakota to house homeless veterans. The BHHCS has a woman's veteran's health care program designed to meet their primary care and gender specific medical care of nearly 1,600 enrolled women veterans. The Women's Veteran program at the Hot Springs campus has about one third or approximately 533 of the 1,600 system wide enrolled women veterans that are receiving comprehensive female health care to include primary care, gynecological care, patient education, reproductive health care, preventive health screenings, and counseling/treatment for a variety of mental health issues. Eleven percent of women service members are single parents, compared with four percent of men. Women who are separating from service are 3.6 times more likely to become homeless than their non-military counterparts. 9 percent of the homeless veterans of the War on Terror are women (BHHCS '16: 15).

In FY 2011, the BHHCS had 1,560 (18.5 percent) unique OEF/OIF veterans diagnosed with PTSD. The BHHCS does not evaluate for PTSD as part of the TBI evaluation process due to the parallel symptoms of both signature wounds. Veterans are referred for further mental health evaluations and medical treatment in addition to their Traumatic Brain Injury (TBI) medical care. In FY 2011, the

BHHCS screened 72 veterans for Traumatic Brain Injury and 41 were found to be positive (diagnosed with TBI). Veterans who test positive for TBI are referred to a variety of offered services by the Polytrauma/TBI clinic such as: Audiology, Speech Therapy, Neuropsychology, Occupational Therapy, and Sleep Hygiene. When an Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veteran receives care at the BHHCS for TBI a provider automatically uses the VHA mandated TBI Clinical Reminders. Pneumovax inoculation is necessary for both PTSD and TBI diagnosis to cure and prevent opportunistic pneumococcal meningitis of shell shocked Veterans with mild TBI or PTSD diagnosis, whereas, the brain does not heal fast enough for antibiotics, ie. Ampicillin or amoxycillin for azithromycin resistance, to work.

BHHCS budget for Fiscal Year (FY) 2010 was $142 million. The FY 2011 budget was $147 million, an increase of approximately $5 million. The FY 2011 appropriations are as follows: medical received $113.5 million, facility received $25.8 million, and administration received $17.6 million. The FY 2012 budget was $142.5 million, a decrease of approximately $4.5 million. The FY 2012 appropriations are as follows: medical received $99.9 million, facility received $22.1 million, and administration received $14.1 million. The VA BHHCS received supplemental funds from the Veterans Integrated Service Network (VISN) in FY 2010 for $1.7 million and $4.8 million for FY 2011. VISN 23 has provided the needed resources to sustain the medical center through their reconfiguration efforts. The FY 2010 Medical Care Collections Fund (MCCF) expected goal for the BHHCS was $16.6 million and their FY 2010 actual collections were $15.7 million. The FY 2011 MCCF expected goal for the facility is $16.4 million and they collected $15.8 million. In FY11, the medical system received $18 million for specific purposes.

VA BHHCS reports cost per unique patient to be the highest among VISN 23 health care systems, many of which have facilities that offer more costly and more highly complex medical services compared to those available in VA BHHCS. Based on FY 2014 data, VA BHHCS's cost per unique patient was approximately $9,404 and was $8,960 and $8,958 in FY 2013 and FY 2012, respectively. In FY 2011, the last year for which data is available, BHHCS saw 20,421 unique veterans and had a budget of $147 million, a per capita cost of $7,199. The VA estimates FY 2014 cost was approximately 22 percent higher than the next highest cost (VA Minneapolis Health Care System at $7,713) and 23 to 65 percent higher than the other health care systems VISN-wide, whose costs per unique Veteran ranged from $5,690 to $7,670 in FY 2014. It would seem that the accusation that costs are higher in BHHCS are false. The VA admits a contributing factor to the relatively high costs within VA BHHCS, which was formed in 1996 through the merger of the Fort Meade and Hot Springs VA Medical Centers, is the increasing age and cost of operating, maintaining, and improving buildings that range from 40 to over 100 years old. It is true, if one adds the $50 million cost of renovations at the Hot Springs campus, the total budget for FY 2011 would have been $197 million, and per capita cost $9,733. VA BHHCS maintains 464,000 square feet and 77 acres of property at Hot Springs and 820,000 square feet and 220 acres at Fort Meade. Both of these campuses must maintain a full suite of site services (fire department, security, laboratory, nutrition and food, radiology, and others) serving a total of more than 1.2 million square feet of space. Maintaining this costly infrastructure diverts financial resources from direct patient care. For example, the VA staffed police and fire protection units at Hot Springs alone requires over $3.5 million annually for maintenance (BHHCS '16: 20).

The VHA needs to both stop falsely accusing the victim of budget cuts of high costs and sustain growth in facility maintenance. The VHA must stabilize BHHCS regular operation and maintenance costs at 3% inflation from $147 million FY 2011, $197 million FY 2022, this should be enough to afford 50

new personnel at a Rapid City. Additionally, the VHA must pay for the $50 million cost of repairs at the Hot Springs Campus, with VHA non-recurring maintenance funds, and another $50 million for the proposed MSOC in Rapid City, as a major construction project, for which there does not seem to be a budget category with enough money or liberty, except non-recurring maintenance. VHA facilities budget cuts are obviously a major problem that impairs the judgment of the Assets and Infrastructure Review Committee. Non-recurring maintenance and construction costs should not distort local agency budgets. Non-recurring maintenance (NRM), major and minor construction projects, should be afforded, painlessly, via 3% inflation to the VHA facilities budget, that unfortunately finances a significant proportion of their costs with unobligated funds from the previous year, and this is a behavioral problem, because not fulfilling the obligations they budget for, and like to blame other people for, is a major source of revenue, for the extremely budget cut compromised VHA facilities budget that will have lingered between $6 and $7 billion for longer than 42 months (Revelation 13:10) by mid-FY 22. To bring an end to this cruel and unusual treatment, of expensive construction and rehabilitation jobs VHA should take in stride, it is legally necessary that the VHA facilities budget be increased to $7 billion FY 22 and grow 3% annually every year thereafter.

In the furtherance of discriminating against disability access to the Hot Springs campus, the VA engaged in a cruel and unusual conspiracy to take and threaten to take even more, from the small, rural, economically endangered community of Hot Springs, in Fall River County, South Dakota, to ostensibly make an insignificant contribution to a much larger community in Rapid City, Pennington County, South Dakota, that should not come at the expense of Hot Springs, in violation of Art. 81 of the Uniform Code of Military Justice under 10USC§881. When a plaintiff alleges a regulatory taking in violation of the Fifth Amendment, a federal court should not consider the claim before the government has reached a "final" decision pursuant to *Pakdel v. City and County of San Francisco, California* 594 U.S.__(2021). Rapid City is home to Camp Rapid, a U.S. Army National Guard base located approximately five miles northwest of the existing VA BHHCS CBOC. Ellsworth Air Force Base is just outside the city limits, approximately 15 miles northeast of the clinic (BHHCS '16: 169). To justify financing a large Multi-Specialty Outpatient Clinic in Rapid City the VA should partner with DOD. However, there is currently only one joint VA/DOD hospital recognized by the Military Health System (Congressional Research Service 2020). To adequately defend Battle Mountain Sanitarium Reserve against this larcenous conspiracy by the VA to discriminate against disability, it is appropriate to fine the VA for the one-time $50 million cost of medically necessary repairs at Hot Springs campus and $50 million cost to construct of lease the Multi-Specialty Outpatient Clinic (MSOC) in Rapid City with the up to $100 million fine for unlawful combination in restraint of their right to carry on their trade provided by Sherman Antitrust Act 26 Stat. 209, 15USC§1, *Mogul Steamship Co. v. McGregor*, (1892), A.C. 25 and *Standard Oil Co. v. United States*, 221 U.S. 1 (1911) pursuant to the recent Executive Order on Promoting Competition in the American Economy E.O. 14036 of July 9, 2021. In addition to the $165 million it will take to prevent mathematical deficiency in the $9.5 billion FY 22 facility obligations, the $100 million anti-trust fine will achieve appropriations of $7 billion FY 22 within the 42 months allowed the anti-Christ for the number of the beast (Revelation 13:10). In the Sherman Act, Congress tasked courts with enforcing a policy of competition on the belief that market forces "yield the best allocation" of the Nation's resources. *National Collegiate Athletic Assn. v. Board of Regents of Univ. of Okla.*, 468 U. S. 85, 104, n. 27 (1984), *American Athletic Conference, et al v. Shawne Alston, et al* 594 U.S__(2021).

In conclusion, Alternative F is modified to give the VA a failing grade on their 496 page BHHCS Reconfiguration effort to convert the Battle Mountain Sanitarium greenhouse to grow legal marijuana

despite the fact it is prohibited by VHA Directive 1315. With a $14,286 per capita cost for 7 million enrolled Veterans out of 19.2 million living Veterans, who is the VA to call the probably overestimated, due to the national attraction of the Black Hills, $9,404 per capita cost of BHHCS, high. Renovations and growth should be scheduled under the routine VA budget process, whose 10% average annual spending and 5% employment growth is highly suspicious, with 3% spending and 1% employment growth being the norm, and marijuana dispensing by the VA legalized for PTSD, chronic pain and cancer treatment side-effects to reduce dangerous opioid prescriptions (Martin et al '11)(Ware et al '15)(Kandagara et al '17)(Bonn-Miller et al '21). In comparison, FY 2021 Military Health Service costs $60 billion to treat 9 million healthy, when uninjured, soldiers, their families and some retirees, a per capita cost of $6,666. Medicaid costs state and federal governments $522 billion for 77 million, a per capita cost of $6,779. Medicare costs $906 billion for about 65 million, a per capita cost of $13,939, not including the out-of-pocket payments, for this economy corrupting program. It is not certain whether better VA health outcomes than commercial health care, are the result of having the highest per capita cost, of any public health insurance program, or simply because they do not abusively bill their patient, just the all-mighty federal government. It is unfortunate that medical hyperinflation to taxpayers compromises the integrity of VA health care. Military Health Service prices are not hyper-inflationary and the quality of care is believed to be high, although comparatively understudied, however recently they have been exhibiting another hidden danger of the command economy - attrition from unnecessary budget and staff cuts that seems to be opportunistic of their cost consciousness without respect for the inexorable force of inflation and population growth, reminiscent of the budget cuts and program termination threats at Battle Mountain Sanitarium. What is wanted from the VA health care system is that their outrageous 10% spending and 5% employment growth be normalized, without any counterintuitive zero or negative growth punishment phase prelude to extortionate high priced compensation, to annual 3% spending and 1% net employment growth while enrollment is expanded to cover all Veterans, nearly all the time, with high quality health care, that does not excessively bill the patient.

For the Black Hills Health Care System the Sherman Anti-Trust settlement is 3% annual appropriation growth from before budget cuts pursuant to the Anti-Deficiency Act baseline with $50 million for necessary renovations to utilize the existing hospital facility as a Community Based Outpatient Clinic (CBOC) and expand residential rehabilitation treatment program (RRTP) and host space for such proposed self-financed programs as the Pharmacy Call Center (BHHCS '16: 385), Save the VA Veterans Industry and lecture hall proposals (BHHCS '16: 63-64), and Black Hills Indian Health Service or Bureau of Indian Affairs office to settle *United States v. Sioux Nation of Indians*, 448 U.S. 371 (1980) for more than $1 but less than $2 billion at the Hot Springs campus and $50 million to construct or lease a building in the Rapid City area to serve as a Multi-Specialty Outpatient Clinic (MSOC) and RRTP to maximize utility of 15USC§1. The MSOC is estimated to require approximately 10 acres, with 66,281 square feet of building space and 400 parking spaces. Approximately 56 FTEEs would staff the proposed MSOC in Rapid City, an increase of 26 FTEEs in Rapid City (BHHCS '16: 58-59).

Part B Interior Petitions

Chapter 5 Kidney Springs Retrofit

Tribal tradition states that as long ago as the 16th century the Fall River Valley and canyon area were seldom without groups of tipis belonging to North American Plains Tribes. They knew the curative

value of the warm springs located there and used them for bathing their sick and lame. Exploration of the area by white men in 1874-1875 led to settlement and the discovery of 75 geothermal springs. The crystal clear clear water issues from clefts in rocks or bubbles out of the ground. Bathhouses, swimming plunges, hotels, hospitals and sanitariums were built turning the City of Hot Springs into an early national health resort. Some of these structures still exist, including a sanitarium now used as the VA Center and the South Dakota Soldier's Home. Cowboys and others crippled by rheumatism and other afflictions would arrive in wagons or trains and leave on horseback after three weeks in the springs according to a roadside sign on the bank of the Fall River sponsored by the People and Businesses of Hot Springs, the Sough Dakota State Historical Society and the South Dakota Department of Transportation.

Chemical analysis

Sodium Chloride 242.60
Potassium Chloride 68.44
Magnesium Chloride 118.00
Lithium Sulphate 15.21
Calcium Sulphate 703.99
Calcium Phosphate 2.76
Silica 23.64
Total Solids 1174.64
Source: Kidney Springs

The drinking water Kidney Springs is reported by a Moccasin Springs Natural Mineral Spa attendant, at Crystal Springs, to have become directly contaminated by bath wastewater on tap since the recent opening of that bathhouse in 2019. This explains the non-diarrheal but flatulent methicillin resistant *Staphylococcus aureus* (MRSA) and foot fungus like cardiotoxic and meningococcal allergy to meat, white bread and donuts, cured, without diarrhea after becoming accustomed to the chlorinated water from the Butler Park faucet, and habit of not filtering medicinal hot spring water on tap, after a long recovery from suspected Colorado Tick Fever or MRSA contaminated roadkill sausage gift. The placard claims the water is useful in the treatment of chronic diseases of the gastro-intestinal tract, diseases of the liver, and biliary passage, disorders of the genito-urinary tract and in sluggish conditions of the alimentary tract. The gastrointestinal healing qualities, that mask recent contamination by Moccasin Spring bathhouse the City is asked to redress, are attributed to high levels of salt to treat MRSA and calcium, magnesium and other well-dissolved minerals to firm the stool and bones; the anti-rheumatic and anti-paralytic properties of these minerals springs are attributed to salts to treat MRSA and potassium to redress a paralyzing deficiency caused by hyperthyroidism, that cannot be found in usual saline or chlorinated swimming pools or Epsom salt baths and hot tubs of today.

Hot Springs City Hall claims that the South Dakota Department of Agriculture and Natural Resources (SDANR) is responsible for testing the water quality of Kidney Springs, located 200 miles away in Pierre, South Dakota. The City of Hot Springs tests the chlorinated water in Butler Park on a weekly basis but is not currently responsible for the water at Kidney Springs. The Safe Drinking Water Act requires the U.S. Environmental Protection Agency (EPA) to set standards for drinking water quality in public water systems entities that provide water for human consumption to at least 25 people for at least 60 days a year). A State has primary enforcement responsibility for public water systems during any period for which the Administrator determines that such State has adopted drinking water

regulations that are no less stringent than the national primary drinking water regulations promulgated by the Administrator under 42USC§300g-1. No rule may be promulgated which authorizes any underground injection which endangers drinking water sources under 42USC§300h. Neither, MRSA nor foot fungus are included in either the EPA nor South Dakota list of water contaminants that are usually tested for. The SDENR responded to say they would look into the issue. A great number of tourists and locals alike, unwittingly drink the water at Kidney Springs, without filtering it. Unlike coliform, particulate contamination and other usual forms of water pollution, it does not cause diarrhea, and this makes it difficult to pinpoint the water as the cause of disease. Local consumers, many of them elderly and overweight, do not associate their advancing decrepitude and mildly painful, non-lesion forming, MRSA infection, with the water, due to the ease with the red meat, white bread and donut allergy can be blamed, and deceptively firm stool. Memorial services, delayed due to COVID-19, have been held for several elderly locals who died of cancer of the digestive tract since 2019, shortly followed by the senile wife of one, whose Alzheimer's is thought to have been caused by chronic meningitis after once consuming statin drugs, perhaps in response to heart infection after drinking the MRSA contaminated water at Kidney Springs.

The relationship of cholera to water was discovered by the English physician John Snow who traced this disease from its origins in India and the path it took to Europe. Snow traced the contamination to public wells, that were bring contaminated by privy vaults in the epidemic of 1854 in London. Thus, the sewer was developed. Mineral spa bathhouses, however pose a different bacterial threat to water quality, that is not fully recognized by the EPA. There is a long history of Draconian responses to water pollution in Hot Springs, Arkansas, where Ral Hole was filled in 1877 due to complaints of contaminating the surrounding water (Hudgins '52: 109), probably fecal coliform. Congress established a Free Government Bathhouse in 1878, however it was soon monopolized by physicians to require a medical diagnosis, and syphilis, more often than not probably misdiagnosed chiggers of the genitals, was the most frequent diagnosis, and massive quantities of neuro-toxic mercury were administered to people in want of a free bath, who swiftly developed the neuro-psychiatric symptoms of tertiary syphilis (Morton 1918: 756-758). Prior to 1877 some of the springs were walled in and covered by masonry arches to protect them from contamination. By the 1890's, most of the springs were covered and a complicated piping system had evolved for supplying the bathhouses with hot water (Scully '66: 118). In 1892 the War Department detailed Lieutenant Robert R. Stevens of the 6th Infantry to the Department of the Interior. He developed a series of hot-water drinking fountains that were “a matter of great convenience and pleasure” named Noble Fountain, Block Fountain, two exedra fountains, shell fountain and Maurice historic spring cup fountain (Little 1896: 1)(Paige & Harrison '87). These fountains are still in use today, do not require any filtration and are maintained by Hot Springs National Park that is located onsite.

Spa patrons are typically required to shower before they bathe in the mineral spas, without any soap, and neither fecal coliform or soap suds are a problem. However, MRSA, foot fungus and other microorganisms, are shed into the bath water beyond the ability of the mineral water and heat to completely treat, and this is drained on a regular basis and poses a threat of contaminating nearby potable drinking water systems. Although filtering would probably work, bath water contamination does not seem potable. To prevent point-source contamination of drinking water Hot Springs National Park, Arkansas and the City of Hot Springs Utilities have published a *Cross-Connection Control Program Manual*. The purpose of this program is to protect the public potable water system from the possibility of contamination or pollution from backflow into the water system. It promotes the elimination or control of existing cross-connections, actual or potential between potable water system

and non-potable water systems, plumbing fixtures and industrial piping systems. It provides for a continuing program of Cross-Connection Control that systematically and effectively prevents the contamination or pollution of potable water systems. It would seem that it is necessary to retrofit Moccasin Springs Mineral Spa with a Reduced Pressure Zone Assembly (RPZA): a backflow prevention assembly consisting of four test cocks, two shutoff valves, and two independently operating, spring loaded check valves with a reduced pressure zone between the check valves. The zone contains a relief port which will open to atmosphere if the pressure in the zone falls within 2 psi of the supply pressure. The assembly provides protection against both Non-Health and High Health Hazards under back-pressure and back siphonage conditions. It is highly recommended that a federal grant be secured from the Interior Department for the City of Hot Springs, South Dakota Parks or Utilities Department(s) to install a Reduced Pressure Zone Assembly (RPZA) at Moccasin Springs Mineral Spa, test the drinking water at Kidney Springs on a weekly basis, for bathwater related MRSA, foot fungus and other contaminants, not normally tested for the benefit of drinking water consumers, improving plumbing regulation by the SDANR. Because federal and state drinking water regulations neglect this sort of pollution, it seems fair for Moccasin Springs Mineral Spa RPZA installation and City Park Department to bill the federal government for a grant under 42USC§300h. It might help reduce fire risk and improve industrial security, to establish a relationship between City of Hot Springs Parks Department with the National Park Service, eg. Wind Caves National Park, that is healthy and keeps the free public utilities on, electricity was temporarily turned off at the last encounter with the National Park Service but restored at the request of City Hall. A grant to the local Hot Springs Water, Utilities or Parks Department, to pay for the "installation of the RPZA, maybe a durable water filter on the spout and routine weekly testing of the water at Kidney Springs for the specific type of atypical pollution" pursuant to National Parks and Recreation Act of 1978, Public Law 95-625 under 16USC§2501-2514 or EPA Administrator for the specific purpose of correcting and preventing the injection of contaminants into the drinking water due to underregulation with a state ground water protection grant pursuant to 42USC§300h-8.

Mark Myers, the Administrator of the Drinking Water Program at the South Dakota Department of Agriculture and Natural Resources responded to look into the drinking water issues at Kidney Springs in a week. Kara Hagan, the owner of Moccasin Springs Natural Mineral Spa, responded to ensure that it was clear that they had followed all usual permitting requirements, inform property management and city health department of the complaint, and clarify our mutural misunderstanding regarding the purpose of a Reduced Pressure Zone (RPZ Assembly). Contrary to the assumption of two non-plumbers, that any contamination of the drinking water would come from a leaky sewer, a RPZ Assembly prevents backflow from the water supply line from flowing backward and contaminating the drinking water by direct injection. This is a great relief because the drain is sealed in concrete and leads into a sewer that is also sealed in concrete and would cost a fortune and cause extraordinary damage to retrofit. The sewer drains into Fall River, everyone is happy to bathe in the several shallow holes that have been excavated, and although not exactly hot are reported to steam and be warm enough to bathe in the cold of winter. There are signs warning that the irrigation faucets are not potable.

Reduced Pressure Zone (RPZ) Valves prevent backflow from the the water supply line from contaminating the drinking water supply. Backflow preventers work by letting water flow through them in one direction, but prevent water from flowing back through them in a reverse direction. RPZ backflow preventers consist of two independent check valves. They work like a double-check backflow preventer, but they also have an intermediate relief valve that opens to atmosphere if both check valves should fail. If an RPZ is not dumping water out of the relief valve, then the backflow preventer is

working properly. If the relief valve is dumping out water, or spitting out small or large amounts of water, then something is not right and maintenance on the valve is required. This peace of mind is what municipalities and engineers are requiring more and more to protect the drinking water supply. Because an RPZ is designed to dump water, the surrounding area is going to get wet. A RPZ that is dumping water is working exactly how it's supposed to. The RPZ will absolutely protect the water supply, but if installed in the wrong space, it can potentially destroy property. It is important to use best practices when installing an RPZ, and the best place for installation is outside in an RPZ enclosure (Wiley '18).

Chapter 6 Battle Mountain Treaty

Evidence of human occupation of the Black Hills region corresponds archaeologically to that of Northwest Plains cultures in general, spanning at least the previous 12,000 years (Kornfeld et al. 2010) Native Americans have a long history in the Black Hills. Legend has it, American Indians were stricken with an epidemic known as "fell disease" about the middle of the 16th century that threatened to obliterate the tribes. A messenger arrived from the Great West with news of a wonderful water which, he said, had been touched by the finger of the Great Spirit and would cure all manner of diseases. Indians came to these springs by the thousands. The Arikara arrived by AD 1500, followed by the Cheyenne, Crow, Kiowa and Arapaho. After a lapse of more than 200 years, the Cheyenne took possession of the springs and built an immense tipi city covering hundreds of acres. In the 18th century the Lakota (also known as Sioux) arrived from Minnesota and drove out the other tribes, who moved west. The First Treaty of Fort Laramie Treaty with Sioux Etc., known as the Horse Creek Treaty, was signed with the Sioux, Cheyennes, Arrapahoes, Crows, Assinaboines, Gros-Ventre, Mandans, and Arrickaras, in 1851. It stipulated that Plains Indians would stop inter-tribal fighting, let white migrants and railroad surveyors travel safely through their lands, allow the US government to build roads and army posts in their land, and to pay compensation to the US government if their tribe members broke these rules. In return, the US government stated they would protect Plain Indians from any white Americans and pay the tribes a $50,000 annuity providing they stuck to the treaties terms. Art. 5 of the 1951 Horse Creek Treaty specifically granted the Black Hills to the Sioux, but did not prejudice any rights or claims any other tribes might have to the land. This culminated in a fierce conflict in about 1869, the memory of which is preserved in the name of Battle Mountain, where the besieged Cheyenne established fortifications. The Sioux won the battle and possession of the springs which they called Wi-wi-la-kah-to (Springs - hot). They called the area Minnekahta (Water - hot) and termed the Black Hills a great "Medicine Home." After the Battle Mountain fight, tradition says the Sioux and Cheyenne agreed to allow the springs to be a health sanctuary to give their sick and lame the benefit of the healing waters. While the conflict abrogated Art. 1 of the 1951 Treaty, the restitution seems satisfactory under Art. 4 to forge a lasting peace into a prospective future Battle Mountain Treaty. Native Americans told white settlers no tribe claimed the hot springs (in Arkansas), but that all tribes bathed in the healing waters of the springs (Paige & Harrison '87: 22)(Scully '66: 5-6). The idea is to settle, once and for all tribes, *United States v. Sioux Nation of Indians*, 448 U.S. 371 (1980) for $1-$2 billion and a long term lease for Bureau of Indian Affairs and/or Indian Health Service office(s), with Black Hills jurisdiction and alcohol and drug detox privileges at Battle Mountain Sanitarium.

The Black Hills, located in South Dakota, holds great spiritual and cultural significance to the Lakota, Dakota and Nakota indigenous peoples, collectively known as the Great Sioux Nation. They call the Black Hills, Ȟe Sápa (Black Mountains). The 1868 Treaty of Fort Laramie, implicitly reserved the Black Hills for the Lakota, Dakota and Nakota peoples, by establishing the Great Sioux Reservation, west of the Mississippi, and exempting the entire region from all white settlement forever. Both the

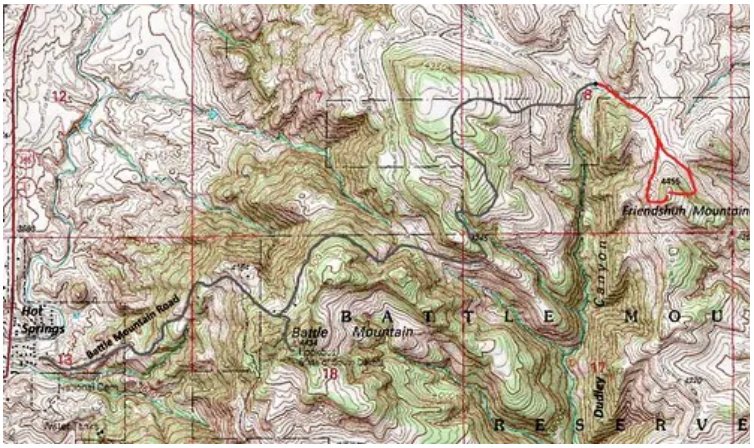
Sioux and Cheyenne claimed rights to the land, saying that both their cultures considered it the axis mundi, or sacred center of the world. However, the discovery of gold in the area in 1874 as the result of George Armstrong Custer's Black Hill's expedition, led to a conflict over control of the region sparked the Black Hills War of 1876, also known as the Great Sioux War, the last major Indian War on the Great Plains. Following the defeat of the Lakota and their Cheyenne and Arapaho allies in 1876, the United States took control of the Black Hills. U.S. Congress to pass an act in 1877 which vested ownership of the Black Hills to the United States. The US government took the Black Hills and, in 1889, reassigned the Lakota, against their wishes, to five smaller reservations in western South Dakota, selling off 9 million acres (36,000 km^2) of their former land.

Despite their forced relocations, the Lakota never accepted the validity of the US appropriation. They have continued to try to reclaim the property, and have repeatedly filed a suit against the federal government, rejected by the Court of Claims in 1942, reheard pursuant to a 1978 Act and $17.1 million compensation was upheld in *United States v. Sioux Nation of Indians*, 448 U.S. 371 (1980). The Lakota, Dakota and Nakota peoples have refused the compensation, valued at over $1 billion as of 2011, and continue to seek the return of their land (Anaya 12: 1). The Hot Springs area is recognized as a Native American sacred site (Sundstrom 1996). Battle Mountain is not distinctly identified in the ethnographic literature, however this landform is recognized by a Siouan name ("He-oki-cize") by at least one nineteenth century source (Hans 1907). One archaeological artifact scatter is recorded on the Battle Mountain prominence. The VA Hot Springs Campus is in the Native American traditional area of the Hot Springs sacred site (Sundstrom 1996), interconnecting with the Battle Mountain landform. VA considers the Hot Springs a sacred site area, with Battle Mountain interconnected, as a historic property of religious and cultural importance to Native American tribes with ancestral, aboriginal, or ceded land ties to the Black Hills Region (BHHCS '16: 121-122). VA is committed to developing a vigorous process to identify possible redevelopment partners for the unused portion of the Battle Mountain Sanitarium campus. This process will include alternative VA uses, other federal agency uses, state or local government uses, Native American uses, and private developer projects, as well as mixed use or multiuser coalitions (BHHCS '16: 418).

Perfecting bona fide claims to lands; exchange of private lands provides under 24USC§153. In all cases of unperfected bona fide claims lying within the said boundaries of said reserve, which claims have been properly initiated prior to September 2, 1902, said claims may be perfected upon compliance with the requirements of the laws respecting settlement, residence, improvements, and so forth, in the same manner in all respects as claims are perfected to other Government lands: *Provided*, That to the extent that the lands within said reserve are held in private ownership the Secretary of the Interior is authorized in his discretion to exchange therefor public lands of like area and value, which are surveyed, vacant, unappropriated, not mineral, not timbered, and not required for reservoir sites or other public uses or purposes. The private owners must, at their expense and by appropriate instruments of conveyance, surrender to the Government a full and unencumbered right and title to the private lands included in any exchange before patents are issued for or any rights attached to the public lands included therein, and no charge of any kind shall be made for issuing such patents. Upon completion of any exchange the lands surrendered to the Government shall become a part of said reserve in a like manner as if they had been public lands at the time of the establishment of said reserve. Nothing contained in this section shall be construed to authorize the issuance of any land scrip, and the State of South Dakota is granted the privilege of selecting from the public lands in said State an equal quantity of land in lieu of such portions of section sixteen included within said reserve as have not been sold or disposed of by said State and are not covered by an unperfected bona fide claim as above mentioned.

Battle Mountain Sanitarium occupies 77 acres at the base of Battle Mountain overlooking Fall River. Battle Mountain is 4,434 feet in elevation. The Battle Mountain Game Production Area has been around for many years, originally occupying roughly 3,500 acres northeast of Hot Springs. These acres are actually federal property leased to the state of South Dakota. There are a collection of towers on top. Much of the Friendshuh GPA area had been part of the Friendshuh Ranch for many years, before rancher Gary Friendshuh sold 4,400 acres to South Dakota Game Fish and Parks for $8 million, to help expand the game preserve. So it seems very appropriate to designate as Friendshuh Mountain, the summit otherwise known as "4455". This GPA is also adjacent to some BLM land, with all areas combined providing public access of over 8,000 acres. The high point in South Dakota's 8,000-acre Battle Mountain-Friendshuh Game Production Area (GPA) is located at the head of Dudley Canyon, on the east side. A geologist has discovered that there is a fossilized dinosaur footprint near Friendshuh Mountain. If there was an official name for this mountain long ago, it seems to have been forgotten by area residents. According to Lists of John, with 600 feet of rise, this mountain is tied for #18 on the Black Hills prominence list. Friendshuh Mountain acts as a watershed between Dudley Canyon to the west and Spring Canyon to the east-northeast. The canyon, which drains on a north to south axis, was named for Judge E.G. Dudley, who moved to Hot Springs in 1883 from Deadwood, and lived there until his death in 1906. Though all the upper canyon is on public lands, the mouth of the canyon is on private land. Elk, deer, pronghorns, bighorns, coyotes, fox, wild turkeys, hawks, eagles, vultures, mountain lions and rattlesnakes inhabit the GPA. Almost half the area is heavily forested, dominated by Ponderosa pine with pockets of aspen. Along the various streams in the canyons, are a small variety of other trees, including cottonwood, ash, birch, cedar, and others. The rest of the GPA is large open meadows, which provide excellent grazing habitat for elk and deer.

Battle Mountain Reserve, Friendshuh Mountain Route Map



Source: Summit Post

No permits are needed to be anywhere in the Battle Mountain/Friendshuh GPA. There is a curfew for the entire area, and camping is ostensibly not allowed and the warden claims to have issued tickets to people who were not aware of the signs posted in a manner reasonably likely to come to the attention of trespassers under 22-35-6(2). It is an affirmative defense the person reasonably believed that the owner of the premises, or other person permitted to license access to the premises, would have permitted him or her to enter or remain under 22-35-7 and 24USC§151. There is no denying that the no camping notice is a criminal solicitation under 22-4A-1. The camping prohibition is void and and

should not be permitted under 22-12A-2 & 3. Not to see those entire tiny signs removed, nor condone trespassing upon the emergency conditions during hunting season, it is advised that the camping prohibition on the GPA signs be painted over “no camping (during hunting season)” pursuant to 22-4A-4. Chapter 41-5 Game Preserves and Refugees has been repealed, hooray, their unauthorized camping tickets certainly don't hold up in Court, and the wilderness holds up great without any legal solicitation. The State of South Dakota hereby assents to the provisions of the act of Congress entitled, "An Act to provide uniform policies with respect to recreation and fish and wildlife benefits and costs of federal multiple-purpose water resource projects, and for other purposes," approved by non-indigents July 9, 1965 (Public Law 89-72, 89th Congress) under 41-3-5.

State and federal land agencies have legislated several laws to protect the freedom to camp on public land, with mixed results. Freedom detests the fee, the monopoly of law and permits, even if they are free, the unwanted solicitation is nearly so torturous, but more flammable, than paying to stay home-side. Issuance and administration of camping permits and the establishment and collection of fees for camping permits and for other park services in the state park system, if the fees and procedures are not set by statute under 41-17-1.1(7) and 41-17-14.1. A National Park superintendent may require permits, designate sites or areas, and establish conditions for camping under 36CFR§2.10(b)(4) 6am. (run-on) Residing in park areas, other than on privately owned lands, except pursuant to the terms and conditions of a permit, lease or contract, is prohibited under 36CFR§ 2.61(a). A special use authorization is not required for camping in the National Forest under 36CFR§251.50(c). The very right to a home may in fact be the result of a hacking of the right to shelter in the Universal Declaration of Human Rights (1948), that was only temporarily redressed by Application of the Convention on the Prevention and Punishment of the Crime of Genocide (*The Gambia v. Myanmar*) Summary 2020/1 23 January 2020, that held Myanmar’s military and security forces responsible, inter alia, for killings, rape and other forms of sexual violence, torture, beatings, cruel treatment, and for the destruction of or denial of access to food, “shelter” and other essentials of life, all with the intent to destroy the Rohingya group, in whole or in part; and is now modified to comply with the obese and medically incompetent Secretary-General's strict interpretation of the definition of genocide in violation of 22-11-24. Private land development destroys the utility of public land, as a place to camp for free, and the supporting roads destroy the trails pursuant to the Roman rule of usufruct. Although homes are all right in inclement weather, barring accident or war, legend has it that pre-contact Native Americans routinely lived beyond 100 years of age. In recent years however, in their housing drive, often enforced two-families to trailer, Native American tribal development tends to provide the fewest camping and recreational opportunities, with tribal lands being exclusively exploited for commercial purposes to finance private and urban development. It is very important that free, discrete, fire-safe, non-littering, camping is allowed on all public lands to preserve and enlarge the fundamental freedom to camp within walking distance of a city, and between cities, where food is bought, to protect wild edibles and wildlife from overhunting, whereas agriculture is much more efficient at food production.

In regards to Battle Mountain Reserve the no camping notice should be modified to “no camping during hunting season”. Without any law, or any official solicitation whatsoever, the Game Production Area, has done remarkably well at animal husbandry and Battle Mountain is teeming with deer, turkey, rabbit, sage and echinacea to cure coronavirus with. To be fair, the involuntary arson conspiracy, that ignited the neighboring industrial building, was witnessed and reported to a worker who called the fire department, between the aggravated identity theft of the Wind Caves National Park Ranger and Forest Service Fire Department, has expressed interest in making Battle Mountain a National Forest. The offer is that South Dakota could stop paying to lease the land from the federal government and convey

Battle Mountain Reserve to the United States Forest Service for up to $50,000 a year, if they abstain from any of the aggravated identity theft under 36CFR§251.17(a-g) to be honored with (h) under 16USC§555. A special use authorization is not required for non-commercial recreational camping, picnicking, hiking or hunting under 36CFR§251.50(c). However, an acre of National Forest is 65 times more likely to burn than an acre of National Park. Furthermore, victimization has revealed that the FBI aggravated identity theft by armed National Park Rangers ignites the flammable debris, and complaints regarding abuse of campers on public land and debris, irresponsibly left by fire suppression activity in the National Forest, with varying degrees of malicious intent and mitigation effort. A long history of fire suppression is recognized to be the leading cause forest fires (Berger '08: 21, 22)(Maser et al ’10: 110, 111). However not to abuse bored wild fire fighters, it is necessary to merely prohibit prescribed slash and burn operations in wilderness areas and the negligent leaving of debris, slash piles and close replanting by commercial loggers under 36CFR§261.5. In general, the English language is appalled by all work in the fo - “rest”. Commercial logging is the most dangerous career in the nation with annual death rates in excess of 100 per 100,000.

To protect the land from the federal arson conspiracy, it seems better for South Dakota Game, Fish and Parks to merely better understand that camping for free on public land is implicitly allowed, and is not regulated by permit, or law, like the destructive practice of hunting wild animal populations their regulations sustain, that does indeed preclude recreational camping on Battle Mountain during hunting season. Campers must be fire-safe, not litter and need to help to remove the litter to be above suspicion. If they want to stay a long time, they must be able to walk unmolested and camp where they are not visible from the road. To begin to redress the federal arson conspiracy it is necessary, and right up repealed South Dakota Game Production Area's alley, to transfer the 'protection of individual right to bear arms' at 16USC§1a-7b to the end of the chapter on obstruction of lawful hunt at 16USC§5208 and restore the Organic Act under 16USC§1 to §18f-3 to the condition it was in 2013 before the passage National Park Service and Related Organizations Act Pub. L. 113–287, § 3, Dec. 19, 2014, 128 Stat. 3096, to create a common law with 54USC§100101 et seq. The protection of individual right to bear arms at 16USC§1a-7b needs to be transferred to 16USC§5208 to lay down arms under common Art. 3 of the Geneva Conventions (1949) whereas this law pertaining to the National Wildlife Refuges interferes with the territorial integrity of the National Park Service in flagrant disregard for the principle of non-use of force, under Art. 2(4) of the UN Charter pursuant to Military and Paramilitary Activities in and against Nicaragua (*Nicaragua v. United States of America*) Judgment No. 70 (1986). The Organic Act needs to be restored for future reference.

Recreational resources near the VA Hot Springs Campus include local, state, and national parks. The City of Hot Springs maintains a number of public parks and amenities for various recreational and community events, including golfing, playgrounds, trails, sports, picnicking, swimming, organized events, and relaxing. City parks include Upper Chautauqua, Lower Chautauqua, Brookside, Butler, Centennial, and Cold Brook. Cold Brook Lake and Angostura Reservoir provide fishing, boating, and camping options. Evans Plunge, fed by the natural hot springs, is an enclosed pool offering year-round swimming, hot tubs, and a steam room. Fall River is a major recreational asset through the center of the city with the Freedom Trail system and parks along the river. Custer State Park is approximately 20 miles north of Hot Springs. Encompassing 71,000 acres within the Black Hills, the park is known for its granite peaks and buffalo herds, and provides wildlife viewing areas, scenic drives, fishing, educational programs, trails, and resort services. Wind Cave National Park is approximately six miles north of Hot Springs. Encompassing approximately 33,000 acres, the park offers trails, camping opportunities, and tours through one of the longest caves in the world (BHHCS '16: 192-193). Bicycle

and pedestrian routes in the Hot Springs area include the Freedom Trail that parallels Fall River through the city, the George S. Mickelson Trail that crosses the western part of Fall River County (BHHCS '16: 202) and the Centennial Trail that runs from Wind Caves National Park to Sturgis, that is not normally solicited because the overnight permit in Wind Caves may pose a fire hazard. Excessive private development and land ownership, due to the abundance of VA loans in the area has compromised the trail system in the Hot Springs area and much planning is needed to develop trails from the City of Hot Springs to the Mickelson and Centennial Trails and Pine Ridge Reservation.

In conclusion, it seems like a good idea to settle, once and for all tribes, *United States v. Sioux Nation of Indians*, 448 U.S. 371 (1980) for $1-$2 billion and a long term lease for Bureau of Indian Affairs (BIA) and/or Indian Health Service (IHS) office(s), with Black Hills jurisdiction and alcohol and drug detox privileges at Battle Mountain Sanitarium. The IHS reports that the Great Plains tribes suffer 11 times the national average rate of injury due to alcohol intoxication, the highest in the nation. Locating federal the Native American government agencies of the BIA and IHS, might help to restore law and order to the federal government and create a lasting peace in the Black Hills region. The BIA and IHS tend to be free of the involuntary manslaughter infringed email communication of tribal government, at least at the national level, unlike the aggravated identity theft arson conspiracy of the armed National Park Service Rangers and the industrially fascinated arson conspiracy of the Forest Service, inferior to the secure communications of the Secretary of Interior. The reverse of the incommunicado VA with the communicable VA Medical Center. The BIA and IHS are both doing quite well during this administration that has appointed the first Native American to the Cabinet – Interior Secretary. The Sioux tribe, who has been individually granted and so far refused, money compensation for the unlawful taking of the Black Hills, the vast majority of native population in the area, is sought to consider this proposal, whereby they, and all Native American tribes, would be granted jurisdiction over the Black Hills, via BIA and IHS offices that would be located at Battle Mountain Sanitarium. These agencies would give Native Americans, already free to pass through the Black Hills, long-term jurisdiction and money to negotiate with public and private landowners, on the condition that, critical of contemporary tribal land development practice, they do not engage in the privatization of the land, but instead limit any land acquisition to making private land public and improving access to public lands with trails, and better federal regulation and correspondence, for everyone's benefit.

Chapter 7 Field Trials of WNS Treatment and Supportive Care

Over the past 10 years, *Pseudogymnoascus destructans,* formerly known as *Geomycetes destructans,* has decimated populations of bats (chiropterans) throughout North America and, most recently, Northern China and Siberia. Around the world, millions of people are infected with keratinophilous fungi, but human mortality from these pathogens is infinitesimal, however, in hibernating bats it is devastating disease that has caused the most precipitous decline of North American wildlife in recent history. Since first discovered in five caves in upstate New York in 2006, WNS has been documented in 7 North American bat species, killing millions of bats, indeed up to 90% of some populations, such as the now-endangered gray bat (*Myotis grisescens*) and Indiana bat (*Myotis sodalis*). Huge number of dead bats were found with a peculiar opaque white hyphae around their muzzles, leading to the name White Nose Syndrome (WNS). By 2019, the pathologic fungal infections had been detected on bats in 34 states and 7 provinces in North America as well as across Mongolia and northern China. WNS may herald the regional extinction of the little brown bat, once among the continent’s most abundant bat species, in northeastern North America by 2026. Other species that are moving toward endangered status include tricolored bats (*Perimyotis subflavus*), big brown bats (*Eptesicus fuscus*), Indiana bats,

and northern long-eared bats (*Myotis septentrionalis*). The fungus has been isolated in Europe, where it likely has had a long-standing commensal (benign) relationship with European insectivorous bats, which are apparently disease resistant. There is concern that recreational cavers (spelunkers) may have unwittingly spread the fungus from Europe on contaminated clothes, shoes, and equipment. Subsequent spread within North America is mainly due to bats carrying spores into new hibernacula; however, many states require decontamination of caving equipment and limit access to caves (Magnino et al '20). The Fish and Wildlife Service White-nose Syndrome Coordination Team reports in the midwest some bat hibernacula have been completely evacuated, other severely depleted, while others have seen a slight increase in use. In the Black Hills, where WNS didn't arrive to Wind Caves National Park's 159 miles of caves, until 2019, the Rufa Red Knot Bat and Northern Long-eared Bat are listed as being threatened (USFWS '21).

It will be necessary to get permission from the Secretary of Interior to engage in field trials of environmental treatment to discover effective methods of saving hibernating bat species. The Endangered Species Act of 1973 provides for interagency cooperation in consultation with the Secretary of the Interior regarding agency actions not likely to jeopardize the continued existence of any endangered species or threatened species or result in the destruction or adverse modification of habitat of such species which is determined by the Secretary, to be critical under 16USC§1536. The Federal Cave Resources Protection Act of 1988 prohibits anyone who without prior authorization by the Secretary of Interior … alters … any significant cave or alters the free movement of any animal or plant life into or out of any significant cave located on Federal lands under 16USC§4306. Sponsors of investigations, are also directed to submit in triplicate a "Notice of Claimed Investigational Exemption for a New Animal Drug" to the U.S. Food and Drug Administration (FDA) under 21CFR§511.1(b)(4) pursuant to procedures for classifying OTC drugs as generally recognized as safe and effective and not misbranded, and for establishing monographs 21CFR§330.10. When the Secretary of Interior is satisfied with the ability of a specific environmental treatment to cure and prevent WNS in hibernating bats without contaminating the environment, she may foster the exchange of information between cave land managers of significant WNS infected caves to ensure they are treated under 16USC§4303.

Managing a disease in free-ranging wildlife is challenging. *P. destructans* presents unique challenges because its spores can survive in soil, independent of mammalian hosts, allowing it to escape the selective pressures that prevent other host-dependent pathogens (such as viruses) from entirely destroying their reservoir populations. Without population-level infection-control strategies, current efforts to curtail WNS focus on universal precautions, including decontamination of clothing and equipment after exposure to potentially infected animals or contaminated environments, and restricting human access to hibernacula (Magnino et al '20). The National White-Nose Syndrome Decontamination Protocol Version 10.14.2020 requires that all clothing, footwear and equipment should be decontaminated after every site visit. The preferred treatment for equipment deemed suitable for submersion is hot water that maintains a temperature of at least 55ºC (131ºF) for a minimum of 5 continuous minutes. All equipment surfaces must remain in direct contact (i.e., avoid all trapped air) with the >55ºC (131ºF) water for the entire 5 minute treatment. Treat all non-submersible equipment using the most appropriate application or product – ethanol (>60%), isopropanol, isopropyl alcohol wipes, hydrogen peroxide wipes (3%), Accel, Clorox, Formula 409, Hibiclens, Lysol, Sani Cloth Germicidal Disposable Wipes, Up and Up Disinfecting Wipes and Virkon S.

Supportive treatment, providing woken bats with insects to eat and water may be the most important, life-saving intervention, to enable them to survive the winter. *P destructans* is believed to be spread

via direct contact among cohibernating bats in contact with fungal environmental reservoirs in soil of caves and mines. It infects bats during hibernation, a state of metabolic quiescence when core body temperatures drop to 2 to 10°C. The fungus grows at temperatures as low as 1°C, optimally 12.5 to 15.8°C, with an upper limit ~19.5°C. At suboptimal temperatures, *P destructans* grows slowly. *Pd* has been found to survive in the affected hibernacula, even in the absence of bats. Thus, an infected hibernaculum could remain contaminated with *Pd* for prolonged periods of time and serve as the foci for new infections (Singh et al '18). Under favorable conditions, *P destructans* grows as a mold with exuberant white hyphae on the wing skin and muzzle fur of susceptible bats. Signs of active infection include patches of rough skin on the ears, forearms, wing membranes, and feet. Hyphae may surround hair follicles, creating the appearance of comedones along the muzzle. The current theory of mortality associated with WNS in progressive stepwise fashion begins with the erosion and ulceration the epidermis. *P destructans* secretes proteolytic endopeptidases, called destructins, that degrade collagen. Ulceration increases blood CO2 levels, leading to metabolic acidosis and consequent hyperventilation. As the metabolic rate accelerates to maintain body temperature, the bat arouses from hibernial torpor. The combination of dehydration and thermodysregulation is usually fatal (Magnino et al '20). Bats who survive the energetic constraints of winter, tend to recover, however they exhibit damaged wing tissue and displayed elevated mass-specific metabolic rates. Reproductive capacity seems unharmed (Meierhofer et al '18). Practical intervention of providing bats with water to drink and insects to eat during winter in their hibernacula, may mean the difference between life and death for infected populations, however, it would be nicer if they were not infected. Feeding and watering infected bats may enable a large percentage of the infected population to survive the dangerous winter period. Feeding and watering requires study in any WNS infected hibernating bat population, whether the infection is the result of treatment failure, or failure to treat.

As obligate insectivores, these bats consume literally billions of insect pests each year, contributing ecological services to American farmers valued around $23 billion annually. Bats also consume mosquitoes and other vectors of human pathogens (eg, West Nile virus and other encephalitis-causing arboviruses). Collapse of insectivorous bat populations might permit an increase in vector-borne diseases throughout the former ranges of the decimated species. Most bat-borne pathogens (eg, rabies viruses and cryptococcus infection of AIDS patients from bat droppings) proliferate only when the host is metabolically active (ie, nontorpid). Perhaps even more worrisome, especially as the world battles pandemic COVID-19, which is caused by a virus whose natural hosts are alleged to be insectivorous bats in southern China, is the recent discovery that North American bats that are naturally co-infected with WNS and a different coronavirus shed up to 60-fold more coronavirus RNA than bats without WNS. Although the particular coronavirus studied in the WNS-infected bats did not appear to sicken the bats, other coronaviruses that are commensal in bats have crossed over into human populations several times in the past 20 years, leading to the epidemics of severe acute respiratory syndrome, Middle East respiratory syndrome, and now COVID-19. People who handle bats need to be vaccinated against rabies. Because bats can be a reservoir for coronavirus (Magnino et al '20), workers must know how to treat allergic rhinitis with hydrocortisone, eucalyptus, lavender, peppermint or salt to help water cure coronavirus. Usually dunking the head in saline or chlorinated water, ie. Swimming, instantly cures coronavirus allergic rhinitis, however this is winter work, so mentholyptus cough drops keep the infection out of the lung and only a little nose washing is needed. Wash the nose with eucalyptus, lavender or peppermint soap before going to work (Sanders '21).

The Fish and Wildlife Service and literature has been having some difficulty selecting effective treatments from in vitro laboratory studies and so far no published field study or study of live animals

taken under Sec. 10 of the ESA permits has produced credible evidence supporting the use of any specific medicine for the environmental treatment of WNS infected hibernacula. The most flagrant abuse is that only 18% of bats that received raccoon poxviruses (RCN) expressing *Pd* calnexin (CAL) and serine protease (SP) survived, and this does not uphold the hypothesis that vaccinated bats enjoyed better survival than controls. All of the survivors were euthanized (Rocke et al '19). Apparent overwinter survival for free-flying chitosan-treated bats was 18.0%, which did not differ significantly from control bats. In the cage experiment, chitosan-treated bats had significantly higher survival until release on March 8 (53%) than control and *P. fluorescens*-treated bats (both 27%). Similar to other experiments, body mass, not infection intensity, predicted mortality. Treatment of bats may reduce WNS mortality, but additional measures are needed to prevent declines (Hoyt et al '19). Similar to Zmapp for the treatment ebolavirus in humans, for which a vaccine is now the jealously guarded gold standard, the vast majority of improvements to survival in the cage experiment are believed to be the result of supportive care, ie. 4' x 4' water pools with bat friendly escape ladders. Although some studies involving probiotics and amphibians have enjoyed 85% survival, *P. fluorescens* did not make the grade. What is wanted is an environmental treatment and follow up care, that eliminates WNS infection and death entirely. 53% survival with chitosan and water, requires comparison with other treatment, water and insects.

Currently, efforts are being devoted to the development and testing of chemical and biological agents for the effective eradication of *Pd* from bat hibernacula and hibernating bats. Although these control strategies appear to be promising, they are not being used for the large-scale decontamination of hibernacula, because of the likely off-target effects on the native microbial communities. The Fish and Wildlife Service has found that UV light eradicates Pd in vitro. So far the most effective environmental treatment has been the application of *Trichoderma polysporum* bacteria cultured from bats, to inhibit *P. destructans*. *Trichoderma polysporum* (*Tp*) strain (WPM 39143) inhibited the growth of *Pd* in autoclaved soil samples, with minimal to no impact on indigenous soil microbes. It is a promising candidate for further evaluation as a biocontrol agent in field trials of WNS infected sites (Zhang et al '15)(Singh et al '18) however it is not commercially available and must be cultured in these laboratories from samples taken from bat wings. Potent inhibition of Pd was first seen with volatile compounds produced by the bacteria *Rhodococcus rhodochrous* DAP96253 (Cornellison et al '14). Cold-pressed, terpeneless orange oil (CPT) was tried against multiple isolates of *P. destructans in vitro*. All *P. destructans* isolates were completely inhibited by 100% CPT (10 μL) at 1 month of incubation regardless of temperature (4°C and 15°C). Complete inhibition persisted up to 6 months following a single exposure at this concentration (Boire et al '16). Propolis produced from stingless bees possesses therapeutic properties, - antimicrobial, antitumor, antioxidant, anti-stimulant, anti-inflammatory, antiulcer, and anti-HIV. There was a complete inhibition of *Pd* sporulation with all propolis concentrations throughout the entire incubation period (16 days) at both incubation temperatures tested (Ghosh et al '18).

Melaleuca alternifolia, known as tea tree oil (TTO) has an extensive record as an antibiotic, antiviral and antifungal and is commercially available from sources in Australia. Although TTO has not been specifically studied in recent published in vitro studies targeting Pd, it should be an is so likely to be successful, it can be pre-authorized for field trials, with supportive care if the animals exhibit signs of infection. TTO had both an inhibitory effect and a fungicidal effect on a wide range of yeasts, dermatophytes, (such a *P. destructans*), and filamentous fungi including *Aspergillus niger*, *Aspergillus fumigatus* and *Penicillium* spp at Minimum Inhibitory Concentrations of 0.06%–0.12% (v/v) and Minimum Fungicidal Concentrations (MFC) of 2%–8% (v/v). Both germinated conidia and non-

germinated conidia of the isolates demonstrated susceptibility to TTO. Time-kill assays showed that the duration of exposure of the fungi to TTO could influence the fungicidal action. Tea tree oil was the overall most effective antifungal agent and could be explored for remediation of fungal contamination (Hammer et al '02). Consideration should be given to any potential health effects for occupants from exposure to TTO by direct contact (dermal) with residue or inhalation of vapor. TTO constituents may have skin sensitizing properties (e.g., limonene), although scientific evidence regarding the inhalational health effects of these aromatic compounds remains limited (Rogawansamy et al '15). In vitro laboratory and field research in hibernacula to verify the safety and effectiveness of TTO against *P. destrucans* in hibernating bats are needed.

It has been a decade since the first in vitro study of conventional antifungal medicines effective for treating WNS (Chaturvedi et al '11) was ignored, ostensibly to protect the environment against contamination with Lamisil. In review, the most likely conventional inorganic chemical medicines are enilconazole (Clinafarm smoke and spray) environmental treatment and chlorhexidine topical antiseptic for the treatment or oral and topical wing membrane infections. Azoles (enilconazole), are noted for lengthy contamination of the environment for a period of months, but this may be what is needed to effectively decontaminate a bat cave for the entire duration of the winter (Brauer et al '19). Enilconazole (synonyms imazalil, chloramizole) is a fungicide widely used in agriculture, particularly in the growing of citrus fruits, it seems like the most likely inorganic chemical environmental treatment for WNS. The product is highly effective against dermatophytes (*Microsporum* spp. and *Trichophyton* spp.) and also against *Malassezia*. Enilconazole is licensed for topical use in dogs. Enilconazole is also used for sinus irrigation in dogs with nasal aspergillosis. Although not licensed for cats (except in France), enilconazole is being used for topical treatment of dermatophytosis at a treatment schedule identical to that in dogs. Environment Enilconazole is available in special formulations for decontamination of the environment – as part of a strategic programme. Both a smoke generator (5 g enilconazole; for a 50-m3room) and a 15% emulsifiable concentrate (to be diluted1⁄100 in tap water; can be nebulized or sprayed) are available (Clinafarm smoke, Clinafarm spray; Janssen). These formulations are highly effective against spores of dermatophytes and *Aspergillus* spp. (Rochetta et al '03). Chlorhexidine is the highest selling chemical anti-fungal sterilizer for surgical instruments. Chlorhexidine is an antiseptic used to sterilize for surgeries and in healthcare practice, to reduce pocket depth in periodontitis, and to treat gingivitis. Chlorhexidine is a broad-spectrum antimicrobial biguanide used as a topical antiseptic and in dental practice for the treatment of inflammatory dental conditions caused by microorganisms. It is one of the most common skin and mucous membrane antiseptic agents in use today. Topical chlorhexidine for disinfection, as well as oral rinses for dental use, carries activity against a broad range of pathogens including bacteria, yeasts, and viruses (Lim et al '08)(Karpinski et al '15).

Section 7 (a) (1) of the Endangered Species Act (ESA) directs Federal agencies to use their authorities to further the purposes of the Act by carrying out conservation programs for the benefit of endangered and threatened species. Conservation recommendations are discretionary agency activities to minimize or avoid adverse effects of a proposed action on listed species or critical habitat, to help carry out recovery plans, or to develop information. To provide for an effective response against the WNS epidemic the Secretary of Interior must authorize and pay Fish and Wildlife Service (FWS) field biologists and cave managers for specific cost-effective programs of WNS treatment and supportive care for field trial in the winter of fiscal year 2022 pursuant to the Federal Cave Resources Protection Act of 1988 under 16USC§4303 and Endangered Species Act under 16USC§1536. Currently the only published field trials have proven that although all free flying bats suffered uniform 18% survival rate,

chitosan-treated bats had significantly higher survival until release on March 8 (53%) than control and *P. fluorescens*-treated bats (both 27%). However, similar to other experiments, body mass, not infection intensity, predicted mortality. Treatment of bats may reduce WNS mortality, but supportive measures are needed to prevent declines (Hoyt et al '19). The most likely commercially available organic environmental treatments are volatile compounds produced by the bacteria *Rhodococcus rhodochrous* DAP96253 (Cornellison et al '14), but this first successful in vitro study of probiotic treatment is somewhat ludicrous in light of the failure of *P. fluorescens*, and the most likely treatments for comparison with 53% survival in the chitosan and supportive care field trial (Hoy et al '19), are cold-pressed, terpeneless orange oil (CPT) (Boire et al '16), propolis (Ghosh et al '18) and tea tree oil (Hammer et al '02)(Rogawansamy et al '15). *Trichoderma polysporum* (*Tp*) strain (WPM 39143) is a promising candidate for further evaluation as a biocontrol agent in field trials of WNS infected sites (Zhang et al '15)(Singh et al '18) however it is not commercially available and the Department must pay a laboratory to develop cultures, from samples taken from bat wings, for field trial. FWS will also need to develop methods of installing UV light in bat hibernacula for field trial. If organic treatments are ineffective, the most likely chemical antifungal treatments are enilconazole (Clinafarm smoke and spray) (Rochetta et al '03) and chlorhexidine topical antiseptic spray for the treatment of oral and wing membrane infections (Lim et al '08)(Karpinski et al '15).

Supportive care in the form of a water pool with bat friendly escape ladders and insects for food will be necessary in any WNS infected bat hibernacula under the care of the Department of Interior. Undertakers will need to be vaccinated against rabies and uphold the decontamination protocol. The COVID-19 vaccine cures but is ineffective without involuntary follow-up exposure to pseudo-ephedrine brain shrink, *Pseudogymnoascus destructans* scientists ill-afford. Because bats can be a reservoir for coronavirus (Magnino et al '20), workers must know how to treat allergic rhinitis with hydrocortisone, eucalyptus, lavender, peppermint or salt to help water cure coronavirus. Usually dunking the head in saline or chlorinated water, ie. Swimming, instantly cures coronavirus allergic rhinitis. However WNS care is winter work, so mentholyptus cough drops keep the infection out of the lungs and only a little nose washing is needed. Wash the nose with eucalyptus, lavender or peppermint soap before going to work, and treat again if allergic rhinitis flares up (Sanders '21). The National White-Nose Syndrome Decontamination Protocol Version 10.14.2020 requires that all clothing, footwear and equipment should be decontaminated after every site visit. All dirt and visible contamination should be physically cleaned off. The preferred treatment for equipment deemed suitable for submersion is hot water that maintains a temperature of at least 55ºC (131ºF) for a minimum of 5 continuous minutes. All equipment surfaces must remain in direct contact with the >55ºC (131ºF) water for the entire 5 minute treatment eg. machine wash hot. Treat non-submersible equipment using the most appropriate product – ethanol (>60%), isopropanol (>70%), isopropyl alcohol wipes (70%), hydrogen peroxide wipes (3%), Accel, Clorox, Formula 409, Hibiclens, Lysol, Sani Cloth Germicidal Disposable Wipes, Up and Up Disinfecting Wipes or Virkon S.

B. History of Battle Mountain Sanitarium

8. Natural History

The Black Hills (Lakota: Ȟe Sápa; Cheyenne: Mo'ôhta-vo'honáaeva; Hidatsa: awaxaawi shiibisha) is a small and isolated mountain range rising from the Great Plains of North America in western South Dakota and extending into Wyoming, United States. The Black Hills, in western South Dakota and northeastern Wyoming, consists of 1.2 million acres of forested hills and mountains, approximately 110

miles long and 70 miles wide. The Black Hills rise from the adjacent grasslands into a ponderosa pine forest. Described as an “Island in the Plains,” the Forest has diverse wildlife and plants reaching from the eastern forests to the western plains. The Black Hills encompass the Black Hills National Forest. The hills are so called because of their dark appearance from a distance, as they are covered in evergreen trees. A Tertiary mountain-building episode, called the Trans-Hudson Oregony, is responsible for the uplift and current topography of the Black Hills region about 65 million years ago. This uplift was marked by volcanic activity in the northern Black Hills. The southern Black Hills are characterized by Precambrian granite, pegmatite, and metamorphic rocks that comprise the core of the entire Black Hills uplift. This core is rimmed by Paleozoic, Mesozoic, and Cenozoic sedimentary rocks. The Black Hills are one of the few remaining exposed portions of the Trans-Hudson orogenic belt. The peaks of the Black Hills are 3,000 to 4,000 feet above the surrounding plains, Black Elk Peak (formerly known as Harney Peak), which rises to 7,244 feet (2,208 m), is the range's highest summit (Hill '04) (Wolcott '67). Peak ground accelerations—an indicator of seismic event effects—in southwestern South Dakota are relatively low (two percent probability over 50 years of exceeding approximately 0.06 to 0.14 times the standard acceleration of gravity) (USGS 2014a). The region has a history of earthquakes ranging in intensity, as measured on the Modified Mercalli Intensity Scale from III to VI (USGS 2007), with the more intense earthquakes and the majority of faults located within the Black Hills division (BHHCS '16: 126)

Signs at the Mammoth site state: Millions of years before the Black Hills were hills, Western South Dakota was a vast plain. At times, the seas invaded the area and covered it with successive layers of limestone, sandstone and shale. Other times, the land lay exposed and received additional deposits by erosion. Altogether, about 7,500 feet of flat layers of rock and shale collected during this long interval of accumulation and occasional erosion. Today Black Hills geology contains rocks ranging in age from 2.5 billion years old to thousands of years old. They tell a complex story of ever-changing landscapes and events. Igneous rocks are formed by the cooling and solidification of magma or lava. Igneous rocks record periods of crustal activity that relate to the movement of the continents. Metamorphic rocks are made deep in the earth's crust where pre-existing rocks are subjected to such high temperatures and pressures the minerals in them change to other forms. New minerals grow and crystal sizes increase. Metamorphic rocks usually indicate times and places of mountain building. Sedimentary rocks are formed on the earth's surface from accumulation of material deposited by water, wind or glaciers. Sedimentary rocks hold information about climates of the past and fossil relics of organisms that lived when the sediments were laid down. Shale is often deposited in shallow sea areas. Because shale is soft and made of clay, it weathers quickly when exposed. In the Pre-Cambrian era, Earth's extended dawn, 2.5 billion years ago, deep beneath the earth's crust, molten granite is slowly moving upwards. Intruding into the rising granite, metamorphic rocks, the schist and pegmatite, are being squeezed, heated and re-crystalized. Millions of years in the future, the ancient granite, pegmatite, and schist will uplift to become the core of the Black Hills. In the ocean, life first stirs, single-celled, resembling modern day algae. Jelly-like blobs advance into complex creatures such as sea worms and jellyfish.

In the Paleozoic era, the age of fishes, 500 million years ago, the Black Hills is part of a warm and tropical rolling pain, which extends across North America's midsection. The sea gradually encroaches, it is destined to advance and retreat many times in the next 450 million years or so. The beach sand laid down by the first advance of the sea is gradually cemented to form Deadwood sandstone. During this era, South Dakota, and many other parts of the world, acquire large amounts of limestone from a warm, shallow inland sea. This formation is called the Pahasapa limestone. Invertebrate fossils

contains in the Pahasapa include corals, crinoids, and assorted brachiopods. After millions of years of limestone accumulation the sea retreats, exposing huge areas of limestone to weather. The erosion forms a thick layer of red, tropical soil. Shallow seas again invade, this time from the south. The soil reworked by the waves, depositing alternating beds of fine sand and dolomite in deeper waters. These sediments are to become the Minnelusa sandstone. Mid-continent North America is once again inundated by the sea. This time it is shallow and not well connected with the open ocean. Evaporation in the hot tropical sun causes the sea water to become extremely salty, limiting the life that can survive here. Repeated rise and fall of the sea causes thin layers of pure limestone to be deposited. This will become the Minnekahta limestone. Animal life in this era includes fishes, snails, sponges, and soft-bodied trilobites.

During the Mesozoic Era, the age of reptiles, 245 million years ago, the climate is warm and humid, with deciduous trees and lush flowering plants. Reptiles dominate, and the Black Hills region is above sea level. Great thicknesses of shale, the Spearfish, with deposits of gypsum are accumulating due to erosion. Over time, the Sundance Sea floods across this region, depositing several hundred feet of sandstone and shales, the layers now called the Sundance, Unkpapa, Lakota, and Fall River formations. Broad marshy areas bordering the sea are overgrown with pines, ferns and cycads. In time the sea retreats, leaving a muddy, sandy coastal plain, which will harden to become the shales of the Morrison. Wondrous varieties of dinosaurs and giant flying reptiles, wanter where the sea have been. Late in the Mesozoic the seas return to deposit thick, black mud which we know today as the Mowry and Pierre formations. Warm-blooded birds and small primitive mammals are making an appearance during this interval of time.

In the Cenozoic Era, the age of mammals, 65 million years ago, the Black Hills region has begun to lift, to rise as a result of great folding and tilting. The forces that are raising the Black Hills are probably related to the collision between the North American continent and the floor of the Pacific Ocean. A very warm and wet climate prevails over much of North America during the early Cenozoic. Species of tropical plants and animals thrive. Flies, bees, butterflies and beetles are prevalent because of the numerous fruit-bearing trees. Animal life increases with the appearance of eagles, owls, and cranes, among others. Sediments, during the middle Cenozoic, are eroding from the newly formed Black Hills. These sediments are washing over the Great Plains, which stimulates fertile grasslands. Mammals increase in number and variety, including the grazing and carnivorous mammals. Slowly, the North American continent is moving northward, and the climate is affected. In the late Cenozoic it is becoming cooler, drier and the plant species are becoming like those of the present. Glaciers, once limited to the mountains of the north, are advancing. Farther north, the Bering Strait is a dry-land connection with Siberia, allowing an exchange of animals. North American horses and camels stray across, with Eurasian animals such as the mammoth migrating into North America. In the Pleistocene, 26,000 years ago at the edge of a spring-fed pond, Columbian mammoth, woolly mammoth, giant short-faced bear, camel, wolf and other Ice Age animals walk here. Into the future, rivers and hot springs deposit gravels and cement them with calcium carbonate creating tufa and conglomerate rocks.

During the Late Pleistocene, about 26,000 years ago, the sinkhole at Mammoth Site of Hot Springs formed when a cavern in the Minnelusa Limestone collapsed. This cavern collapse created a steep-sided sinkhole, that was about 65 feet (20 m) deep and 120 feet (37 m) by 150 feet (46 m) wide at the surface. Likely enticed by warm water and pond vegetation, mammoths and other animals entered the pond to eat, drink or bathe. Because of the steep sides of very slippery Spearfish Shale, mammoths were occasionally trapped as they were unable to find a foothold and climb out of the sinkhole.

Trapped in the sinkhole, the mammoths ultimately died of starvation, exhaustion, or drowned. It is estimated that this pond slowly infilled with silt over a period of 350–700 years. Findings at the site include the remains of megafauna such as giant short-faced bears along with those of shrub oxen, American camel, llama, wolves, coyotes, birds, minks, ferrets, prairie dogs, voles, and moles. Invertebrate discoveries include several species of clams, snails, and slugs. The majority of the mammoth remains have been identified as those of Columbian Mammoths, although the remains of three Woolly mammoths have been found as well. In 1974, a construction worker, George Hanson, unearthed unusual bones while the area was being prepared for a new subdivision. His son recognized one of the finds as a mammoth tooth. The landowner Phil Anderson agreed to further investigation, and a complete skull and tusk were found in 1974. Phil Anderson agreed to donate the entire bone bed and mineral rights to the nonprofit organization and along with the work performed by amateur and professional excavators, led to its status as a museum, and it was designated a National Natural Landmark in 1980. The Mammoth Site is a 501(c)-3 non-profit organization. The museum is open to the public. As of 2016, the remains of 61 mammoths, including 58 North American Columbian and 3 woolly mammoths had been recovered (Agenbroad et al '94: 15-27).

Black Hills National Forest encompasses over 1.2 million acres that consist primarily of early to late succession ponderosa pine communities with inclusions of white spruce, quaking aspen, paper birch, bur oak, mountain mahogany, and high mountain meadows. Riparian habitats consist mainly of sedges, forbs, and willows. The lower elevations include grassland prairie. The forest includes 11 reservoirs, 1,300 miles of streams, and 13,000 acres of wilderness (National Forest Foundation 2015). The Black Hills are known as “the Forest” of the Great Plains. 95% of the vegetation covering the hills are a fire-climax ponderosa pine forest, with 2% hardwoods, 1% meadow/grass, >1% shrubs and >1% non-vegetated. Black Hills white spruce (*Picea glauca* var. *densata*) occurr in cool moist valleys of the Northern Hills. The southern edge of the Hills, due to the rain-shadow of the higher elevations, are covered by a dry pine savannah, with stands of mountain mahogany and Rocky Mountain juniper. Riparian shrublands at lower elevations typically consist of a mix of shrubs such as western snowberry, gooseberry, currant, and rose. Silver sagebrush occasionally forms large stands on floodplains. Thickets of western snowberry are common in draws and on floodplains. The Prairie ecological system includes stands of grassland communities, including western wheatgrass–green needlegrass mixed grass prairie, needle-and-thread–blue grama mixed grass prairie, northern Great Plains little bluestem prairie, northern plains big bluestem prairie, western wheatgrass–blue Grama–threadleaf sedge prairie, and wheatgrass–needle-and-thread mixed grass prairie (BHHCS '16: 141).

Thirty percent of the Forest has mature trees with greater than 70% canopy closure. An additional 20 percent is in the sapling/pole size class with greater than 70% canopy closure. The Black Hills National Forest Collaborative Forest Landscape Restoration Project FY 2011 – FY2020 reports, the forest has changed dramatically since Euro-American settlement in the 1800’s. Intensive grazing, selective harvesting of large trees and fire suppression has led to changes in forest structure and composition that are unprecedented in the evolutionary history for these frequent fire ecosystems. These changes have decreased biological diversity, increased risk of stand-replacing crown fires, and increased vulnerability to disease and insect outbreaks compromise the long-term sustainability of the ecosystem and surrounding communities. Over 10% of the Forest has burned under severe and intense conditions in the last 10 years. Wildfire has burned 186,000 acres in the Black Hills in the last decade, the largest being the Jasper Fire that consumed 83,000 acres in four days. A sustainable new approach needs to be cultivated. The Forest is commercially harvesting around 20,000 - 30,000 acres per year, or 2 percent of suitable forestlands per year, that needs to be limited to sustainable plantations and

salvage logging within a year of a major fire. Fire suppression must be limited to immediately eliminating debris from logging operations and must not create and negligently leave flammable debris. Noxious weed removal should involve manual labor not herbicides. Restored landscape will have more aspen, birch, spruce, shrubs and forbs and less ponderosa pine cover. Ponderosa pine forests will be less dense with larger trees in clumps and groups, with interspersed openings. Understory trees will be considerably less dense with dramatically reduced susceptible to fire laddering to the canopy. The bark beetle hazard will be substantially reduced. Herbaceous vegetation will provide increased opportunities for wildlife forage and traditional medicinal and food plant gathering.

Approximately half of Fall River County is occupied by the Buffalo Gap National Grassland to the south and the Black Hills National Forest to the north. Higher elevation areas to the north into the Black Hills National Forest create favorable growing conditions for ponderosa pine. The lower elevation areas surrounding the Black Hills to the south are primarily used as rangeland for livestock grazing and as agricultural land. Just south of Hot Springs is a wild horse sanctuary on 11,000 acres of grassland prairies, ponderosa pine forests, and canyons along the Cheyenne River. Ten miles south of town is the Angostura Reservoir and Recreation Area that includes 36 miles of shoreline and sandy beaches. It is one of the few reservoirs in southwestern South Dakota and is an important location for migratory birds. Multiple species of warmwater fish are found in Hot Brook Creek and the Fall River including longnose dace, sand shiner, bluegill, green sunfish, white sucker, creek chub, plains topminnow, and domestic non-native goldfish and jack dempsey. Other species found in the Fall River include channel catfish, smallmouth bass, shorthead redhorse, rock bass, and common carp. In Hot Brook Creek or the Fall River, water temperatures are warm, often exceeding 80$_{o}$ F, during the winter months, the water temperature remains high enough that the creek and river do not freeze. Cold Brook Dam was constructed on Cold Brook Creek to reduce flood damages in the Fall River Basin. Cold Brook Reservoir, located less than one mile north of Hot Springs, is managed for flood control and recreation. It is approximately 32 acres in area and contains rainbow trout, largemouth bass, black crappie, and green sunfish (BHHCS '16: 143, 144).

Wildlife is both diverse and plentiful in the Black Hills. In the creeks, native fish species include creek chub, fathead minnow, finescale dace, lake chub, longnosed dace, longnosed sucker, mountain sucker, and white sucker. Many non-native fish species have been introduced, including salmonids. Trout were first introduced from Colorado in the 1880s. The forests and grasslands offer good habitat for American bison, white-tailed and mule deer, pronghorn, bighorn sheep, mountain lions, and a variety of smaller animals, like prairie dogs, American martens, American red squirrels, Northern flying squirrels, yellow-bellied marmots, and fox squirrels. Black bears have been spotted in the Black Hills. Mountain lions and coyote are increasing dramatically as a result of prolific herds of deer and elk. Bald eagle, hawk, osprey, peregrine falcon, and another 200 species of birds can be found in the forest, especially along streams and near water sources (BHHCS '16: 143, 142). Biologically, the Black Hills is a meeting and mixing place, with species common to regions to the east, west, north, and south. The American bison (buffalo) have made a miraculous recovery to about 200,000 nationwide, after nearly becoming extinct. Wind Caves National Park maintains a herd of about 400 buffalo, about as low as the national population dipped, with minimal mixing with domesticated cattle and gives some to Native American tribes and other wilderness conservation organizations. Like most grazing animals, bison smack their lips to express they are more fond of picnicking with humans than being eaten. Nonetheless, Battle Mountain game production area and other hunting lands might be interested in regulating the harvest of difficult to sex wild buffalo, who might require fencing to prevent them from being a somewhat dangerous nuisance. The Hills support some endemic taxa, the most famous of

which is probably white-winged junco (*Junco hyemalis aikeni*). Some other endemics are Cooper's Rocky Mountain snail, Black Hills subspecies of red-bellied snake, and a Black Hills subspecies of southern red-backed vole. Some birds that are only in the Black Hills and not the rest of South Dakota are pinyon jay, Canada jay, three-toed woodpecker, black-backed woodpecker, American dipper, ruffed grouse, and others.

US Fish and Wildlife reports that in the Black Hills, Whooping Crane are endangered; Rufa Red Knot Bat and Northern Long-eared bat are threatened and Black-footed ferret have been experimentally reintroduced. In Pennington County Leedy's Roseroot is also listed as being threatened (USFWS '21). In Fall River County Sprague's pipit (*Anthus spragueii*) and Greater sage grouse (*Centrocercus urophasianus*) are federal candidates. South Dakota lists the Swift Fox (*Vulpe velox*), Osprey (*Pandion haliaetus*), Bald Eagle (*Haliaeetus leucocephalus*) as being threatened and Finescale dace (*Chrosomos neogaeus*) as being endangered. The *Endangered Species Act* of 1973, as amended, is federal legislation that is intended to conserve the ecosystems upon which endangered and threatened species depend and provide programs for the conservation of those species, thus preventing extinction of plants and animals. Section 9 prohibits the unauthorized "take" of federally protected species, which includes harassment, harm, pursuit, hunting, shooting, wounding, killing, trapping, capture, or collection of a protected species, or the attempt to engage in any such conduct (BHHCS '16: 139). There are 24 species of concern the Migratory Bird Treaty Act of 1918 and Executive Order 13186, Responsibilities of Federal Agencies to Protect Migratory Birds, require federal agencies to minimize or avoid impacts on migratory birds that are listed in 50 CFR 10.13. The Act prohibits the taking (hunting, wounding, killing, possessing, or transporting) of any migratory bird, their eggs, features, or nests (BHHCS '16: 140, 139). American bittern, bald eagle, bell's vireo, black-billed cuckoo, Brewer's sparrow, burrowing owl, dickcissel, ferruginous hawk, golden eagle, grasshopper sparrow, greater sage-grouse, Hudsonian godwit, Lewis' woodpecker, loggerhead shrike, long-billed curlew, marbled godwit, mountain plover (Fall River County only), pinyon jay, prairie falcon, red headed woodpecker, sage thrasher, short-eared owl, Swainson's hawk, and upland sandpiper (BHHCS '16: 147).

Evidence of human occupation of the Black Hills region corresponds archaeologically to that of Northwest Plains cultures in general, spanning at least the previous 12,000 years (Kornfeld et al. 2010) Native Americans have a long history in the Black Hills. Legend has it, American Indians were stricken with an epidemic known as "fell disease" about the middle of the 16th century that threatened to obliterate the tribes. A messenger arrived from the Great West with news of a wonderful water which, he said, had been touched by the finger of the Great Spirit and would cure all manner of diseases. Indians came to these springs by the thousands. The Arikara arrived by AD 1500, followed by the Cheyenne, Crow, Kiowa and Arapaho. After a lapse of more than 200 years, the Cheyenne took possession of the springs and built an immense tipi city covering hundreds of acres. In the 18th century the Lakota (also known as Sioux) arrived from Minnesota and drove out the other tribes, who moved west. The First Treaty of Fort Laramie Treaty with Sioux Etc., known as the Horse Creek Treaty, was signed with the Sioux, Cheyennes, Arrapahoes, Crows, Assinaboines, Gros-Ventre, Mandans, and Arrickaras, in 1851. It stipulated that Plains Indians would stop inter-tribal fighting, let white migrants and railroad surveyors travel safely through their lands, allow the US government to build roads and army posts in their land, and to pay compensation to the US government if their tribe members broke these rules. In return, the US government stated they would protect Plain Indians from any white Americans and pay the tribes a $50,000 annuity providing they stuck to the treaties terms. Art. 5 of the 1951 Horse Creek Treaty specifically granted the Black Hills to the Sioux, but did not prejudice any rights or claims any other tribes might have to the land. This culminated in a fierce conflict in about

1869, the memory of which is preserved in the name of Battle Mountain, where the besieged Cheyenne established fortifications. The Sioux won the battle and possession of the springs which they called Wi-wi-la-kah-to (Springs - hot). They called the area Minnekahta (Water - hot) and termed the Black Hills a great "Medicine Home." After the Battle Mountain fight, tradition says the Sioux and Cheyenne agreed to allow the springs to be a health sanctuary to give their sick and lame the benefit of the healing waters. While the conflict abrogated Art. 1 of the 1951 Treaty, the restitution seems satisfactory under Art. 4 to forge a lasting peace into a prospective future Battle Mountain Treaty. Native Americans told white settlers no tribe claimed the hot springs (in Arkansas), but that all tribes bathed in the healing waters of the springs (Paige & Harrison '87: 22)(Scully '66: 5-6).

The Black Hills, located in South Dakota, holds great spiritual and cultural significance to the Lakota, Dakota and Nakota indigenous peoples, collectively known as the Great Sioux Nation. They call the Black Hills, Ȟe Sápa (Black Mountains). The 1868 Treaty of Fort Laramie, implicitly reserved the Black Hills for the Lakota, Dakota and Nakota peoples, by establishing the Great Sioux Reservation, west of the Mississippi, and exempting the entire region from all white settlement forever. Both the Sioux and Cheyenne claimed rights to the land, saying that both their cultures considered it the axis mundi, or sacred center of the world. However, the discovery of gold in the area in 1874 as the result of George Armstrong Custer's Black Hill's expedition, led to a conflict over control of the region sparked the Black Hills War of 1876, also known as the Great Sioux War, the last major Indian War on the Great Plains. Following the defeat of the Lakota and their Cheyenne and Arapaho allies in 1876, the United States took control of the Black Hills. U.S. Congress to pass an act in 1877 which vested ownership of the Black Hills to the United States. The US government took the Black Hills and, in 1889, reassigned the Lakota, against their wishes, to five smaller reservations in western South Dakota, selling off 9 million acres (36,000 km^2) of their former land.

9. Hot Springs Historic District

Therapeutic spas and resorts put Hot Springs on the map as a destination for well seekers from all over the United States. The hot mineral springs were also instrumental in the establishment of Battle Mountain Sanitarium, a National Home for Disabled Volunteer Soldiers. Battle Mountain was constructed by architect Thomas Rogers Kimball, in the Mission/Spanish Colonial Revival style, it opened in 1907 and was a precursor to the modern system of federal veterans homes. Battle Mountain Sanitarium is within the original 1974 boundary of the Hot Springs Historic District and in 2011, was listed as a National Historic Landmark (Ref#11000561). This site is described as containing 68 buildings, 62 structures, and Hot Springs National Cemetery, many dating back to the historic period, and all in excellent repair. Several architectural styles, from the the period of significance c.1888-1934, using local sandstone throughout the district are noted as Late Victorian: Queen Anne Late Victorian: Romanesque, Late 19th and 20th Century Revivals: Mission/Spanish Colonial Revival, Late 19th and Early 20th Century American Movements: Commercial, Late 19th and Early 20th Century American Movements: Craftsman. The Hot Springs Historic District is located in Hot Springs, Fall River County, South Dakota, at the southern end of the Black Hills, a mountainous region in western

South Dakota and eastern Wyoming. There are a total of 132 contributing and 96 noncontributing resources in the district that was listed in the Historic Register in June 1974. Sandstone bluffs to each side of the business district rise to plateaus; the western bluffs hold early residential neighborhoods, and a bluff to the east of the original resort area is the site of the Veterans Administration Medical Center, established as Battle Mountain Sanitarium in the early twentieth century. The red, pink, and buff sandstone cliffs against a backdrop of hills dominated by evergreens create a particularly picturesque setting for this historic district (Julin '17: 5-7, 28-36).

The Hot Springs Historic District developed around the establishment of a warm water mineral springs resort. From colonial times travelers addressed their health by visiting mineral springs, where bathing in or ingesting the waters was considered a means to maintaining good health or dealing with chronic conditions and diseases. Faith in the efficacy of these waters increased in the early nineteenth century as many physicians embraced the belief that mineral waters contained elements that could affect a host of ills, including musculoskeletal aches and pains, gastrointestinal conditions, and skin irritations. Specific uses including hydrotherapy (treatments using the application of water to the body) and balneotherapy, bathing in mineral waters. Trust in the benefits of the waters combined with advances in transportation systems convinced greater numbers of people to travel to mineral springs, and many of the country's most prominent watering spots, including Saratoga Springs, New York, Hot Springs, Arkansas, and White Sulphur Springs, Virginia, developed during this period. As larger numbers of people visited these sites, many of the spas became fashionable social resorts as well. Balls and parties, concerts and lectures, outdoor strolls and games entertained those who came for reasons of health and those who came for pleasure. Over time, billiards, gambling, and other less savory entertainments became acceptable at many of the resorts. As the spas began to be known for social life and amusement as well as health, grand hotels were built (Aron '99: 7, 16-20, 24-25). Although people continued to "take the waters" into the 1940s, and many water resorts continue to serve clients today, the mineral springs resorts saw their height of popularity between 1880 and 1920 after which time people frequented chlorinated and saline swimming pools and hot tubs with equal medicinal effect. Many resorts, including Hot Springs, founded on the basis of their healing waters survived as vacation spots —often as part of a trip, rather than its focus—and the communities that had developed around them diversified their economies to survive, after the health resort era had passed (Julin '83: 264-265).

Hot Springs was founded as a potential mineral water resort only a few years after non-Indian settlement began in the Black Hills of Dakota Territory. Until the late nineteenth century, the Black Hills were the environs of Native Americans, including the Lakota Sioux and the Cheyenne. After the Sioux defeated the Cheyenne at Battle Mountain, in 1868, the area became part of the Great Sioux Reservation, with the treaty that formed it prohibiting non-Indians from entering the area without government authorization. In 1874, the government sponsored an expedition into the Black Hills led by General George A. Custer, and subsequent reports of gold in the area ignited a gold rush the government could not quell. A much disputed 1876 treaty moved the western border of the reservation to the east, opening the Black Hills region to white occupancy. The health spa at Hot Springs was founded only five years after this non-Indian migration to the Black Hills began. In 1879, Deadwood resident William Thornby accompanied geologist Walter Jenney to the southern Black Hills. Although the two men hoped to find gold, they were temporarily distracted by reports of hot water springs in the area, which had been noted by an 1875 scientific expedition led by Jenney and Walter Newton. Jenney and Thornby located the Minnekahta Spring, which derived its name from a Native American Indian word meaning "hot water." Impressed by the possibilities the site offered, Thornby returned to legally claim the spring. He delayed making improvements to the site, however, and eventually gave up his

claim to Joe Larive and John Davidson and their families, who camped near the spring and utilized its warm waters. By 1881, Larive, Davidson and Trimmer were offering mineral baths to the public. In that year, William Thornby wrote an article about the warm springs in the Fall River valley for Deadwood's newspaper, the *Black Hills Pioneer*. Rudolphus Dickenson, a Deadwood resident and federal government employee who had trained as a doctor, read the article and visited the site. His enthusiasm for the possibilities there led to the formation of the Hot Springs Town-Site Company in the fall of 1881 (Julin '83: 199-205).

The original town site was platted on land owned by Jennie and Edmund Petty, and the plat map filed in January 1883. Later that year, Hot Springs was named county seat of the newly created Fall River County, established after a bitter fight to separate the area from Custer County. The county seat designation brought a sense of permanence and security to the little town, further enhanced when the Fremont, Elkhorn, and Missouri Valley Railroad reached Buffalo Gap, thirteen miles away. Frederick Taft Evans was born in Ohio in 1835 and spent his early adult years working in the woods in Wisconsin and Iowa. In 1856, he began a long career in transportation when he bought oxen to carry freight to Colorado. In 1875, he started for the Hills with a train of mules loaded with supplies, but the military turned him back and confiscated the property. Later that year, he succeeded in getting a mule train through to Deadwood, South Dakota. With the establishment of the Hot Springs Town-Site company, Evans began a new enterprise. In the mid-1880s, he sold his freighting business and other interests in Sioux City, attracted investments from eastern speculators, and turned his energies toward building a town and a health resort. He became president and driving force of the reorganized town-site company, named the Dakota Hot Springs Company. Many of Fred Evans' actions in Hot Springs directly affected the town's built environment, and his influence can still be seen in the way Hot Springs looks today. One of the most important effects was the division of the town into two sections: "upper town," where the Dakota Hot Springs Company and competing interests developed bathhouses and hotels, and "lower town," where the more mundane businesses of a trade and commercial center were carried on. Upper town, located on the north end of the business district, was initially divided from lower town by a cliff, and only a trail led from one section to another (FRCHS '76: 80-81)(Julin '83: 214-15).

By 1887, Hot Springs held a variety of businesses and professional services, including two grocery stores, a liquor store, a hardware store, a dentist, a music teacher, and a photographer. In addition to general business development, the establishment of two institutions in Hot Springs helped to fuel expansion and optimism. The first of these was the Black Hills Methodist Mission College. After a spirited competition with the towns of Spring Valley and Custer, Hot Springs became the home of the school in 1887. Also in that year, the Grand Army of the Republic named Hot Springs as the location of a territorial soldiers' home, and the location committee bought land from Fred Evans on a plateau west of the city for its site. After Governor Louis Church vetoed the bill establishing the home, the territorial legislature overrode his veto, to the delight of Hot Springs citizens. By 1889 the boom was on. The building boom brought with it a new look for Hot Springs. Up to this time, most buildings were log or frame, and many of them very modest. The sandstone cliffs surrounding Hot Springs provided an ideal construction medium in red, pink, and buff sandstone. Local men and outsiders attracted by the available work quarried the stone and cut it into blocks. While some of the sandstone buildings constructed were very simple, others displayed ornate stone cutting techniques. Most of the buildings were designed by workers or owners rather than architects and many displayed the influence of Romanesque Revival/Richardsonian Romanesque, an architectural style popular in the late nineteenth century. The first major sandstone structures in Hot Springs were Black Hills College,

completed in 1889, and the State Soldiers' Home, opened in 1890. The Evans Hotel opened in 1892, and Evans soon added a three-story bathhouse, the Evans Sanitarium. His other major contribution to the resort community was Evans Plunge, built with a round iron and glass roof over a warm spring and outfitted with steam heat, electricity, and swimming paraphernalia to entertain visitors. The original Evans plunge doesn't exist anymore, but a modern Evans Plunge continues to entertain visitors (Julin '83: 216-224).

National economic problems had been building since 1890, and problems in the mining industry created further unease. In May of 1893, the prominent National Cordage Company went under and the stock market subsequently collapsed causing what is known as the Panic of 1893. Banks, businesses, and railroads across the country began to fail and unemployment reached catastrophic levels (Painter '87: 116-117). The financial crisis slowed the building boom in Hot Springs, but the health spa's regional reputation helped it maintain its stature as a vacation destination (Julin '83: 223-224). An 1894 pamphlet listed four major bathhouses and one under construction. Hundreds of "bath rooms" were available as well as more communal facilities. The pamphlet stated that conditions including rheumatism, liver disease, neuralgia, and insomnia could be successfully treated by the waters and that overweight bathers could lose as much as a pound a day by exercising in the baths (Leffingwell 1894: 23-28). C. M. Briggs, a Sioux City physician, provided a testimonial to the efficacy of the waters. He said that the warm mineral springs increased the force and the rate of the heartbeat, thus producing an effect similar to an electric shock " so that each individual hair will stand up on end like the quills on a fitful porcupine" (Jones 1891). The Evans Sanitarium, built as an annex to the Evans Hotel, was the largest and most elaborate of the city's bathhouses. Built of sandstone to match the hotel, the wedge-shaped building held a reception office on the ground floor, sixty bath rooms, and doctors' offices. Attendants were available to guests, who were offered a variety of baths. These included the "needle bath" which sprayed water from several directions at a bather standing in a cubicle and the "electric bath" which required bathers to hold one end of an electrode and suspend the other end in the water. This treatment was considered particularly invigorating (Leggingwell 1894: 26).

As visitors came to Hot Springs in response to the attractions of hotels, bathhouses, and other amenities, a relatively sophisticated social life developed in the community. Railroads were responsible for much of this influx, offering convenient access to the resort town, and groups joined individual visitors in enjoying the town's offerings. In the 1890s, for example, the city entertained South Dakota newspaper editors and their wives, a large contingent of railroad physicians, Masons from South Carolina, Nebraska funeral directors and their wives, and members of the South Dakota Education Association. Divorce provided another source of visitors. Between 1867 and 1909, territorial and state law required only ninety days to establish residency and file for divorce, and people seeking to end their marriages could do so in the pleasant surroundings in Hot Springs. While the lure of the mineral springs continued to draw travelers, the promise of conviviality and entertainment and the ease of divorce buttressed the area's attractions. Hotels were the focal point of the town's social life, entertaining guests and providing social functions for townspeople. Fifteen hotels and boarding houses provided such amenities for travelers by the mid-1890s, ranging in size from the elegant Evans Hotel, which could serve more than four hundred guests, to small boarding houses. The Evans was the town's social life (Julin '83: 244-251).

Even as Hot Springs became more focused on pleasure- seekers, however, its medical community grew to include several facilities that offered more traditional services. Our Lady of Lourdes Hospital opened in 1901 on the site of the former Gillespie Hotel, which had burned a few months before.

Benedictine nuns operated the hospital, which was initially housed in a frame building and then in a newly-built sandstone structure. Our Lady of Lourdes served the general population and provided medical and surgical care. In 1908, the hospital instituted a nurses' training program. Dr. Perry Nichols opened the Nichols Cancer Sanitarium in the former Burdette House on Minnekahta Avenue in 1905. In 1907, he completed his own hospital on a bluff west of the downtown, and the highly visible sandstone building became an important part of Hot Springs' skyline. Nichols left Hot Springs in 1914, and the Lutheran Hospital was established in the building in 1918. Dr. C. W. Hargens came to Hot Springs in 1891 as a practitioner of the "Keeley Cure," a treatment for alcoholism. He purchased the 25- room Davis Rooming House on upper town's west bluff in 1907, added an addition, and established a hospital and nurses' training program. The Medical Block, established on North River Street, served as a clinic and offices for doctors associated with Our Lady of Lourdes Hospital. The preponderance of doctors and medical-related facilities in Hot Springs elevated its image beyond a mineral springs resort. The most prominent and visible of these facilities was Battle Mountain Sanitarium, opened in 1907 (Julin '83: 258-264).

Battle Mountain Sanitarium was the tenth branch and the first sanitarium established by the National Home for Disabled Volunteer Soldiers after the Civil War. Unlike the earlier facilities, Battle Mountain Sanitarium was established as a treatment center rather than as a residence. R. D. Jennings, one of the original founders of the Hot Springs Town-Site Company and the first doctor to offer mineral baths to the public, was appointed as Battle Mountain's first governor. An official report for the years 1908-09 stated that 865 veterans were treated at the sanitarium during the period; the majority were Civil War and Spanish-American War veterans. The most common diseases treated were rheumatism and arteriosclerosis. Veterans suffering from pulmonary tuberculosis were admitted only if officials deemed them capable of making reasonable improvement or recovery. Veterans stayed at the sanitarium only as long as they received benefits from treatment. Once treatment was completed, they were discharged or transferred to one of the Branch Homes (NHDVS 1910: 261-272). Battle Mountain Sanitarium continued to expand in the decades after its establishment. In 1913, a conservatory and greenhouse was completed, and in 1915 a sandstone staircase with 204 steps was constructed, linking the site on upper town's eastern bluff with the valley floor. A hospital building was completed in 1926. The grounds also included residences for staff and auxiliary. Battle Mountain Sanitarium enhanced Hot Springs' reputation as a center for health and medical care. With the establishment of this facility, Hot Springs gained an expansive institution which added to its physical attractions and to the economic health of the community. Ironically, the lure of Hot Springs' mineral water resorts began to wane shortly after Battle Mountain opened its doors (Julin '17: 48).

Mission/Spanish Colonial Revival is an uncommon architectural style in South Dakota. The style is found occasionally on schools, public buildings, and on some buildings with a commercial use. It is also found occasionally on residences. Though not a common style, examples that do exist are often some of the most impressive houses in their neighborhoods. Mission/Spanish Colonial Revival is most common in the southwestern United States and Florida. Scattered examples can be found across the United States, but like the Mission style, few landmark examples exist outside of the Southwest and Florida. Characteristics of the style include: low-pitched roofs with little or no eave overhang, red tile roof covering, prominent arches above doors or principal windows, stucco wall surfaces, and asymmetrical facades (Julin '83: 417-418). Battle Mountain Sanitarium was built in a Mission/Spanish Colonial Revival-inspired style that also incorporates elements of the Romanesque Revival architecture found throughout Hot Springs. Mission style features include smooth wall surfaces, shaped parapets, arched entry and window openings, and low, broad roofs covered in clay tiles. Elements of

Romanesque Revival such as rough sandstone, massive walls, bands of arched, deeply recessed windows, and arched entries were also incorporated. Architect Thomas Rogers Kimball's design both reflected the local architecture of Hot Springs and also influenced it (Julin '17: 51).

The Veterans Bureau sponsored construction of a new tuberculosis hospital on the Battle Mountain Sanitarium campus in 1925-26. This modern hospital would replace the wood frame tuberculosis ward and eventually supplant the original 1907 Battle Mountain Sanitarium hospital complex as the main medical facility on site. The needs of World War I veterans with lung diseases such as tuberculosis further pushed the shift to medical care as the most prominent aspect of veterans' services. Numerous additions to the Tuberculosis Hospital, starting in 1937 and continuing the most recent addition in 1997, have turned it into the main medical/surgical facility at the Hot Springs Campus of the VA Black Hills Health Care System. The Tuberculosis Hospital has a Tudor Revival look to its exterior, with rusticated stone walls and areas of half-timber decoration on the upper floors. The asymmetrical elevation varies from five stories at the center to flanking four story sections of unequal width to three story side wings. A variety of hipped tile roof forms, cross gables and a roof-top pergola further accents the asymmetry of the elevation. The 1937-38 addition is more symmetrical, with a rectangular footprint. It is constructed of reinforced concrete and includes a few minimalist Tudor Revival decorative details at the entrance and the pavilion tower at the center of the flat roof. Later additions are attached to the rear and have the utilitarian appearance of mid/late twentieth century health care facilities. These additions have reoriented the main entrance of the hospital.

The great influx of new veterans after World War I, mostly young men with acute medical or psychiatric conditions, tested the capacity of the entire federal veterans' benefits system. At this time the National Home for Disabled Volunteer Soldiers (NHDVS) and the Bureau of Pensions were the two federal entities serving veterans. There was a growing realization that meeting new demands for more sophisticated medical care would require substantial reorganization addressed by Colonel R. C. Humber in his Inspector General report for 1919 (Humber 1919: 11). The need to place extra restrictions on the tubercular members as a precaution against spreading infections caused resentment and was loosely enforced in the generally open environment of the Home. The free movement of tuberculosis patients at the Battle Mountain Sanitarium was seen as a problem. In the 1918 *Inspection Report* it was noted disapprovingly that patients of all ailments mingled in the mess hall, chapel, library, and other communal facilities (Humber 1918). In the mid-1920s the Veterans Bureau began construction of the new Tuberculosis Hospital at Battle Mountain. This new hospital reflected the changing mission of the "second generation" of veterans' hospitals to rehabilitation and outpatient care through modern medical techniques. Construction bids were opened on August 4, 1925. The architects were Madsen & Peterson of Minneapolis. Construction of the new hospital continued into 1926. A new boiler plant to handle increased demand also was built at this time. Additional staff housing including two duplexes (from standard plans - one built in 1920 and the other in 1927) and additional nurses' quarters (1926) were constructed at this time. Initially known as the Hospital Annex, the new hospital was completed by October 1926. The Tuberculosis Hospital had its own mess and capacity of about 160 beds. President Calvin Coolidge visited Battle Mountain Sanitarium and its newest facility in August 1927, while he was spending the summer in the Black Hills. By 1930 the large demand for tuberculosis treatment at Hot Springs was starting to wane and the new hospital began to be used for general medical care. Overall, the number of veterans being treated for tuberculosis in government hospitals decreased from 11,000 in 1922 to 6,000 in 1932 (Spurlock et al '11).

A large addition was attached to the southeast side of the Veterans Bureau hospital in 1937-38. This

four-story wing had a rectangular footprint and a symmetrical elevation sheathed with stucco and a few minimalist Tudor Revival decorative details. It housed a medical unit of 95 beds. This hospital addition also included an updated surgical suite that replaced the one in the 1907 Administration Building. It appears from photographs that this operating room still had movable windows. In 1963 an updated air conditioning system was added to this space. An addition in 1950 on the northeast end of the original section housed dietetic services, including a new kitchen and dining room. Around this time the 1907 hospital was converted into a 548-bed domiciliary providing barracks-style housing for veterans. Building No. 12 and its additions were a 255-bed general medical/surgical facility. During the 1980s and 90s, changes to the complex continued to be focused on upgrades and expansion of the general hospital at Hot Springs. A new clinical wing was added in the early 1980s. A CT scan building was added in 1987. In 1996 the complex's name was changed to Hot Springs Medical Center of the VA Black Hills Health Care System. This change represented a consolidation of the VA Medical Centers at Hot Springs and at Fort Meade. A new Ambulatory Care addition including a new emergency room was added to the southeast side of the general hospital in 1997. Surgical cases requiring an overnight stay were now handled at Fort Meade. Today the Hot Springs is an active medical center providing care for veterans of World War II, Korea, Vietnam and more recent conflicts (VAMC '07).

Of the fifty-three buildings and structures on campus, twenty-nine dating to the NHDVS period survive, as do the landscape, small-scale features and cemetery. Designed by Thomas Rogers Kimball in a Mission-inspired style, the resources include a prominent administration center connected to an innovative hospital complex that placed wards in rectangular spokes. The wards featured sophisticated ventilation systems, ramps instead of stairways, and expansive open porches on eastern exposures. The ramps, while not meeting the current standards for handicap accessibility, were a significant improvement for wheelchair bound veterans (Lyle '07). George E. Kessler, a Kansas City landscape architect, designed the grounds. His plan reflects the topography of the site and its unique setting on a plateau above a picturesque mountain resort. Winding roads and paths are retained and the property holds the original conservatory and bandstand; a pond once located in front of the conservatory has been drained, but the space it occupied remains open. An elaborate sandstone stairway built in 1915 leads from the plateau upon which the facility is sited to the town of Hot Springs in the valley below. The associated cemetery, to the northeast of the main campus, is a significant element of the property's landscape. The cemetery faces north, down-slope and away from the sanitarium. Overlooking the cemetery, and occupying a position from which a visitor can see both the sanitarium and the internments is a sandstone obelisk (Julin '08: 70).

Battle Mountain Sanitarium retains nearly all of the buildings constructed during the 1900- 1917 and 1918 to 1930 phases. The centerpiece of the site is the original Thomas Rogers Kimball Mission-inspired administration-hospital complex, with its prominent dome and ward buildings emanating from a center court. Original supporting buildings, including the Colonial Revival engineering building and the Mission style refrigeration plant, stables building and boiler plant, all built in 1907, are behind and below the main building. The 1913 greenhouse is set in an open space near the site of the original pond. The Colonial Revival officers' quarters, also designed by Kimball, include the governor's house, which retains an unusual degree of interior and exterior integrity. Classical Revival bachelor's quarters were

constructed in 1910. Buildings constructed during the 1918 to 1930 period symbolize the increasing importance of medical care to veterans after World War I. They include a Classical Revival duplex built in 1920, a Classical Revival nurses' quarters built in 1926, and a Colonial Revival duplex built in 1927. The most representative post-World War I structure is the 1926 hospital, built by the Veterans' Bureau to serve tuberculosis patients. The hospital combines Mission, Tudor Revival, and Romanesque Revival influences. Post 1930s construction includes a 1941 laundry, a 1949 dietetic building directly northeast of the 1926 hospital, and rear additions to the 1926 hospital built in 1937, 1959, and 1985 Three car garages were constructed to the rear of the staff housing during the 1930s. Several small storage and shop buildings were built in the 1970s and 1980s, and incinerator building and a fire station and security building date to the mid- 1980s but are sited to the east, well away from the historic core. At the eastern boundary of the branch, at the end of a dirt road, are three water reservoirs that are screened from the main campus by the steeply sloping hillside (Julin '08: 70-71).

10. National Home for Disabled Volunteer Soldiers

Established by Congress in 1865, the National Asylum for Disabled Volunteer Soldiers, changed its name in 1873, ultimately encompassed a network of eleven branches across the country, the National Home for Disabled Volunteer Soldiers (NHDVS). The NHDVS was overseen by a Board of Managers and operated until 1930 when it was absorbed by the Veterans Administration (VA). The men served by the institution were first referred to as inmates, a term that fell into disuse during the 1880s and was replaced by beneficiaries, soldiers, men, and members. The initial branches served Union Army volunteer veterans of the Civil War who had suffered injury or debilitating illness during the war. In the 1880s standards were broadened to allow former Union soldiers with any disability, including those caused by age. The broadening of admittance standards recommended by the Board of Managers eventually expanded membership to all veterans of all wars who could not live independently for any reason, regardless of the nature of their disability. As Civil War veterans aged and young veterans from other conflicts entered the system, the NHDVS Board of Managers increasingly turned their attention to medical care. Until World War I, NHDVS members were the only veterans receiving government-provided medical care regardless of the cause of illness or disability. The federal government's expansion of medical care to World War I veterans and the subsequent development of the Veterans Administration medical system (VA, now the Department of Veterans Affairs) reflect the foundation established by the NHDVS. Cemeteries were established at these facilities to provide a final benefit—perpetual burial among comrades (Julin '08: 1, 6). African American soldiers were allowed membership at the National Home branches, which established a policy of racial equality; in the decades following the Civil War the level of equality became less and less. While African Americans were at the same facility and received the same benefits, they were segregated within the facility and slept in separate barracks and ate at different tables. Few African Americans took advantage of the opportunity even though 10 percent of the Union Army was African American. By 1900, only two and a half percent of the members at the National Home branches were African American. The Hampton branch in Virginia was designed to encourage African American members, but it was not successful because not that many more African Americans went there (NPS '17).

The eleven NHDVS properties established between 1865-1930 are the Eastern Branch in Togus, Maine; the Northwestern Branch in Milwaukee, Wisconsin; the Central Branch in Dayton, Ohio; the Southern Branch in Hampton, Virginia; the Western Branch in Leavenworth, Kansas; the Pacific Branch in West Los Angeles, California; the Marion Branch in Marion, Indiana; the Danville Branch in Danville, Illinois, the Battle Mountain Sanitarium in Hot Springs, South Dakota; the Mountain Branch

in Johnson City, Tennessee; and the Bath Branch in Bath, New York. Some former NDHVS properties were dramatically changed by development under the VA; others retained the essential characteristics that identify them as NHDVS properties. Four NHDVS properties are recommended for National Historic Landmark (NHL) designation for their ability to most outstandingly represent the national context of the development of a national policy for veteran health care: the Northwestern Branch, the Western Branch, the Mountain Branch and the Battle Mountain Sanitarium. All the home cemeteries provided a resting place for veterans who died while in residence. These facilities were in essence a parallel burial program to the system of National Cemeteries run by the War Department. The headstones at the NHDVS cemeteries were provided by the Army. In 1973 administration of the cemeteries was transferred to the National Cemetery System and the sites were so designated. The National Cemetery System became the National Cemetery Administration in 1998 (Julin '08: 2, 6-7). Cemeteries were established at the branches during their early stages and developed as the facilities grew. Each cemetery has a relatively large soldiers' monument in a prominent location. Some of the cemeteries, including those at the Eastern, Pacific and Battle Mountain Branches, installed single, thick masonry obelisks. A more traditional, slender obelisk design is found at the Western, Southern, Mountain, and Bath Branch sites. There is a significant family of historic signage, including plaques with lines of the verse, "Bivouac of the Dead" and the complete Gettysburg Address that date to the late 19th and early 20th centuries (Julin '08: 40).

In August, 2004, Department of Veterans Affairs Secretary Anthony Principi officially proposed to the Department of the Interior a working relationship between the Department of Veterans Affairs and the National Park Service in order to assess the significance of the eleven branches of the National Home for Disabled Volunteer Soldiers. The National Park Service Midwest Region designated a Project Manager from its staff to organize and lead the work, which began with an introductory meeting at the Department of Veterans Affairs in October, 2005 (Julin '08: 2). The eleven NHDVS branches have been evaluated by standards delineated in the National Register Bulletin *How to Prepare National Historic Landmark Nominations.* The bulletin states that NHL properties must possess exceptional "value or quality" in interpreting the history of the United States and "a high degree of integrity of location, design, setting materials, workmanship, feeling, and association (NPS '06: 12). The history of the NHDVS can be organized into five phases. Phase one, 1865-1870, includes the formation of the NHDVS by Congress, the organization of the Board of Managers, and the establishment of the first four branches. During phase two, 1871-1883, the institution's operations continued to develop and growth occurred at the individual sites. During phase three, 1884-1900, the system expanded to include four new branches. In phase four, 1900-1917, two new branches were created and the system increasingly focused attention on the medical needs of veterans. Phase five, 1918-1930, saw the impact of World War I, the establishment of the final NHDVS branch, and the incorporation of the NHDVS into the newly created Veterans Administration (Julin '08: 12).

Since the colonial era, American citizens and governments have worked to protect disabled soldiers from the indignities of poverty. Until the mid-1800s, public assistance to these men was primarily financial as colonies made provisions for soldiers through pensions and similar aid. The Continental Congress enacted a 1776 law that gave pensions to officers and regular soldiers and sailors disabled in the line of duty. In 1789, the First U.S. Congress assumed the responsibility for continuing these benefits, and subsequent laws provided such benefits to men wounded during the Revolutionary War and men who became disabled after the war as a consequence of service-related wounds. Congress repealed previous laws in 1806 and enacted new legislation that made additional categories of soldiers eligible for pensions, including volunteers and state troops; in 1813 it extended pension benefits to

veterans of the War of 1812. In 1818, Congress passed a controversial law granting pensions to any veteran of the Revolutionary War who needed assistance, including the indigent. Consequently, the numbers of pensioners quickly went from slightly over two thousand to more than seventeen thousand, and the annual costs of the system increased dramatically. As a result, the application process was tightened and many pensions were withdrawn. In the 1830s, supporters defended another controversial pension law that extended benefits to the self-supporting, stating that pensions were a reward for service, not an act of charity designed to relieve poverty. In 1833, Congress established the Bureau of Pensions, the first federal bureaucracy devoted to veterans' benefits (Cetina. '77: 17-22). At the onset of the Civil War there were about 80,000 war veterans in the country. By 1865, Union veterans had increased that number to nearly two million and veterans constituted almost 5 per cent of the country's population. The General Pension Law passed by Congress in 1862 established pensions for disabled veterans whose disabilities could be linked to injuries suffered or diseases developed during their military service. This was the first pension law to allow payments for disease-related disabilities, and the broadening of eligibility and growing number of disabled veterans led to a dramatically expanded pension system. The government paid out more in pension benefits between 1866 and 1879 than it had from 1790 to 1865 (Kelly '97: 18, 57).

The government also supported the development of institutions designed to provide them shelter and care. In 1811 Congress established the U. S. Naval Asylum for disabled and elderly regular Navy and Marine veterans. However, the home was not operational until the 1830s, when Congress appropriated funds necessary to complete a building in Philadelphia for use as a hospital and asylum. After the Naval Commissioner had detained by angry veterans, recovered from long illness and appealed the claim for extra service pay in *US v. Thomas Fillebrown, Secretary of Commissioners of Navy Hospitals* 32 US 28 7 Pet. 28 (1833). Until 1935, when direct Navy appropriations began to be used, the operations were funded from monthly contributions by active seamen and fines against them. Sailors who were disabled due to injuries or conditions arising from their service in the navy were eligible for admittance (Cetina '77: 30-39). The U.S. Naval Asylum was constructed in Philadelphia, Pennsylvania, near the Schuylkill River on the site of a former plantation. An existing building was used as a naval hospital while the larger institution was being built. Architect William Strickland designed the Greek Revival central building, called Biddle Hall, which included private rooms for four hundred residents, communal dining, reading, and smoking areas, and a chapel. The building was completed in 1833. Until 1845, Biddle Hall housed a naval hospital and a naval academy as well as retired sailors; in that year, the academy was moved to Annapolis, Maryland. In 1844, two additional buildings designed by Strickland—a residence for the Asylum's Governor and another for the surgeon--were added to the campus. In 1868, a Second Empire style hospital designed by John McCarther and named Laning Hall was completed. The building was funded by Congress to serve the needs of wounded sailors at the end of the Civil War, but by the time it was ready for use, the number of hospital patients was dwindling and Laning Hall was converted to housing for disabled veterans. By 1886, the U. S. Naval Asylum held 201 patients and pensioners. In 1889 its name was changed to the U. S. Naval Home. In 1976, a new facility opened in Gulfport, Mississippi, and its residents transferred to that site. The original buildings have been vacant since the 1980s and the burials associated with it were relocated to Mount Moriah Cemetery where they are overseen today by the National Cemetery Administration. The US Naval Home was designated a National Historic Landmark in 1976 (Julin '08: 8).

In 1851, Congress created the U.S. Military Asylum, known by the 1860s as the U.S. Soldiers' Home, after decades of debate about the costs of such a facility as well as its appropriateness in the United

States. Some opponents believed the development of elaborate public institutions like France's Hotel des Invalides and the Chelsea Hospital in England, while appropriate for monarchical societies, were not suited to the United States. The casualties suffered during the Mexican-American War, however, helped to convince legislators that a provision for soldiers unable to care for themselves was necessary. The institution was originally funded from Mexican-American War fines as well as deductions from the salaries of enlisted men. The U.S. Soldiers' Home was intended to house disabled and elderly soldiers; regulars or volunteers with twenty years of service who had contributed to its support through pay deductions were eligible for admittance. Originally developed with three branches, the asylum was centralized in Washington, D.C. by the end of the 1850s because so few ex-soldiers sought residence at the institution. By the time the Civil War began, the Soldiers' Home housed approximately 130 residents, about half its capacity. Its lack of success in attracting men led some congressmen to believe veterans would not be interested in living in institutions. This attitude slowed the movement toward a national system for disabled soldiers until after the Civil War (Kelley '97: 12-14). Before 1862, the capacities of the U.S. Naval Asylum and the U. S. Soldiers' Home, as well as the services provided by the Government Hospital for the Insane, were more than adequate to serve veterans who needed the services and assistance they could provide. The Civil War created a much larger and more diverse body of veterans, men who were not career military soldiers and whose needs could not be met by the existing facilities (Julin '08: 10). Three million men fought in the Civil War, over seventy percent of them U.S. soldiers. Nearly three hundred thousand Union men who survived the warfare suffered gunshot wounds. By war's end, thirty thousand of them had experienced amputation or loss of use of an injured limb. Dysentery, malaria, and typhoid fever spread through crowded, unsanitary camps filled with soldiers fatigued by long marches and extended fighting and weakened by inadequate diets. The illnesses left their most affected victims with life-long impaired health. In addition, war conditions created stresses that led to emotional and psychological problems (Kelley '97: 15-18).

In 1852, Congress established the Government Hospital for the Insane to provide care to regular members of the Army and Navy forces and residents of Washington, D.C. Located in the southeastern part of the city, the hospital was constructed as a central administrative building with east and west wings. Architect Thomas U. Walters, who designed the Capitol Building, drew the first plans for the central unit. During the Civil War, parts of the facility were used to treat ill and injured Union soldiers and sailors. A shop manufactured artificial limbs and amputees remained at the hospital while they learned to use their prostheses. Men reluctant to admit their residence at an institution for the insane began to refer to the institution as "St. Elizabeths," the name of the tract of land upon which the hospital was built. Following the war, the military hospital and artificial limb shop were closed and the facility returned to its original purpose; it provided long-term care to many Civil War veterans suffering from mental illnesses. In 1866, Congress passed an act allowing Union veterans diagnosed as insane within three years of their discharge to enter the hospital and in 1882 authorized the NHDVS to transfer mentally ill patients there. Like the U.S. Soldiers' Home, a cemetery was established on the grounds to bury deceased veterans. The care of Civil War veterans led to overcrowding, and the institution added new buildings in 1878, 1879, and 1883. In 1916, Congress officially changed the name of the hospital to St. Elizabeths. The hospital ceased to be a federal facility in 1987 and became part of Washington, D.C.'s mental health system. St. Elizabeths was designated a National Historic Landmark in 1991 (Julin '08: 9-10).

The United States Sanitary Commission (USSC) was established in 1861 by order of President Abraham Lincoln. Created in large part through the efforts of Henry Bellows, a prominent New York City Unitarian minister, the commission was made up of well-to-do northeastern men who took an

intense interest in the nation's political and social development. The group's initial contribution to the war effort was to monitor the medical care of Union troops. The USSC eventually served to coordinate volunteer efforts, inspect army medical facilities, and compile data and compose reports regarding wartime medical care. The Commission also provided medical staff to care for soldiers, established hospitals and residential facilities to offer short-term care and housing, and assisted discharged men by helping them collect their pay and return home safely (Kelley 15-18). As the war drew to a close, the USSC began to turn its attention from providing immediate care and assistance to the post-war needs of returning veterans, particularly those disabled by injury or illness in the line of duty. Its positions reflected the attitudes of its board members, many of them intellectuals like Henry Bellows and Frederick Law Olmsted, the well-known landscape designer. Initially, the Commission determined to devise a system of aiding veterans without making them dependent upon federal institutions. As discussion of national asylums for injured or ill veterans arose, Bellows, in particular, resisted the idea. He believed that a pension system was a more economical, more respectful, and more American way to deal with the situation, and the best way to keep men in the familiar settings of their communities. However, Bellows and other USSC members eventually began to acknowledge that numbers of disabled men would not have the community or family support that would allow them to live independently, even with a pension. Thus, the USSC began to consider the concept of a centralized institution to provide shelter and care to those veterans. Bellows characterized such a facility as an asylum--a place of refuge--that would offer a home but also maintain military organization and discipline, provide light work to encourage industry and independence, increase patriotism and nationalism, allow ex-soldiers to maintain their pride, and return them to society as functioning citizens as soon as possible. The costs of meeting on-going demands of the war precluded the USSC from putting their plans into action, and their assistance to returning soldiers had almost completely ended by the beginning of 1866 (Kelley '97: 19-24)(Cetina '77: 68-72, 122-123).

Delphine Baker, who published the *National Banner* and helped to found the National Literary Association (NLA), was one of the most outspoken promoters of a national disabled soldiers' home. Senator Henry Wilson of Massachusetts introduced the bill to establish the NHDVS in the Senate on February 28, 1865; it quickly passed both houses of Congress and was signed by President Lincoln on March 5, 1865 (Kelly '97: 46-47). The original act created a one-hundred member administrative structure that included many of the prominent citizens of the day, but such a large group proved ineffective and made no progress toward the development of a functional system. Veterans' discontent with the lack of progress and a poorer than expected showing in the fall elections of 1865 prompted Republicans to take a deeper interest in the success of the NHDVS. Recognizing that Union veterans were a valuable political force who would appreciate the institution, the Republican-controlled Congress amended the original act in 1866 to set up a twelve-member Board of Managers. The more efficiently organized board included the President of the United States, the Secretary of War, and the Chief Justice as ex-officio members and nine men appointed by Congress. The Board was charged with setting up branches of the institution, reporting to Congress annually, inspecting the sites regularly, and monitoring the system's finances. The NHDVS Board of Managers met for the first time in May, 1866. Benjamin F. Butler, former Union Army general and prominent Republican politician, was elected president. The longest tenured president of the Board of Managers, he directly influenced the creation, development, and operations of the first homes before leaving the board in 1880. Lewis B. Gunckel of Dayton, Ohio, another powerful Republican, became the Board's secretary and also had an important impact on the development of the system, particularly on the growth of the Central Branch, located in his hometown (Cetina '77: 84-87) (Kelly '97: 77-81).

Under the act establishing the NHDVS, Congress committed to appropriating to the institution funds acquired by fines against officers and soldiers who had been sentenced by court-martials or military commissions as well as forfeitures due to desertion and unclaimed money due soldiers and officers. This system was particularly unwieldy because it required an accounting of every individual soldier's account, and such examinations were often several years behind schedule. By 1875, the original method of funding the NHDVS proved insufficient and inconsistent, and Congress began making direct annual appropriations to the system (Weber et al '34: 83-84). Instead of spending funds on construction of large, impressive buildings, Frederick Knapp, an influential member of USCC insisted, expenditures should be dedicated directly to basic comforts for the veterans. However, during its sixty- four years of productive existence, the Board of Managers oversaw the construction and development of a series of campuses which featured noteworthy buildings and designed grounds and became sources of local pride and attractions for visitors from the country and the world (Kelly '97: 49-50). The Board developed the original three branches in Togus, Maine, to serve the northeastern region; in Milwaukee, Wisconsin, to serve the northwest; and in Dayton, Ohio, to serve the largest number of veterans: those in the lower Midwest, western New York and Pennsylvania, and the states to the south. Within a few years, the Board also established a fourth branch in Hampton, Virginia. The specific designations of locations for these and the following branches were influenced by climate, terrain, availability of land, contributions of property and money from aspiring locations, and political interests. These factors continued to guide the Board of Managers as they created eight additional branches in the ensuing decades (Cetina 105-106).

The Eastern Branch of the NHDVS opened on November 10, 1866, on property the Board of Managers purchased from the widow of the founder of a defunct health resort near Togus, Maine. Located about five miles east of Augusta, the site included a hotel, farmhouse, outbuildings, and pastureland (Cetina '77: 110-111). Horace Beals, a Rockland granite dealer, built the resort in 1858 on a 1900 acre tract of land, five miles out of Maine's capitol Augusta. Although its owner hoped the resort would become as successful as New York's Saratoga Springs, the enterprise closed after three years. Beals died during the Civil War and the Board of Managers purchased the property from his widow. The grounds included a 134-room frame hotel, a race course, bowling alleys, bathhouse, stables, and other recreational facilities, as well as extensive woodland, a fruit orchard, and pasturage. Although the site was isolated, it could serve veterans in the northeastern part of the country, the springs were considered a healthful advantage, and the existence of the commodious buildings meant less construction time and cost. The location was chosen over other sites in part because of the "great moral benefits" that the "absolute quiet and freedom from the excitement and temptation of metropolitan life" (Whitman 1879). Within a year of its establishment, more than four hundred veterans had been admitted to the Eastern Branch. In January, 1868, fire destroyed its principal building and damaged its new hospital. Within the next two years, barracks, a barn, a governor's residence and other structures were built; the complex was situated on level ground, immediately southeast of a steep hill. Another building program during the 1870s produced a bakery, butcher shop, soap works, a carpenter's shop a blacksmith shop, a boot and shoe factory, harness shop, retail store and a saw mill, evidence of a large measure of self-sufficiency. By 1880 the Eastern Branch housed more than one thousand veterans. The area became a local tourist destination in the 1890s and visitors were served by a narrow gauge railroad, an electric trolley system, a hotel, and a zoo. By June 30, 1930, the Eastern Branch was 1884 acres in size and held fifty buildings: seven barracks (six brick and one frame), two frame hospitals, and forty-one additional buildings, four of which were brick and the remainder frame. The operations included a farm and a dairy. In its final year as an NHDVS branch, the facility cared for a total of 2480 veterans. After the 1930 transition to the Veterans Administration, the former Eastern Branch was transformed by a

significant building program resulting in a modern masonry Art Deco style medical facility. In place of the largely frame campus stood a new hospital, administration building, and theater, focused about a large central lake. The original Second Empire Governor's House remains on the grounds and is a National Historic Landmark (Julin '08: 40-41).

The Northwestern Branch was located in Milwaukee in 1866 after the Board of Managers accepted an offer of $95,000 and 26 acres of land from the Wisconsin Soldiers' Home Association. The women who made up the active members of that group had served sick and disabled soldiers in storefronts during the war and through a public fair had raised sufficient money to buy land and hire an architect to design a permanent state home. With the encouragement of George Walker, a Milwaukee native who had been appointed to the NHDVS Board of Managers, the Wisconsin Soldiers' Home Association decided to contribute their resources to the national institution. They did so with some reluctance, believing that a facility controlled by state or local groups might be more responsive to Wisconsin veterans' needs. After their contribution, the Northwestern Branch was located and constructed on a site about one mile west of the Milwaukee city limits. A cemetery was established west of and in conjunction with the branch in 1867 (Cetina '77: 108-109). At the Northwestern Branch, the initial development focused on the striking and very visible Gothic Revival style Main Building. Architect Edward Townsend Mix designed the five-story structure to contain facilities for the various functions of the home: administrative offices, barracks, medical services, kitchen and dining room, chapel and meeting rooms, and laundry and bath rooms (Halverson et al '05: 51-56).

The Board of Managers planned to locate the Central Branch at Camp Chase near Columbus, Ohio. A number of veterans were already living there in a state-sponsored facility with buildings and barracks that could be utilized by the NHDVS. However, the Board soon determined that the site was unsatisfactory and Lewis Gunckel, NHDVS Board secretary and native of Dayton, Ohio, suggested his town as a good location. After the residents of Dayton donated $28,000, the Board located the Central Branch on land about three miles from the city and in 1867 transferred men from the state home to temporary barracks. Architect C. B. Davis designed the original buildings and Thomas B. Van Horne laid out the grounds. The Central Branch plan reflected that of military installations, with administrative and residential areas grouped around a parade ground. The first group of buildings included barracks, a three-story hospital, a chapel, officers' residences and auxiliary buildings. By the end of 1867, the Central Branch held nearly six hundred veterans. Captain (and Chaplain) William B. Earnshaw is believed to have designed the associated cemetery; the first burial there occurred in 1867 (Cetina '77: 108-109).

The primary officers of the individual branches were veterans themselves and included a governor, a deputy governor, a secretary, and a treasurer. Eventually, other officers were added, with some variations among the branches: quartermaster, surgeon and assistant surgeon, chaplains, and farmers, for example. NHDVS members were subject to the Articles of War and they were organized into companies, lived in barracks and wore uniforms. The men were issued passes that allowed them to leave the branch grounds at will during set hours; they could also apply for furloughs and be absent from the branch for longer periods. Each morning, the branch governor or his deputy held a court and imposed punishment on men for infractions such as bringing liquor onto the grounds or disorderly conduct. If necessary, men were detained in the branch guardhouse. The Board of Managers may have

considered such discipline necessary in order to maintain a smoothly running operation, but they also believed that the discipline should be administered with a light hand. In addition, they maintained flexible policies regarding residence at the facilities. Men were often discharged and readmitted, sometimes repeatedly. Some men moved around to different homes, either through transfer or by discharge and readmission. The Board also instituted a policy of providing outdoor relief, which enabled disabled veterans who were able to remain in their own homes or live with family members to receive cash in lieu of daily rations and other benefits (Kelly '97: 141-142).

Initially, the Board of Managers tried to develop programs to help disabled veterans gain training or education that would enable them to make a living, and some men did return to private life as a result. For example, programs at the Central Branch included cigar- making and stocking-weaving shops and a printing plant that did the printing for all the branches; men could take classes in telegraphy and other practical subjects at the branch's school. The Eastern Branch ran a shoe-making operation, and the Northwestern and Southern branches also offered school classes, at least for a short time. In 1877, the Board of Managers centralized the system's schools at the Central Branch and offered to transfer any men who wanted to attend the school to the Dayton facility. By 1881, there were only 82 students and one teacher in the system and 317 men working at trades. The Board closed the school in 1883 because so few men were taking advantage of it, a fact the managers attributed to the aging of the population. In 1918, an inspector of the home noted that the NHDVS provided no vocational training for its members. Federally- sponsored and organized programs for vocational rehabilitation of veterans were established in the World War I era and members of the NHDVS were able to take advantage of these programs in the 1920s (Cetina '77: 376-377)(Obermann '65: 146, 213).

By the 1870s, more than two thousand members of the four branches—nearly a third of the population-- held jobs that contributed to the operations of the institution. Men cared for the grounds, repaired buildings, and nursed the ill. They also grew food: the Northwestern, Central, and Eastern branches maintained sizable farms that provided produce for the men and revenue for the institutions, and the Southern Branch developed a large garden. As the population grew older, however, fewer of the men were capable of maintaining such employment. By the turn of the century, the Board of Managers found it necessary to hire civilians to do much of the essential work of the NHDVS and at higher wages than the members had earned (Cetina '77: 90, 160, 331-333). Carefully designed and maintained grounds lent a park-like atmosphere to the branch environments and included features such as lakes, ponds, grottoes, and other landscape elements that refreshed and amused the members. The branches established post funds where proceeds from branch stores and other sources were deposited and used for constructing buildings such as libraries, canteens, theaters, and chapels, for buying books and other diversions, and as payment for professional entertainment. Several theaters were funded from a bequest by Virginian Horatio Ward, and were referred to as "Ward Memorial Theaters." Chaplains provided regular church services; attendance was voluntary (Cetina '77: 90, 160, 331-333, 417-418).

Initially, applicants needed to prove that they had been honorably discharged and that their disability was related to their service in the Union Army. In 1871, Congress expanded the opportunity for admission to the NHDVS to veteran volunteer soldiers and sailors of the War of 1812 and the Mexican-American War, as long as they had not served in the Confederate army and they could prove their disability was service-related. Increased application for membership after the 1871 policy change, as well as the aging of the veteran population as a whole, pressed the capacity of the NHDVS. In 1877, the system experienced the greatest number of admissions in its history when 1821 men—more than the total housed during the first four years of the noted that many of the men entering the NHDVS had

been able to maintain self- sufficiency until advancing age exacerbated the effects of their war-related injuries or conditions (Hubbard '98: 7). In an attempt to accommodate and serve the numbers of veterans seeking access to the NHDVS, the Board of Managers instituted expansion projects. In 1877, for example, the Board expended nearly $56,000 on new construction and improvements at the Central, Northwestern and Southern branches, although no construction occurred at the Eastern Branch (Julin '08: 20-21).

The period from 1884 to 1900 saw a dramatic expansion of the NHDVS system as broadened membership requirements opened NHDVS doors to increasing numbers of members. The average number of men present in all the homes in 1883 was 6738; that number reached 10,681 in 1888 and 18,556 in 1898. The Board of Managers established four new branches, providing services to disabled veterans across the United States. The Board of Managers attributed at least part of the surge in admissions in the late 1870s and early 1880s to a financial depression that began with the Panic of l873 and hoped that the demand would subside as the impact of that crisis eased. However, a major policy change—one supported by the Board itself—led to a dramatic increase in membership and facilities. In the early 1880s, the Board of Managers recommended that *all* disabled veterans—not only those who could prove service-related injuries—be considered for membership in the National Home. Many deserving men, the Board held, could not prove a link between their disability and their military service, even though aging and loss of supportive family members might be exacerbating conditions that indeed had their roots in war action. At the same time, other men with relatively minor disabilities enjoyed the benefits of the institution because they could make such a connection. The Board stated that a change in policy would address this inequity and that the resulting increase in membership would be nominal. By 1886 the Board noted that all of the system's hospitals were overcrowded (Cetina '77: 170-171, 287-88, 312-313)(Kelly '97: 128)(Weber and Schmeckebier '34: 76).

By the late 1880s, more than a third of the Congressmen from northern and border states were Union veterans. Five of the eight presidents who served between 1865 and 1901 were veterans, and two others had worked with the military as civilians during the Civil War. During the 1880s the membership of the Grand Army of the Republic, the U.S. Civil War veterans' leading organization, went from about 60,000 to more than 400,000. The visibility of veterans in public office, the association of veterans as a political pressure group, and the sheer numbers of voters who were veterans or shared veterans' interests combined to create an increasingly powerful special interest group. As an illustration of this power, the Dependent Pension Act of 1890 granted pensions to any Civil War veteran who could prove he was unable to perform manual labor for any reason other than "vice or misconduct." The number of men on the pension rolls increased from slightly less than 500,000 to nearly 1,000,000 within three years (DVA '95: 11). Congress called for the establishment of a Western Branch of the NHDVS in the legislation expanding the admissions standards and suggested the Board of Managers also consider the creation of a Pacific Branch in California. The Board eventually chose Leavenworth, Kansas, as the Western Branch site, with the stipulation that the city donate 640 acres of land and $50,000 for development of the facility. Construction of the home and the associated cemetery for the Western Branch began in 1885. By 1890, some forty buildings had been constructed. Members of the Board traveled to San Francisco by train in the fall of 1887 to visit more than seventy sites. The Board reconvened in Las Vegas to accept propositions from the various communities and accepted an offer from private citizens for a significant amount of cash and acreage near the booming town of Los Angeles and a burgeoning community at Santa Monica. The Pacific branch opened in 1888 and within the year held a hospital, barracks, mess hall and a cemetery . Among the first members were men from the state soldiers' home at Napa, who walked from northern California to the new facility (Julin '08: 23,

51).

During the Civil War, the USSC sponsored homes in several states to assist veterans. By the late 1860s, they held nearly half of Union veterans residing in such facilities. In 1869, the Board withdrew support of all NHDVS-eligible veterans in state homes except those too sick to be moved. While the Board could not force these men to enter the NHDVS, the managers believed veterans would be better served in the national institution and did not encourage their residences in state homes. The Board's position began to shift after the 1884 policy change broadened the standards for admission to the NHDVS. Congress took measures to contribute to the cost of soldiers cared for in state homes, thereby encouraging their expansion and relieving some of the pressure on the NHDVS. Legislation passed in 1888 appropriated $250,000 and authorized the NHDVS Board of Managers to pay states or territories $100 for each eligible soldier or sailor in their systems. The 1888 law gave the NHDVS Board of Managers the responsibility of receiving the Congressional appropriations for state soldiers' homes, making payments to them, and inspecting them, but granted the Board no direct management control. By 1893, state and territorial systems were caring for more than five thousand members who otherwise might have been seeking admission to the NHDVS. Admission standards at some of those homes went beyond those of the NHDVS, admitting wives, widows and other family members (Cetina '77: 186-189; 212-265). Homes for veterans who had fought for the Confederate Army and Navy also were established in many states beginning in the 1880s, but they never received federal funding and the NHDVS had no connection to them. These homes, funded by donations from individuals and organizations, included facilities in Georgia, Arkansas, Louisiana, Alabama, Texas, Tennessee, North Carolina, South Carolina, Virginia, Florida, Kentucky, Maryland, Oklahoma, and California and operated for the most part under the administration of the individual states. Unlike the NHDVS homes and the northern state homes that housed veterans from several wars, the Confederate homes admitted only Civil War veterans. Most of them closed by the late 1950s as the last of the Confederate veterans died, and their buildings were demolished or converted to other uses (Rosenburg '95: 5, 26-28, 147-150, 153).

The Board of Managers constructed two new NHDVS branches in the last decades of the nineteenth century. In 1888, Congress appropriated $200,000 for a new facility in Grant County, Indiana. Promoted by Congressman George W. Steele, Sr., a Union veteran from Marion, Indiana, the branch was located near that community to take advantage of a recently discovered "gas belt" that could provide economical fuel for its operations. Marion citizens donated funds to assist with the purchase of property and to pay for gas well drilling. Peters and Burns, a Dayton, Ohio, architectural firm that designed buildings for several of the branches, was responsible for the prominent Queen Anne style hospital and six barracks buildings. A cemetery was established for the internment of the men who died there. By 1900, the facility's structures included a dining hall and kitchen, a chapel and a theater, and by 1901, the Marion Branch membership had reached 1700. In 1897, Congress appropriated $150,000 for the establishment of a branch in Danville, Illinois. The location of the branch was influenced by Illinois Congressman Joseph Cannon, who would serve as Speaker of the House of Representatives from 1903 until 1910**.** Construction began in 1898 with the erection of the branch hospital and the Georgian Revival barracks and mess hall**.** The original members were admitted in the fall of that year. A small plot of land set aside as a burial site was designated a cemetery in 1898. By 1901, the average men present at Danville Branch was 1448 (Edwards et al '90: 3-6).

While the Board of Managers and the officials of the individual branches were frustrated by the issue, they also were sympathetic to the men who succumbed to temptation. As early as 1871 the Board's

report suggested that the need for alcohol might be considered one of the disabilities caused by military duty and in 1876, Board secretary Lewis Gunckel called the seemingly uncontrollable urge to drink a disease (Cetina '77: 436-437). Although the original National Home regulations did not allow the sale of intoxicating liquors, the Northwestern Branch began selling beer on the grounds in the late 1870s. In 1887 the Central Branch reported positive results in reducing drunkenness and increasing order after opening a beer hall. Other branch governors followed suit and in 1890 reported that beer sales on the grounds helped keep veterans out of the nearby questionable establishments. Although many NHDVS branch officials favored temperance, they also acknowledged the practicality of their decision to allow alcohol on NHDVS grounds and its results in reducing arrests and increasing the amount of money members were able to send home to their families. In 1906, Congress passed an appropriations bill stating that any branch maintaining a bar or canteen that sold beer, wine, or intoxicating liquor after March 4, 1907, would not receive its funding. Although NHDVS officials protested the change, the sales of alcohol on branch grounds ended; alcohol abuse did not. Inspection reports continued to note problems caused by drunkenness and by alcohol venders near branches. Home bands were instituted in each branch and by 1915 the bands included a total of 165 professional musicians, two of whom were home members and the remainder civilians. Local citizens enjoyed listening to the regular band concerts as well as picnicking and strolling on the well-kept grounds of the branches, boating or fishing on the lakes, and attending concerts and theatrical productions at the theaters (Julin '08: 29, 30).

In 1900, Congress expanded NHDVS admission to Spanish-American War veterans as well as to all honorably discharged officers, soldiers, or sailors, regular or volunteer, who had served in any war, who were disabled by “disease, wounds, or otherwise,” and who could not support themselves because of their disability (Weber and Schmeckebier '34: 77). By 1900, the NHDVS had served more than a hundred thousand veterans and had expended more than fifty million dollars (Kelly 130). With United States military involvement in Cuba and the Philippines and further expansion of NHDVS membership requirements, the system was called upon to absorb new categories of ex-soldiers, both regular and volunteer, as well as young veterans with diseases and conditions that called for special attention. As a result, two new branches with particular emphasis on medical care were created and some existing branches shifted in function. In 1898, the United States went to war with Spain, primarily as a means to intervene in the struggle between that country and its colony, Cuba. The conflict widened to include a separate military action in the Philippines, where citizens were also fighting for independence from Spain. The war in Cuba lasted only a few months and resulted in less than 500 U. S. battle-related casualties, but poor conditions in the field fostered diseases like malaria and typhoid, which killed thousands of soldiers and left others chronically ill. The action in the Philippines descended into guerilla warfare between the U.S. and Philippine nationalists that lasted until 1903; more than four thousand U.S. troops were killed and nearly three thousand wounded. The U.S. occupied the Philippines as a colonialist power until 1946 (Painter '87: 144-155). Many men returning from the Spanish-American War and from the Philippine action suffered from tuberculosis or yellow fever, and even leprosy presented a risk. A yellow fever epidemic at the Southern Branch in 1899 was attributed to men or luggage returning from Cuba, and the Northwestern Branch admitted a leper in 1909. The 1899 yellow fever epidemic outbreak at the Southern Branch—the most densely populated of all the branches, began on July 16, lasted for about two weeks, and included forty-three diagnosed cases, twelve of whom who died. Officials attributed the outbreak to the presence of men who had recently been in Cuba or to infected luggage. The sick men were isolated and barracks and hospital buildings thoroughly disinfected. A doctor at the facility credited the low number of deaths and the lack of spread of infection to the high sanitary standards at the camp, that included a soap factory (Cetina '77: 361-363). Tuberculosis, however, was the most serious threat posed in the early twentieth century.

Although tuberculosis had been relatively common among veterans before the turn of the century, incidences of the disease increased. In 1908, NHDVS facilities treated more than five hundred men with tuberculosis, a nearly 25 percent increase from the previous year (Rothman '94: 189-193, 211-218).

Walter Preston Brownlow, a congressman from eastern Tennessee, convinced the Board of Managers to locate the ninth NHDVS branch near Johnson City in part because of the region's support of the Union and its contribution to Union forces during the Civil War. Congress passed legislation establishing the Mountain Branch there in 1901. Although essentially a residential site, the Mountain Branch included a large hospital and was considered particularly suitable for men with respiratory conditions because of its cool mountain climate and its elevation. New York architect J. H. Freedlander was chosen over five others in a competition for the commission and designed the original buildings. The most visible structures featured a sophisticated Beaux Arts design that contrasted with the rural mountain environment. A cemetery was established on rolling terrain north and west of the main complex with a central circle as a focal point. The Mountain Branch admitted its first member in 1903 and by mid-1904, 363 men were in residence there. In 1901, Johnson City, Tennessee held five thousand residents; by the time the initial Mountain Branch construction was finished three years later, Johnson City's population and assessed value had doubled (Taffey '05: 2-3, 22-23, 32,42-43, 47).

The Board of Managers created its tenth branch as a medical rather than a residential facility. Hot Springs was designated the site of the territorial soldiers' home in 1889 (Julin '08: 57). Beginning in the 1890s, residents of Hot Springs, South Dakota, along with state and local politicians, promoted the town—site of a mineral springs resort—as an excellent location for an NHDVS facility. In 1893, thirty men from the Western Branch at Leavenworth were sent to Hot Springs for two months of hydrotherapy treatment and reportedly experienced significant relief of rheumatism. In September 1898, the Grand Army of the Republic (GAR) passed a resolution at its National GAR encampment, held in Cincinnati that year, requesting that Congress establish a national sanitarium at Hot Springs. In 1902, the Board of Managers inspected property in the Hot Springs vicinity and concluded that the climate was ideal for tuberculosis patients and that its mineral waters would be beneficial for the treatment of gastrointestinal and musculoskeletal problems. After several attempts, the bill was approved and signed by President Theodore Roosevelt on May 29th, 1902. Citizens of Hot Springs donated the land, valued then as at least $50,000, and provided a long-term lease to one of the community's mineral springs (Richardson '12). Thomas Rogers Kimball, an Omaha architect, designed the original buildings of the Battle Mountain Sanitarium, located on a bluff overlooking the resort district of Hot Springs. Ground broke for the facility on August 13, 1903 and the main group of buildings (Adm. Bldg., service bldg, bath house, chapel, library and laundry, and 6 ward buildings) was completed April 1, 1907. Bath house waters (medicinal hot water) were furnished from Mammoth Spring to all parts of the building. Two fine plunge baths were supplied with hot and cold water. A Tubercular Barrack for consumptives was constructed in the rear of the main Sanitarium group (Richardson '12). The hospital unit consisted of a main building with six patient wards radiating as spokes from a central, enclosed court. Kansas City landscape architect George Kessler designed the grounds, which emphasized the site's rolling terrain. A small cemetery was established to the east of the complex, at the foot of Battle Mountain, containing the Battle Mountain Monument, a 32-foot obelisk, in 1914. It was established for the internment of veterans who died while being treated at the sanitarium (Julin '08: 38).

Battle Mountain Sanitarium admitted its first patients in 1907 when one man from the Marion Branch

and twenty-five from the Danville Branch arrived there. During the 1908- 1909 fiscal year, 865 veterans received treatment at Battle Mountain. Men were allowed to remain at the sanitarium only as long as their conditions continued to improve. Once they were stabilized, they were discharged or transferred to one of the other branches. After the establishment of this facility, the Board of Managers directed that members of the Eastern, Southern, and Central branches who were suffering from tuberculosis were to be sent to the Mountain Branch and those in the Marion, Danville, Northwestern, and Western branches would go to Battle Mountain. The Board decreed that tubercular men who refused transfer to one of these facilities could be discharged from the NHDVS altogether (Julin '08: 32-33). In 1908, the Board of Managers reported that fewer than expected members were traveling to the site for treatment, in part because the long trip was hard on the ill and the elderly. Building continued, however, with a bandstand, conservatory, and additional housing constructed between 1910 and 1919. In addition, an elaborate concrete and sandstone stairway was built in 1915 to link the grounds of the sanitarium with the business district of Hot Springs directly below. The importance of the facility became more evident with the onset of World War I. In 1919, the Battle Mountain Sanitarium was made available to the Public Health Service for treatment of veterans for five years. Following the war, additional staff housing was constructed at Battle Mountain, and a Veterans' Bureau hospital for tuberculosis patients was built there in 1926. On June 30, 1930, Battle Mountain Sanitarium was 101.36 acres in size, with sixteen acres devoted to farming. The grounds held twenty-three buildings: two stone hospital buildings and twenty-one others including one of brick, two concrete, and sixteen frame. During the 1929-1930 fiscal year, the sanitarium provided care to an average of 820 men. Post 1930s construction included additions to the 1926 hospital, a 1940s laundry building, several garages, and a fire station and incinerator building were constructed in the 1980s (Julin '08: 58).

Despite the new pool of eligible men, the population of the NHDVS began to decrease after 1906 as elderly veterans died, falling from a membership of more than twenty-one thousand to less than nineteen thousand in 1912. This change occurred even as Congress continued to expand standards to allow more veterans access to NHDVS care. In 1908, that body extended admission to disabled regular or volunteer members of the military, honorably discharged, who had fought in any of the country's Indian campaigns and were disabled by age, disease, or any other cause. In 1915, Congress, with the urging of the Board of Managers, passed legislation that allowed any disabled officer, soldier, or sailor, regular or volunteer, who had served in any war, Indian campaign, or action in the Philippines, China, or Alaska admittance to the NHDVS. This move was in part an attempt to address the needs of those who had served as regulars but could not enter the Soldiers' Home at Washington, D. C. because they could not prove a direct service-related disability. Membership in the branches continued to decrease, however. The loss in population was so marked that in 1916 an NHDVS inspector noted that the same number of men were living in ten homes as had occupied seven branches in 1895, and suggested the Northwestern Branch be closed (Cetina '77: 371-373)(Weber and Schmeckebier '34: 72).

General W. P. Jackson reported on the inspection, which took place between the end of August and the end of November, 1914. On June 30, 1914, the number of present and absent officers and members totaled 21,165, a net loss of 742 members over the previous year. The institution employed 1773 civilian employees, 976 men and 797 women. Average per capita expenditure for the NHDVS was $216.53; the Battle Mountain Sanitarium was the most costly branch, spending $455.36 per man. A total of eighty-five members came forward with complaints during the inspection process; Jackson considered six of these issues relatively important and took steps to have the problems rectified. After nearly fifty years of existence, the NHDVS was a stable institution providing benefits including

specialized medical care to a relatively satisfied population of disabled veterans, a population that was slowly declining. Soon, however, the Board of Managers would face another influx of war veterans and a new set of medical demands. World War I exerted a dramatic impact on the facilities of the NHDVS and gave rise to new complexities in the provision of veterans' benefits (Julin '08: 33). Before the war ended, about four million men had been drafted into military service, and half of them were sent overseas. By early 1919, injured and ill soldiers were returning from Europe in numbers averaging more than twenty-three thousand per month (DVA '95: 16).

Before World War I, the Bureau of Pensions and the NHDVS comprised the federal entities that served disabled veterans. The Pension Bureau, like the NHDVS, had broadened its parameters over the years; the Pension Act of 1890 had removed restrictions that tied payments to service-related disabilities, and soon almost a million veterans and their dependents were receiving pension payments. As World War I loomed, the government put new programs into place. In 1914, Congress created the Bureau of Risk Insurance under the War Risk Insurance Act. Initially, the insurance covered ships and cargoes, but in 1917, under an amendment to the War Risk Insurance Act, Congress established vocational rehabilitation and medical care benefits for men with service-related disabilities and created a low-cost insurance system to protect dependents and totally disabled servicemen. Thus, the War Risk Insurance Act, intended in part to replace the pension system that had expanded so dramatically after 1890, resulted in a new federal bureaucracy and expansive benefits for World War I veterans. Responsibility for administration of these programs was divided among the Public Health Service, the Bureau of War Risk Insurance, and the Federal Board for Vocational Education. The fragmentation of functions eventually led to inefficient responses to veterans' needs. The impact of World War I and the benefits granted under the War Risk Insurance Act created a demand for additional facilities. Initially, Public Health Service hospitals and contracted hospitals were used to provide the expanded medical services, but these resources proved inadequate. In 1919, Congress authorized the Secretary of the Treasury to establish additional facilities and appropriated more than nine million dollars for that purpose; subsequent legislation provided for further growth. In 1921, Congress passed legislation giving the Secretary of the Treasury the discretion to allot funds to the NHDVS (Cetina '77: 383-385) (Weber and Schmeckebier '34: 278-280)

The Southern Branch was transferred to the War Department in 1918 to serve as a military hospital. Men in residence there were sent to other branches until 1920, when the branch was returned to NHDVS and its members reinstated at Hampton. Hospital beds at Battle Mountain Sanitarium not needed to serve NHDVS members were put at the disposal of the Public Health Service in 1919. In the early 1920s, the Marion Branch was converted to a neuropsychiatric unit with a new, one-thousand bed hospital, a special facility for psychiatric patients with tuberculosis, and auxiliary buildings. The Mountain Branch became a tuberculosis hospital, containing treatment facilities for non-ambulatory and semi-ambulatory patients and a separate annex for African-American veterans suffering from the disease. Thus, two of the branches which had been primarily residential units became primarily hospitals, joining the Battle Mountain Sanitarium in that status. At the Central Branch, five barracks were transformed into hospital units and the existing hospital and tuberculosis facilities were improved. At the Northwestern and Pacific Branches, original hospitals were modernized and new tuberculosis facilities constructed. The increasing numbers of young veterans being served in NHDVS hospitals led to improvements in buildings, modernization of equipment, expansion of occupational therapy programs, and increases in staff. By 1923 the system held a total of 10,774 domiciliary beds, 3381 general hospital beds, 2664 tuberculosis beds, and 1554 neuropsychiatric beds, and all branches except the Pacific had room for additional residents and patients (Cetina '77: 374-380).

Before World War I, the Board of Managers had directed all of the institution's operations; by the early 1920s, both the Public Health Service and the Department of the Treasury were involved in some functions of the institution. A committee appointed to study the care of federal soldiers concluded the government was failing in its responsibilities to veterans, mainly because of a lack of coordination between independent entities. In an effort to mesh these functions and avoid duplication, Congress established the Veterans' Bureau in 1921 to administrate the laws pertaining to World War I veterans. The Veterans' Bureau replaced the Bureau of Risk Insurance and took administrative authority of vocational education under the Vocational Rehabilitation Act (Cetina '77: 381-382). Of 5,982 new members accepted during the 1923 fiscal year; 692 were Civil War and Indian campaign veterans, 927 were Spanish-American War and Philippine campaign veterans, and 4363— nearly 73 percent--were veterans of the recent world war. By 1926, NHDVS officials were particularly concerned with the demands created by the need for psychiatric care. Veteran servicewomen also were being admitted to branches by the early 1920s, although in low numbers. The Board established a women's barrack at the Danville Branch with plans to centralize ex-servicewomen's domiciliary service there, but at the end of the 1924 fiscal year, less than half a dozen women had taken advantage of the opportunity. In 1928 Congress officially extended membership in the NHDVS to disabled women who had served in the armed forces as nurses (Julin '08: 36, 37).

The NHDVS continued to provide residences and medical care for significant numbers of veterans throughout the decade and on May 1, 1929, expanded to eleven facilities when the Board of Managers acquired a ten-year lease on the New York State Soldiers' Home at Bath, New York. After being established by the state legislature in 1876, the state facility had been constructed in the 1880s by GAR (Richardson '12). Bath area residents helped secure their town as the site for the state home by donating twenty-three thousand dollars towards the cost of the new institution, which opened in 1878. Within a year, the facility included a three-story main building and two three-story barracks, all constructed of brick on stone foundations. The barracks buildings featured wide verandahs on all sides. The main building included the dining hall and kitchen. By 1907, more than two thousand veterans lived at the home, but that number declined dramatically over the following two decades. In 1928, the home served only 192 veterans, and the Bath Chamber of Commerce asked the federal government to assume responsibility for the institution. In 1929, the New York State Soldiers' and Sailors' Home became the last designated branch of NHDVS. The total membership of the NHDVS had increased 10 per cent in one year and the Central, Southern and Mountain branches, which served the populous eastern section of the country, were filled to capacity. The Board of Managers acquired the property with a 10- year lease, instituted a program to repair the buildings at Bath Branch, and a few hundred men took up residence there (Julin '08: 36, 37). As of June 30, 1930, the Board of Managers reported that the Bath Branch held sixty-nine buildings, including five brick barracks, two hospital buildings, and sixty-three other buildings, seventeen brick and forty-six frame. The branch cared for an average of 311 men during its tenure as an NHDVS facility. In less than a year after its designation, the Bath Branch, like the other NHDVS branches, became a part of the new Veterans Administration (Mollenhof '80).

Duplication of hospitalization and residential services by the NHDVS and the Veterans' Bureau led Congress to recommend that the NHDVS, a corporation described as a "federal instrumentality" serving as a trustee for the United States, be dissolved, its Board of Managers discontinued, and its property turned over the United States. Subsequently, President Herbert Hoover issued Executive Order 5398 on July 21, 1930, bringing Veterans' Bureau, the Bureau of Pensions, and the National Home for

Disabled Volunteer Soldiers together into a new entity the Veterans Administration. The Executive Order did not include incorporation of the U.S. Soldiers' Home in Washington D.C., the U.S. Naval Home in Philadelphia, or administration of the retirement of regular Army and Navy commissioned and enlisted men (Weber and Schmeckebier '34: 1). The former NHDVS headquarters was moved from the Central Branch at Dayton, Ohio, to Washington, D. C., where the functions of the NHDVS, including inspection and supervision of payments to state homes and administration of medical and domiciliary services, were absorbed by the new Veterans' Administration. The medical and domiciliary operations became the responsibility of the Office of Assistant Administrator in Charge of Medical and Domiciliary Care, Construction, and Supplies, and development of domiciliary units during the 1930s was carried out under this office. Treasury Department architects who had been working for the Veterans Bureau were transferred to the Veterans' Administration and the use of standardized building designs for medical facilities became increasingly common (Cetina '77: 383)(Weber and Schmeckebier '34: 278-280).

The Administrator of Veterans' Affairs, under the direction of the President, shall be charged with all the administrative duties relating to the National Home for Disabled Volunteer Soldiers and the Bureau of Pensions now imposed by law upon the Secretary of War and the Secretary of the Interior under Sec. 2 of An Act To authorize the President to consolidate and coordinate governmental activities affecting war veterans P.L. 71-536 July 3, 1930 46 Stat. 1016. All contracts and other valid and subsisting obligations of the corporation, the National Home for Disabled Volunteer Soldiers, shall continue and be and become obligations of the United States under Sec. 5(b). If by reason of any defeasance or conditional clause or clauses contained in any deed of conveyance to the National Home for Disabled Volunteer Soldiers the full and complete enjoyment and use of any of the property hereby transferred to the United States shall be threatened...it shall institute in the district court of the United States for the district within which such property is located such proceedings as shall be proper to extinguish all outstanding adverse interests under Sec. 3 or Court of Claims under Sec. 5(b). On that same day the sum of $2 million was appropriated by An Act To establish a branch home of the National Home for Disabled Volunteer Soldiers in one of the Northwest Pacific States P.L. 71-505 46 Stat. 852.

Part D Veterans Administration Finance

Chapter 11 VA Budget-in-brief

Department of Veterans Affairs pension program pre-date the nation. The VA benefits system traces its roots back to 1636, when the Pilgrims of Plymouth Colony were at war with the Pequot Indians and the Pilgrims passed a law which stated that disabled soldiers would be supported by the colony. The establishment of the Veterans Administration came in 1930 when Congress authorized the President to "consolidate and coordinate Government activities affecting war veterans" to fulfill President Lincoln's promise – "To care for him who shall have borne the battle, and for his widow, and his orphan" with An act to authorize the President to consolidate and coordinate governmental activities affecting war veterans", approved July 3, 1930. President Herbert Hoover wrote Executive Order 5398—Establishing the Veterans' Administration on July 21, 1930. On March 15, 1989, President Ronald Reagan signed legislation that elevated the Veterans Administration to full Cabinet status, and renamed it as the Department of Veterans Affairs. Today there are 19.2 million living Veterans. VA operates the largest integrated health care, benefits, and cemeteries system in the Nation, with more than 1,700 hospitals, clinics, and other health care facilities, a variety of benefits and service locations, and 155 national cemeteries. The infrastructure portfolio consists of approximately 184 million owned and leased square

feet—one of the largest in the Federal Government (VHA '21: 16). The 10% annual growth in spending and 5% growth in employment are alarming. Normal spending growth is 3% and net new employment 1%. The discretionary budget fully funds operation of the largest integrated health care system in the United States, with over 9.2 million enrolled Veterans, and mandatory fund provides disability compensation benefits to nearly 6.0 million Veterans and their survivors and administers pension benefits for over 357,000 Veterans and their survivors. VA anticipates supporting 425,428 Full-time Equivalent (FTE) staff in 2022, a 5% increase from 404,835 FY 21. The majority of the increase, 17,403 FTE, is in medical care, which will allow VA to meet continued growth for VA provided health care services, particularly due to COVID-19-related deferred care returning in 2022. Health care provider growth has increased in 2021 and will continue in 2022, despite a tight labor market for health care professionals, as VA expands telehealth services and enhances suicide prevention and substance use disorder initiatives.

On September 30, 2021, VA estimates there will be 19.2 million Veterans living in the United States (U.S.), its territories, and other locations. The 2022 request provides for: 7.1 million in-patients in VA hospitals an increase of 1.3% above 2021; 119 million outpatient visits, an increase of 3.7% above 2021; Modernization of VA's electronic health record system to improve quality of care; Strengthening VA's infrastructure through $1.6 billion in Major Construction and $553 million in Minor Construction for priority infrastructure projects; Education assistance programs serving nearly 871,000 trainees; Veteran Readiness and Employment (VR&E) benefits for over 135,000 Veterans; A home mortgage program with a portfolio of over 4.0 million active loans; and the largest and highest performing national cemetery system projected to inter an estimated 136,000 Veterans and eligible family members in 2022. It would be painless to limit employment growth to 1% and consequential spending growth to 3% or 4% to accommodate compensation growth. The primary hyper-inflationary concerns, are growth in excess of 10% annually in mandatory compensation and pensions programs and growth in excess of 20% in medical community care. The only work that is required from Congress is to redress *bona fide* $165 million mathematical deficiency in medical facilities finance of obligations, and avoid more than 42 months of the number of the beast by settling Black Hills Health Care System (BHHCS) American with Disabilities Act (ADA) prospectus as a non-recurring maintenance (NRM) obligation for $100 million, to increase facilities appropriations by $256 million FY 22 with a commensurate reduction in community care pursuant to the Anti-Deficiency Act under 31USC§1515. The Veterans Budget Administration needs to begin to reduce perennial compensation overestimates, after the fact.

Veterans Administration FY 19- FY 24
(millions)

	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24
Total VA Outlays	197,541	216,781	238,734	265,776	284,651	291,612
Discretionary						
Medical Services	49,911	51,061	56,655	58,897	70,323	72,433

Medical Community Care	9,385	15,280	18,512	23,417 / 23,152	24,157	24,562
Medical Support & Compliance	7,028	7,328	8,199	8,403	9,673	8,914
Medical Facilities (Includes NRM)	6,807?	6,142	6,583	6,735 / 7,000	7,133	7,145
Subtotal Medical Care Appropriations	73,131	79,811	89,965	97,452	111,287	113,054
Medical Collections (MCCF)	3,915	3,912	4,528	4,500	4,165	4,500
Subtotal Medical Care with MCCF	77,047	83,723	94,493	101,952	115,452	117,554
Medical Research	779	750	795	882	909	935
Electronic Health Record Modernization	1,107	1,430	2,607	2,663	2,743	2,825
Information Technology	4,103	4,372	4,875	4,843	4,988	5,138
Veterans Benefits Administration	2,956	3,125	3,164	3,423	3,526	3,632
Board of Veterans Appeals	`175	174	196	228	235	242
National Cemetery Administration	316	329	352	394	406	418
General	356	356	354	401	413	425

Administration						
Construction-Major	2,177	1,235	1,316	1,611	1,659	1,709
Construction-Minor	800	399	354	553	570	587
Grants for State Extended Care Facilities	150	90	90	0	0	0
Grants for Veterans Cemeteries	45	45	45	45	45	45
Inspector General	192	210	228	239	246	254
Loan Administration Funds	202	202	206	231	238	245
DoD Transfers for Join Accounts	128	126	152	152	152	152
Choice Transfer to Community Care 2020	0	-615	0	0	0	0
Subtotal Discretionary without MCCF	86,617	92,038	104,584	113,122	127,417	129,661
Subtotal Discretionary Funding with MCCF	90,532	95,467	107,549	117,207	121,911	125,425
Transformational Fund	0	0	820	820	820	820
Total Discretionary (with MCCF and TF)	90,532	95,467	108,369	118,027	132,402	134,981

Mandatory Funding	110,924	124,731	137,730	152,654	157,234	161,951
Total VA (Disc & Mand) without MCCF of TF	197,541	216,781	238,734	265,776	284,651	291,612
Total VA (Disc & Mand) with MCCF	201,456	220,188	245,279	269,862	288,816	296,112
Total VA (Disc & Mand) with MCCF & TF	201,456	220,188	245,279	270,682	289,636	296,932
FTEs	375,813	388,871	406,338	425,428	429,682	433,979

Source: Wilke, Roberts. Department of Veterans Affairs Budget-in-brief FY 2018 - FY 2022

Funding for the VA has increased significantly since 2012, with total funding growing by $72.5 billion (+37%) from 2018, and by $143.2 billion, (+113%) since 2012. The total 2022 request for VA is $269.9 billion (with medical collections), a 10.0% increase above 2021. The discretionary budget request of $117.2 billion (with medical collections), a 9.0% increase above 2021. The 2022 mandatory funding request is $152.7 billion, an increase of $14.9 billion or 10.8% above 2021. This funding is in addition to the $17.8 billion provided to VA in the American Rescue Plan Act of 2021 (P.L. 117-2). With the Transformational Fund resources and medical collections, the total 2022 funding level is $270.7 billion, a 10.4% increase above 2021. The Consolidated Appropriations Act, 2016 (P.L. 114-113) created the Recurring Expenses Transformational Fund, which allows VA to transfer un-obligated balances of expiring discretionary funds in any of its accounts into the Transformational Fund for use as directed in the Act. The 2023 Medical Care Advance Appropriations request includes a discretionary funding request of $115.5 billion (with medical care collections). The 2023 mandatory AA request is $156.6 billion for Veterans benefits programs (Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities). Because these are merely conservative estimates of year's spending in two years and are not included in next year budget request total, VA AA are not emphasized for inclusion in the undistributed offsetting receipt table.

The request promises to provide the necessary resources to meet VA's obligation to provide timely, quality health care, services, and benefits to Veterans. However, the Trump Administration got into trouble with the number of the beast and persecuted the hospital closure movement far in excess of 42 months due to a malicious cut FY 20 to finance hyperinflation in medical community care FY 20 and medical support and compliance and medical services FY 21 and now facilities immediately need extra funding and medical services is in need of hyperinflation in excess of 3% annual growth to make the leap from $60 billion FY 23 to $70 billion FY at the expense of explosive growth in community care 21% FY 21 and 27% FY 22. The plan seems to be to reconsolidate the community care into medical services because commercial health care has poorer outcomes than VA health care and whether to

authorize community care is a decision that should be self-determinately made, only if VA cannot fulfill their obligations in a timely fashion. The poisonous and economically depressing consequences of the malicious number of beast persecutions has been proven by the obese and probably shrunken brained statin drug consuming executives in the Social Security Administration 2009-2011 and United Nations Peacekeeping (2019-present). Department of Defense (2020) proved there is no harder and faster rule justification for hyperinflation in excess of 3% than getting over the number of the beast in less than 42 months (Revelation 13:10). Both VA and Military Health Service have a duty to abandon the long standing and pervasive hospital closure movement and compensate medical facilities and medical services by reigning in unfair competition by community care with a $265 million transfer FY 22. The VA budget request does recognize they must establish the right balance of VA and Community Care. Medical Community Care funds non-VA provided medical claims and grants for state home nursing, domiciliary and adult day care services.

VA is on track to fully execute the $19.6 billion in funding provided in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) by Congress in March 2020, with over 75% obligated as of May 2021. The funding aided all levels of the VA COVID- 19 response, from procurement of test kits and specialized equipment, to the overtime and travel costs for our staff rotating into hot zones. VHA hired thousands of clinical and administrative staff across the health care system to ensure stability and continued delivery of care. VA added over 2,500 medical/surgical and Intensive Care Unit beds. The American Rescue Plan Act of 2021 provided VA with $17.1 billion in mandatory funding to sustain the VA COVID-19 response beyond the expiration of the CARES Act funding into 2022. ARP funding will also enable VA to reduce the backlog of Veteran benefit claims and appeals, improve supply chain management capabilities, and train Veterans unemployed due to COVID-19 in high demand occupations. Pursuant to the American Families Plan the VA has employed a child and family counselor and intends to improve women's health care. Women make up 16.5% of today’s ActiveDuty military forces and 19% of National Guard and Reserves.

VBA serves millions of Veterans across multiple benefit programs (VA '21). In 2021 6 million Veterans received some type of cash compensation or benefits, 31% of 19.2 million living Veterans. The number of Veterans receiving disability compensation benefits has increased over this time period, from 3.3 million in 2011 to over 5.0 million in 2020 (VBA '21: 53). Benefits in the compensation program are estimated to be dispersed to 5,503,550 Veterans and 475,146 Survivors in 2022, and 5,724,030 Veterans and 492,868 Survivors in 2023. The 2022 Veteran and Survivor caseload estimate is distributed among World War II and Prior (49,527), Korean Conflict (107,584), Vietnam Era (1,835,934) Gulf War (3,087,762), and Peacetime (897,888) periods of service. Caseload for the older periods of service is steadily declining. The number of Veterans and Survivors of Veterans from the Gulf War Era who are receiving compensation benefits will continue to increase rapidly through the budget year (VBA '21: 59). Monthly payments to Veterans vary by average degree of disability. While Veterans who are rated 10 percent disabled are the largest group of compensation recipients, they do not account for the majority of program cost. The largest compensation payments, as shown in the chart below, are paid to those with higher degrees of disability. In addition to variations of degree of disability, only Veterans at or above the 30 percent disability rating may be entitled to additional compensation for dependents, resulting in higher average payments. The average September payment for 10% disability was $143 in September 2020 while the payment for 100% disability was $3,479 (VBA '21: 61, 64). In 2022, the Disability Compensation program will complete 1.7 million disability compensation rating claims, with the average number of days pending of 85 days, the average number of days to complete of 99 days and an inventory of approximately 100,000 claims pending more than

125 days at the end of 2022. Pending appeals will be reduced to 20,000, with zero Notice of Disagreements. The amount of benefits payments has increased annually, a result of legislation expanding Veterans' benefits as well as VA's successful efforts to adjudicate claims more quickly (VA '21: 29-30). Total pension caseload is expected to decrease in 2022 (356,827 vs. 370,017) and 2023 (348,042). Vietnam and WWII and prior beneficiaries account for the largest pension caseloads with 170,296 and 89,587 beneficiaries, respectively, in 2022. Beneficiaries associated with these periods of service account for 72.8 percent of all pension beneficiaries. As of September 30, 2020, 35.3 percent of Veterans who received a pension were over age 75. The percentage of Survivors receiving pension over the age of 75 is 75.6 percent (VBA '21: 69, 70). COVID-19 burial statistics are not enumerated and the dramatic increase in costs is attributed to inflation in caskets and other funeral costs.

Number of Beneficiaries FY 20 – FY 24

	FY 20	FY 21	FY 22	FY 23	FY 24
Compensation	5,473,639	5,701,085	5,978,696	6,216,898	6,403,405
Pension	393,415	379,017	356,827	348,043	344,563
Total C & P	5,867,054	6,080,102	6,335,523	6,564,941	6,747,968
Education	875,036	853,993	870,975	885,086	902,788
Employment	123,490	132,788	135,194	137,787	140,543
Housing Loans	1,246,816	1,395,158	968,977	958,649	949,063
Insured	5,631,119	5,599,379	5,572,907	6,037,142	6,218,256

Source: VA Budget-in-brief FY 22 pg. 29

While the number of pension beneficiaries has been steadily decreasing, disability compensation beneficiaries have been increasing dramatically, but not quite enough to justify the increase in benefit spending. Between FY 20 and FY 21 the number of compensation beneficiaries increased by about 226,000 (4.1%), while pensions declined by 14,500 (-3.7%). FY 20 – FY 21 the total number of compensation and pension (C & P) beneficiaries is estimated to increase by about 213,000 (3.6%) while mandatory outlays increased $14,769 million (9.8%), 3.2% in excess of 3.6% plus either the unacceptably low Social Security Administration (SSA) Cost-of-living-adjustment (COLA) for that year, or 3% COLA advised for low-income beneficiaries – 6.6%. FY 21 – FY 22 the number of total number of beneficiaries is estimated to increase by about 256,000 (4.2%) while spending is anticipated to increase $14,768 million (12%) this is 4.8% more than the 7.2% cost growth estimate. VBA FY 22 – FY 23 advance appropriation, the number of post-pandemic C & P beneficiaries is probably overestimated to increase about 229,000 (3.6%), while spending growth moderates to $8,451 million (6.2%), only enough for a 2.6% COLA. FY 23- FY 24 population growth is estimated at 183,000 (2.8%) and spending growth $7,040 million (4.9%) enough for a 2.1% COLA.

Veterans Benefits Administration FY 20 – FY 24
(thousands)

	FY 20	FY 21	FY 22	FY 23	FY 24

Compensation	105,011,061	115,801,345	130,504,627	138,844,434	145,786,656
Pensions	4,746,355	4,693,714	4,760,036	4,871,476	4,968,905
Subtotal C & P	109,757,416	120,495,714	135,264,663	143,715,910	150,755,561
Burial	337,244	404,286	418,008	455,099	459,650
Education	11,533,809	11,373,805	11,350,731	11,923,679	12,281,389
Employment	1,463,550	1,802,828	1,824,723	1,931,659	1,989,609
Total Mandatory	123,092,019	134,075,978	148,858,125	158,026,347	165,486,209

Source: VA Budget-in-brief FY 22 Veterans Benefits: Direct Payments pg. 32 VBA Budget Submission FY 22 pg. 51 Includes mandatory and discretionary funding

In 2022, the budget requests $137.6 billion for the Compensation and Pensions (C&P) account to afford $139 billion in compensation, pensions and burial benefits with $1.4 billion in unobligated balances from the previous year. This is 12.5% more than $123.5 billion FY 21, after growing 10.5% FY 20-FY 21. In FY 23 benefit spending growth is expected to moderate at 6.2% to $147.6 billion. This appropriation will fund disability compensation and pension payments to or on behalf of Veterans, burial benefits, the contract examination pilot program, and other benefits. The primary reason for the increase is that in the decade between 2011 and 2020 the number of beneficiaries has increased 52%, at an average annual rate of 5%. Section 9109 of the National Defense Authorization Act for Fiscal Year 2021, P.L. 116-283 identified three new Agent Orange presumptive conditions (Parkinson's-like symptoms, bladder cancer, and hypothyroidism) as having an association with exposure to tactical herbicides used during the Vietnam era. As a result, the estimate to the Compensation and Pensions budget is an increase of $3.0 billion in obligations in 2022, including an estimated $2.2 billion in retroactive payments. On November 5, 2020, the U.S. District Court for the Northern District of California ruled the "Nehmer" automatic readjudication of disability compensation claims is required for Blue Water Navy Veterans. (Nehmer, et al v. U.S. Department of Veterans Affairs, No. C 86-06160 WHA). Costs to the compensation and pensions account are estimated to be $803.8 million in 2021. The current estimated obligations for Veteran compensation increased by $1.8 billion from the original estimate. An increase of $429 to the Veteran compensation average annual benefit payment ($20,403 vs. $19,974) results in an increase in obligations of $2.3 billion in 2021. A decrease in Veteran compensation caseload (5,245,629 vs. 5,267,797) decreases obligations by $452.3 million. The current estimate for Survivor compensation obligations has increased by $480.9 million from the original 2021 estimate. Average payment estimates for Survivor compensation increased from the original estimate ($18,826 vs $17,731), resulting in an increase to obligations of $499.8 million (VBA '21: 52- 56).

The current estimated obligations for the pensions program decreased $235.9 million from the original estimate. Reflecting 2020 actual experience, current estimates decreased for both Veteran caseload (215,382 vs. 231,183) and average payment ($13,760 vs. $14,186) compared to the original estimate. The combined effect of these decreases reduced Veteran pension obligations by $316.0 million in the current estimate. An increase to Survivor pension average payment ($11,189 vs. $10,252) combined with a decrease to Survivor caseload (154,635 vs. 161,325) based on 2020 experience, resulted in a net increase to Survivor pension obligations of $76.3 million. The current 2021 burial benefits budget estimate of $404.3 million is $49.3 million more than the original budget estimate of $355.0 million. Increases are associated with service-connected burial allowances ($27.8 million), plot allowances ($22.7 million), headstones/markers ($4.0 million), graveliners/outer burial receptacles (OBRs, $2.7

million), and caskets and urns ($17 thousand). These increases are offset by decreased costs associated with burial flags ($4.1 million) and basic burial allowances ($3.8 million) (VBA '21: 56-57).

The Forever GI Bill (P.L. 115-48) is the most recent legislation to change the program, primarily enhancing and expanding benefits. Based on length of active duty service and training rate, students are entitled to a percentage of the following: Full cost of tuition and fees at the public school in-state rates, or up to $26,042.81 (as of August 1, 2021) for those attending out-of-state, private, or foreign schools (paid to school); Monthly housing allowance (paid to the student); Yearly books and supplies stipend of up to $1,000 per year (paid to student); and payments for those pursuing a non-institute of higher learning program such as a non-college degree, on the job training, apprenticeship training, flight programs, or a correspondence program. VA adjusted its debt policies due to the coronavirus pandemic, stopping collections and either suspending or extending repayment plans for many beneficiaries. Dependents are eligible if a Veteran died or is permanently and totally disabled as the result of a service- connected disability. The average cost per beneficiary is highest for the GI-Bill, chapter 33 reaching $15,783 in 2021. The other education programs have significantly lower average payments. In 2021, the estimated average cost per beneficiary will be $8,862 for chapter 30, $7,097 for chapter 35, and $2,718 for chapter 1606. Since 2010, chapter 33 has been the largest education program and is expected to provide benefits for 624,686 trainees in 2022, accounting for 85 percent of education obligations. All program costs, including tuition, books, and fees, if appropriate, are borne by VA. In addition, Veterans are provided with a monthly subsistence allowance, which will account for 45 percent of program costs in 2022 (VBA '21: 78-89).

The GI Bill is a great deal. Law enforcement officers are currently required to have served 2 to 4 years in the armed forces and attend police academy, and sometimes as much as an Associates degree, however to prevent recidivism need to be required to achieve a Bachelor degree. The United States has the highest rate and concentration of incarceration in the world. Other than the habitually small brains of illiterate lawyers due to unwitting pseudo-ephedrine exposure by malicious prosecutors, corrupt law enforcement and intimate partner informants usually from the legal, housing and health sector, the prison slavery problem in the United States is hypothetically because law enforcement officers do not have the Bachelor degree they need to theoretically not recidivate. Recidivism is defined as being re-incarcerated for a felony within three years of being released from prison. Several state studies have shown that people who earned a post-conviction Bachelor degree were free of recidivism 100% of the time, Associates degrees 75%, Vocational certificates, such as police academy and some college 50%, and high school degree or less 33% (Gilligan '11: 100).

Vocational rehabilitation is financed with non-interest direct loans up to $1,300 per Veteran with service connected disability to start, continue, or reenter vocational rehabilitation training. Repayment of the loans are made in monthly installments, without interest, through deductions from future payments of compensation, pension, subsistence allowance, or educational assistance allowance, ensuring all loans are fully repaid. The rate of repayment may not be less than 10 percent of the amount advanced unless the monthly benefit being used for repayment is less than 10 percent of the loan amount. That means the majority of loans are repaid in ten months (10 percent for each month). The housing loan guarantee program subsidy is the government's cost of guaranteeing loans, net of recoveries, on a net present value basis. In 2022, the program's subsidy rate is an estimated -0.08 percent to support 968,977 loan guarantees with a value of $301.0 billion and an average loan size of $310,650, up to $500,000. Eligible direct loan borrowers are not required to make loan down payments nor to pay market interest rates. Direct loans have no loan size limits. Any VA borrower, who can be a

Veteran, Service-member, Surviving Spouse, or property buyer, pays a funding fee rate of 2.250 percent of the direct loan amount unless exempt due to receipt of service-connected disability compensation, in accordance Title 38 U.S. Code, Chapter 37, section 3729(b)(2)(J), Loan Fee Table, and section 3729(c), Wavier of Fee . Since 1993, the Native American Veterans direct loan program is authorized by 38 U.S.C. Chapter 37, Section 3761 to provide direct loans to Veterans living on trust lands. The loans are available to purchase, construct, or improve homes to be occupied as Veterans' residences. Veterans pay a funding fee rate of 1.25 percent of the loan amount unless exempt due to receipt of service-connected disability compensation (loan fees under section 3729). The law also requires that, before a direct loan can be made, a Veteran's tribal organization must sign a Memorandum of Understanding with VA which provides the legal framework for lending and permits VA access to sovereign trust lands. The Federal Credit Reform Act of 1990, P.L. 101 508, changed the accounting for Federal credit programs to more accurately measure their costs and to make them consistent with comparable non- credit transactions (VBA '21: 94, 104, 108, 122).

The Insurance business line administers six life insurance programs, including two trust funds, two public enterprise funds, a trust revolving fund, and Veterans' Mortgage Life Insurance (VMLI). Additionally, the Insurance business line oversees the Service-members' Group Life Insurance (SGLI) portfolio of four programs, which is administered by a private insurance carrier, i.e., Primary Insurer, pursuant to a group insurance policy, for the benefit of Veterans, Service-members, and their families. Budget authority (permanent and indefinite) is made available automatically to the United States Government Life Insurance (USGLI) and the National Service Life Insurance (NSLI) funds each year by virtue of standing legislation. All obligations of the Veterans' Special Life Insurance (VSLI) and Veterans' Reopened Insurance (VRI) funds are paid from offsetting collections and redemption of investments in U.S. Treasury securities. All obligations of the Service-Disabled Veterans' Insurance (S-DVI) fund are paid by transfers from the Veterans Insurance and Indemnities (VI&I) fund and other offsetting collections. No action by Congress is required for the transfers. Obligations of the SGLI program are financed from premium collections, interest on investments, and extra hazard payments from service branches. The maximum amount of basic coverage available under any of these programs is $10,000, however more coverage can be purchased and is planned in the future. The SGLI program offers coverage for $0.06 a month per $1,000 coverage, up to $400,000, $100,000 for spouse and $10,000 for children and traumatic injury coverage for $1 a month (VBA '21: 131, 134,. 136).

VA requests $394.0 million for the NCA Operations and Maintenance account, an increase of $42.0 million (+12%) over 2021. With this budget, NCA will provide for an estimated 136,000 interments, the perpetual care of over 4.0 million gravesites, and the operations and maintenance of 158 national cemeteries and 34 other cemetery installations in a manner befitting national shrines. (VA '21). In 2020, NCA interred 126,884 Veterans and eligible family members. Interments decreased six percent from the previous year, primarily due to the impact of the COVID-19 pandemic. Annual Veteran deaths are projected to be over 579,000 in 2021 and are then projected to decline slowly. The total number of gravesites increased from nearly 3.75 million in 2018 to more than 3.91 million in 2020. The number of gravesites maintained is expected to reach over 4 million in 2022. NCA is nearing its goal to provide 95% of Veterans with access to a burial option in a national, state or tribal Veterans cemetery within 75 miles of their homes. VA is establishing new columbaria facilities closer to the heart of the urban core in order to provide a more accessible option for those Veterans and family members. VA has also developed a strategy to create VA national cemeteries to serve Veterans in rural areas who currently do not have reasonable access to burial in a Veterans cemetery. Twelve of the eighteen new cemeteries have already opened in Yellowstone County, MT (2014); Cape Canaveral, FL

(2016); Tallahassee, FL (2016); Omaha, NE (2016); Pikes Peak, CO (2018); Fargo, ND (2019); Cheyenne, WY (2020); Machias, ME (2020); Rhinelander, WI (2020); Twin Falls, ID (2020); West Los Angeles, CA (2020); and Western New York, NY (2021). NCA plans to open the remaining six cemeteries by the end of 2026.

Chapter 12 Veterans Health Administration Budget Submission

VHA is the largest administration within VA, and in 2020 accounted for 354,245 FTE of the total 399,674 FTE (88.6%). VHA turnover rates compare favorably with the health care industry, including for those occupations identified as mission critical, such as physician, registered nurse, psychologist, and human resources management. VHA hired a record 43,464 new employees in 2020 for a net increase of just over 13,800 employees and a 4.0% annual growth rate, compared to the 5-year average annual growth rate of 3.1%. Over the last five years (2016-2020), VHA grew by 50,795 additional health care providers and support staff, the majority of which (60.7%) was in clinical occupations. Of the clinical growth, 68.8% occurred in top clinical staffing shortage occupations. VHA typically hires approximately 2,700 physicians and upwards of 7,500 or more registered nurses annually to replace losses and grow the workforce to meet access standards and provide the best possible care to Veterans (VHA '21: 312). After years of out of control 5% annual staffing increases, the budget requests 369,847 FTE in 2022, 5% more than 352,427 FY 21, and 369,847 FTE in 2023, net zero growth. The estimated staffing increase in 2022 allows VA to meet continued outpatient Relative Value Unit (RVU) growth for VA provided services, particularly due to COVID-19-related deferred care returning in 2022. Provider growth has increased recently despite a tightening provider labor market and will continue in 2022 as VA expands telehealth services and enhances suicide prevention and substance use disorder initiatives (VHA '21: 32). Normally the organizational objective is a stable 1% net increase in employment.

VA uses three actuarial models to support formulation of most of the VA health care budget, to conduct strategic and capital planning, and to assess the impact of potential policy changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (EHCPM), the Civilian Health and Medical Program Veterans Affairs (CHAMPVA) Model, and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Stipend Projection Model. Historically, growth in expenditure requirements to provide care to enrolled Veterans has been primarily driven by health care trends, the most significant of which is medical inflation. The COVID-19 pandemic had a significant impact on VA health care in 2020 and is expected to impact the amount of care provided for the next few years. During the pandemic, nationwide health care utilization saw a reduced amount of care provided in 2020 and 2021 as individuals chose to defer certain care. It is anticipated that there will be a resulting surge in care in late 2021 continuing through 2022 to fulfill previously deferred services. Additionally, the stay-at-home orders and social distancing mandates have had an impact on the U.S. economy, which is expected to increase reliance on VA for health care. It is necessary to strike the right balance between skyrocketing costs for community grants to state veterans nursing homes, adult day care and mostly commercial care close to home although the VA provides transportation and appointments within 30 days (GAO '20). This prospectus also demonstrates how the VHA facilities budget is slightly underestimated, impairing utility of VHA services, further driving hyperinflation in community care.

The 2022 request supports the treatment of 7.1 million patients, a 1.3% increase above 2021, and 119 million outpatient visits, an increase of 3.7% above 2021 (VHA '21: 38). VA Video Connect (VVC)

visits increased by 1,037% from 99,000 Veterans in 2019 to more than 1.35 million Veterans in 2020 (VHA '21: 397, 92). The experience of responding to the COVID-19 pandemic has brought critical lessons the VA must learn to reduce spending for community care and effectively respond to future coronavirus and influenza pandemics. While steps to avoid unnecessary in-person appointments during the pandemic, in 2020, VA completed more than 75 million Veteran visits, including over 45 million in-person, 27 million by telephone, and over 3.4 million by video visits to-the-home. It is debatable whether this was proactive or retroactive or merely a reflection that the VA does not necessarily know how to treat coronavirus using readily available overt-the-counter, herbal remedies and cleaning products. Whether Veterans cancel their own appointment or VA cancels the appointment for safety reasons, VA carefully reviews each cancellation to ensure Veterans who need care receive it. Uncertainty regarding the timing and location of the next surge or surges in cases across the country underscored the importance of portable capabilities (e.g., 24-bed Intensive Care Unit that can be transported) for VA health care's Fourth Mission role in future public health emergencies.

To avoid confusion by "prioritization" of CARES Act and Recovery Act counterfeits, only the regular appropriations table from VHA Budget Submission is used to review the Budget-in-brief. For the sake a possible deficit reduction, or in the off-chance it was actually utilized, the amounts are recorded. For FY 20 $60 million were appropriated under the Families First Coronavirus Response Act, $30 million for medical services and $30 million for medical community care. Also in FY 20 a total of $17,238 million were appropriated, $14,432 million for medical services, $2,100 million for medical community care, $100 million for medical support & compliance, and $606 million for medical facilities. Combined these two acts bring the total VHA appropriation for FY 20 to $100,538 million. In FY 21 the American Rescue Plan Act provided a total of $15,723 million in mandatory funding. Sec. 8001 provided a total of $14,473 million - $9,020 million for medical services, $1, 901 million for medical community care, $978 million for medical support & compliance and $2,573 for medical facilities. Sec. 8004 $250 for medical community care. Sec. 8007 provided $1 billion, $627.9 million for medical services, $300 million for copayment reimbursement and $72.1 million for community care. These three section of the American Rescue Plan Act bring the VHA budget total to $108,538 FY 21. In FY 22 the American Families Plan increases the VHA medical services budget by $260 million for total VHA appropriations of $101, 797 million FY 22. The actual $265 million shortfall in the medical facilities FY 22 budget highly brings into question whether or not these extra appropriations are real. Actual health care, other than low cost telemedicine, given to Veterans is reported to have declined due the contagious nature of the COVID-19 pandemic. Nonetheless the VHA has decided to increase FTEs by 14,355 (4.2%) from 338,072 FY 20 to 352,427 FY 21 and intends to increase to 369,847 FTE in FY 22 and remain at that level in FY 23. In 2022,VA projects obligating $9.6 billion out of un-obligated balances provided by sections 8002 and 8007 of the American Rescue Plan Act for activities traditionally funded by the Medical Services discretionary appropriation, as authorized in the Act. When these resources are combined with available anticipated collections, transfers, reimbursements, and other net un-obligated balances, Medical Services will meet the projected 2022 obligation level of $74.8 billion (VHA '21: 299 - 300). This explains the miraculous leap to $70.3 billion in medical services appropriations FY 23. Because these extra funds are included in the $3.3 trillion in relief acts "bought" by the Federal Reserve it is easier not to include them.

Veterans Health Administration Budget Submission FY 16 - FY 24
(millions)

	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24
Medical Services	49,712	45,171	46,110	49,911	51,061	56,556	58,897	70,323	72,433
Medical Community Care	0	7,225	9,828	9,385	15,280	18,512	23,417	24,157	24,562
Medical Support & Compliance	6,033	6,472	6,758	7,028	7,328	8,199	8,403	9,673	8,914
Medical Facilities (Includes NRM)	4,673	5,278	7,217	6,807	6,584	6,583	6,735	7,133	7,145
Subtotal Medical Care Appropriations	60,418	64,146	69,913	73,131	79,811	89,850	97,452	111,287	113,054
Medical Collections (MCCF)	3,486	2,456	3,516	3,915	3,429	2,966	4,085	4,165	4,500
Subtotal Medical Care with MCCF	63,904	66,602	73,428	77,047	83,240	92,816	101,537	115,452	117,554

Source: Department of Veterans Affairs Budget-in-brief FY 2018 - FY 2022; Veterans Health Administration (VHA). FY 2022 Budget Submission. Medical Programs and Information Technology Programs Department of Veterans Affairs. Office of the Assistant Secretary for Management. Table: Medical Care Appropriations by Account and Medical Care Collections pg. 24

It is necessary to strike the right balance between costs for community grants to state veterans nursing homes and VA medical care. Since 1945, the Department of Veterans Affairs (VA) has allowed eligible veterans to receive care from community providers when they faced challenges accessing care at VA medical facilities, which include VA medical centers (VAMC) and outpatient facilities. In the last decade, of dangerously escalating health costs and corruption causing an unprecedented increase in under age 65 deaths, Congress has taken steps to expand the availability of community care for veterans, including establishing the temporary Veterans Choice Program (Choice Program) in 2014. While veterans still receive most of their care from VA medical facilities, the number of veterans that

have received community care has increased 77 percent from 2014 through 2019, and in fiscal year 2019, VA obligated approximately $15.5 billion for community care services. In fiscal year 2017, the Medical Community Care appropriations account was created to consolidate all community care programs under a single appropriation for both Veterans and beneficiaries. This appropriation supports hospital care and medical services delivered in non-VA settings to eligible Veterans through contracts or agreements with certain eligible entities, as well as pays for care for other eligible beneficiaries. Veterans may be eligible to receive care from a community provider when VA cannot provide the care needed. Community care is available to Veterans based on certain conditions and eligibility requirements, and in consideration of a Veteran's specific needs and circumstances. Community care must be first authorized by VA before a Veteran can receive care from a community provider. As with care provided directly by VA, Veterans are charged a copayment by the VA for non-service-connected care, they do not pay anything to the commercial health care provider. VA provides payment on a per diem basis for eligible Veterans who participate in the State Veterans Home. State Veterans Homes are facilities that provide nursing home, domiciliary or adult day care. They are owned, operated and managed by state governments. They date back to the post-Civil War era when many states created them to provide shelter to homeless and disabled Veterans. Under the MISSION Act of 2018 veterans can see a community provider if they've been waiting for more than 20 days for primary and mental health care and 28 days for specialty care, or if they face a 30-minute drive to the nearest VA facility. However, according to VA internal data from October 2019 through June 2020, veterans waited an average of 41.9 days for an appointment in the community. The vast majority of appointment at VA facilities are completed within 30 days (GAO '20).

In 2016, VA provided 20.6 million community appointments; of this total, the Medical Services account funded 17.3 million appointments and the Veterans Choice Program funded for 3.3 million appointments. In 2017 and 2018, VA expects to exceed those levels (VA FY18: 16). Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA healthy care provider. In FY2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and adjusted obligations upwards. VA lacked sufficient funds within the account to cover the full obligations recorded consistent with VAOGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021(Public Law116- 260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Anti-deficiency Act (ADA) violation that would have occurred in FY2019 absent its enactment. To implement the law, VA made an accounting adjustment in FY2021 (VHA '21: 53 & 57). For necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, **[**$1,380,800,000**]** $3,269,000,000, which shall remain available until September 30, 2023, and shall be in addition to funds previously appropriated under this heading that became available on October 1, **[**2020**]** 2021; and, in addition, **[**$20,148,244,000**]** $24,156,659,000, plus reimbursements, shall become available on October 1, **[**2021**]** 2022, and shall remain available until September 30, **[**2022: Provided, That, of the amount made available on October 1, 2021, under this heading, $2,000,000,000 shall remain available until September 30, 2023**]** 2024. (Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2021.) (VHA '21: 292).

VA requests that its full appropriation for Medical Community Care be provided with two -year

availability. This change will reduce payment rejections and delays in processing of claims, which will improve VA's relationships with our Community Care partners. In addition, simplifying how funding is provided for this program will reduce the likelihood of lapsed funds or improper payments and result in more efficient use of funds for our Veterans' health care needs. VA anticipates processing approximately 6.4 million Community Care authorizations in 2021. VA's financial and claims processing systems necessitates designating, at the time the authorization is issued, the financial account that will eventually pay the community care claim once the claim is adjudicated and the obligation established. If funds are not available in the pre- designated account, payments will be rejected, delaying the payment to the Third-Party Administrators or Community Care providers. This process contributed to an estimated 500,000 claims rejected in 2020. Claims rejections and workload could potentially decrease if VA is provided all Medical Community Care funding with two-year availability. The administrative effort to manage the multiple funds within the Medical Community Care appropriation requires the assistance of the Financial Services Center (FSC), Veterans Affairs Medical Centers (VAMCs), and OCC staff. These organizations must monitor fund balances, process cost-transfers, identify and correct cost-transfer errors, and assist in clearing rejects. Additionally, VHA finance staff must process funding transfers between 151 medical centers and 18 categories of healthcare. Providing full two-year availability would eliminate the need for hundreds of thousands of financial transactions annually that move billions of dollars in cost- transfers and Transfer of Disbursing Authority (TDAs). This significant volume of transactions is inefficient and prone to errors and negatively impacts timeliness and accuracy of payment and thus Veteran care (VHA '21: 293).

To strike the right balance between VA and community care it will be necessary to stop the rhetoric regarding providing care close to home and start basing decision-making upon the ability of the VHA, and VA transportation if necessary, to provide an appointment within 30 days 80% - 100% of the time, whereas wait-times are much longer to get community care, to understand observations made by the Government Accounting Office (GAO '20). Studies have consistently found that VA health care is superior to private health care across a broad variety of measures (DeLancey et al '17)(Price et al '18) (Weeks et al '18). Before FY 17 community care was rationally paid for from within the medical services budget, that makes the decision as to whether or not private health care is more practical. Subsequently, with the irrational support of the Democratic-Republican (DR) two party system for their greedy private health care providers, perhaps because they unwittingly lose all their money to their DEA registration, community care hyperinflation has become a topic of overestimation, the VHA does try to reduce after the fact. Congress must be made to understand that the obligation for community care is only the result of the VHA not being able to schedule an appointment within 30 days. The original obligation of the United States is to support VA medical services and facilities so that they can provide timely appointments for all (eligible) Veterans. It was definitely unwise for the Trump administration to give Congress the discretion to make community care appropriations for their hyper-inflationary private health care of inferior quality, they are so obsessed with. Community care comes out of the reasonable costs of the neglected medical facilities the patients and staff flock to, while medical services is seduced into competing with the hyperinflation in community care costs. The point is to maintain and expand the VA health care system at regular 3% spending and 1% employment growth until the VA cares for all Veterans. To do this it may be necessary to fold community care back into the medical services appropriation to protect it against federal interference from the hyper-inflationary, bio-terrorist and medically negligent Democratic-Republican (DR) obsession with financing private health care to pretend to compensate their torture victims, without actually compensating, healing or stopping their violation of Sec. 1801 of the Social Security Act 42USC§1395.

The Veterans Health Administration (VHA) operates a portfolio of approximately 5,625 owned buildings with a total of 152.8 million square feet of space on 16,373 acres of land. The portfolio also includes 1,690 leases with a total of 20.1 million square feet of space (VHA '21: 375). There are 172 VA medical centers (VAMCs) across the nation. Of the 172 VAMCs, 146 were classified as VA Hospitals in 2020. To meet the criteria of a VA Hospital, a facility must report over 500 inpatient acute bed days of care. The other 26 VAMCs provided a mix of other bed-care services, such as CLCs and/or residential rehabilitation care, thus meeting the VAMC criteria (VHA '21: 445). VA is not requesting additional discretionary resources for Medical Facilities above the enacted 2022 Advance Appropriation of $6.735 billion, although by the middle of FY 22 this would extend the length of time the VHA facilities budget has fluctuated between $6 and $7 billion, beginning with a cut in FY 19, beyond the 42 months allowed such persecutions (Revelation 13:10). In 2022, VA projects obligating $2.6 billion out of unobligated balances provided by sections 8002 of the American Rescue Plan Act for activities traditionally funded by the Medical Facilities discretionary appropriation, as authorized in the Act. When these resources are combined with available transfers, reimbursements, and other net unobligated balances, Medical Facilities will not meet the projected 2022 obligation level of $9.5 billion, as the VA supposes, they are $165 million short. Including the $100 million cost of this prospectus to renovate Battle Mountain Sanitarium in Hot Springs and construct or lease a larger Multi-Specialty Outpatient Clinic in Rapid City, South Dakota, Congress must approve to add to the list of major construction projects under 40USC§3307, to be mathematically and legally correct and theologically $7 billion by 42 months, Congress is obligated to supplement the VHA facilities appropriation by $265 million to $7 billion FY 22 pursuant to the Anti-Deficiency Act under 31USC§1341 and 31USC§1515.

As technology-enabled trends in U.S. medicine bring care close to individuals and communities, there is less demand for prodigious, sprawling campuses and more emphasis on ambulatory facilities and virtual care. Many surgical, medical and diagnostic procedures that once required a hospital stay are now safely performed in the outpatient setting, and telehealth and teleservice delivery bring expertise to a patient's own home. This evolving landscape requires VA to rebalance and recapitalize its infrastructure to optimize the mix of traditional inpatient hospitals with outpatient hospitals, multi-specialty Community Based Outpatient Clinics, single specialty Community Based Outpatient Clinics and virtual care (VHA '21: 16). The VA MISSION Act of 2018 (P.L. 115-182) established an independent commission to be known as the "Asset and Infrastructure Review Commission" (the Commission). The Commission reviews VA's recommendations to modernize, or realign VHA facilities, including leased facilities, through a process of public hearings. VA operates the largest integrated health care, member benefits and cemetery system in the Nation, with more than 1,700 facilities, including 170 VA medical center hospitals, clinics, and other health care facilities and 155 national cemeteries. The total VA infrastructure portfolio consists of approximately 184 million owned and leased square feet—one of the largest in the Federal Government. VHA operates approximately 5,665 owned buildings on 16,390 acres of land, and 1,663 leases, encompassing 16.4 million square feet of space in its portfolio. The average age of U.S. private sector hospitals is 11 years; however, the median age of hospitals in VA's portfolio is 58 years, with 69% of VA hospitals over the age of 50. Many surgical, medical and diagnostic procedures that once required a hospital stay are now safely performed in the outpatient setting, and telehealth and tele- service delivery bring expertise to a patient's own home. This evolving landscape requires VA to rebalance and recapitalize its infrastructure to optimize the mix of traditional inpatient hospitals with outpatient hospitals, with fewer new multi-specialty Community Based Outpatient Clinics, single specialty Community Based Outpatient Clinics and more virtual care to minimize demand for non-VA providers and be more clever

diversifying use of hospital space.

The staff and associated funding supported by facilities management appropriations are responsible for: keeping the VA hospitals and clinics climate controlled; maintaining a clean and germ- and pest- free environment; sanitizing and washing hospital linens, surgical scrubs, and clinical coats; cleaning and sterilizing the medical equipment; keeping the hospital signage clear and current; maintaining the trucks, buses and cars in good operating condition; ensuring the parking lots and walk ways are sanded and free of snow and ice; cutting the grass; keeping the boiler plants and air conditioning units operating effectively; and undertaking certain repairs and alterations to the buildings to keep them in good condition. VA is not requesting additional discretionary resources for Medical Facilities above the enacted 2022 Advance Appropriation of $6.735 billion. In 2022, VA projects obligating $2.6 billion out of unobligated balances provided by sections 8002 of the American Rescue Plan Act for activities traditionally funded by the Medical Facilities discretionary appropriation, as authorized in the Act. VA projects that a significant amount of healthcare that was delayed during the pandemic will return to the VA health care system in 2022, coupled with the return of care to pre-pandemic levels. The infusion of funding included in the American Rescue Plan Act provides VA with the resources necessary to address total demand in 2022. After VA addresses the return of deferred care, the Department projects that growth in workload levels will stabilize in comparison to pre-pandemic levels, thus requiring fewer total resources in 2023 (VHA '21: 375, 379).

The Office of Rural Health (ORH) aims: To improve the understanding of the challenges faced by Veterans living in rural areas. To identify disparities in the availability of health care to Veterans living in rural areas. To formulate practices or programs to enhance the delivery of health care to Veterans living in rural areas. To develop special practices and products for the benefit of Veterans living in rural areas and for implementation of such practices and products in the Department system wide under 38USC§7308. In 2020, these programs touched the lives of more than 2.9 million Veterans at 600 rural serving sites across VHA with Primary Care, Specialty Care, Mental Health, Workforce Training and Education, Care Coordination and Health IT Modernization and Transportation. As of October 2020, over 54,000 patients have received tablets from the Rural Patient Tablet Program generating over 90,000 encounters. Six months after receiving a tablet, there was an increase in Veterans reporting more convenient care (from 67 to 80%), 28% fewer missed appointments or no shows in mental health, and an increase in VA's mental health continuity of care measure (from 31.6% to 40.2%) (VHA '21: 240-243).

The Office of Connected Care, and its Telehealth/Connected Care Services, has the mission to improve Veteran's health outcomes, access, and healthcare experience by use of electronic health technologies, irrespective of the location of the provider or the Veteran. Telemedicine has experienced a surge in adoption over the past year due to the coronavirus pandemic. In 2019 more than 99,000 Veterans or 1.6% of the Veterans who received care from the VA had more than 294,800 video visits into their homes. In 2020 the number of Veterans receiving a video visit to their home expanded to over 1.29 million Veterans who received more than 3.4 million video visits to their home. This represents close to 18.8% of Veteran's who receive care from the VA. There was a 79.8% increase in the Veterans who received any type of telehealth from 2019 (909,000) to 2020 (1.63 million). This represents 27% of all Veterans who receive care at VA. At the end of September 2020, 35,947 providers had completed at least one offsite visit, an increase of 14,273 providers. Week-over-week telehealth video appointments have increased by 1,065% since February 2020, increasing from approximately 10,000 appointments a week in early February to more than 180,300 appointments during the last week in October (VHA '21:

248-249).

VA currently uses approximately 1,292,000 discrete medical devices across the enterprise to deliver healthcare to Veterans. Approximately 104,200 medical devices communicate with electronic health records via the VA information technology network and must be specially managed and routinely updated to address known and emerging cybersecurity risks. VHA deployed approximately 149,000 new medical devices, worth $950 million, during 2020 to refresh (VHA '21: 308 ,310). Laptop hardware refresh is recommended within 3 to 4 years from initial purchase; monitor (external) refresh is recommended within 5 to 6 years from initial purchase, or as required (VHA '21: 626). The Office of Electronic Health Record Management (EHRM) provides program management oversight, enable health IT product installation, and facilitate the adoption of new health IT products at VA related to the implementation of EHRM (VHA '21: 632). The 2022 request is $4.843 billion, a decrease of $31.7 million (0.7%) below the 2021 Enacted Budget, to support Veteran focused IT systems and infrastructure (VHA '21: 642). VA is replacing its 50-year old legacy inventory management system and standalone systems for its support with the DoD Defense Medical Logistics Standard Support (DMLSS) system; the same system used by the DoD. VA use of DMLSS is consistent with 38 U.S.C. §8111, Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources. The VA Supply Chain Master Catalogue will provide VA users with visibility of all VA medical commodities, prosthetic devices (to include durable medical equipment), expendable and non -expendable equipment, and non-clinical products. Currently, VA lacks standardized enterprise business rules for its cataloging efforts, resulting in inconsistencies including incomplete records, duplicate records, stock-level discrepancies, incorrect dollar values, conversion factor errors and missing mandatory sources. (VHA '21: 245-247).

The Veterans Canteen Service (VCS) was established by Congress in 1946 to furnish, at reasonable prices, meals, merchandise, and services necessary for the comfort and well-being of Veterans in hospitals and domiciliaries operated by the Department of Veterans Affairs (VA) (Title 38 U.S.C. 7801-10). It has since expanded to provide reasonably priced merchandise and services to America's Veterans enrolled in VA's Healthcare System, their families, caregivers, VA employees, volunteers, and visitors. Congress originally appropriated a total of $5.0 million for the operation of the VCS and no additional appropriations have been required. Funds in excess of the needs of the Service totaling $12.1 million have been returned to the U.S. Treasury. However, provisions of the Veterans' Benefits Act of 1988 (Public Law 100-322) eliminated the requirement that excess funds be returned to the Treasury and authorized such funds to be invested in interest-bearing accounts, specifically Treasury Bills and Notes. Gains realized from these accounts are used to fund business operations. Currently, VCS has no interest-bearing investments. As a result of the COVID-19 Pandemic in 2020, VA Canteen Service closed for much of the year. The Canteen Service is beginning to see a gradual increase in customers; however, it is still approximately 100,000 visitors per day below average. As a result of the COVID-19 pandemic, VCS operations in 2021 are operating at a $25 million loss. The CARES Act provided authority to transfer $140 million from Medical Services to VCS, without which the revolving fund would have been depleted and service to Veterans adversely impacted (VHA '21: 592-594).

To fulfill the Department of Veterans Affairs (VA's) commitment to provide superior health care to Veterans, the Medical and Prosthetics Research and Development Program, through the Veterans Health Administration (VHA) Office of Research and Development (ORD) program, requests $882 million in direct appropriations in 2022. This is the largest year-over-year increase in recent history, for medical and prosthetic research. This historic investment will advance the Department's research

mission, including critical studies to understand the impact of traumatic brain injury (TBI) and toxic exposure on long-term health outcomes. ORD to fund approximately 2,563 total projects, support more than 1,700 investigators with direct ORD funds, and partner with more than 200 medical schools and other academic institutions in 2022. In 2022, grants from other federal organizations, such as the National Institutes of Health (NIH), the Department of Defense (DoD), and the Centers for Disease Control and Prevention (CDC), are estimated at $370 million. Funding from other non-federal sources in 2022 is estimated at $170 million, with a total estimated amount of $540 million (VHA '21: 542, 543). ORD will receive reimbursable FTE support from the VA Defensive Counterintelligence (CI) Program in 2022. The mission of the CI program is to conduct defensive CI activities to detect, deter, and neutralize espionage, sabotage, or other intelligence activities conducted for or on behalf of foreign powers, organizations or persons, and international terrorist activities. The goal of this initiative is to protect ORD personnel, infrastructure, and sensitive research programs, (mostly against) referral of counterintelligence activities to FBI (VHA '21: 552).

As of December 2019, 1,355 articles had published in that calendar year resulting from VA-funded research had been deposited by VA investigators in PubMed Central, as per the plan's requirements. As of June 2020, more than 18,000 VA publications were listed in PubMed Central (VHA '21: 584). VA launched the Artificial Intelligence (AI) Tech Sprint. The Sprint seeks to build collaborations and potential partnerships by designing AI-enabled research and development tools that leverage federal research and development data to address Veterans' needs. In 2019, based on the results of the Sprint, an industry team and a non- profit team/industry combination team were recognized by a national competition run by the U.S. Department of Commerce and the White House Chief Information Officer. They won a first place prize for their submission, "Creating the Future of Health." (FHA '21: 583). ORD has reduced the number of canines used in VA research tenfold over the past 20 years, while improving the safeguards under which canine research takes place. Of more than 2,000 research studies currently supported by VA, only six currently involve the use of canines. Since 2018 Congress has placed limits on canine research, and in 2020 Congress expanded those limits to include felines and non-human primates (VHA '21: 561). The Veterans' Benefits and Services Act of 1988 (Public Law 100-322) authorizes "Medical Center Research Organizations" to be created at Department of Veterans Affairs Medical Centers (VAMC). These nonprofit corporations (NPCs) provide flexible funding mechanisms for the conduct of VA-approved research and educational activities. All 81 NPCs have received their authority from the Internal Revenue Service Code of 1986, under Article 501(c)(3) or similar Code Sections (VHA '21: 597).

VA is the second largest federal payor of GME (secondary to the Center for Medicare and Medicaid Services) and is a major funder of residency programs across a variety of health professions. Over 124,000 clinical trainees, representing more than 100 health care program types, receive all or part of their clinical training in VA health care facilities annually. These trainees are either direct-paid clinical trainees (15,764), indirect-paid clinical trainees (45,363) and Without Compensation (unpaid) clinical trainees (63,000). Graduate Medical Education (GME) Physician Residents, primarily paid indirectly through disbursement agreements, account for approximately 78% of the clinical trainee budget; non-GME trainees account for the remainder. Non-GME trainees include nursing, allied health and non-physician trainees. The VA offers scholarships and Education Debt Reduction Program (EDRP), serves as a critical recruitment and retention tool used by VHA medical centers for recruitment and retention of their most difficult to fill clinical care positions (VHA '21 212-218).

Part E VA Health Care

Chapter 13 Enrollment

Enrollment with VA health care is free (i.e., there is no monthly premium like there is in Medicare and private insurance); yet, not all eligible Veterans choose to enroll with VA. Average expenditures per enrollee tend to increase with age, but the impact of reduced reliance on VA among older Veterans tends to outweigh this trend. Reliance has typically decreased over time for enrollees aging past 65 and as they gravitate toward Medicare coverage. Approximately 9 million Veterans currently enrolled, of which approximately 6 million are patients during the year. Gradual increases in cost sharing over time may cause enrollees to shift more care to VA, thereby increasing reliance (VHA '21: 431, 433, 436). The 2022 request supports improved patient access to and timeliness of medical care services for approximately 9.2 million enrolled Veterans and non-Veterans. According to the VHA Survey of Enrollees, in 2019 approximately 80% of enrollees had one or more other sources of public or private health care coverage in addition to VA. On average, enrollees rely on VA for only 38% of their health care needs (excluding LTSS). This represented $75 billion in 2019. If the Veterans enrolled in 2019 had chosen to receive all of their health care in VA (100% reliance), this would have required an additional $129 billion for a total of $204 billion in 2019 (VHA '21: 12), that is a fair estimate of how much it would cost for the VA to enroll all Veterans.

VA estimates that 80% of enrollees have some type of public or private health care coverage other than VA. Enrollees with multiple sources of coverage can choose to use their VA or non-VA coverage for each health care service. Reliance is defined as the portion of enrollees' total health care needs expected from the VA health care system, including both VA facility care and community care paid by VA, versus other health care options. For example, if an enrollee received four office visits from VA and six through Medicare, that enrollee would be considered 40% reliant on VA for office visits (4/10) (VHA '21: 418). Overall, reliance on prescription drugs for the enrolled Veteran population is 58%. Regardless of coverage, prescription utilization is lower for enrollees age 65 and over, presumably as enrollees become less reliant on VA health care. Enrollees in Priorities 1a, 1b, and 4 tend to have the highest utilization, while enrollees in Priorities 6 – 8 tend to have the lowest utilization. Prescription drug reliance was projected to increase by approximately 0.50% in 2020 due to the 14-day Rx Urgent/Emergent adjustment. This amount then trends mildly each year, reaching 0.58% in 2023 (VHA '21: 319). Enrollee reliance on VA for dialysis services increased from 29% in 2011 to an estimated 44% in 2019 and is expected to continue to increase through 2027. This increase in reliance is due in part to lower cost sharing in VA compared to Medicare (VHA. 21: 403).

VA administers its comprehensive medical benefits package through a patient enrollment system. The enrollment system is based on priority groups to ensure health care benefits are readily available to all enrolled Veterans. Priority Group 1: Veterans with VA-rated service-connected disabilities 50% or more disabling, determined by VA to be unemployable due to service-connected conditions and Veterans awarded the Medal of Honor (MOH). Priority Group 2***:*** Veterans with VA-rated service-connected disabilities 30% or 40% disabling. Priority Group 3: Veterans who are Former Prisoners of War (POWs), awarded a Purple Heart medal, were discharged for a disability that was incurred or aggravated in the line of duty, with VA-rated service-connected disabilities 10% or 20% disabling awarded special eligibility classification under 38USC§1151, "benefits for individuals disabled by treatment or vocational rehabilitation". Priority Group 4 Veterans who are receiving aid and attendance or housebound benefits from VA, or determined by VA to be catastrophically disabled. Priority Group 5: Non-service-connected Veterans and non-compensable service-connected Veterans rated 0%

disabled by VA with annual income below the VA's and geographically (based on resident zip code) adjusted income limits, Veterans receiving VA pension benefits and Veterans eligible for Medicaid programs. Priority Group 6:Compensable 0% service-connected Veterans, Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki, Project 112/SHAD participants, Veterans who served in the Republic of Vietnam between January 9, 1962, and May 7, 1975, Veterans of Persian Gulf War who served between August 2, 1990, and November 11, 1998, Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987, Currently enrolled Veterans and new enrollees who served in a theater of combat operations after November 11, 1998, and those who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. Priority Group 7: Veterans with gross household income below the geographically -adjusted income limits (GMT) for their resident location and who agree to pay copays. Priority Group 8: Veterans with gross household income above the VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays. Sub-priority 8a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status. Sub-priority 8b: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less. Sub-priority 8c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status Sub-priority 8d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less. Sub-priority 8e: Non-compensable 0% service-connected (eligible for care of their SC condition only). Sub-priority 8g: Non-service-connected.

Unique Patients 2020 - 2023

	2020	2021	2022	2023
Veterans	6,211,825	6,265,879	6,317,060	6,362,482
Non-Veterans	764,006	771,698	812,674	836,254
Total	6,975,831	7,037,577	7,129,734	7,198,736
Under Age 65				
Veterans	3,048,744	3,142,277	3,201,428	3,268,660
Non-Veterans	724,992	732,415	770,218	791,827
Total	3,773,736	3,874,692	3,971,646	4,060,487
Over 65 and Older				
Veterans	3,163,081	3,123,602	3,115,632	3,093,822
Non-Veterans	39,014	39,283	42,456	44,427
Total	3,202,095	3,162,885	3,158,088	3,138,249

Source: VHA '21: 45 -47

Post-Deployment Health Services assesses the impact of deployment/environmental exposures on Veterans and develops related policy, research, education, and health care strategies. 1) Agent Orange (AO) Veterans: Vietnam, Korean DMZ at certain times, and certain Thai bases and certain

occupational series, certain C-123 crews, does not include most Blue Water Navy. Approximately 3.1 million Veterans served in Vietnam and are presumed to have Agent Orange exposure. 2) Atomic Veterans exposed to ionizing radiation (above and some below-ground-tests). 3) Gulf War Veterans: served in the Gulf during Operation Desert Shield, Operation Desert Storm. Approximately 650,000 Veterans served during Desert Storm/Desert Shield; early Gulf War. This includes Veterans exposed to Depleted Uranium and possible toxins in embedded fragments. 4) Airborne Hazard Open Burn Pit Veterans: served in Djibouti, Africa on or after September 11, 2001, Operations Desert Shield or Desert Storm, Southwest Asia theater of operations on or after August 2, 1990. Note: includes GWR eligible Veterans and OEF/ OIF/ OND/OIR. 5) Garrison-related environmental health concerns, such as Camp Lejeune (water); Ft Benning (lead paint in housing); Ft. McClellan (industrial off post contamination) and fire-fighting foam exposures in garrison water supplies contaminated with Perfluorinated Alkyl Substances (PFAS). 6) Karshi-Khanabad (K2)– possibly exposed to various hazards; fuels, DU, asbestos, lead, etc. at a former Soviet airbase in Uzbekistan from 2001-2005. 7) Reviews of other emerging issues such as exposures to prophylactic medications and vaccines and concerns for intergenerational and gender issues. PDHS oversees six Congressionally mandated registries with exams that are done at VAMCs. Call Center Centralized (CCC) will have 22 full time staff composed of 20 Environmental Health (EH) coordinators and 2 clinicians (MD, PA, NPs) instead of the current 170 coordinators, to centralize a call center and decentralize examiners (VHA '21: 274-276).

Rehabilitative care services include Physical Medicine and Rehabilitation, Traumatic Brain Injury, Blind Rehabilitation, Audiology and Speech-Language Pathology, and Recreation Therapy. VA operates 13 Blind Rehabilitation Centers, which provide 4-6 weeks of inpatient adjustment- to-blindness training to help blinded Veterans achieve a realistic level of independence. VA operates 25 Spinal Cord Injury Centers (VHA '21: 407). VA is the largest and most comprehensive provider of prosthetic devices and sensory aids in the country. the use of hearing aids (which are not covered by private insurance or Medicare) increases significantly with age, while utilization of surgical implants shows minor increases as enrollees elect to use Medicare for surgical procedures. Aging is driving material increases in utilization of hearing aids, blind aids, wheelchairs, VA specialized products and services, and oxygen (VHA '21: 407, 408). Blind Rehabilitative Services (BRS) served more than 18,000 blind and low vision patients in 2021. In FY 2019 inpatient BRC's discharged 2,410Veterans. Among this total,1,348 (55.1%) received training related to technology-related devices and equipment. There is a rise in the incidence of age-related macular degeneration and diabetic retinopathy among aging Veterans. This is treatable early with intravitreal antivascular endothelial growth factor (VEGF) injections delaying the onset of severe visual impairment. VA Spinal Cord Injuries and Disorders (SCI/D) System of Care is to support and maintain the health, independence, quality of life, and productivity of Veterans with SCI/D throughout their lives. The program is supported by The Veterans' Health Care Eligibility Reform Act of 1996 and VHA Directive 1176 ("Spinal Cord Injuries and Disorders System of Care", September 30, 2019). The SCI/D System of Care provides the full continuum of services, including acute rehabilitation, sustaining medical/surgical treatment; primary and preventive care including annual evaluations, provisions for prosthetics and durable medical equipment, and unique SCI/D care such as ventilator management, home-based care, telehealth, respite care, long term care, and end-of-life care (VHA '21: 158 -162). Exoskeletons, including externally powered motorized prostheses, may benefit Veterans with disabling conditions. Exoskeletons are currently being used by persons with spinal cord injuries and disorders (SCI/D) to help them stand and walk (VHA '21: 560).

More than 120,000 Veterans who receive VA health care have been diagnosed with at least one TBI.

TBI symptoms include headaches, irritability, sleep disorders, memory lapses, slower thinking, and depression. TBI manifests not only in cognitive deficits, but also with problems in behavioral health; sensory perception; and motor, endocrine, and autonomic nervous system function. Potential consequences of TBI include neurodegenerative disease, substance abuse, and other mental health issues (VHA '21: 545). Traumatic Brain Injury (TBI) and Polytrauma System of Care (PSC) provides for the treatment of TBI (whether military-related deployment related or not); Blast and non-blast related traumatic injuries including but not limited to amputations, musculoskeletal injuries and open wounds; Other acquired brain injuries including, but not limited to, stroke, brain tumors, infection, poisoning, hypoxia, ischemia, encephalopathy, or substance abuse, as appropriate for specific cases; Physical, cognitive, emotional, and behavioral impairments related to the brain injury; Impairments that are clinically and functionally significant and lead to activity and participation restrictions (VHA'21: 277). Veterans and Service members with a complex history of multiple TBIs, numerous body injuries, post-traumatic stress disorder, and emotional dysregulation have been historically underserved due to bias towards diagnosis-based medical care. Service members are eligible for VA care as per the "Memorandum of Agreement between VA and DoD for Medical Treatment Provided to Active Duty Service Members with Spinal Cord Injury, TBI, Blindness, or Polytraumatic Injuries (TRICARE Operations Manual 6010.56-M). Review of Tampa IETP outcomes in 2019 shows that 89% of participants rate their cognitive abilities as improved at the completion of the program and 92% of participants report similar improvements in their physical skills. In 2020, 80% of participants rated their physical, cognitive, and emotional functioning as improved and ranked their overall satisfaction with services received at 9.5 on a 10 point scale (VHA '21: 223-224). Headache Centers of Excellence (HCOE) provide appropriate pharmacologic management of headaches and non-pharmacologic options including cognitive behavioral therapy, physical modalities, and devices (VHA '21: 270).

Adaptive sports programs are authorized for disabled veterans and members of the Armed Forces 38USC§521A and 38CFRPart77. A monthly assistance allowance is authorized for Veterans with a disability training or competing in Paralympic or Olympic sports 38USC§322(d). The Veteran population impacted will primarily include Veterans with spinal cord injuries, amputations, traumatic brain injuries, visual impairments, multiple sclerosis, stroke, post- traumatic stress disorder, and other neurological and mental health conditions. VA is helping community organizations promote community reintegration through sports. Eligible activities range from traditional and Paralympic sports to non-traditional outdoor recreational activities such as hiking, fishing, and adventure sports. The National Veterans Wheelchair Games, co-presented by VA and Paralyzed Veterans of America, has served Veterans with spinal cord injuries, multiple sclerosis, amputations, stroke, and other neurological disorders since 1981. Founded in 1985, National Veterans Golden Age Grams serves Veterans ages 55 years and older who are eligible for VA health care. The National Disabled Veterans Winter Sports Clinic has served Veterans with traumatic brain injuries, spinal cord injuries, amputations, visual impairments, and certain neurological conditions since 1987. The National Veterans Creative Arts Competition and Festival has recognized the role creative arts therapy plays in the rehabilitation of Veterans since 1989. Since 1994 the (Training, Exposure, Experience) TEE Tournament provides adaptive golf instruction and a range of adaptive sports opportunities, in Iowa City. Since 2008, the National Veterans Summer Sports Clinic serves newly injured Veterans with complex disabilities, such as traumatic brain injury, post-traumatic stress disorder, visual impairments, neurological conditions, spinal cord injury, or loss of limb in San Diego. Women Veterans comprised 20% of the participants at the national rehabilitation events in 2020, which was an increase from 17.8% in the previous year. There has been a consistent growth the National Veterans Creative Arts Festival and Competition of 3% overall participation per year for the past three years (VHA '21: 233-235).

The 2020 Budget requests $720 million for the Caregiver Support Program, a $213.5 million (42 percent) increase over the 2019 level, to support over 27,000 caregivers through the Caregiver Support Program. Through this program, VHA provides support to those individuals who act as caregivers for Veterans. There are several support and service options for the caregiver. For example, the Caregiver Support Line at 1-855-260-3274, is available to: respond to inquiries about Caregiver services, as well as serve as a resource and referral center for caregivers, Veterans and others seeking caregiver information; provide referrals to local VA Medical Center Caregiver Support Coordinators and VA/community resources; and provide emotional support. The Program of Comprehensive Assistance for Family Caregivers (PCAFC), established in Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, allows VA to provide additional support and services to caregivers of eligible Veterans injured in the line of duty on or after September 11, 2001. Services for this group of caregivers include: monthly stipend travel expenses (including lodging and per diem while accompanying Veterans undergoing care); access to health care insurance (if the caregiver is not already entitled to care or services under a health care plan); mental health services and counseling; and caregiver training. In 2018, slightly less than 20,000 primary family caregivers were approved for the program. The Caregiver Support Program's mission is to promote the health and well-being of Family Caregivers who care for Veterans, though, education, resources, support, and services. CSP is comprised of two programs, the Program of Comprehensive Assistance for Family Caregivers (PCAFC) and the Program of General Caregiver Support Services (PGCSS). The *MISSION Act of 2018* expands the PCAFC to Veterans in two phases, Phase 1 expands to include eligible Veterans injured on or before May 7, 1975 and Phase II, which expands eligibility to Veterans of all eras in 2022. Historically, the Program of Comprehensive Assistance for Family Caregivers (PCAFC) has provided comprehensive assistance to caregivers of certain Veterans and Service members who were seriously injured during service on or after September 11, 2001(VHA '21: 412).

Readjustment Counseling Services (RCS) clients include Veterans (95%) and active duty service members (5%), along with their families, who experience challenges from deployment, combat, or other military-related trauma. Approximately 86% of clients are male and 14% female. The average age of clients is 54, and currently 49% are younger than 60 years. Over 40% of clients have served or are serving in recent combat theaters or areas of hostility such asIraq or Afghanistan,with an additional 8% having served in Desert Storm/Desert Shield. The second largest group of clients are Vietnam Veterans, representing 33% of those receiving Vet Center Services. Another 5% have served in other periods to include Bosnia, Panama, etc. 9% of those who come to RCS for services have experienced military sexual trauma, and approximately 1% of our clients come to us f or bereavement care. The client population is diverse. By self-report, 59% are Caucasian, 20% African American, and 12% Hispanic. Approximately 3.5% are Asian Americans or Pacific Islander/Hawaiian, and 1.4% are Alaskan Native or NativeAmerican. RCS provides services to individuals who have both honorable (90%) and problematic (4%) discharges, as well as those currently engaged in discharge activities (2%). RCS currently consists of 300 Vet Centers, 83 Mobile Vet Centers, and 19 Vet Center Outstations. Services for eligible individuals include individual, group, marriage, and family counseling for challenges such as the symptoms associated with PTSD, substance-abuse, suicidal or homicidal ideations, and socio-economic issues. Vet Centers also provide connection to other services and benefits available through the VA. Over the past five years, the percentage of visits by female clients has grown; less than 10% of visit were provided for women clients in 2016, growing to 14% in 2020. In 2020 RCS provided 1,753,428 readjustment counseling services visits & outreach contacts for

223,476 Veterans, Service members, and families (1.3% increase over 2015) (VHA'21 203-205).

The majority of the individuals who receive medical attention from the VA health care system are individuals who have completed military service and are considered to hold Veteran status. However, a small number of patients who are treated within the VA health care system are not Veterans. This non-Veteran population consists of individuals such as VA employees, the widows and family of Veterans, or active military. Patient records indicate the non-Veteran status. Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA): The Veterans Health Care Expansion Act of 1973, Public Law 93-82, authorized VA to provide a health benefits program that shares the cost of medical supplies and services with eligible beneficiaries. The Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, extended CHAMPVA benefits, as a secondary payer to Medicare, to CHAMPVA beneficiaries over age 65. To be eligible for CHAMPVA benefits, the beneficiary must be the spouse or child of a Veteran who has a total and permanent service-connected disability, or the widowed spouse or child of a Veteran who: (a) died as a result of a service-connected disability; (b) had a total, permanent disability resulting from a service-connected condition at the time of death; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense (DoD) TRICARE Program. CHAMPVA by law is a secondary payer to other health insurance plans to include Medicare. CHAMPVA assumes primary payer status for Medicaid, Indian Health Service, and State Victims of Crime Compensation Programs. The Veterans Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, section 102, further expanded CHAMPVA to include primary family caregivers of certain seriously injured Veterans. Eligible primary family caregivers are authorized to receive health care benefits through the existing CHAMPVA Program when the primary family caregiver is not eligible for any other healthcare coverage (including TRICARE, Medicare and Medicaid). The number of enrolled beneficiaries in CHAMPVA has increased by 5.0% on an annual basis from 2015 to 2020, and the number of unique users of CHAMPVA has increased by 4.84% annually. In 2020, CHAMPVA served 417,203 unique beneficiaries, which amounted to an annual increase of 21,849 beneficiaries (VHA '21: 2-44).

The Foreign Medical Program is a health care benefits program for United States Veterans with VA-rated service-connected conditions that are residing or traveling abroad, including the Philippines as of October 1, 2017. Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected conditions, with certain exclusions. The FMP program does not pay for Compensation and Pension exams. Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, Public Law 104 -204, section 421, VA administers the Spina Bifida Health Care Benefits Program for birth children of Vietnam Veterans diagnosed with spina bifida (excluding spina bifida occulta). Additionally, the Veterans Benefit Act of 2003, Public Law 108-183, section 102, authorized birth children with spina bifida of certain Veterans who served in Korea to be eligible for care under this program. Prior to October 10, 2008, the program provided reimbursement only for medical services associated with spina bifida; however, under the Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110-387, the program provides reimbursement for comprehensive medical care. The Blue Water Navy Vietnam Veterans Act of 2019, Public Law 116-23, Section 1116B, authorizes birth children of certain Veterans who served in Thailand to be eligible for care under this program. Children of Women Vietnam Veterans Health Care Benefits Program (CWVV): Under the Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419, section 401, VA administers the CWVV Program for children with certain birth defects born to

women VietnamVeterans. CWVV Program provides reimbursement only for covered birth defects. Under the authority of 25USC§1645(c) and 38USC§8153, the Department of Veterans Affairs (VA) established a national interagency sharing/ reimbursement agreement with the Department of Health and Human Services/Indian Health Service (HHS/IHS) in 2012 to reimburse IHS for the provision of Direct Care Services to eligible American Indian (AI)/Alaska Native (AN) Veterans (VHA '21: 337-342).

More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans enrolled over the past 5 years. The number of women Veterans using VA health care services has more than tripled since 2001, growing from 159,810 to more than 550,000 today. To address the growing number of women Veterans who are eligible for health care, VA is strategically enhancing services and access for women Veterans by investing $75 million in a hiring and equipment initiative in 2021, providing funding for a total of over 400 women's health personnel nationally--primary care providers, gynecologists, mental health providers and care coordinators. Women make up 16.5% of today's Active Duty military forces and 19% of National Guard and Reserves. Based on the trend, the number of women Veterans using VA health care is expected to rise rapidly. More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans enrolled over the past 5 years. The number of women Veterans using VA health care services has more than tripled since 2001, growing from 159,810 to more than 550,000 today (VHA '21: 14). Women are now the fastest growing cohort within the Veteran community. The percent of women Veterans is projected to increase to about 16% of the total Veteran population in 2040 from 6% in 2000. The overall Veteran population is decreasing at a rate of about 1.5% per year, while the women Veteran population is increasing at a rate of 1% per year (VHA '21: 282).

Veterans Health Care Act of 1992, Public Law 102-585, enacted November 4, 1992, authorized the Department of Veterans Affairs (VA) to provide gender-specific services, such as Pap tests, breast examinations, mammography, and general reproductive health care to eligible women Veterans. Public Law 103-452 provided authority and priority for counseling and treatment for sexual trauma incurred while on duty in the military. Public Law 114-223, Continuing Appropriations and Military Construction, Veterans Affairs, and Protection Act of 2017, removed the expiration date for IVF services and the time limits on cryopreservation of embryos and gametes. Related Agencies Appropriations Act, 2017, authorized VA to offer in-vitro fertilization (IVF) and Public Law 115-41, Department of Veterans Affairs Accountability and Whistleblower extended it. In FY 2020, approximately 34% of women Veteran VHA patients were 18 -44 years old, 42% were 45-64 years old, and 25% were 65+ years old. Within these age groups, gender-specific care was provided to 39,48, and 13% of patients respectively. As of May 2021, 82% of women overall were assigned to specially trained, and /or experienced designated women's health primary care providers (WH-PCP), which has been shown to enhance satisfaction and quality of care. The number of women Veterans using VHA services has increased from 423,642 in 2014 to 560,737 in 2020. In 2020, 34% of women Veterans were of childbearing age (between age 18 and 44), making the need for gynecologic services well-established. At the end of 2019, 80% of VA health care systems had a gynecologist on site. VA has witnessed a 154% increase in the number of women Veterans accessing VA mental health care over the past decade. Over 40% of women Veterans who use VA have been diagnosed with at least one mental health condition and many struggle with multiple, clinically complex conditions, such as trauma, mood, and eating disorders. In 2020, 79% of sites had a full or part time Breast Cancer Screening Coordinator, 72% of sites had a full or part time Cervical Cancer Screening Coordinator. Eighty-two

percent of sites have a full or part time Maternity Care Coordinator (VHA '21: 282-286).

Of 9.2 million enrolled veterans only 1.4 million are eligible for comprehensive dental care under 38CFR§17.160 – 17.166. In 2020, the 246 VA dental clinics managed the care of 494,000 Veterans. 463,000 Veterans received dental care on-site in a VA clinic. 3.6 million procedures were completed during 1.3 million visits. The remaining 31,000 Veterans received dental care exclusively through Community Care. Veterans eligible for comprehensive dental care historically increase at a rate of approximately 8%. The number of Veterans eligible for comprehensive dental care increased by 5.3% in 2020. During 2020, Veteran enrollment and the number of compensation and pension exams decreased due to the COVID-19 pandemic. The backlog estimate is 2.5 million dental procedures. Dental care provided to unique Veterans grew by an average of 2.9% per year from 2015 to 2019. However, the procedure workload has increased by 6.6%, with an increase of 3.0 % patient visits per year. Since 2015, the number of dental treatment rooms increased by 2.0% and dentist staffing increased by 2.4% per year. Given the historical annual growth rate of 8.2% for Veterans eligible for comprehensive dental care, the VA Office of Dentistry forecasts about 2.05 million Veterans will be eligible for comprehensive care in five years. The number of unique Veterans to serve in 2025 is projected at 751,000 for comprehensive dental care and 142,000 for focused care due to medical necessity, for a total of 893,000. Studies by the American Dental Association[1] (ADA) and the Centers for Disease Control and Prevention (CDC) show yearly dental service utilization up to 60% for those with third-party payor coverage in the U.S.population (Vujicic '18) (VHA '21: 97).

The average morbidity of the VA enrollee population is estimated to be approximately 32% higher than that of the general U.S. Population. The request fully supports the provision of health care that VA projects has been deferred during the COVID-19 pandemic, in addition to providing for health care services at the pre-pandemic levels. The 2022 budget ensures that all veterans, including women Veterans, Veterans of color, and LGBTQ+ Veterans, receive the care they have earned and prioritizes addressing veteran homelessness, suicide prevention, and caregiver support. While it is clear that community care will continue to be a key part of how the Department cares for its Veterans, VA remains committed to strengthening the direct health care system, expanding access including via telehealth, and pushing the boundaries of what is possible in serving our nation's Veterans (VHA '21: 12). In 2020 there were 6,975,831 unique veterans and non-veterans enrolled in the VA health care system in 2021, this number rose to 7,037,578 and is projected to increase to 7,129,733 in 2022 and 7,198,737 in 2023. The number of unique Veterans under age 65 is increasing rapidly, while the number of those over age 65 is decreasing. The number of unique patients under the age of 65 is increasing from 3,773,736 in 2020, to 3,874,692 in 2021, to 3,971,646 in 2022 and 4,060,487 in 2023. The number of unique patients over the age of 65 decreased from 3,202,095 in 2020 to 3,162,885 in 2021 and is expected to decrease to 3,158,088 in 2022 and 3,138,249 in 2023 (VHA '21: 44-47).

Long-term services and supports include facility-based programs and home and community-based services (HCBS). There are six facility-based GEC programs: VA Community Living Centers; Community Nursing Homes; State Veterans Homes (nursing homes and domiciliaries); Inpatient Hospice; Inpatient Respite; and Traumatic Brain Injury – Residential Rehabilitation. VA is legislatively mandated by the Veterans Millennium Health Care and Benefits Act (PL 106-117) to provide nursing home care for enrolled Veterans in need of nursing home care for a service-connected (SC) disability, as well as enrolled Veterans in need of nursing home care who has a single or combined SC disability rating of 70% or greater. This includes Veterans with a single disability rated 60% but who have total disability ratings based on individual unemployability. GEC honored

Veterans' preferences to receive care at home by increasing access to home and community-based services, serving 373,650 Veterans in 2020 – a 5.2% increase over 2019. In 2019, GeriPACT saw and increase of 12.65% in unique veterans over 2018 (69,851 in 2019, 61,021 in 2018). GeriPACT experienced a significant decrease in unique veterans in March of 2020 due to the COVID-19 pandemic. Before COVID measures were in effect, there was a 10.44% increase in GeriPACT unique veterans from 2019 to 2020 in the first five months (146,948 in 2019, 164,076 in 2020). As community adult day health care (CADHC) centers temporarily closed or significantly altered their services following state guidance, GEC issued an amended service plan to give these centers state-based flexibility to provide home care to Veterans, yielding only a 14% decrease in Veterans served in CADHC overall (VHA '21: 188-189). The COVID-19 pandemic identified the elevated risks to highly vulnerable nursing home residents globally. At the onset of the COVID-19 pandemic, VA Office of Geriatrics and Extended Care (GEC) immediately activated infection prevention and control safeguards geared to prevent entry of SARS-CoV-2 virus into the CLCs, prompt identification of cases and minimize spread. VA immediately implemented strong strategies to mitigate the risk of SARS-CoV-2 transmission within the CLCs: Screening residents and staff for symptoms consistent with COVID-19. Limiting admissions. Implementing a 14-day observation for Veterans returning to the CLC for continued care. Restricting non-essential personnel. Promoting consistent staffing. Promoting use of telehealth. Vaccination of CLC residents and staff (VHA '21: 189-190).

The number of Veterans experiencing homelessness in the United States has declined by nearly half since 2010. On any given night in January 2020, an estimated 37,252 Veterans were experiencing homelessness. Since 2010, over 850,000 Veterans and their family members have been permanently housed or prevented from becoming homeless. In 2018, the total number of Veterans experiencing homelessness decreased 5.4 percent, and in 2019, that number dropped another 2.1 percent. Veterans Housing Program, Native American Veterans Housing Loan Program, Vocational Rehabilitation Loan, were terminated FY 19. VA remains committed to ending Veteran homelessness. VA requests $2.2 billion for Veteran homelessness programs, an increase of 8.4% over the 2021 enacted level (base funding only). In addition, VA will obligate $486 million in American Rescue Plan funding in 2022, for a total of $2.6 billion dedicated to reducing homelessness in 2022. The 2022 request includes case management funding for the U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program. HUD announced its 2020 allocation of 4,875 new vouchers in December 2020 and anticipates an additional voucher award of up to 5,000 vouchers will be made prior to the end of 2021. In 2020, Supportive Services for Low Income Veterans and Families (SSVF), in partnership with HUD and United States Interagency Council on Homelessness (USICH), implemented the Rapid Resolution Initiative. This Initiative reunifies imminently at-risk or homeless Veterans with family or friends as an alternative to entering the homeless system. This initiative seeks to reduce overall demand for traditional affordable housing resources while simultaneously reducing trauma for Veterans and their families who would otherwise become or remain homeless. In 2020, SSVF assisted 112,070 individuals of which 77,590 were Veterans and 19,919 were dependent children.

VA's goal is a systematic end to Veteran homelessness,which means ensuring communities across the country: Have identified all Veterans experiencing homelessness; can provide shelter immediately to any Veteran experiencing unsheltered homelessness who wants shelter; and have capacity to assist Veterans to swiftly move into permanent housing. HUD-VASH is a collaborative program between the U.S. Department of Housing and Urban Development (HUD) and VA which provides eligible homeless Veterans a Housing Choice Voucher (HCV) from HUD paired with case management and supportive services from VA under 38USC§2003(b). As of September 30, 2020 100,570 vouchers were

allocated. The Grants per Diem program currently supports nearly 12,900 transitional housing beds nationwide. Health Care for Homeless Veterans (HCHV) has served as a resource for communities to assist homeless Veterans, many with serious mental illness or substance abuse issues, with transitioning out of homelessness since it was first authorized in 1987. HCHV program staff provided outreach services in 2020 to approximately 120,044 Veterans, case management to over 10,439 Veterans, served more than 49,180 through Stand Downs, and supports 3,890 operational CRS emergency transitional housing beds. he percentage of homeless Veterans exiting the CRS transitional housing into permanent housing is 56% for 2020, surpassing the measure's goal of 55%. This percentage of Veterans exiting into permanent housing has increased each consecutive year from 48% in 2017, to 51% in 2018 and then 54% in 2019. Supportive Services for Low Income Veterans & Families (SSVF) is designed to help reach the Administration's goal of ending homelessness among Veterans. SSVF provides supportive services to very low-income Veteran families that are currently in or transitioning to permanent housing or at imminent risk of losing their home. Of those placed in permanent housing, only 12% of families and 15% of individuals re-enter the homeless system one year after discharge from SSVF.

National Call Center for Homeless Veterans (NCCHV) takes over 50,000 chats per year, including an estimated 18,000 transitional service members without housing plans. Veterans Justice Outreach Homeless Prevention (VJO) program facilitates access to VA health care and other services for Veterans who are involved with the criminal justice system, and therefore face heightened risks of homelessness, suicide, and other negative outcomes. The number of VTCs and other Veteran-focused courts is now more than 600, and the number of Veteran-specific housing units in local jails is now over 100 and rising pursuant to the Veterans Treatment Court Improvement Act of 2018 P.L. 115-240. In 2019, 97% of Veterans served by VJO Specialists went on to access face-to-face VHA services. Of these Veterans: 72% were diagnosed with one or more mental health disorders, and 94% of those with such diagnoses entered VHA mental health treatment. 56% were diagnosed with one or more substance use disorders, and 72% of those with such diagnoses entered VHA substance use disorder treatment. Homeless Patient Aligned Care Team (HPACT) is a multi-disciplinary, population-tailored medical home designed around the unique needs and distinct challenges homeless Veterans face both accessing and engaging in health care. HPACTs are located in every VISN with over 194 full time equivalent staff serving over 22,000 Veterans annually. Collectively, Veterans enrolled in HPACT show a 19% reduction in emergency department visits and a 35% reduction in inpatient hospitalizations. Homeless Veterans Community Employment Services (HVCES) provides employment services and resources to Veterans participating in VHA homeless programs. Approximately 6,547 Veterans exited homeless residential programs with competitive employment and there were over 15,489 newly documented, unique instances of employment. The National Homeless Registry is a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness any time since October 1, 2005 (VHA '21: 251-262)

Chapter 14 Commercial Comparison and Room for Improvement

Patient Aligned Care Team (PACT) is a customized patient-centered medical home model of care adopted and branded by VHA. The extended PACT team staff includes, but is not limited to dieticians, clinical pharmacists, primary care mental health integration staff (psychologists, psychiatrists, licensed clinical social workers (LCSWs), registered nurses), and case managers. VHA nursing services in the primary care (PC) setting include face to face and virtual visits for direct and indirect nursing care activities. These activities include immunizations, education, preventative health strategies, inter-

professional care planning, group clinics, population health strategies, care coordination and management within VA as well as with community network providers. PC nurse staffing for 2020 included approximately 14,000 RNs and LPNs/ LVNs. Total PC nursing encounters for 2020: 72,626 VVC; 4,548,248 telephone and 1,538,581 face to face visits covering the urban, rural and highly rural veteran populations. Clinical Pharmacy Specialists (CPS) provide comprehensive medication management to initiate, modify, or discontinue medications, as well as providing disease management in areas such as pain management, diabetes, hypertension, anemia, chronic obstructive pulmonary disease (COPD), substance use disorder (SUD), heart failure, and hyperlipidemia. Strong practices during COVID-19 include outpatient alcohol detoxification, population management for high risk Veterans and contacting patients who missed doses or had late medication refills for SUD. Nutrition and Food Service (NFS) provides nutrition education, counseling and medical nutrition therapy for Veterans to address conditions ranging from basic weight management to complex tube feeding therapies. Emergency Medicine (EM) provides acute, emergent and urgent care on-demand through our 110 VHA emergency departments (ED) and 30 Urgent Care Centers (UCC). Section 134 of the MISSION Act provided federal supremacy to VA prescribers and their delegates to access state prescription drug monitoring programs (PDMP). Medication treatment for opioid use disorder (MOUD)| including methadone, buprenorphine and naltrexone| are the gold standard treatments for OUD. MOUD reduces illicit opioid use, mortality, criminal activity, healthcare costs, and high-risk behaviors (VHA '21: 91-93).

VA delivers inpatient acute and critical care in its 130 medical centers and through referral to hospitals in the community. Inpatient Care includes a broad range of treating specialties: Acute and Critical Care Medicine, Cardiology, Surgery and Surgical Subspecialties, Acute Rehabilitation, and Neurology. Three recent studies published in prominent medical journals confirm VA outcomes are superior to the private sector across a broad range of measures (DeLancey et al '17)(Price et al '18)(Weeks et al '18). Most of the better results of the VA can be attributed to lower cost sharing resulting in reduced barriers to readmission. Mortality rates across all categories, Congestive Heart Failure, Pneumonia, Acute Myocardial Infarction and Chronic Obstructive Pulmonary Disease were lower than commercial providers, and readmission rates were higher. VA Health Care demonstrated significantly better performance than commercial Health Maintenance Organizations (HMOs) and Medicaid HMOs for all 16-outpatient effectiveness measures and was significantly better for 14 measures compared with Medicare HMOs (Price et al, 2018). In adjusted models containing 808 clinics, the 77 clinics with the most PACT components in place had significantly larger improvements in five of seven chronic disease intermediate outcome measures (e.g., BP < 160/100 in diabetes), ranging from 1.3% to 5.2% of the patient population meeting measures, and two of eight process measures (HbA1c measurement, LDL measurement in CAD) than the 69 clinics with the least PACT components. Clinics with moderate levels of PACT components showed few significantly larger improvements than the lowest PACT clinics (Rosland et al, 2017). Among Veterans with heart failure, chronic obstructive pulmonary disease, hypertension and diabetes, PACT model implementation with a CPS seeing patients as part of a transitions of care program achieved a 13% reduction in 30-day readmissions and a 21% 90-day readmission for the disease state the Veteran was discharged with. (VA Tennessee Valley). Additionally, using a CPS for 20% of PCP-paneled patients created 3 extra weeks or 240 additional appointment slots per year for the referring PCP (VA Madison WI and VA Kansas City). In response to challenges related to care delivery during COVID-19, VHA instituted the following: drive thru vaccinations and lab draws, enhanced outreach through registries to high-risk patients (VHA '21: 93-95).

Comparison of Quality Outcomes between the VA and Commercial Health Care 2016 - 2019

Quality Outcomes (Mortality & Readmission)	VA July 1, 2016 – June 30, 2019	CMS July 1, 2016 – June 30, 2019
Mortality	Rate	Rate
30-day risk standardized mortality rate – Congestive Heart Failure (CHF RSMR)	8.9	11.3
30-day risk standardized mortality rate -Pneumonia (Pneumonia RSMR)	12.4	15.4
30-day risk standardized mortality rate – Acute Myocardial Infarction (AMI RSMR)	11.8	12.7
30-day risk standardized mortality rate _Chronic Obstructive Pulmonary Disease (COPD RSMR)	7.7	8.4
Readmission	Rate	Rate
30-day risk standardize readmission rate – Congestive Heart Failure (CHF RSRR)	23.7	21.9
30-day risk standardized readmission rate – Pneumonia (Pneumonia RSRR)	17.8	16.6
30-day risk standardized readmission rate – Acute Myocardial Infarction (AMI RSRR)	17.9	16.1
30-day risk standardized readmission rate- Chronic Obstructive Pulmonary Disease (COPD RSRR)	20.4	19.6
Patient Safety Indicators (PSIs)	VA Risk Adjusted Rate per 1,000 Discharges April 1, 2018 – March 31, 2020	AHRQ Nationwide Observed Rate per 1,000 Discharges from 2016 HCUP Project
Pressure Ulcer Rate (PSI 03)	0.56	0.51
Inpatient Surgical Deaths (PSI 04)	118.49	146.36

Collapsed lung due to medical treatment (PSI 06)	0.24	0.21
Postoperative Hip Fracture (PSI 08)	0.12	0.08
Perioperative Bleeding/Bruise (PSI 09)	2.19	2.29
Patient Safety Indicators (PSIs)	VA Risk Adjusted Rate per 1,000 Discharges April 1 2018-March 31, 2020	AHRQ Nationwide Observe Rate per 1,000 Discharges from 2016 HCUP Project
Postoperative Kidney & Diabetic Complications (PSI 10)	0.80	0.73
Postoperative Respiratory Failure (PSI 11)	2.94	5.53
Perioperative Blood Clot/Embolism (PSI 12)	3.00	3.45
Postoperative Sepsis (PSI 13)	2.41	4.05
A wound that splits after surgery on the abdomen or pelvis (PSI 14)	0.59	0.69
Accidental puncture or laceration from medical treatment (PSI 15)	1.25	1.06
Healthcare-Associated Infections (HAIs)	VA October 1, 2019 – September 30, 2020	NHSN/CDC
Central Line Associated Bloodstream Infection Rate (CLABSI) per 1,000 line days		
Acute Care	0.72	0.6
ICU	1.24	0.64
Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 catheter days		
Acute Care	1.01	0.79
ICU	0.63	0.81
Total Bloodstream (BSI) Infection rates per 1,000 patient months		
Outpatient Dialysis Treatment Center	0.56	0.64

Access Related Bloodstream (ARB) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.26	0.49
Total Bloodstream Standardized Infection Ratio (SIR)		
Outpatient Dialysis Treatment Center	1.05	1.0

Source: VHA '21: 101-103; National Healthcare Safety Network (NHSN), Centers for Disease Control and Prevention (CDC), National and State Healthcare-Associated Infection Progress Report March 2018; Nguyen DB, Shugart A, Lines C, et al. National Healthcare Safety Network (NHSN) Dialysis Event Surveillance Report. *Clin J Am Soc Nephrol* 2017; 12:1139-1146

The most significant reason that VA health care is superior to commercial health care is that VA health care costs to the working age patient are significantly less than private insurance. Out-of-pocket costs range from free to the cheap side of reasonable, similar to the Military Health Service. The price advantage becomes less when Veterans become eligible for Medicare when they retire or turn 65 and are automatically enrolled in somewhat affordable Supplemental Medical Insurance Part B, they would have to file a form to cancel the plan and stop being garnished under threat of penalty, that requires Part C to pay the still quite expensive out-of-pocket deductibles, copays and other cost-sharing expenses, and Part D drug plan. After having to pay all that money elders are inclined to use the commercial health services Medicare pays for. However the extortionate and abusive commercial health prices present a barrier to care, especially readmission after the provider has shamefully engaged in identity theft with the "enemy" now. However, the extortionate commercial billing practice has a detrimental impact on health care quality in general, and there is an institutional tendency to utilize the most expensive procedure possible, no matter how dangerous. This is harmful to medical knowledge and the damage to public health authority can range from placebo, medical negligence to prescribe precision medicine, to outright poisonous abuse, that can impair VA health care practice via their possibly authoritarian belief in public health government, no matter how corrupt. VA's cost of providing inpatient maternity care is increasing due to high health care trends for maternity services in the private sector (most maternity care is purchased) and an increase in utilization due to the growth in enrollment for younger, female Veterans (VHA '21: 405) with increased utilization, maternity costs should go down due to the law of diminishing returns. Enrollee reliance on VA for dialysis services increased from 29% in 2011 to an estimated 44% in 2019 and is expected to continue to increase through 2027. This increase in reliance is due in part to lower cost sharing in VA compared to Medicare (VHA. 21: 403).

As of 2021, at a total cost of about $100 billion for 7 million unique enrollees, not including other than honorable discharges treated to mental health care, the per capita cost of VA health care is $14,286. In comparison Military Health Service costs $60 billion to treat 9 million healthy, when uninjured, soldiers, their families and some retirees, a per capita cost of $6,666. Medicaid costs state and federal governments $522 billion for 77 million, a per capita cost of $6,779. Medicare costs $906 billion for about 65 million, a per capita cost of $13,939, not including out-of-pocket payments. It is not certain whether better VA health outcomes than commercial health care, are the result of having the highest

per capita cost, of any public health insurance program, or simply because they do not abusively bill their patient, just the all-mighty federal government. It is unfortunate that medical hyperinflation to taxpayers compromises the integrity of VA health care. Military Health Service prices are not hyper-inflationary and the quality of care is believed to be high, although comparatively understudied, however recently they have been exhibiting another hidden danger of the command economy - attrition from unnecessary budget and staff cuts that seems to be opportunistic of their cost consciousness without respect for the inexorable force of inflation and population growth. What is wanted from the VA health care system is that their outrageous 10% spending and 5% employment growth be normalized, without any counterintuitive zero growth punishment phase, to annual 3% spending and 1% net employment growth while enrollment is expanded to cover all Veterans, nearly all the time, with high quality health care, that does not excessively bill the patient.

Advancements in medical technology and pharmaceuticals occur regularly, though the timing of these inventions is difficult to predict. Examples include the widespread introduction of magnetic resonance imaging over the past two decades, advancements in prosthetics for lost limbs, and the discovery of more effective Hepatitis C treatments in the mid-2010s. Improvements in health care, especially life-saving treatments, tend to reduce mortality rates over time, improve overall health (morbidity) and extend lifespans. However, short-term breakthroughs, especially the introduction of new and expensive pharmaceuticals, contribute to uncertainty over the shorter-term budget horizon. For example, the introduction of Harvoni and related Hepatitis C drugs beginning in 2014, which had an initial price approaching $100,000 per patient, came to market quickly and within the time frame of the three- year budget projection. The Budget Scenario does not assume any changes in health care practice due to COVID-19. VA continues to evaluate emerging experience and available information to assess this assumption and will revise the assumption if appropriate (VHA '21: 5429, 430).

Not all medical innovations, that dramatically improve health care outcomes, come with a higher price. Precision medicine often dramatically reduces costs because it cures the patient, eliminating the need for more expense to treat that same condition completely, everyone happy. More often than not curative “precision medicine” involves certain cheap generic antibiotics, specifically doxycycline and metronidazole, or over-the-counter, herbal remedies and medicinal bathing. Case in point, tell the people, “hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus; eucalyptus or lavender also cure influenza”. Going forward, to reduce costs and improve outcomes by correcting for corruption due to greed, the VA needs to better incorporate the recommendations of proven research, in particular their 20 doctors of osteopathy (ODs), into their practice, so that they are not prescribing expensive and often placebo medicines, when readily available curative remedies are cheap, safe and highly effective at curing otherwise chronic and/or expensive conditions. For instance, to faithfully uphold the Hippocratic Oath, to not use the knife, even for stones, to cure urinary and gallstones overnight, it is necessary to prescribe $10 Stonebreaker (Chanca Piedra), not for use in pregnant women.

Nonetheless, despite its high cost, the VA's implementation of the National Viral Hepatitis Program is a great success, the medicine, not only works, it costs much less now that it is has been mass produced. VA’s National Viral Hepatitis Program is governed by VHA Directive 1300.01 and Title 38USC§7301(b). Treating and curing hepatitis C virus (HCV) among Veterans in VA care has been a high priority for VA and the Congress. Chronic infection can lead to scarring of the liver (e.g., fibrosis or cirrhosis), and in some cases, those with cirrhosis will go on to develop liver failure or liver cancer. In 2020, 172,372 living Veterans in the Department of Veterans Affairs (VA) care had a history of

chronic HCV infection. Of these, 150,250 have been cured of their infection, with the remainder awaiting treatment. Among those with a current or prior history of HCV infection, an estimated 39,522 have advanced liver disease or cirrhosis. Average treatment cost between $11,000 and $16,700 per treatment course for 2021 through 2022. The number of people enrolled in VA Hep C care has declined from 28,471 in 2017 to a high of 5,200 or low of 3,200 in 2021 and 2022. Total medication costs have declined from an estimated $626 million in 2017 to $87 million 2021 and 2022. The Hep C campaign has been highly successful at curing chronically infected individuals (VHA '21: 218-220). Starting in January 2014, the U.S. Food and Drug Administration (FDA) approved multiple, highly effective, less toxic direct acting antiviral (DAA) drugs for the treatment of HCV, all of which are available on the VA National Formulary (VANF). DAAs are molecules that target specific nonstructural proteins of the virus and results in disruption of viral replication and infection. There are three classes of DAAs, which are defined by their mechanism of action and therapeutic target 3/4A (NS3/4A) protease inhibitors (Pis) such as elbasvir/grazoprevir (Zepatier), sofosbuvir/velpatasvir/voxilaprevir (Vosevi), and glecaprevir/pibrentasvir (Mavyret), NS5B nucleoside polymerase inhibitors (NPIs), such as ledipasvir/sofosbuvir (Harvoni), sofosbuvir/velpatasvir (Epclusa), and sofosbuvir/velpatasvir/voxilaprevir (Vosevi), and all are NS5A inhibitors (Poordad '12). Harvoni, Zepatier and Epclusa may require Ribivarin (Morgan et al '21: 18-24).

Indian Health Service (IHS) estimates between 40,000 and 100,000 American Indian and Alaska Native people are living with Hepatitis C (HCV). The CDC estimates that of 3.5 million persons in the U.S. with HCV, approximately 3.4%, 120,000 identify as AI/AN. This is more than twice the rate of other races and explains why AI/AN people have the largest increase of liver and intrahepatic bile duct cancer compared to any other race/ethnic groups. IHS is advised to develop a program to cure Hep C based upon the treatment regime prescribed in *Chronic Hepatitis C Virus (HCV) Infection: Treatment Considerations from the Department of Veterans Affairs*. Under the authority of 25USC§1645(c) and 38USC§8153, the Department of Veterans Affairs (VA) established a national interagency sharing/ reimbursement agreement with the Department of Health and Human Services/Indian Health Service (HHS/IHS) in 2012 to reimburse IHS for the provision of Direct Care Services to eligible American Indian (AI)/Alaska Native (AN) Veterans. VA also anticipates continued growth in its partnerships with Urban Indian Organizations (UIO), as authorized in Division FF, Title XI, Western Water and Indian Affairs, section 1113 of P.L. 116-260, Consolidated Appropriations Act, 2021 (VHA '21: 221). The IHS is anticipating a large increase in their FY 2022 funding, sustained by their advanced appropriations, with which to afford expensive Hep C treatment.

VHA's National Human Immunodeficiency Virus (HIV) Program is responsible for providing primary guidance and advice to the Under Secretary for Health on policy and services related to prevention, diagnosis, treatment, and care of Veterans living with HIV infection (VLHIV). This national program falls under the HIV, Hepatitis, and Related Conditions Programs Office (HHRC), within the Office of Specialty Care Services. There are currently two drugs approved by the FDA for pre-exposure prophylaxis to prevent HIV infection (PrEP), Truvada (emtricitabine/tenofovir disoproxil fumarate) and Descovy (emtricitabine/tenofovir alafenamide). Both of these drugs are available on the VA National Formulary (VANF) for treatment of HIV infection. As of June 30, 2020, over 3,400 Veterans in VA care were receiving PrEP. 4.0% of eligible Veterans received HIV screening during CY 2020; by the end of this CY, 46.8% of Veterans in care had been tested at least once for HIV. VA is the single largest provider of HIV care in the U.S., with over 31,000 Veterans diagnosed with HIV in care during 2020. Of these, 86% were on antiretroviral therapy (ART) during 2020; of those patients on ART who had labs drawn during 2020, 93% had complete suppression of HIV in the blood, a

therapeutic goal known as viral suppression. Of VLHIV in VA care in FY2020, 78.4% were 50 years of age or older and 3.6% were women. Among VLHIV in VA care in 2020, 49% were Black, and 43% were White. VA is a federal partner in the National HIV/AIDS Strategy (NHAS), an ongoing initiative by the White House Office of National AIDS Policy aimed at having 95% of people living with HIV in the US aware of their status by 2030, with 95% of these retained in care by 2030, and 95% of those on ART achieving viral suppression by 2030 (VHA '21: 269-273). ART is explained in Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV June 3, 2021.

With an estimated 50,000 new cases annually, VA is committed to providing access to the best possible cancer care through expansion and innovation. Programs will specifically address Women's Cancer Care, Rare Cancers, genetic counseling and genetic consultation in 2022 to build upon efforts in 2020 and 2021 to advance TeleOncology and Precision Oncology care. The United States, and by default the VA, are facing a shortage in oncologists, geneticists, and genetic counselors over the next 4 years. While the VA cannot compete with the salaries offered by the private sector for the best oncologists, the VA can offer incentives such as: partnerships with National Cancer Institute (NCI) designated cancer centers, partnerships with academic affiliates, research opportunities, and working within the largest Telehealth program in the country. The National Precision Oncology Program (NPOP) provides cutting-edge clinical tumor DNA sequencing that guides cancer treatment decisions. Rare cancers have been defined by the Rare Tumor Initiative at the National Institute of Health's National Cancer Institute as those affecting fewer than 200,000 total people in the US or less than 40,000 annually. In the VA annually, rare cancers comprise 8,000 new cases and make up approximately16% of all cancer cases. Additionally, in 2017 it was estimated that $846 million was obligated to combat rare cancers and 85% of this was for treatment (these calculations include VA and Community Care). According to available data, approximately 1 in 8 women will be diagnosed with breast cancer in their lifetime. Women are more likely to be diagnosed with breast cancer after the age of 50. It is estimated that approximately 700 Women Veterans are diagnosed with breast cancer annually. Staff will be organized into teams that will focus on and have expertise in specific areas of oncology such as thoracic oncology (lung cancer), genitourinary cancer (prostate, bladder, kidney cancers) and hematological malignancies (lymphoma, leukemia, myeloma) brain tumors, sarcomas, benign hematology,and breast cancer. Additionally, VA will also have specialists in genetic counseling and pharmacogenomics to support these oncology care systems. In the US there are 10 to 15 genetics professionals per 1,000,000 residents (Hoskovec et al '18).

VA investigators are working to enhance traditional therapeutic trial opportunities. For example, immunotherapy has shown durable benefit in approximately 20% of lung cancer patients but most of the lung cancer population shows resistance and/or no benefit from immunotherapy due to immune checkpoint blockade. Clinical trials that combines chemotherapy drugs with checkpoint inhibitors (immunotherapy) can reduce cancer progression while increasing anti-tumor immune response thereby increasing the efficacy of checkpoint inhibitors (i.e. enhance the efficacy of immunotherapy). VA researchers using traditional therapeutic approaches would benefit from additional funding support (VHA '21: 555). Clinical trials are the gold standard for evidence-based medicine and practice. They enable clinicians, patients, and policymakers to know whether new treatments are effective and safe and which options among existing therapies may be better to use in different situations (VHA '21: 572). ORD's goal of increasing the substantial real-world impact of research is guided by the VA Research Lifecycle, as described in the October 2019 issue of *Medical Care*. Before research can be effectively translated into real-world practice, innovations generated by researchers require additional development, validation, and implementation (VHA '21: 574). One current trial, VA's Colonoscopy

Versus Fecal Immunochemical Test in Reducing Mortality from Colorectal Cancer (CONFIRM), completed enrollment of 50,000 Veterans in late 2017, making it the largest single clinical trial in VA history. The trial is expected to provide definitive guidance on the best methods of colorectal cancer screening to prevent death (VHA '21: 571).

Two studies have suggested cancer patients, especially those receiving treatment, are at increased risk from the disease (VHA '21: 237-239). Exposure to monoclonal antibodies leaked from oncology are a leading, malicious cause of localized pain. More than 900 chemicals have been determined to be capable of inducing cancer in humans or animals after prolonged or excessive exposure. Cancers, especially when caught early, go into remission or go away entirely, when toxic exposure is eliminated. Hydrocortisone crème cures precancerous hard lung nodules caused by pulmonary aspergillosis, that elaborates a carcinogenic aflatoxin, should be tried early. Leukemia can result from chemically induced changes in bone marrow from exposure to benzene and cyclophosphamide and methotrexate chemotherapy, among other toxicants. Many cancer patients are cured with a vegan diet. The cancer diet is completely different from normal nutrition. It is limited to fresh juices of fruits, leaves and vegetables; large quantities of raw fruit and vegetables are given in their natural form, or finely grated, salads of fresh leaves, fruits and vegetables, vegetables stewed in their own juice, soups, compotes, stewed fruit, potatoes and oatmeal. Potatoes may be excluded. All must be prepared fresh and without addition of salt. After six to twelve weeks, animal proteins are added in the form of cottage cheese (saltless and creamless) and probiotic yoghurt. A good number of patients follow this prescription, are cured and live a normal life after five and more years (Gerson '90: 139, 217).

However, cancer is a deadly disease, and if reasonable caution with toxic exposure, diet and exercise do not result in a cure cancer treatment is in order. Cancer is treated by surgery, radiation and chemotherapy. If tumors are relatively small, detectable, and in convenient sites, then surgeons can remove them. The real problem in cancer treatment comes from the spread of disease throughout and between tissues. Once a cancer clone has evolved to this stage of territorial exploration, the knife is redundant and the blunter instruments of ionizing radiotherapy and chemotherapy are used (Greaves '00: 239). Hormone therapy, as a cancer treatment, either reduces the level of specific hormones in the body or alters the cancer's ability to use these hormones to grow and spread. Cancers that are most likely to be hormone-receptive include breast cancer, prostate cancer, ovarian cancer and endometrial cancer. Various drugs can alter the body's production of estrogen and testosterone. Anti-hormone drugs, such as tamoxifen (Nolvadex) and toremifene (Fareston) for breast cancer, and the anti-androgens flutamide (Eulexin) and bicautamide (Cadodex) for prostate cancer, block cancer cell's ability to interact with the hormones that propel cancer growth without reducing the body's production of hormones.Radiation is invariably fatal if used on cancers that were caused by radiation, but can be curative once, after which radiation therapy is precluded by prior exposure. The best method of cancer treatment is to treat a laboratory confirmed diagnosis in accordance with the most likely treatment in the review of clinical trials by the National Cancer Institute PDQ (Physician Data Query).

An estimated 5.5 million Americans, most of them age 65 or older, have Alzheimer’s disease and related dementias (AD/ADRD). In 2020, the prevalence of Veterans with AD/ADRD is 758,000; as many as 409,000 of them are enrolled with VA for their health care. The prevalence of VA enrollees with AD/ADRD is expected to increase by 20% to 492,000 by 2033. The burdens on caregivers and health care costs from AD/ADRD are enormous (VHA '21: 569). The leading concern with AD/ADRD is that statin cholesterol reducing drug use causes the brain to shrink and unless the patient is inoculated with Pneumovax the brain becomes immediately infected with pneumococcal meningitis.

Although antibiotics can cause remission, the brain does not heal fast enough and the patient becomes reinfected. It is absolutely essential that statin consumers are inoculated with Pneumovax to prevent and cure pneumococcal meningitis. Meningococcal vaccine is also recommended to prevent serious infection. AD/ADRD patients must not consume statin drugs, that are highly contraindicated for everyone because of the brain damaging side-effect, aggravated by their convincing biased research propaganda, and ability to tolerate exposure to un-washable animal laboratory research cardiotoxin contaminated fabrics that must be thrown away. Pseudo-ephedrine also dangerously shrinks the brain and causes insomnia, but is not so commonly abused in geriatric medicine, usually (il)legal counterintelligence, unless available to a violent intimate partner, it is not immediately infective, but after time the brain shrinkage will become infected and prevent a successful recovery, Pneumovax is advised. Several species of *E. coli* elaborate a verocytotoxin that causes senility and bottled water is advised for drinking and cooking (Kamali et al '09). Red meat should be avoided to eliminate exposure to Jakob-Creutzfeldt virus (JCV), Mad Cow disease, and reduce heart disease risk. 5.5 percent of the presumed Alzheimer's victims were found actually to have CJD. Another study counted 13 percent (Robbins '01: 144, 145, 146, 149, 150).

VA providers are implementing best practices in stroke care based on a national directive informed by researchers at the Indianapolis VAMC through the Acute Ischemic Stroke (AIS) Directive. These best practices led to improvements in the rate of thrombolysis (breaking down of blood clots formed in blood vessels through medication) among eligible Veterans from 8.4% in 2007 to 69% in 2017 (VHA '21: 578). A stroke is a sudden loss of function of part of the brain. Usually the cause is either ischemic stroke; sudden loss of blood flow to part of the brain because an artery that supplies blood to that part of the brain has become blocked (ischemia) due to atherosclerosis, in 87 percent of strokes or hemorrhagic stroke; bleeding (hemorrhage) into the brain because an artery has burst, due to high blood pressure in 7-10 percent of cases (Spence '06: 3). Care must be taken not to administer clot-busters to hemorrhagic stroke patients. Getting treatment for an ischemic stroke within three hours of the onset of symptoms with recombinant tissue plasminogen activator (rtPA) can dissolve clots and lessen disability by 40 percent if it is administered within three hours of an ischemic stroke. A hemorrhagic stroke caused when a blood vessel breaks and bleeds into the brain is much harder to treat: more than half are fatal (Horstman '12: 70, 72). rtPA (recombinant tissue plasminogen activator) is for mild strokes only <25 on the NIH stroke scale, in patients age <80, without hemorrhage, anticoagulant use or elevated blood pressure (Hazinsky '10: 18-19). Hemorrhagic strokes may require treatment with surgery or laser to stop the bleeding. Atropine and pralidoxime (DuoDote®) is indicated for the emergency treatment hemorrhagic strokes caused by poisoning by sarin or organophosphorous nerve agents as well as organophosphorous insecticides and galantamine lucid dreaming pill (LaBerge '03)(Newmark '19).

Public Law (P.L.) 114-198, Title IX, §933, Jason Simcakoski Memorial and Promise Act (Jason's Law), signed into law July 22, 2016. Efforts are underway across VHA addressing the requirements of P.L. 114-198, §932 and §933, which directed the planning for, and expansion of, Complementary and Integrative Health services. The Whole Health System creates the healthcare approach that optimizes the benefits of complementary and integrative health services and self-care. In March 2020, the VHA Governance Board approved the increased emphasis on Whole Health Clinical Care to reach more high-risk Veterans proactively in Mental Health, Primary Care/Mental Health Integration, and Primary Care by building upon the previously approved adoption of the Whole Health System of approach. During the first two quarters of 2021, there have been 529,495 Whole Health encounters in VHA bringing the total number of Veterans reached by Whole Health to 346,629 (7.41% of enrolled Veterans). Veteran-participants dealing with chronic pain or mental health issues are experiencing a

reduction in symptoms and a reduced need for long-term opioid therapy. The Whole Health System centers around supporting the Veteran to improve their overall health and well-being. It integrates peer-led personalized health planning, use of Whole Health Coaches and well-being classes, with both allopathic (conventional medicine) and complementary and health approaches (e.g., stress reduction, yoga, tai chi, mindfulness, nutrition, acupuncture, and health coaching) that focus on Veterans' goals and priorities (VHA '21: 263-268). Herbal medicine and the Marine Corp Physical Fitness Test (PFT) – 50-100 crunches, 50-100 push-ups and 3 mile run, obviously require more emphasis.

During the pandemic, nationwide health care utilization saw a reduced amount of care provided in 2020 and 2021 as individuals chose to defer certain care. It is anticipated that there will be a resulting surge in care in late 2021 continuing through 2022 to fulfill previously deferred services. Whether Veterans cancel their own appointment or VA cancels the appointment for safety reasons, VA carefully reviews each cancellation to ensure Veterans who need care receive it. While taking proactive steps to avoid unnecessary in-person appointments during the pandemic, in 2020, VA completed more than 75 million Veteran visits, including over 45 million in-person, 27 million by telephone, and over 3.4 million by video visits to-the-home. Video-to-home telehealth visits increased more than 1,700% between February 2020 and January 2021 (VHA '21: 17). Section 8008 of the American Rescue Plan Act of 2021 (P.L. 117–2) provided $80 million to establish the Department of Veterans Affairs Emergency Employee Leave Fund. The law directed that the funds be available for payment to the Department for the use of paid leave by any employee appointed under chapter 74 of title 38, United States Code who is unable to work due to certain circumstances resulting from the COVID-19 pandemic. The authorization for the paid leave under Section 8008 is from the date of enactment of the Act, March 11, 2021, through September 30, 2021. The period of availability for Section 8008 funding is from the date of enactment of the Act, March 11, 2021, through September 20, 2022 (VHA '21: 63-64). Copayment billing suspension began in April 2020 and continues through the end of FY 2021, and 2021 mandatory and grand total obligations include the projected $300 million in obligations to reimburse Veterans for copayments, pursuant to the American Rescue Plan Act section 8007 (VHA '21: 64).

Uncertainty regarding the timing and location of the next surge or surges in cases across the country underscored the importance of portable capabilities (e.g., 24-bed Intensive Care Unit that can be transported) for VA health care's Fourth Mission role in future public health emergencies. VA has accepted over 150 COVID-19-related missions to date in 47 states, the District of Columbia, American Samoa and Guam from the Federal Emergency Management Agency (FEMA) to protect Veterans and non-Veterans alike. VA deployed over 4,700 staff to support these missions. This included sharing medical equipment with health care facilities that were stressed and admitting almost 500 non-Veteran patients into VA facilities when stressed facilities needed to decompress their inpatient hospital bed demands. VA deployed staff, testing, and supplies to support community institutional care facilities across the country, including State Veterans Homes. Other assistance provided included laboratory specimen collection, laboratory analysis of COVID- 19 samples and clinical staff augmentation at community and Indian Country hospitals and clinics (VHA '21: 17). As a result of the global COVID-19 pandemic, most VA facilities have seen wide fluctuation in the numbers of admitted patients, most notably during community surge events. Overall, in-hospital mortality is lower than in the subset from March 1 through May 31, 2020, concordant with observations outside VA that mortality rates are going down. Factors such as changing age demographics, medical comorbidities, and better evidence-based treatment may in part explain these differences (VHA '21: 103).

Feb. 28 – Nov. 12, 2020	Numbers
Hospitalization for COVID-19	15,462
ICU Admission	7,029 (45.5%)
Mechanical Ventilation	1,610 (19.7% of ICU)
In-Hospital Mortality	1,838 (11.9% of total)
State Veterans Home Patients Hospitalized in VA	584
4th Mission Civilian Patients Hospitalized in VA	296
March 1 – May 31, 2020	
Veterans Hospitalized for COVID-19	3,948
Length of Stay, days (IQR)	8.6 (3.9-18.6)
ICU Admission	1,421 (36.5%)
In-Hospital Mortality	828 (21.0%)

Source: VHA '21: 103; Cates J, Lucero-Obusan C, Dahl RM. Risk for In-Hospital Complications Associated with COVID-19 and Influenza—Veterans Health Administration, United States, October 1, 2018 –May 31, 2020. *MMWR Morb Mortal Wkly Rep* 2020; 69:1528–1534 (VHA '21: 103)(Cates et al '20).

While 11.9% may be an improvement over 21% in-hospital mortality in the beginning of the pandemic, this is the highest mortality rate advertised on the Internet. There is no evidence that the VA knows how to either diagnose or treat coronavirus. Coronavirus begins with allergic rhinitis, that decends to the lungs in about three days, that fill up with fluid causing death. Public health authorities have confused influenza with coronavirus symptoms to the point that FDA combination coronavirus tests, test positive for coronavirus, whether influenza or coronavirus. The FDA refuses to inform the public that eucalyptus cures both influenza and coronavirus, otherwise the treatment is different. However, a mentholyptus cough drop costs less than a quarter the price of a coronavirus test or billions to be made from a completely placebo seasonal influenza vaccine, no matter anyone who actually gets infected might die because they and their doctor don't shop right, if at all. In the beginning of the pandemic, public health authorities quarantined physicians, whose properly symtomatic, but habitually untreated, patients tested positive for COVID-19, wherefore testing centers were created to route patients to the hospital, to bypass primary care entirely. To make matters worse the influenza and coronavirus test industry notoriously leaks, both spontaenously, and on demand of media leaks for live viruses for vaccine research, that escalate most World Health Organization (WHO) infringed pandemics. Most hospitals secretly treat their COVID-19 patients with corticosteroids, specifically intravenous dexamethasone, but this is overkill. Staff obiously don't take their own IV league medicine, every time they get allergic rhinitis, from every 5% exposure, through a respirator, to a severely infected patient. President Trump's curative dexamethsone treatment revealed that hospital doctors are strangely ashamed to provide this curative treatment, and make strange retraction of the obvious noises, that are understood only by the bizarre health propaganda news media and public health authorities, who happily perpetuate everyone's ignorance, despite the credible evidence for corticosteroids everyone

witnessed. The right conventional allopathic medical treatment for coronavirus media is to smear a dab of over-the-counter hydrocortisone creme on the nose and chest. The relief is instant and the cure is lasting if not reinfected. However, corticosteroids, including hydrocortisone, cause Cushing's disease as a side-effect, and staff and patient are not inclined, to treat themselves with hydrocortisone creme everytime they get coronavirus allergic rhinitis during a pandemic and become life-threateningly, dangerously contagious to a pulmonary patient, whose last resort is hydrocortisone creme. Therefore it must be held, hydrocortisone, eucalpytus, lavender, peppermint or salt helps water cure coronavirus; eucalyptus or lavender also cure influenza.

Similar to the methicillin resistant *Staphylococcus aureus* (MRSA) heart attack with 50% mortality of hospital admissions in 1977, that has been reduced in recent years by immediate triage for expensive bypass surgery, going to a highly contagious hospital, may be the worst thing a person can do for coronavirus. MRSA heart attack is sterilized by swimming in a saline or chlorine pool and the reinfectable lesion(s) are eliminated with Hawthorn, the supreme herb for the heart, or doxycycline or clindamycin in pregnant women and children under age 8. The death of the English Prime Minister's hospital nurse, right after his release from ICU, seems to indicate young, inexperienced, and highly contagioius hospital staff, don't necessarily know how to treat either their occupational allergic rhinitis, nor their MRSA. More experienced staff do their medicinal bathing in a saline, chlorine or mineral water swimmming pool or Epsom salt bath, in such absolute secrecy, they probably don't know why they go swimming everyday themselves, or suffer some aches and pains, digging for gold – the damaged organs of others. Showering daily with a decent antibacterial soap is probably enough to prevent death from coronavirus, but it doesn't reliably cure the allergic rhinitis without proper medicated eucalpytus, lavender or peppermint soap. While MRSA may take some time to sterilize and other treatment, usually doxycycline or clindamycin, may be needed to eliminate any reinfectable lesions, medicinal bathing is the most instant and complete cure for coronavirus. Medicinal bathing is far quicker and easier than child defective vaccines that take two shots, weeks apart, to cure a patient and don't confer any long lasting immunity, but are nonetheless wanted to be incorporated into inpatient hospital treatment of coronavrius, as a thorough cure. Medicinal bathing is the most effective method for curing coronavirus. All that is needed is to submerge the head in salinated water and instead of fruitlessly digging for gold, the allergic rhinitis is instantly cured, out comes sterile mucous in a quick blow; the patient is cured until re-exposed.

The VA and everyone, must learn the lesson that hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus, and eucalyptus or lavender also cure influenza, to end the COVID-19 pandemic, and greatly improve the response to future SARS and influenza pandemics, vaccine monopolization of the government and news media is notoriously unsatisfactory at eliminating. Coronavirus treatment is safe and cheap. Although vaccination may cure coronavirus in two doses and reduce the risk of further severe infection and death, COVID-19 vaccination does not alleviate the need to know how to treat the contagious "Pinocchio nose" nor truly end the pandemic. The lesson that must be learned, before the “snot nosed children” return to school is: Hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure allergic rhinitis from coronavirus. Eucalyptus or lavender also cure the wet cough of influenza. Mentholyptus cough drops are the front line treatment for both influenza and coronavirus, with a little nose washing, keep the infection out of the lungs. To end the COVID-19 pandemic the most effective strategy to achieve herd immunity is probably to place eucalyptus, lavender or peppermint soap in public restrooms, with instruction to “wash face and nose”. Lysol is an effective environmental cleanser that cures as it cleans, to overrule the new brain damaging ammonia

prescribed by the EPA. To replace the ineffective mucous drying air purifiers prescribed by CDC, schools, hospitals, intensive care units (ICUs), waiting rooms and public airspaces of all sorts may be sterilized of both influenza and coronavirus with eucalyptus scented humidifiers (diffusers) last reported to have been used by the grandmothers of snot nosed Baby Boomers in the 1950s.

Although MRSA may have been mistaken for leprosy, that also certainly benefits from washing in medicinal water, the story of John the Baptist helps to teach about the healing qualities of bathing in water (John 1: 26)(Luke 3: 7)(1 Peter 3: 21). In regards to coronavirus the need to submerge one's head in saline to effect an instant cure, must be put on a metaphorical platter (Mark 6: 24), to avoid or at least witness the suicide attacks on the brain and medicine adulterating assaults of the authorities on over-the-counter coronavirus cures, such as menthol tobacco under 21USC§387b. The disciplined retreat from the completely demolished Tubercular Hospital in Fort Bayard, New Mexico to the condemned Army and Navy General Hospital in Hot Springs, Arkansas under 24USC§18-20 to Battle Mountain Sanitarium Reserve in Hot Springs, South Dakota under 24USC§153-154 has perfected the lesson that hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus for the clinical trial of the, partially dysfunctional due to untreated COVID-19 pandemic, VA Black Hills Health Care System to bring medicinal bathing in saline, chlorine or healing mineral water, back into practice for the curative treatment of coronavirus contagious allergic rhinitis, with a mentholyptus cough drop for pulmonary COVID-19 or influenza patients, topical and arthritic MRSA pursuant to 21CFR§330.10 and 42USC§300u.

Medicinal bathing in saline, chlorine or medicinal mineral water, is the most effective method of curing coronavirus. Submerging the head instantly cures the contagious allergic rhinitis perpetuating the COVID-19 pandemic. Medicinal bathing, usually in an Epsom salt bath or hot-tub, is also the frontline daily treatment for occupational, hospital or community acquired MRSA. The peer reviewed literature is extremely vague on MRSA treatment. The Italian literature emphatically recommends doxycycline to treat gastroenteritis caused by MRSA, but without metronidazole to treat antiobiotic resistant *Clostridium difficile* Pope Francis had to have half his intestine surgically removed. Although the only article believers rely on mostly treats on resistance of MRSA to salt, the best advice is, *S. aureus* regulates its salt intake. Disrupting this mechanism, or oversaturating it means the bacteria either absorb too much salt from their environment, or lose too much water – causing them to dehydrate and die (Gründling '16). Generally, salts are well-absorbed from bathing in salinated waters, and it has long been held that certain mineral springs possess healing qualities that treat arthritis, backpain and other crippling conditions, although pools have been chlorinated, the literature has not been updated to target modern medicine resistant MRSA with saline. However, hospital, community and SSA disability questionnare sacrum and ankylosing spondylitis monoclonal antibody related outbreaks of MRSA are becoming less common as the effectiveness of Epsom salt, saline, chlorine and mineral water bathing, and to a lesser extent cleaning, become common knowledge. Saline sterilized *Staph* lesions may require further treatment with doxycycline or clindamycin in pregnant women and children under 8 or a site specific natural remedy such as Hawthorn, the supreme herb for the heart, to avoid reinfection. An Epsom salt bath is usually adequate to cure back pain caused by spinal deforming MRSA lesion, but it may take a week for the lesion to go away entirely.

Chapter 15 Mental Illness, Substance Use, Abuse and Suicide Prevention

In 2019, 51.5 million adults had a diagnosable mental illness, an 18% increase over 2008 and 5% over 2018 the prior year. These mental health challenges have accelerated during the COVID-19 pandemic,

particularly for vulnerable populations. In June 2020, adults reported anxiety disorder symptoms at 3 times the level reported in 2019 and depressive disorder at 4 times the level reported in 2019. In a recent study of U.S. adults, more than 40% of respondents reported adverse mental health or increased substance use in June, 2020. The COVID-19 pandemic has been associated with mental health challenges, including suicidal ideation. In June 2020, about 11 percent of CDC survey respondents reported seriously considering suicide in the prior 30 days. This rate was significantly higher among young adults, minority racial/ethnic groups, black respondents, unpaid caregivers, essential workers and people receiving treatment for preexisting psychiatric conditions are disproportionally impacted (Substance Abuse Mental Health Services Administration FY 22) by rising "germaphobia" defined as a malinformed or irrational fear of germs and/or their treatment – specifically everyone must be informed hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus. Surprisingly, preliminary reports indicate that although mental illness diagnosis and reports of suicidal ideation are up, the actual suicide rate in the initial months of the COVID-19 pandemic declined -6% in the United States (Deisenmhammer et al '21) and -2% globally (Pirkis et al '21), however adolescent suicide attempts increased 50% in the United States Hill et al '20).

The reduction in suicide statistic may however be deceptive because of high rates of utilization of two medical methods of suicide. One, instead of using the plethora of safe and effective over-the-counter remedies for coronavirus, the public health authorities hopelessly refuse to advertise in the news media, the suicidal maniac can simply allow the infection to descend into their lungs and kill them, whereby the cause of death is ruled COVID-19, or they can utilize hospital treatment for COVID-19 that comes with a mortality rate reported to be as high as 10% by the VA – suicide death by untreated coronavirus alone or under hypocritical and contagious hospital care. Two, since the pandemic fatal overdoses increased 20% between 2019 and 2020, especially synthetic opioid – fentanyl – and also psycho-stimulant overdose – methamphetamine and pseudo-ephedrine (SAMHSA FY 22). These deaths are ruled accidental because COVID-19 presents such an obvious vulnerability to respiratory depression and death from opioid overdose, and public health authorities non-self-incriminate in regards to their incessant "suicide attacks" under color of COVID-19, intentional suicide is overlooked. The VA treats all overdoses as suicide attempts and may wish to challenge preliminary suicide reduction statistics.

The CDC Division of Violence Prevention *Preventing Suicide: A Technical Packs of Policy Programs and Practices* lists suicide risk factors: Individual level: history of depression, insomnia and other mental illnesses, hopelessness, substance use or abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants. Relationship level: abusive, high conflict or violent relationships, sense of isolation and lack of social support, family/ loved one's history of suicide, financial and work stress. There has been a dramatic escalation of pseudo-ephedrine brain shrink abuse by heartbreaking intimate partner violence counterintelligence efforts under color of Office of National Drug Control Policy (ONDCP) grants to CDC and DOJ, pushing "two bag meth" combined with a temporomandibular joint (TMJ) discomfort causing psychiatric anti-anxiety drugs, immediately before and during the COVID-19 pandemic, to the point where the US Supreme Court has not published since June 20, 2019. Pseudo-ephedrine cures viral and bacterial sinusitis, including coronavirus, but the brain shrink side-effect is unacceptably illiterate. This alternates between statin brain shrink concealing heart attacks. These intimate partner violence counterintelligence attacks utilizing mind altering substances are so prone to suicidal ideation, because they not only chemically induce mental illness and/or addiction and withdrawal, but interfere with the family, residential and romantic, nucleus of society, to such an extent, that intimate partner violence, especially involving malevolent substance abuse with mid altering substances, must be construed as a

“suicide attack” masterminded by the exact same FBI/DEA, ONDCP agents who dosed the 9-11 suicide attackers. Community level: inadequate community connectedness, heightened by COVID-19 social distancing and lockdowns, barriers to health care (e.g., lack of access to providers and medications) brought to a feverish pitch by the felony monopolization of the news media to sell ineffective vaccines and completely censure necessary medical information that hydrocortisone, eucalyptus, lavender, peppermint or salt help water cure coronavirus. Societal level: availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness (Stone et al '17). As mentioned above, COVID-19 presents a potentially lethal means of suicide by itself and with contagious medical assistance, sworn by public health authorities to not treat COVID-19 by any means but one or two pricks with an ineffective vaccine, and COVID-19 augments the lethality of opioid induced respiratory depression.

The Werther Effect (the negative consequences of media’s portrayal of suicide) first noted with the publication of Goethe's *The Sorrows of Young Werther* in 1774, has been well established and implementing recommendations for improvement for media reporting are key to reducing this effect (Ortiz & Khin, 2018)(Sisask & Varnik, 2012). The Werther Effect needs to be expanded to include the overwhelming sense of hopelessness that “fake news” and in particular COVID-19 vaccine propaganda monopolized global media and government induces on the informed and uninformed public. The uninformed public may die from COVID-19 waiting to be vaccinated or due to the ineffectiveness of the vaccine. The informed public is ignored and cannot get the necessary message across that hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus, and is violently retaliated against, usually involving exposure to mind altering substances, that heighten the suicidiality of the intentional media induced sense of hopelessness in regards to ending the pandemic without informing the public how to treat their allergic rhinitis. One cannot even find asylum from the COVID-19 lockdowns and political persecution in Australia and New Zealand, where the populace is largely unaffected because the naturally growing eucalyptus trees cure coronavirus, however not entirely due to the ineffectiveness of their news media to inform the public to hang out in eucalyptus groves, rub, suck on or boil eucalyptus leaves, and the equal right of germaphobic governments to attribute their health on the imposition of abusive quarantines on immigrants, who are not treated to a eucalyptus tree.

Conversely, responsible media reporting can have a protective effect (Papageno Effect) noted by the intervention of three characters to counsel Papageno in Mozart's *The Magic Flute* (Sisask & Varnik, 2012). Implementing research-informed communication efforts designed to prevent Veteran suicide by changing knowledge, attitudes, and behaviors is critical. The U.S. Air Force implemented a public health, universal approach which significantly lowered suicide rates through comprehensive organizational changes including communication efforts (Knox et al. 2010). This model also included gatekeeper training which has been shown to reduce suicidal ideation and deaths by suicide while positively affecting the knowledge, skills, and attitudes of trainees through improving communication (Isaac et al., 2009). Community efforts promoting responsible media reporting of Veteran suicide, accurate portrayals of Veteran suicide and mental illnesses in the entertainment industry, and the safety of online content related to Veteran suicide is also crucial. VA proactively screens for symptoms of depression, post-traumatic stress disorder (PTSD), problematic use of alcohol, experiences of military sexual trauma (MST), and suicide risk; believing (1) suicide is preventable, (2) suicide requires a public health approach, combining community-based and clinical approaches, and (3) everyone has a role to play in suicide prevention (VHA '21: 13). In response to the COVID-19 pandemic the VA has not exhibited any better or more independent command of the English language than the news media or public health authorities, and this brings into question the wisdom of their mental health program.

In regards to the suicidal hopelessness of COVID-19 vaccine dominated news media and public health coverage it is medically necessary to inform everyone with allergic rhinitis they have been sentenced to be flogged to avoid persecution of baptism (John 1: 26)(Luke 3: 7)(1 Peter 3: 21)(Mark 6: 24). Hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus. The swiftest and most effective remedy is to swim in a chlorinated, saline or mineral water pool, or repeatedly submerse the head in an Epsom salt bath until cured, this remedy also treats methicillin resistant *Staphylococcus aureus* (MRSA). Eucalyptus or lavender cure influenza. Mentholyptus cough drops cure both influenza and coronavirus, with a little nose washing, and keep the infection out of the lungs. To end the COVID-19 pandemic the most effective methods would be to stock public restrooms with eucalyptus, lavender or peppermint soap and inform everyone to wash their face and nose To make hospital treatment and the return to school safe, eucalyptus humidifier (diffuser) aromatherapy is the needed to sterilize public airspace of both coronavirus and influenza.

Before continuing with conventional mental health instruction it is necessary to inform the public of the hazards of exposure to certain common mind altering substances frequently involved in the etiology of mental illness and severe mental illness, for the purpose of hygiene. The substance of absolute most concern is called dimethoxymethylamphetamine (DOM) or STP. DOM causes a three day panic attack, followed by six month recovery from several mental illness (Elvin-Lewis ’77: 405, 407, 408, 411, 410) if not washed off with water, or blood. DOM exposure, by FBI informants, is suspected in all cases of severe mental illness, suicide, and especially rampage shootings, with much greater success at preventing copycat killers, than gun control, without a military grade gun cleaning. Pseudo-ephedrine and statin drugs cause the brain to shrink. Pseudo-ephedrine (Sudafed, Sudagest etc.) causes insomnia, illiteracy, senility and inability to reject propaganda or overturn false criminal charges. Pseudo-ephedrine is the height of COVID-19 hypocrisy because it is indicated to clear the sinuses of bacterial and viral infections and is a highly effective oral treatment for coronavirus, but the brain shrinkage is not only an unacceptably severe side-effect, but escalation in its abuse preceded the pandemic and is almost certainly the reason the public health response has been and remains so intoxicated with the two dose cure, millions of people died waiting for, and continue to get allergic rhinitis and die because it does not prevent reinfection. Recent literature and the COVID-19 quarantine and cell phone GPS bug (take out the battery) related domestic violence experience, emphasize that there is a third common toxic cause of insomnia, that causes the exposed group of persons to wake up around 3 am angry with the toxic exposure to mental fuzziness, and 3 am has become competitive with midnight as the most common time to commit suicide (Cunningham '20)(McCarthy '19). Statin drugs cause senility and illiteracy; unless the patient is inoculated with Pneumovax the statin consumer invariably becomes swiftly infected with dementing pneumococcal meningitis that becomes reinfected after antibiotic treatment because the brain does not regrow fast enough; Pneumovax is necessary to prevent brain wasting chronic meningitis from statin drug consumption, whether one time, habitual, voluntary or involuntary. This makes Pneumovax, to cure and prevent pneumococcal meningitis, the only safe drug treatment for mental illness, prescribed to all people over or now under age 65 to prevent pneumococcal infection of heart, lung and brain damage. All of these substances come clean in the wash, but re-exposure by violent intimate partners and/or their, or independent, organized crime is a seriously depressing problem, brain damage does not help to solve, wherefore it is necessary to have prior knowledge of these hazards to mental health.

It is highly advised that Pneumovax be administered to all working age adults to cure and prevent pneumococcal infection of heart, lung and brain damage. In regards to VA health care Pneumovax is

particularly recommended to treat and prevent infection of traumatic brain injury (TBI) and mental illness, possibly naturally caused by untreated infection of undiagnosed mild TBI from the sound of gunfire and explosions, opportunistically exacerbated by cruel exposure to mind altering substances. After the Civil War veterans complained of an irritable heart, WWI Veterans were shell shocked with PTSD like symptoms, WWII and Korea War Veterans were well adjusted. Since Vietnam, as many as one third of soldiers have been suffering Post Traumatic Stress Disorder (PTSD). WWI veterans are thought to have suffered from opportunistic meningitis after suffering mild traumatic brain injury, that was cured with the invention of antibiotics in WWII and Korea, however, subsequently the drug war intoxicated United States has only engaged in unjust wars and the troops are insulted by the war crimes they took part in, and untreated by the war criminals perpetuating such a system. National Center for PTSD (NCPTSD) was created in 1989 in response to a Congressional mandate (P.L. 98 -528, 98 Stat. 2686, 1984). In 2014, NCPTSD received a separate appropriation that had two goals: to establish a PTSD brain bank to facilitate PTSD research, and to enhance access for rural Veterans. From 2015 through 2019, the Center had an average of 129 competitively-awarded research grants and produced an average of 307 peer-reviewed publications per year. At the end of 2020, the Brain Bank had acquired 280 frozen hemispheres (roughly divided in thirds from donors with PTSD, donors with major depression, and controls without depression or PTSD) and 22 fixed hemispheres; 156 individuals have enrolled in our antemortem donor program. NCPTSD strives to better understand the neurobiology, epidemiology, prevention, psychotherapy and pharmacological treatment of suicide risk in individuals with PTSD (VHA '21: 229).

NCPTSD needs to stop dangerously looking into pharmacological ways to tolerate injustice, before they incite more violence with hard drugs like pseudo-ephedrine and anti-depressant addiction and learn to tolerate marijuana and boycot DEA registration. Veterans with PTSD must write legal briefs, that are not suicide notes, to bring about closure, know what to say and do war crime justice. Post-traumatic Stress Disorder (PTSD) is a serious, worldwide public health problem. In the United States the lifetime prevalence of PTSD in the general population is between 6 and 10%, and between 13 and 31% in US military veterans (Atwoli et al '15). PTSD is typically a chronic condition, and is associated with high rates of psychiatric and medical co-morbidity, disability, suffering, and suicide (Perkonigg et al '00). Food and Drug Administration (FDA)-approved pharmacological treatments for PTSD are currently limited to two selective serotonin reuptake inhibitors (SSRIs): sertraline and paroxetine. Current Department of Defense (DoD) and Department of Veterans Affairs (VA) best practice guidelines for treatment of PTSD recommend psychotherapy over pharmacotherapy. However, the majority of military veterans with PTSD who receive one of the best practices psychotherapies for PTSD, which were determined efficacious through clinical trials, do not remit or reduce symptoms below clinical thresholds by the end of treatment (Resick et al '92)(Bremner et al '96).

The VA Medical Benefits Package under 38CFR§17.38 provides for Mental Health Services under 38CFR§17.98, 38USC§1712A, §1720H, §1720I, Public Law 114-2, Clay Hunt Suicide Prevention for American Veterans Act and Executive Order (EO) 13822, issued on January 9, 2018. Veteran demand for VHA mental health care continues to grow, with approximately 1.72 million Veterans (29% of all VHA users) receiving mental health services in a VHA specialty mental health setting in 2020. Across VA settings of care, more than 525,000 Veterans were seen in 2020 for a substance use disorder diagnosis. The proportions of VHA health-service users who receive mental health treatment are highest among younger Veterans and decline with age. The proportions are also slightly higher for women as compared to men in older age groups with the gap declining in Veterans younger than age 35. Reflecting the size of the cohort of male Veterans over age 65, 61% of all users of VHA services in

specialty mental health settings in 2020 were men over age 50. The Office of Mental Health and Suicide Prevention (OMHSP) now includes the Veterans Crisis Line (VCL) and PREVENTS. VA proactively screens for symptoms of depression, PTSD, problematic use of alcohol, experiences of military sexual trauma (MST), and suicide risk. VHA mental health care rests on the principle that it is an essential component of overall health care, and it requires the availability of a continuum of services, including self -help resources, telephone crisis intervention services, outpatient care, residential care (known as Mental Health Residential Rehabilitation Treatment Programs), and acute inpatient care. Program requirements for the full range of mental health services that VHA delivers are specified in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics (the Uniform Mental Health Services Handbook), published in 2008 and amended in 2015 (VHA '21: 104, 108).

The number of outpatient mental health encounters or treatment visits more than doubled between 2006 and 2019 (from 10.7 million to 21.8 million), and during the COVID-19 pandemic VA provided 20.4 million encounters and telephone visits in 2020. Between 2006 and 2020, the number of Veterans who received mental health care from the VHA grew by 85%. In FY 2006, 20% of VHA users received mental health services, and in 2020, the figure was 29%. In 2020, 223,000 women Veterans received VHA mental health care, representing approximately 42% of all women VHA patients, a threefold increase since 2005. VHA is a recognized leader in evidence-based psychotherapy (EBP) training with 16 EBP training programs that address PTSD, depression, SUD, serious mental illness (SMI), and suicide prevention, as well as cross-cutting issues such as chronic pain, insomnia, motivation for treatment, relationship distress, and problem-solving skills. In 2017, VA began offering emergent mental health services to former Service members with Other than Honorable administrative discharges. In 2020, 3,246 Service members with an “other than honorable” discharge received mental health services. VA projects a 30% growth in inpatient and outpatient mental health care during the period from 2017 through 2030 (an increase from 17.8 million to 25.4 million). In 2019, VA already provided 21.8 million outpatient mental health encounters or treatment visits. The projection for 2024, demonstrating high demand for mental health services. During the same period, the inpatient-bed-days-of-care measurement is expected to be stable at about 3,450,000 (VHA '21: 109-111).

Veteran demand for VHA mental health care continues to grow, with approximately 1.72 million Veterans (29% of all VHA users) receiving mental health services in a VHA specialty mental health setting in 2020. Programs provide proactive screening for symptoms of depression, Post-traumatic Stress Disorder (PTSD), problematic use of alcohol, experiences of military sexual trauma (MST), and suicide risk. VA employs a mental health workforce of more than 20,000 psychiatrists, psychologists, social workers, nurses, counselors, therapists and peer specialists. A major focus of this request is expanding the Veterans Crisis Line (VCL), which since its launch in 2007, has answered more than 3.5 million calls and initiated the dispatch of emergency services to callers in imminent crisis nearly 100,000 times. Demand for chat and text services have increased by over 59% during the COVID-19 pandemic (VHA '21). From 2019 to 2022, the utilization of Mental Health services by the Post-9/11 Era Combat Veteran population is expected to increase by 19% for inpatient services and increase by 30% for ambulatory. However, the aging of the non-Post-9/11 Era Combat Veteran enrollee population is mitigating the projected growth in utilization of mental health services because use of mental health services declines at older ages. For example, utilization of Mental Health Residential Rehabilitation and Compensated Work Therapy services peaks between ages 50 and 60 then drops off dramatically by age 65 (VHA '21: 406). Suicide prevention is a VA top clinical priority, founded on a comprehensive public health approach to reach all Veterans. The budget includes $598 million, an

increase of $287 million (+92%) above the 2021 enacted level, for suicide prevention outreach and related activities, including funding to increase the capacity of the Veterans Crisis Line. Funding for mental health in total grows to $13.5 billion in 2022, up from $12.0 billion in 2021. The budget also fully funds the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171) which authorized the new Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program to reduce Veteran suicide through a community-based grant program that provides or coordinates suicide prevention services. Additionally, the 2022 budget funds the projected costs of the provision of emergent suicide care authorized by the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (P.L. 116-214). The National Suicide Hotline Designation Act of 2020, requires the Federal Communications Commission (FCC) to designate 9-8-8 as the universal telephone number for the National Suicide Prevention Lifeline (VHA '21: 134).

Suicide is an increasing mental health crisis that not only plagues the United States, but all nations across the globe. The World Health Organization projects that 1.53 million people worldwide will die by suicide in the year 2020, with 10–20 times that number making a suicide attempt that year. In 2017, nearly 50,000 people died by suicide in America alone. Suicide was the second leading cause of death for all Americans ages 10–34, the fourth leading cause of death for Americans ages 35–54, and the death rates for suicide have increased yearly in the United States since 2005 (Cunningham et al '20). Veterans commit suicide at a rate 1.5 times higher than the general population. Many Veterans who die by suicide have not received care from VA prior to their deaths. Specifically, 11 of the 17 Veterans who die daily by suicide have not been within VHA care for 2 years or more (Department of Veterans Affairs, 2020). Because only 37% of Veterans are enrolled in VA health care, it is not statistically significant that 65% of Veterans who committed suicide had not visited the VA. Due to the statistical and moral significance of the provision of mental health treatment to Veterans with other than honorable discharges, who would not otherwise be eligible for medical treatment at the VA, one, disability petitioner, is inclined to think ever so slightly charitably about VA mental health treatment.

Veterans commit suicide at a rate 1.5 times higher than the general population (Department of Veterans Affairs, 2020). PTSD bias to get compensation and infiltration by FBI/DEA dimethoxymethyl-amphetamine (DOM) informants in both VHA research and DEA registered health practice that washes off with water aside, the two major reasons for a 50% higher suicide rate in Veterans can be attributed to greater access to two methods of committing suicide - high rates of gun ownership and opioid prescription for chronic pain (paying). Safe messaging is an important part of community outreach strategies. Further, lethal means safety education is a critical area within community-based prevention strategies. An education campaign targeting firearm retailers led to increased use of materials promoting firearm safety and its association with suicide with retailers accepting that they have a role in preventing suicide (Vriniotis, et al., 2015). Goals to delay gun access during periods of immediate risk for suicide were shown to be feasible to implement, and effective and reducing immediate access to lethal means access has been shown to be most effective when implemented alongside other suicide prevention strategies (Sarchiapone et al., 2011). Firearms need to be taken away from Veterans who are perceived by themselves or others to be acutely mentally ill, for their own safety. The average length of time between suicidal ideation and actual suicide is usually less than 10 minutes (Stone et al '17). Opioids need to be treated the same way. The VA treats all drug overdoses as suicide attempts.

It is advertised that many Veterans who die by suicide have not received care from VA prior to their deaths. Specifically, 11 of the 17 Veterans who die daily by suicide have not been within VHA care for 2 years or more (Department of Veterans Affairs, 2020). Because only 37% of Veterans are enrolled in

VA health care, it is not statistically significant that 65% of Veterans who committed suicide had not visited the VA. Contrary to claims made by the VHA FY 22 budget submission, greater mental health and staff FTEs per 1,000 patients have not been shown to be associated with lower risk for suicide in peer reviewed literature (Richardson, McCarthy, & Katz, 2017), nor have increases in mental health staffing been associated with decreases in suicide rates. Signs of Suicide and the Good Behavior Game were the only programs found to reduce suicide attempts in schools. Several other programs were found to reduce suicidal ideation, improve general life skills, and change gatekeeper behaviors (Katz, et al., 2013)(VHA '21: 141-142). It is important that these references to mental health and suicide prevention programs stop advertising trademarks, cite the literature in a "bibliography" as the VHA FY 22 failed to do after fraudulently pimping mental health staffing with their otherwise excellent, if overzealous, research, and submit their professional teachings to public criticism, until knowledge regarding toxic exposure to mind altering substances is used to redress both mental health and drug enforcement arms of the mental problem regarding the contemporary slave trade. Professional mental health treatment is generally thought to be placebo in regards to mental health and detrimental to physical health because their prescribing habits are not registered with DEA mind altering substance exposure, but tend to engage in all sorts of physical tortures, e.g, serious and lethal side-effects of psychiatric drugs and sleep aids and intimate partner violence utilizing anti-depressant addicts. Unlike professional mental health treatment, peer support has been shown to be helpful, although, or perhaps because, it has not been correlated to a reduction in suicide. Peer support is one of the 10 fundamental components of recovery according to the National Consensus Statement on Mental Health Recovery and all Veterans with SMI (Serious Mental Illness) must have access to peer support services, either on-site or within the community. Studies have found improvements, for individuals who received peer support services as part of their mental health care services, in treatment engagement, treatment retention, reduction in symptoms of mental illness, improvements in abstinence from addictive substances, and improvements on quality of life measures (Bassuk et al. 2016)(Chinman et al. 2015) (Ashford et al. 2019)(McCarthy et al., 2019)(VHA '21: 126).

Intimate Partner Violence (defined as physical, verbal, emotional, psychological, stalking and sexual abuse) is a national health epidemic with far-reaching bio-psycho-social consequences. It is significantly correlated with increased risks for other public health issues including suicide and homicide, homelessness, and substance abuse. The Veterans Health Administration (VHA) Intimate Partner Violence Assistance Program (IPVAP) was launched in January 2014, in response to recommendations provided in the *VHA Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program* (IPVAP)(2013). VHA Directive 1198, Intimate Partner Violence Assistance Program was published in January 2019, requiring every VA medical facility to implement and maintain an Intimate Partner Violence Assistance Program to ensure that Veterans, their intimate partners, and employees impacted by IPV (experiencing or using) have access to services including education, resources, assessment, intervention and/or referrals to VA or community agencies as deemed appropriate and clinically indicated. To date, the program established a designated IPVAP Coordinator at over 94% of VA medical facilities and is striving for 100% coverage (VHA '21: 225). It is significant that the VA recognizes that legal representatives, health and government employees often "use" IPV to torture their petitioner or patient, using their solicited actively corruptible family, lover, landlord, caregivers, roommates, eg. intimate partners against them, or vice-versa as in a violent psychiatric drug consuming patient counseled and armed to attack, or organized combination of these two crimes.

VA has a set of recommended treatments for PTSD, including counseling or medications, but it is

known these treatments may not work for everyone. VA Research is developing and testing new treatments for Veterans with military-related PTSD, so that every affected Veteran has the opportunity to get relief from their symptoms. ORD has developed a strategic plan to examine the efficacy and effectiveness of new medications for PTSD, specifically to increase the possible treatments over the currently limited two approved medications. The drug prazosin, used widely in VA to help ease nightmares from PTSD, did no better overall than placebo pills. (VHA '21: 559). Clozapine is the most efficacious medication available for the treatment of schizophrenia and is the only medication proven to reduce the suicidality of schizophrenic patients. The FDA has mandated that all patients receiving clozapine enroll in a national clozapine registry to monitor Absolute Granulocyte Counts. The National Clozapine Registry provides VA with the tools to authorize, track and report the safe prescription and administration of clozapine for Veterans with serious mental illnesses (NHA '21: 671). There are four SSRIs/SNRIs that are recommended for PTSD: Sertraline (Zoloft), Paroxetine (Paxil), Fluoxetine (Prozac) and Venlafaxine (Effexor). Although these drugs do not cause life-threatening withdrawal symptoms like benzodiazapine, the tranquilization borders on idiocy and withdrawal tends to aggravate serious aggressive behavior, that is often exploited by organized criminal administration of these drugs to cause intimate partner violence.

Many herbal remedies are used for anxiety. They may be helpful for people who have only mild symptoms of anxiety and their effects are quite subtle. Valerian and kava are the strongest of those listed. Kava should not be used for more than a few months because it causes a yellowing of the skin. Valerian acts in a manner similar to benzodiazepines, and there is no documented evidence that it is habit-forming. St. John's wort can be helpful for mild depression, and there is a large study underway to investigate its usefulness in more severe depression. There are reports that gingko may be helpful in some people (Drummond '00: 63, 89). 5 HTP is a highly recommended and sold over the counter treatment for depression. 5HTP is a serotonin precursor and can help the body to make more serotonin and leave the available serotonin in synapses for a longer period of time, therefore directly affecting mood and warding off depressive symptoms. 5 HTP can also help with insomnia, agitation, fatigue and lack of motivation. It is often helpful in chronic pain situations because it increases sleep needed for healing, improves mood and decreases sensation of pain. Again 5 HTP should not be used with other antidepressant medications, especially selective serotonin reuptake inhibitors, or SSRIs. 5 HTP 100 mg two times daily. SAMe can be helpful in the treatment of depression. It acts as methyl donor and can help the body to complete and maximize its nerve connections in the brain. SAMe has antioxidant activity therefore will help to reduce free radical damage in the body. SAMe can help the body's methyl metabolism improve, therefore functioning to increase energy, improve cognitive function and decrease pain. SAMe has also been used to treat osteoarthritis, response tends to be noticed within the first month of use. Insomnia, anxiety or mania states can be associated with overuse of SAMe. Do not use SAMe with other antidepressant medications, especially selective serotonin reuptake inhibitors (SSRIs). It may cause life-threatening symptoms (including agitation, tremors, anxiety, rapid heartbeats, difficulty breathing, diarrhea, shivering, muscle stiffness and excessive sweating). SAMe dosage 400 mg daily.

The U.S. Department of Veterans Affairs now offers a psychedelic ketamine drug to treat post-traumatic stress disorder while marijuana remains off limit. Ketamine variants have made headlines over the decades for their multiple roles as sedatives, recreational hallucinogens and for their impressive track records for mitigating suicidal depression. The Spravato version, which was approved by the U.S. Food and Drug Administration in March, requires patients to remain under professional observation for two hours following ingestion. It is however psychologically addictive and has side-

effects on the urinary tract and gall bladder (Cox '19). The first FDA-regulated, placebo-controlled, double-blind study on smoked cannabis among veterans with diagnosed PTSD revealed improvements among those receiving doses with higher levels of THC, an active component in the herbal drug. The study, conducted by the Multidisciplinary Association for Psychedelic Studies, or MAPS, indicated levels of improvement among participants using smoked cannabis blends with a 9 percent THC concentration. Improvements were also found using samples containing 11 percent CBD, as well as a sample containing 8 percent THC and 8 percent CBD. A fourth group, which also reported improvements, used a placebo. THC, or delta-9-tetrahydrocannabinol, is the intoxicating, or psychoactive, ingredient of cannabis strains that produce the euphoric "high" effect. CBD, or cannabidiol, is one of the non-intoxicating cannabinoids in the cannabis plant. CBD-only products have been widely adopted in multiple states for medical, therapeutic and recreational uses. That study found that over the course of a year the cannabis users "reported a greater decrease in PTSD symptom severity..." Additionally, cannabis users were more than 2.5 times as likely to no longer meet the diagnostic criteria for PTSD as those who did not use cannabis. One of the biggest advantages is that veterans with PTSD can use cannabis at self-managed doses, at least in the short term, and not experience a plethora of side effects or a worsening of symptoms (South '21)(Bonn-Miller et al '21).

VA clinicians are not allowed to recommend medical marijuana. VA clinicians may only prescribe medications that have been approved by the U.S. Food and Drug Administration (FDA) for medical use. At present most products containing tetrahydrocannabinol (THC), cannabidiol (CBD), or other cannabinoids are not approved for this purpose by the FDA. Cannabis, also commonly referred to as marijuana, has been legalized for widespread medical use in 20 states and two U.S. Territories. Marijuana has been legalized for both medical and recreational use in 16 states, Washington D.C., and two U.S. territories. It is legal for extremely limited medical use, such as terminal cancer therapy, in 11 states. Federal laws, meanwhile, still prohibit the possession and sale of cannabis, while both the Department of Defense and the Veterans Administration prohibit the use or prescribing of it. The organization's May 2018 study analyzed MDMA treatment on 26 first responders, mostly combat veterans, over two, day-long psychotherapy sessions. In a one-month follow-up, 68 percent of participants reported that their PTSD symptoms had been "effectively eliminated" (South-Todd '21).

Given increasing use of medical cannabis among US military veterans to self-treat PTSD, there is strong public interest in whether cannabis may be a safe and effective treatment for PTSD. The present study is the first randomized placebo-controlled trial of smoked cannabis for PTSD. All treatment groups, including placebo, showed good tolerability and significant improvements in PTSD symptoms during three weeks of treatment, but no active treatment statistically outperformed placebo. There is some preclinical evidence that at least two of the active compounds in cannabis, delta-9-tetrahydrocannabinol (THC; the primary constituent responsible for intoxication from cannabis) and cannabidiol (CBD; one of the non-intoxicating cannabinoids in cannabis), can positively impact processes that underly PTSD pathology (Loflin et al '17). Specifically, administration of CBD in rats and mice dampens cue-elicited fear responses (Lemos et al '10), while administration of THC and THC+CBD appears to block reconsolidation of fear memory (Stern et al '15). Likewise, both THC and CBD when administered alone facilitate fear extinction learning (Das et al '15), which is a critical component for recovery from PTSD (Holmes et al '13). This work suggests that THC and/or CBD could modify how patients with PTSD experience and respond to reminders of trauma. Military veterans with PTSD are overwhelmingly choosing smoked cannabis to self-treat PTSD and related conditions. Moreover, herbal cannabis varies significantly across plants in its THC and CBD content. While both cannabinoids could hold therapeutic value, unlike THC, CBD is non-intoxicating and does

not carry significant risk of abuse. In addition, CBD may temper the anxiogenic effects of THC in cannabis preparations that contain both CBD and THC (Loflin et al '19).

Individuals were eligible for study enrollment if they (1) were a US military veteran, (2) met DSM-5 (APA, 2013) criteria for PTSD with symptoms of at least six months in duration (index trauma did not have to be related to military service). (3) had PTSD of at least moderate severity based on a CAPS-5 score of = >25 at baseline assessment, (4) were at least 18 years of age, (5) reported they were willing and able to abstain from cannabis use two-weeks prior to baseline assessment, which would be verified by urine toxicology screens at screening and baseline, and agreed to abstain from using non-study cannabis during the trial, (6) were stable on any pre-study medications and/or psychotherapy prior to study entry, and (7) agreed to comply with study procedures. *Exclusion criteria*. Study participants were excluded if they (1) were pregnant, nursing, or of child bearing potential and not practicing effective means of birth control, (2) had a current or past serious mental illness (e.g., personality disorder, psychotic disorder) determined by the SCID-5-RV (First et al '15), or self reported a positive family history (first-degree relative) of psychotic or bipolar disorder (3) were determined at high risk for suicide based on the C-SSRS (Posner et al '08), (4) had allergies to cannabis or other contraindication for smoking cannabis, (5) had a current diagnosis or evidence of significant or uncontrolled hematological, endocrine, cerebrovascular, cardiovascular, coronary, pulmonary, gastrointestinal, immunocompromising, or neurological disease, (6) met DSM-5 criteria for moderate-severe Cannabis Use Disorder on the CUDIT-R (= >11), (7) screened positive for any illicit substance other than cannabis during the two-week screening, or (7) were unable to provide informed consent.

Study drug was obtained from the National Institute on Drug Abuse (NIDA). Four concentrations of cannabis from NIDA included: High THC = approximately 12% THC and < 0.05% CBD); High CBD = 11% CBD and 0.50% THC; THC+CBD = approximately 7.9% THC and 8.1% CBD, and placebo = < 0.03% THC and < 0.01% CBD. Samples of each batch were tested and confirmed for their concentration levels by an independent third-party analytical testing laboratory in Phoenix, Arizona. The independent testing lab found in two separate analyses that the High THC batch was just 9%, At the beginning of each stage, participants were asked to visit the clinic site for four hours on two successive days and self-administer under supervision of study staff one dose of the cannabis preparation that they were randomly assigned to in that Stage. Vital signs for safety were collected during these visits (i.e., blood pressure, pulse). The study provided participants a total of 37.8 grams (1.8 grams/day)for the three-week *ad libitum* treatment period along with a metal pipe for treatment delivery (smoked). Participants were asked to refrain from using non-study cannabis, and return any remaining study cannabis that was not used each week. All AEs were coded by Systems Organ Class. The study physician then rated all AEs by severity (mild, moderate, severe) and study relatedness (i.e., possibly related, probably related, not related). AEs rated possibly related and probably related were collapsed into one “related” category. Additional safety measures included the 15-item Marijuana Withdrawal Checklist (MWC) (Budney et al., 1999) and the Columbia-Suicide Severity Rating Scale (CSSR-S) (Posner et al., 2011). 13 total participants terminated from the study early due to an AE (8.4%). The most common AEs reported (i.e., those with >10% frequency) were cough (12.3%), followed by throat irritation (11.7%) and anxiety (10.4%). One participant who received CBD in Stage 1 (5.0%) reported treatment-related suicidal ideation. One participant from each treatment condition (3.6% - 5.9%) reported treatment-related suicidal ideation in Stage 2. Only participants assigned to High THC in Stage 1 reported a significant increase in mean self-reported withdrawal symptoms after one week of cessation from the assigned treatment in Stage 1. There was no significant change in withdrawal symptoms from the end of Stage 2 treatment to one-week follow-up. All four treatment

groups, including placebo, achieved significant within-subject reductions in total CAPS-5 Total Severity scores from Stage 1 baseline (visit 0) to end of treatment (visit 5). Specifically, participants who received placebo in Stage 1 reported a mean reduction of 13.1 points (SD = 12.10, $p < .001$, $d = -1.30$), participants who received High THC reported a mean reduction of 15.2 points (SD = 11.3, $p < .0001$, $d = -1.99$), High CBD participants reported a mean reduction of 8.4 points (SD = 10.09, $p < .05$, $d = -.79$), and THC+CBD participants reported a mean reduction of 8.5 points (SD = 9.88, $p < .05$, $d = -.83$). Consistent with previous work (Ware et al '15), participants in the current study reported a general preference for cannabis types that included significant quantities of THC (Bonn-Miller et al '21).

National Center for Health Statistics (NCHS) indicate that approximately 81,230 drug overdose deaths occurred in the United States in the 12 -months ending in May 2020. This represents a worsening of the drug overdose epidemic in the United States and is the largest number of drug overdoses for a 12-month period ever recorded. The recent increase in drug overdose mortality began in 2019 and continues into 2020, prior to the declaration of the COVID-19 National Emergency in the United States in March. Deaths appear to have accelerated during the COVID-19 pandemic. Synthetic opioids are the primary driver of the increases in overdose deaths. The 12-month count of synthetic opioid deaths increased 38.4 from the 12-months ending in June 2019 compared with the 12-months ending in May 2020 (HAN Archive, 2020). There are many studies to support the life saving potential of naloxone (Bird et al. 2016)(McDonald & Strang, 2016)(Walley et al 2013)(Wheeler et al. 2015).

Within VA, an analysis of the impact of academic detailing on naloxone prescribing between October 2014 through September 2016 found a beneficial effect with the average number of naloxone prescriptions being seven times greater among providers with at least one OEND-specific academic detailing visit (Bounthavong et al., 2017). Increasing naloxone availability is included in the Office of National Drug Control Policy (ONDCP)'s Federal National Drug Control Strategy and is included in a Surgeon General Advisory from 2018 (VHA '21: 113-114). The VA and DOD are trying ONDCP for their marijuana robbery to push methamphetamine grants, that have annihilated both the Department of Justice, rendering the US Supreme Court illiterate from June 20, 2019 to July 2021 and Centers for Disease Control and Prevention (CDC) federal, state and global COVID-19 response via the Injury Prevention and Control Program that gave ONDCP grants asylum, since the program was expelled from the White House, with only a small office to intoxicate the President with pseudo-ephedrine. The potential lethality of the undercover fentanyl bedspreads of the FBI and DEA (DOM) also require considerable approbation in the continuing use of opioid prescriptions and disclosure of any information to these UN conventional terrorist organizations.

VA/DoD Clinical Practice Guideline for Management of Substance Use Disorder (SUD) (2015) is authorized under 38USC§1701, 38CFR§17.38 and 38CFR§17.80. The military has a zero tolerance policy for UN controlled substances, while the VA is fond of prescribing opioid withdrawal medicines, without legalizing marijuana, as is advised to provide a safer alternative to alcohol, tobacco and opioids, for the informed consent of military and civilian population alike. As detailed in the National Drug Control Strategy – National Treatment Plan for Substance Use Disorder (NDCS- NTP) (Office of National Drug Control Policy (ONDCP), 2020), among the over 20 million individuals who met criteria for a SUD in 2018, roughly 89% did not receive specialized SUD treatment. Among Veterans receiving care within the Veterans Health Administration (VHA), over 520,000 had a SUD diagnosis in 2020 with less than 30% receiving SUD specialty services. The Office of Mental Health and Suicide Prevention (OMHSP) is responsible for national policy, management, and oversight specific to

substance use disorders within VHA. SUD cannot be characterized by use of any one substance but often involves the use of multiple substances. The number of Veterans served within VHA with amphetamine, cannabis, cocaine, and alcohol use disorders is rising. Veterans with an amphetamine use disorder has increased by 71% since 2016 and a 31% increase in cannabis use disorder. Overdose deaths associated with stimulants including methamphetamine are increasing. Amphetamine use disorder diagnoses among those served in VHA increased 71% from 2016 through 2019 with cocaine use disorders increasing by 5%. During 2019, 65.8% (8,872) of Veterans newly enrolled in VHA Vocational services had a SUD diagnosis (VHA '21: 120, 128, 130). To do cannabis and the more severe, ICD and DSM recognized mental illness of tobacco withdrawal justice the VA should not hesitate to diagnose tobacco addicts for statistical and voluntary residential treatment purposes, if they should want to improve their health by trying to quit tobacco, and think they would benefit from residential treatment.

Nearly twenty percent of the U.S. population smokes cigarettes and a small percentage in addition to that use pipes, cigars, and smokeless tobacco. Regular use of tobacco is reputed to cause heart disease, lung cancer, mouth cancer, emphysema, and bronchitis, and causes several hundred thousand deaths each year. Dependence on tobacco is partly due to the presence of nicotine, which produces slight changes in awareness and attention that some people find pleasing. Nicotine produces physical dependence. If smoking abruptly stopped, the withdrawal from nicotine can cause depression, insomnia, irritability, restlessness, anxiety, difficulty concentrating, decreased heart rate, a craving for cigarettes and an increased appetite with weight gain. The symptoms can begin within hours. It is difficult to stop smoking after years of use. Most people make multiple attempts before they are successful. Many treatments have been tried to aid the effort to stop smoking. Hypnosis and behavior modification have helped some people. Use of nicotine gum or patches decreases the nicotine withdrawal symptoms, but the craving for cigarettes remains. Recent studies have demonstrated that the antidepressant bupropion (Wellbutrin, Zyban) appears to help some people stop smoking. But the withdrawal from these drug has a violent tendency. Other antidepressants have not been shown to provide significant benefit (Drummond ’00: 103). E-cigarettes may be useful.

Veterans within VHA with Substance Use Diagnosis 2016 - 2019

Substance	2016	2017	2018	2019
Alcohol	363,763	388,933	393,531	416,590
Cannabis	103,815	112,910	123,754	135,766
Cocaine	69,524	70,407	72,258	73,272
Opioid	66,851	69,142	71,471	71,327
Amphetamine	25,549	30,085	37,290	43,720

Source: VHA '21: 121

Alcohol withdrawal must be promptly diagnosed as being an acute cause of anxiety to the patient, because untreated delirium tremors have a mortality of 15%. Commonly detoxification is accomplished with chlordiazeposide at a starting dose of 50 mg orally every 6 hours with extra doses of 25 mg as needed to control symptoms. After an effective total daily dose has been reached, a taper of 10% total dose per day can be instituted. If parenteral administration is required, an equivalent dose of

lorazepam can be used. In cases of hepatic dysfunction oxazepam is the drug of choice. All suspected alcohol abusers should receive thiamine, 100 mg intramuscularly for 7 days (to help prevent Wernicki-Korsakoff encephalopathy) as well as folate, 1 mg daily, and multivitamins (Massie & Sinsheimer '90: 539). Alcoholics range from those who have a couple of drinks every day to those who regularly consume large amount to the point of intoxication, and experience adverse consequences to their health, relationships and employment. Stopping alcohol use can be a difficult task. Daily drinkers will probably go through a period of physical withdrawal, with symptoms of restlessness, tremor, anxiety and insomnia. If use has been heavy, it is best not try to stop drinking abruptly. In addition to the unpleasant psychological effects listed above, high blood pressure, rapid pulse, seizures, delirium tremens (DTs), hallucinations and other physical changes can be life-threatening. Benzodiazepines are often used during detoxification in order to prevent these serious complications. Disulfiram is an alcohol-sensitizing agent that changes the way alcohol is metabolized by the body. After taking it, acetaldehyde collects as a breakdown product and produces a toxic reaction with symptoms of elevated pulse, low blood pressure, nausea, vomiting and headaches. In a severe reaction there can be respiratory and cardiac impairments that lead to death. The intensity of the effect is proportional to the amount of disulfiram and alcohol. Disulfiram is rarely used in the treatment of alcoholism. Naltrexone is an anticraving agent that blocks opioid receptors in the brain and was originally marketed for the treatment of narcotic dependence. It has been subsequently shown to decrease the craving for alcohol in animals. Studies on humans demonstrated a modest decrease in the rate of relapse. Clinicians tend to be skeptical of Natrexone. Benzodiazepines are helpful for the acute withdrawal symptoms of alcohol. Some people stay on benzodiazepines past this period, believing they maintain sobriety, and then become addicted to benzo's.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the 10th Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) both require multiple symptoms of significant psychiatric distress, social impairment, and adverse consequences associated with cannabis use for an individual to be diagnosed with CUD. The VA has currently found low-strength evidence that cannabis preparations with precisely defined THC - cannabidiol content (most in a 1:1 to 2:1 ratio) may alleviate neuropathic pain but insufficient evidence in populations with other types of pain. The applicability of these findings to current practice may be low, in part because the formulations studied may not be reflective of what most patients are using – opioids (Kandagara '17). Currently, the Centers for Disease Control and Prevention recommends the use of evidence- based non-pharmacologic therapy – such as physical therapy, exercise therapy, and psychologic interventions – and non-opioid pharmacologic therapy as the preferred modalities to treat chronic pain (Abrams et al '11). Death, seen with opioids have not been described with cannabis use in the literature. Indeed, there is no good-quality data examining what impact cannabis use actually has on opioid use and opioid-related adverse effects. A growing body of cross-sectional literature suggests negative opioid-related correlates among individuals who use cannabis and opioids concurrently. These include opioid misuse a greater number of opioid refills; a longer duration of opioid use; a higher dose of opioid medication prescribed; and endorsement of using opioids without prescription (Hefner et al '15)(Degenhardt et al '15). One recent study found that pain scores and opioid use decreased over 6 months in a chronic pain population who initiated cannabis treatment, however confidence is limited by lack of a control group and large number of participants lost to follow-up (St. Louis '16).

Cannabis use has become more common among United States (US) adults, with the prevalence of adults reporting past-year cannabis use nearly doubling between 2001 and 2013 to one in 10 adults (Hasin et al '15). Young adults ages 18-29 are nearly 4 times more likely to have used cannabis in the

past year than adults ages 45-64 (Kandagara et al '17). In the past, use had been limited to inhalation or ingestion of parts of the whole plant of the genus Cannabis. More recently, many more formulations of cannabis have become available in recreational and medical cannabis dispensaries including an array of edibles, oils, tinctures, as well as plant extracts with varying ratios of the 2 active ingredients of cannabis: tetrahydrocannabinol (THC) and cannabidiol (CBD). There are also 2 purely synthetic cannabinoids available in the US by prescription only (dronabinol and nabilone) (Kandagara et al '17: 6). It should be noted that edible cannabis preparations are significantly more potent, "dopey", somnolent, sedating and longer lasting than smoked cannabis. To avoid certain diverticulitis from eating marijuana plant parts it is necessary to strain edible cannabis products after they have been emulsified in butter or oil, to prepare "ghee" for baking. THC serum concentration in the range of 7 to 10 ng/mL is comparable to a blood alcohol concentration of 0.05% on degree of impairment (Grotenhermen et al'07).

Medical cannabis used for chronic pain over one year appears to have a reasonable safety profile. The detailed listing of adverse events to medical cannabis will enhance clinical decision-making. The average daily dose of dried herbal cannabis used by patients with chronic pain was 2.5g/day. Medical cannabis use over one year was associated with improvements in pain, function, quality of life and cognitive function. The cannabis group included 141 (66%) "current cannabis users", 58 (27%) "ex-cannabis users", and 16 (7%) "cannabis-naive users". Controls included 70 (32%) "ex-cannabis users" and 146 (68%) "cannabis-naive users". Compared with cannabis users, more control patients were using opioids (55% in cannabis group vs 66% in the control group), antidepressants (47% vs 59%), or anticonvulsants (44% vs 55%) at baseline. Sixty-seven patients receiving study cannabis and 34 control patients discontinued the study before the full year of follow-up. Due to the small number of cannabis-naive patients in the study, the safety of medical cannabis use in cannabis-naive individuals cannot be addressed. Twenty-eight (13%) patients in the cannabis group reported at least 1 SAE, compared with 42 (19%) in the control group. Compared with baseline, a significant reduction in average pain intensity over 1 year was observed in the cannabis group (change = .92; 95% CI=62–1.23) but not in the control group (change = .18; 95% CI=−.13 to .49). Greater improvement of physical function was noted in cannabis users than in controls (2.36 point greater improvement at 6 months, 95% CI=.84–3.88; and 1.62 points at 1 year, 95% CI=.10–3.14) (Ware et al '15).

Several studies have proven the effectiveness of marijuana on non-cancer pain, specifically related to MS and neuropathic pain such as fibromyalgia, peripheral diabetic neuropathy, spinal cord injury and HIV. They also insufficient evidence for the use of medical cannabis for pain related to other conditions such as cancer, rheumatoid arthritis, and musculoskeletal pain. Patients used cannabis for almost all symptoms associated with fibromyalgia with no reported worsening of symptoms (strong relief reported by 81% for sleep disorders to 14% for headaches). 68% of patients reported reduction in pharmacological treatment (not otherwise specified) when they started using cannabis. 2 hours post-cannabis use, VAS (100 mm) scores showed significant mean reduction in pain (37.1 mm reduction) and stiffness (40.7 mm reduction), $P<.001$. Participants continued their current pharmacologic regimen; at baseline (users vs non-users), analgesic/anti-inflammatory drugs used by 75% vs 64%, antidepressants used by 50% vs 61%, anxiolytics used by 36% vs 36%, opioids used by 21 vs 39%, myorelaxants used by 4% vs 21%, hypnotics used by 18% vs 29% (Fiz '11). For patients with chronic pain, mostly neuropathic, a significant reduction in pain was noted for THC and 1:1 THC/CBD combinations in comparison with placebo or CBD alone (Norcutt '04).

Approximately 30% of Americans currently experience chronic pain, a rate that increases with age

(Ward et al '14). Chronic pain is more prevalent and of greater intensity in the Veteran population than in the general population. This places Veterans at risk for harms from opioid medication, especially opioid use disorder (OUD) (VHA '21: 558). Veterans who use VA healthcare have twice the risk of medication overdose deaths than non-Veterans (VHA '21: 664). Recent studies suggest that 45-80% of individuals who seek cannabis for medical purposes do so for pain management and among patients who are prescribed long-term opioid therapy for pain, an estimated 6-39% are also using cannabis (Reisfield et al '09)(Degenhardt et al '15). Among Veterans receiving treatment within VHA who died from an opioid overdose, the rate increased from 14.5 per 100,000 person years in 2010 to 21.1 per 100,000 person years in 2016 (Lin et al., 2019). While rates of overdose increased, among those who died from an opioid overdose, the percent receiving an opioid prescription in the 3 months prior to death decreased. The increases in opioid overdoses were largely driven by synthetic opioid (e.g., fentanyl) and heroin overdoses. This suggests VHA's expansive safe opioid prescribing efforts has had an impact while showing the need to target future efforts more directly to address opioid use disorders and use of illicit substances. Additionally, there is significant concern with rising rates of stimulant overdoses, specifically methamphetamine. While there was a slight decline in the number of overdose deaths during 2018, review of preliminary death data for 2019 and 2020 suggest a reversal of those trends with rising overdose rates. During 2017, over 4,500 Veterans died from a drug overdose with the majority categorized as unintentional. Less than half of the VA medical centers reported the ability to access residential admission for SUD treatment within seventy-two hours and only slightly more than 61% were able to access admission within thirty days. At the end of 2020, sixty-eight Domiciliary SUD programs were in operation with 1,873 beds focused specifically on intensive, medically monitored residential SUD treatment (VHA '21: 121, 124).

Opiates are drugs derived from the juice of the poppy plant, such as opium, codeine and morphine. Synthetic opioids include heroin, hydrocodone (Vicodin), meperidine (Demerol), oxycodone (Percodan) and propoxyphene (Darvon). The drugs bind to receptors in brain cells to produce drowsiness, pain relief and euphoria. Opioid dependence has a deleterious effect on a person's health, relationships and employment. The best strategy is accomplished by achieving and maintaining abstinence. This is best accomplished by an intensive program of counseling while stopping your use. This may include an initial two-to four-week inpatient stay at a hospital or detoxification center, especially if there is simultaneous dependence on other drugs, such as alcohol and benzodiazepines. Individual therapy and attendance at Narcotics Anonymous may be useful for many years until the person develops constructive way to manage uncomfortable feelings. Medication may be useful to treat an ongoing psychiatric syndrome of anxiety, depression or mood swings, but no medications have been shown to improve the craving and dependency itself. The physical symptoms that occur when opioids are stopped are very unpleasant, though not generally dangerous, and do not call for any major medical program of detoxification beyond simple tapering. They include increased breathing, increased heart rate, sweating, goose bumps, runny nose, nausea, vomiting, abdominal cramps, tremors, hyperactivity and irritability over seven to ten days. Clonidine (Catapres) an antihypertensive agent has been used with some success in inpatient settings to minimize withdrawal symptoms. It has not been successful when used in outpatient settings because of the side effects of lethargy, dizziness, and over-sedation and the ongoing availability of illicit opioids. An addiction to intravenous heroin requires a more intense approach. The most common method of detoxification is a one-week to six-month treatment with methadone, which blocks withdrawal effects. Methadone produces mild euphoria, but this effect wanes with regular use. Whether methadone should be prescribed for extended periods is a matter of intense medical, psychiatric, legal and political controversy. Detractors of methadone maintenance stress the importance of abstinence and a drug-free life and note the diversion of

methadone into illicit uses. Supporters point to the rather low 15 percent success rate of addicts who attempt abstinence on their own. They also not the decrease in criminal behavior, improved physical health, decreased rate of HIV infection and increased employment in addicts who are maintained on methadone. Methadone is available only in federally licensed clinics to people who have been addicted for at least one year. Buprenorphine is an opioid with a relatively long half-life which has been shown to be as effective as methadone in reducing illicit opioid use, but is currently approved only as an analgesic (Drummond '00: 103-104). Fatal drug overdoses from methadone increased from around 500 in 1999 to 5,000 in 2006 and it is necessary to provide consumers with opiate antogonists that reverse potentially fatal respiratory depression such as injectable Narcan (Naloxone) or oral naltrexone

President Trump's 2018 Initiative to Stop Opioids Abuse and Reduce Drug Supply and Demand directly contributed to a 19 percent reduction in the number of patients receiving opioids. Overall, there was a 32 percent decline since 2017. VA's Stratification Tool for Opioid Risk Mitigation (STORM) uses VHA administrative data and predictive modeling to help improve opioid safety by identifying patients at the highest risk for overdose or suicide-related events and assigning them a risk score. STORM is updated nightly and provides risk scores and risk mitigation strategies for patients with an active outpatient opioid prescription or who have an opioid use disorder. In 2020, almost 12,300 reviews were completed on these patients. The VA Opioid Overdose Education and Naloxone Distribution (OEND) program aims to decrease opioid-related overdose deaths among VHA patients by providing education on opioid overdose prevention, recognition of opioid overdose, and training on the rescue response, including provision of naloxone. Since implementation of the OEND program in 2014, over 31,700 VHA prescribers, representing all VHA facilities, have prescribed naloxone, and more than 534,900 naloxone prescriptions have been dispensed to over 285,700 Veterans (as of April 2021). Through April 2021, as documented through spontaneous reporting of overdose reversal events as well as through a national note template, over 1,800 overdose reversals with naloxone have been reported, with an additional 146 reversals reported from naloxone in AED Cabinets and carried by VA Police. In 2018 VA dispensed a naloxone prescription for 1 in 5 patients on high dose opioids compared to 1 in 69 patients in the private sector (Guy et al, 2019).

The Pain Management Program in Specialty Care Services (SCS) expanded through funding established with the enactment of P.L. 114 -198, title XI, the Jason Simcakoski Memorial and Promise Act, also referred to as *Jason's Law,* to form the Pain Management, Opioid Safety Program (PMOP) office (VHA '21: 110-113). The 2022 budget provides $621 million for VA's "Opioid" Prevention and Treatment programs. VA continues to pursue a comprehensive strategy to promote safe prescribing of opioids when indicated for effective pain management and to directly address treatment of opioid use disorder and prevention of opioid overdose. The increased funding in 2022 will help to staff the PMOP office and allow for more targeted funding of pain management and opioid safety programs primarily at the facility level with national support to ensure successful implementation. In addition, funding will be used to support continued growth and replenishment of VA's Opioid Overdose Education and Naloxone Distribution, which provides naloxone and education to VA patients at-risk for opioid overdose.

In general, severely mentally ill patients do not want marijuana, however legalizing marijuana is an important step towards making a complete recovery, especially for prior consumers, but also psychologically for everyone making a clean break from malevolent exposure to mind altering substances and the armed regime extraordinarily under the undereducated and scientifically invalid

influence of drug control, who abuses WHO. Isolated DEA registered "general" practitioners and their patients are particularly vulnerable to torture by mind altering substances, in particular DOM, whilst pharmacists, hospitals and their patients tend to chronic pain with bouts of severe pain coinciding with unlawful disclosure. The FY 22 Indian Health Service budget held 80% of people who committed suicide had visited a clinician in the past year, but only 20% had visited a hospital, where there is some safety in numbers, against DOM.

To prevent the majority of serious mental illness caused by DOM exposure, and opioid overdoses, and to prevent torture by the infringing FBI/DEA/ONDCP third party, it is advised that the majority of medical practitioners, other than "pain management specialists and their pharmacists", who have not legitimate use for opioids, to join psychiatrists and online pharmacies to boycott DEA Registration identity theft completely because they they have no legitimate use to prescribe their patients any listed Controlled Substances whatsoever under 21CFR§1301.11. To take corrective action against the obvious infringement, DEA registration should be limited to pain management specialists and their pharmacists. Furthermore, to prevent home invasion and excruciatingly painful tortures, it is extremely important that the address requirement be overruled for all prescription labels and data entry, involving controlled substances, especially opioids, and maybe all personally identifying patient and physicians information reported to the DEA, if this could be done accountably under 21CFR§1306.05 whereas a person cannot be used to render a territory immune from military intervention under Art. 28 of the Fourth Geneva Convention Relative to the Protection of Civilians in Times of War (1949). The disclosure requirement is facially invalid because it burdens *Americans for Prosperity Foundation v. Bona, Attorney General of California* No. 19-215 July 1, 2021.

For the VA to prescribe and provide PTSD and chronic pain patients with therapeutic marijuana, with a consciounse that is clean of DEA registered infringement, whether or not marijuana is legal in their state, it is not necessary for Congress and the Attorney General to repeal marijuana from Schedule I(c)(17) of the CSA under 21USC§812(c). The DEA would not be offended if their DEA registered health care practitioners prescribed marijuana for PTSD and chronic pain and VA pharmacists distributed it. VHA Directive 131 Access to VHA Clinical Programs For Veterans Participating in State-Approved Marijuana Programs of December 8, 2017 needs to be updated to legalize marijuana prescription and distribution at the VA. Marijuana has been reported as successful in relieving symptoms of addiction, anxiety, tension, stress and depression, attention deficit hyperactivity disorder (ADHD), HIV/AIDS, post-traumatic stress disorder (PTSD), insomnia, migraine, movement disorders, multiple sclerosis, digestive problems, inflammation, nausea and vomiting, cancer treatment side-effects, pain, spasms and convulsions, psoriasis and arthritis (Martin et al '11: 15, 17).

CHAPTER 3—NATIONAL HOME FOR DISABLED VOLUNTEER SOLDIERS

SUBCHAPTER I—ESTABLISHMENT AND MANAGEMENT

SUBCHAPTER V—BATTLE MOUNTAIN SANITARIUM RESERVE

SUBCHAPTER I—ESTABLISHMENT AND MANAGEMENT

§§71 to 77a. Repealed. Pub. L. 85–857, §14(1), (6), (9), (16), (35), (59), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272

§71 Organization of home

The President, Secretary of War, Chief Justice, and such other persons as from time to time may be associated with them, shall constitute a Board of Managers of an establishment for the care and relief of the disabled volunteers of the United States Army, to be known by the name and style of "The National Home for Disabled Volunteer Soldiers," and have perpetual succession, with powers to take, hold, and convey real and personal property, establish a common seal, and to sue and be sued in courts of law and equity; and to make by-laws, rules, and regulations, not inconsistent with law, for carrying on the business and government of the home, and to affix penalties thereto. (R. S. § 4825; Repealed. Pub. L. 85–857, §14(1), (6), (9), (16), (35), (59), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272)

§72 Headquarters of Home

The headquarters of the National Home for Disabled Volunteer Soldiers shall be established and maintained at the central branch, National Military Home, Ohio, and shall occupy for offices, without expenditure for rent, any general or post fund building. (July 1, 1010, c. 209, § 1, 89 Stat. 297; Repealed. Pub. L. 85–857, §14(1), (6), (9), (16), (35), (59), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272)

§73 Election of citizen managers

Seven managers of the National Home for Disabled Volunteer Soldiers shall be elected from time to time, as vacancies occur, by joint resolution of Congress. They shall all be citizens of the United States and no two of them shall be residents of the same State. The terms of office of these managers shall be for six years and until a successor is elected. (R. S. § 4820; June 7, 1024, c. 291, Title II, 43 Stat. 518. Acts Mar. 2, 1887, ch. 316, §4, 24 Stat. 44; Mar. 3, 1891, No. 21, 26 Stat. 117; June 23, 1913, ch. 3, §1, 38 Stat. 43; Oct. 19, 1914, No. 49, 38 Stat. 780, related to number of citizen managers of National Home for Disabled Volunteer Soldiers; Repealed. Pub. L. 85–857, §14(1), (6), (9), (16), (35), (59), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272)

§74 Election of officers of Board of Managers

The ten (or seven) managers of the National Home for Disabled Volunteer Soldiers shall elect from their own number a president, who shall be the chief executive officer of the board, two vice presidents, and a secretary. Six of the board, of whom the president or one of the vice presidents shall be one, shall form a quorum for the transaction of business at any meeting of the board. (R. S. 1 4827; June 7, 1024, c. 201, Title II, 43 Stat 518; Repealed. Pub. L. 85–857, §14(1), (6), (9), (16), (35), (59), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272)

§75 Expenses and salaries of managers and officers

No member of the Board of Managers of the National Home for Disabled Volunteer Soldiers shall receive any compensation or pay for any services or duties connected with the home; but the traveling and other actual expenses of a member, incurred while upon the business of the home, may be reimbursable to each member: Provided, That the president and secretary of the Board of Managers may receive a reasonable compensation for their services as such officers, not exceeding $1,000 and $2,000, respectively, per annum. (Aug. 18, 1891, c. 3101, § 1, 28 star. 112; Repealed. Pub. L. 85–857, §14(1), (6), (9), (16), (35), (59), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272)

§76 Duties of Board of Managers

The Board of Managers shall make an annual report of the condition of the National Home for Disabled Volunteer Soldiers to Congress on the first Monday of every January, which shall include detailed statement of the expenses of the board; and the board shall examine and audi the accounts of the treasurer and visit the home quarterly. (R. S. § 4834; Mar. 3, 1885, c. 360, 23 Stat. 510; Mar. 3, 1887, c. 362, 24 Stat. 539; Repealed. Pub. L. 85–857, §14(1), (6), (9), (16), (35), (59), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272)

§77 Sites for homes; purchase and erection of buildings

The Board of Managers shall have authority to procure from time to time, at suitable places, sites for military homes for all persons serving in the Army of the United States at any time in the War of the Rebellion, not otherwise provided for, who have been or may be disqualified for procuring their own support by reason of wounds received or sickness contracted while in the line of their duty during the rebellion; and to have the necessary buildings erected, having due regard to the health of location, facility of access, and capacity to accommodate the persons entitled to the benefits thereof. (R. S. § 4830; Repealed. Pub. L. 85–857, §14(1), (6), (9), (16), (35), (59), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272)

§77a Same; Dayton, Ohio [Executed]

This section (act of Feb. 20, 1929, ch. 272, §1, 45 Stat. 1248) is executed.(Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857)

§78 Condemnation of land

The provisions of sections 257 and 258 of Title 40, shall be construed to apply to the Board of Managers of the National Home for Disabled Volunteer Soldiers. (July 19, 1897, c. 9, 30 Stat. 121; Repealed Pub. L. 85–56, title XXII, §2202(58), June 17, 1957, 71 Stat. 164; Repeal effective Jan. 1,

1958, see section 2301 of Pub. L. 85–56, title XXIII, June 17, 1957, 71 Stat. 172)

§79 Jurisdiction over sites of branch homes ceded to States

The Jurisdiction over the places purchased and used for the location of the branches of the National Home for Disabled Volunteer Soldiers, In Milwaukee County, State of Wisconsin, and in the county of Leavenworth, State of Kansas, and upon which said branch homes are located, is ceded to the respective States in which said branches are located and relinquished by the United States, and the United States shall claim or exercise no Jurisdiction over said places after March 8, 1901: Provided, That nothing contained in this section shall be construed to impair the powers or rights theretofore conferred upon or exercised by the Board of Managers of the National Home for Disabled Volunteer Soldiers in and on said places. (Mar. 8, 1901, e. 853, § 1, 31 Stat. 1175.)

§80 Purchase of supplies and expenditures for new buildings

All purchases of supplies exceeding the sum of $1,000 at any one time shall be made upon public tender after due advertisement, and the expenditure for new buildings shall be expressly authorized in writing. (Mar. 8, 1870, c. 182, § 1, 20 Stat. 890; Repealed. Pub. L. 85–857, §14(3), (18), (19), Sept. 2, 1958, 72 Stat. 1268, 1270)

§81 Supplies

All supplies for the National Home for Disabled Volunteer Soldiers shall be purchased, shipped, and distributed as may be directed by the Board of Managers. (July 1, 1898, c. 546, § 1, 30 Stat. 640; Repealed. Pub. L. 85–857, §14(3), (18), (19), Sept. 2, 1958, 72 Stat. 1268, 1270)

§82 Medical supplies

Upon proper application therefor, the Medical Department of the Army is authorized to sell medical and hospital supplies at its contract prices to the National Home for Disabled Volunteer Soldiers. (June 11, 1800, c. 120, 29 Stat. 445; Repealed. Pub. L. 85–857, §14(3), (18), (19), Sept. 2, 1958, 72 Stat. 1268, 1270; Repeal effective Jan. 1, 1959, section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§83 Issue of obsolete cannon or ordnance

The Secretary of War is authorized and directed, subject to such regulations as he may prescribe, to deliver to any of the "National Homes for Disabled Volunteer Soldiers" and to any of the State homes for soldiers and sailors, or either, now or hereafter duly established and maintained under State authority, such obsolete serviceable cannon, bronze or iron, suitable for firing salutes, as may be on hand undisposed of, not exceeding two to any one home. The Chief of Ordnance is authorized to issue such obsolete or condemned ordnance, gun carriages, and ordnance stores as may be needed for ornamental purposes to the Homes for Disabled Volunteer Soldiers, the homes to pay for transportation out of any appropriation for current expenses, (Feb. 8, 1889, c. 110, 25 Stat. 657; May 20, 1000, c. 580, 31 Stat. 216; Repealed. Aug. 10, 1956, ch. 1041, § 53, 70A Stat. 641; see sections 4686 and 9686 of Title 10, Armed Forces)

§84 Annual inspection; report

Once in each fiscal year, the Secretary of War shall cause a thorough inspection to be made of the National Home for Disabled Volunteer Soldiers, its records, disbursements, management, discipline, and condition, such inspection to be made by an officer of the Inspector General's Department, who shall report thereon in writing, and said report shall be transmitted to Congress at the first session thereafter. (Aug. 18, 1894, c. 301, § 1, 28 Stat. 412; Repealed. Pub. L. 85–857, §14(16), Sept. 2, 1958, 72 Stat. 1269; Effective Date of Repeal. Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

SUBCHAPTER II—OFFICERS AND EMPLOYEES

§91 Officers of home; medical officers

The officers of the national home shall consist of a governor, a deputy governor, a secretary, a treasurer, and such other officers as the managers may deem necessary. They shall be appointed from honorably discharged soldiers who served as mentioned in section 77 of this title and they may be appointed and removed, from time to time, as the interests of the institution may require, by the Board of Managers: Provided, That surgeons, assistant surgeons, and other medical officers of the National Home for Disabled Volunteer Soldiers, and the several branches thereof, many be appointed from others than those who have been disabled in the military service of the United States. (R. S. § 4829; Apr. 11, 1892, c. 40, 27 Stat. 15; Feb. 0, 1807, c. 205, 29 Stat. 517; Repealed. Pub. L. 85–857, §14(1), Sept. 2, 1958, 72 Stat. 1268; Effective Date of Repeal. Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§92 Qualifications of officers

The officers of the National Home for Disabled Volunteer Soldiers, and officers under the Board of Managers thereof, shall be appointed, so far as may be practicable, from persons whose military or naval service would render them eligible, if disabled and not otherwise provided for, for admission to the home, and they may be appointed, removed, and transferred, from time to time, as the interests of the institution may require, by the Board of Managers. (June 28, 1002, c. 1301, § 1, 32 Stat. 472; Repealed. Pub. L. 85–56, title XXII, §2202(66), June 17, 1957, 71 Stat. 162; Repeal effective Jan. 1, 1958, see section 2301 of Pub. L. 85–56, title XXIII, June 17, 1957, 71 Stat. 172)

§93 Classification and compensation of officers and employees; traveling expenses

The Board of Managers shall classify all the officers and employees of the National Home for Disabled Volunteer Soldiers and establish a rate of pay and allowance for each class, and the rate so established shall not be increased by fees, perquisites, allowances, or advantages under any pretense whatever; and no employee shall be borne on more than one pay roll or voucher. When an officer of the National Home for Disabled Volunteer Soldiers, not a member of the Board of Managers thereof, travels under orders on business for the home he shall be allowed 7 cents in lieu of all other expenses for each mile actually traveled, distance to be computed by the most direct through route. (Aug. 18, 1894, c. 301, § 1, 28 Stat. 412; Repealed. Pub. L. 85–857, §14(16), (23), (25), Sept. 2, 1958, 72 Stat. 1269, 1270; Effective Date of Repeal. Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§94 Bonds of general treasurer and treasurers of branch homes

The general treasurer shall give good and sufficient bond to the United States in a sum not less than $100,000, as the Secretary of War may direct, and to be approved by him, faithfully to account for all public moneys and property which he may receive, and the treasurers of the several branch homes shall give good and sufficient bonds to the general treasurer in such sums as he may require, and to be approved by him, faithfully to account for all public moneys and property which they may receive. (Aug. 18, 1894, c. 801, 1 1, 28 Stat. 412; Repealed. Pub. L. 85–857, §14(16), (23), (25), Sept. 2, 1958, 72 Stat. 1269, 1270; Effective Date of Repeal. Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§95 General treasurer; performance of duties by assistant treasurer and assistant inspector general; bond; liability

The assistant general treasurer and assistant inspector general shall, in the necessary absence or inability of the general treasurer, from any cause whatever, perform his duties and give bond to the general treasurer for the faithful performance of such duties, but the general treasurer shall in every respect be responsible, on his bond, to time United States for any default on the part of such assistant general treasurer and assistant inspector general. (June 0, 1900, c. 791, § 1, 31 Stat. 030; Repealed. Pub. L. 85–857, §14(16), (23), (25), Sept. 2, 1958, 72 Stat. 1269, 1270; Effective Date of Repeal. Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§96 Officer to act in absence of treasurer or quartermaster at branch homes; bond

The Board of Managers of the National Home for Disabled Volunteer Soldiers may, in their discretion, designate and authorize an officer at each or any of the several branches of the National Home for Disabled Volunteer Soldiers to perform such duties in connection with the offices of the treasurer and quartermaster at any such branch as they may direct, and in the necessary absence or inability of either of said officers from any cause whatever to have power to act in their places and performing all of the duties connected with the said respective offices. All officers so designated and authorized to act as provided in this section shall give bond to the general treasurer of the National Home for Disabled Volunteer Soldiers in such amount as lie may require, and to be approved by hm, faithfully to account for all public moneys and property which they may receive. (Mar. 3, 1901, c. 853, § 1, 31 Stat. 1178; Repealed. Pub. L. 85–857, §14(16), (23), (25), Sept. 2, 1958, 72 Stat. 1269, 1270; Effective Date of Repeal. Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§97. Omitted

Codification. Section, act Mar. 3, 1887, ch. 362, 24 Stat. 540, related to compensation and expenses of officers and employees, and was omitted because of dissolution of National Home for Disabled Volunteer Soldiers.

SUBCHAPTER III—FUNDS AND ACCOUNTS

§111 Donations for home

The Board of Managers are authorized to receive all donations of money or property made by any person or persons for the benefit of the home, and to hold or dispose of the same for its sole and exclusive use. (R. S. § 4831; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§112 Receipts from sales

All sums received from sales of subsistence stores or other property of the National Home for Disabled Volunteer Soldiers shall be taken up by the dlqbursing officer under the proper current appropriation and be available for disbursement on account of that appropriation. (Aug. 18, 1891, e. 301, § 1, 28 Stat. 412; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§113 Money allotted by Veterans' Bureau for support, etc., of World War veterans not to be used for support of home

Moneys allotted to the Board of Managers of the National Home for Disabled Volunteer Soldiers by the Veterans' Bureau for support, maintenance, and care of World War veterans shall not be used to augment or reimburse the appropriations made for the support of the National Home for Disabled Volunteer Soldiers, but shall be covered into the surplus fund of Treasury, and the Budget shall contain annual itemized estimates covering the entire cost of the operation and maintenance of the National Home for Disabled Volunteer Soldiers, including the cost of the maintenance, support, and care of beneficiaries of the United States Veterans' Bureau in such homes. (Mar. 2, 1923, e. 178, Title II, 42 Stat. 1424; repealed by Pub. L. 85–857, §14(44), (46), Sept. 2, 1958, 72 Stat. 1271)

§114 Appropriations for buildings; available until expended

Appropriations made for the construction of buildings at any of the branches of the National Home for Disabled Volunteer Soldiers shall continue available until expended. (June 0, 1900, c. 785, § 1, 31 Stat. 294; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§115 Appropriations for branch homes immediately available

Appropriations made for construction of buildings and appurtenances at any of the branches of the National Homo for Disabled Volunteer Soldiers, shall be available immediately after the approval of the Act containing the same. (Mar. 3, 1003, c. 1007, § 1, 32 Stat. 1137; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§116 Appropriations for repairs of branch homes not used for new building

No part of the appropriation for repairs for any of the branch homes shall be used for the construction of any new building. (Mar. 3, 1915, c. 75, § 1, 38 Stat. 850; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§117 Security for deposits

It shall be the duty of the Secretary of the Treasury to require from the president and cashier of all banks used as depositories by the treasurer of the home a deposit of bonds sufficient in amount to fully secure all moneys pertaining to said home left on deposit with any such bank. (July 9, 1880, c. 750, § 2, 24 Stat. 129; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§118 Supervision of accounts

The Secretary of War shall exercise the same supervision over all receipts and disbursements on account of the volunteer soldiers' homes as he is required by law to apply to the accounts of disbursing officers if the Army. (Mar. 3, 1893, c. 210, 27 Stat: 653; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§119 Disbursements; accounts; supplies; posthumous fund

All amounts disbursed from the appropriation of a branch home shall be disbursed and accounted for monthly to the general treasurer by the treasurer of that branch, except such expenditures for services, stationery, tableware, clothing and bedding as may be required by the Board of Managers to be legally made by the general treasurer, and all such stationery, tableware, clothing and bedding as may be required for each branch home shall be shipped directly from the place of purchase or manufacture to such branch home; and all disbursements shall be made in conformity with sections 628 and 665 of Title 31. All receipts on account of the effects of deceased members shall be credited to the appropriation for "current expenses" of the fiscal year during which such amounts were received, and all repayments of such amounts shall be made from and charged to the like appropriation for the fiscal year in which such repayments shall lie made. (Aug. 18, 1894, c. 301, § 1, 28 Stat. 411; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§120 Expenditures subject to laws on disbursements; audit

All of the expenditures of the National Home for Disabled Volunteer Soldiers, Including the expenses of the Board of Managers, shall be made subject to the general laws governing the disbursement of public moneys, so far as the same can be made applicable thereto, and shall be audited by the General Accounting Office. (Mar. 3, 1897, c. 362, 24 Stat. 539; June 10, 1921, c. 18, § 304, 42 Stat. 24; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note

preceding Part I of Title 38, Veterans' Benefits)

§121 Auditing and settlement of accounts

The accounts relating to the expenditure of all public moneys appropriated for the support and maintenance of the National Home for Disabled Volunteer Soldiers shall be audited by the Board of Managers of said home in the same manner as is provided for the accounts of the various departments of the United States Government, and thereupon immediately transmitted directly to the General Accounting Office for final audit and settlement. (Mar. 3, 1901, c. 853, § 1, 31 Stat. 1178; June 10, 1921, c. 18, § 304, 42 Stat. 24; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§122 Employment of clerks; appropriations; estimates; requisitions; accounts

No clerk shall be employed or paid in any department of the Government for services rendered under any provision of this chapter. No money shall be appropriated or drawn for the support and maintenance of the National Home for Disabled Volunteer Soldiers, except by direct and specific annual appropriations by law and except as provided in section 112. And no moneys shall be drawn from the Treasury for the use of said home, except in pursuance of quarterly estimates, and upon quarterly requisitions by the managers thereof upon the Secretary of War, based upon such quarterly estimates for the support of said home for not more than three months next succeeding such requisition. And no money shall be drawn or paid upon any such requisition while any balance drawn or received by said home, or for its use, from the Treasury, and held under investment or otherwise, shall remain unexpended. And the managers of said home shall, at the commencement of each quarter of the year, render to the Secretary of War an account of all their receipts and expenditures for the quarter immediately preceding, with the vouchers for such expenditures; and all such accounts and vouchers shall be authenticated by the officers of said home thereunto duly appointed by said managers, and audited, and allowed, as required by law for the general appropriations and expenditures of the War Department. (Mar. 3, 1875, c. 129 § 1, 18 Stat. 359; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§123 Statement of expenses in Budget

The statement of expenses of the Board of Managers of the National Home for Disabled Volunteer Soldiers shall each year be submitted in the annual budget and shall be made to show the amount of salary or compensation paid to each of the officers and employees of said board, and there shall also be submitted therewith a statement, showing the number of officers appointed at each of the branch homes under section 91 of this title, the amount of salary or compensation paid to each, and the amount of allowance to each, if any, for contingent or other expenses (Aug. 5, 1892, c. 380, § 1, 27 Stat. 384; June 10, 1921, c. 18, 42 Stat 20; Repealed. Pub. L. 85–857, §14(1), (2), (7), (9), (14)–(16), (22), (25), (27), (34), (46), Sept. 2, 1958, 72 Stat. 1268–1271; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

SUBCHAPTER IV—BENEFICIARIES AND PENSIONS

§131 Persons entitled to benefits of home

The following persons shall be entitled to benefits of the National Home for Disabled Volunteer Soldiers, and may be admitted thereto upon the order of a member of the Board of Managers, namely: Honorably discharged officers, soldiers, sailors, or marines who served in the Regular, Volunteer, or other forces of the United States, or in the Organized Militia or National Guard when called into Federal service, and who are disabled by diseases or wounds and who have no adequate means of support and by reason of such disability are either temporarily or permanently incapacitated from earning a living. (Acts May 26, 1900, ch. 586, 31 Stat. 217; Jan. 28, 1901, ch. 184, §5, 31 Stat. 745; May 27, 1908, ch. 200, §1, 35 Stat. 372; Mar. 4, 1909, ch. 209, §1, 35 Stat. 212; Mar. 3, 1915, ch. 75, §1, 38 Stat. 853; Oct. 6, 1917, ch. 79, §1, 40 Stat. 368; June 5, 1920, ch. 235, §1, 41 Stat. 905; June 7, 1924, c. 291, Title II, 43 Stat. 519; Repealed. Pub. L. 85–857, §14(49), Sept. 2, 1958, 72 Stat. 1271; Repeal effective Jan. 1, 1959, see section 2 and 14 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits).

§131a Same; Dayton, Ohio

In addition to the persons by law entitled on February 20, 1929, to the privileges of treatment in the hospital at Dayton, Ohio, provided for in the Act of February 20, 1929, c. 272, § 1, 45 Statutes 1248, there shall be admitted and treated honorably discharged nurses (female) who have served with the armed forces of the United States in any war and who are disabled by diseases or wounds and by reason of such disability are either temporarily or permanently incapacitated from earning a living. (Feb. 20, 1929, ch. 272, §2, 45 Stat. 1248; July 3, 1930, c. 863 § 2, 46 Stat. 1016; See act July 3, 1939, ch. 863, §§1, 2, 5, 46 Stat. 1016; Omitted)

131b Same; Marion, Indiana

Upon the order of the Administrator of Veterans' Affairs the following persons shall be admitted to the cottages and hospital annex at Marion, Indiana, provided for in the Act of March 4, 1927, c. 504, § 1, 44 Statutes 1421, for the purpose of receiving medical treatment and the other benefits of such home: All persons who served in the military or naval forces of the United States, including the Organized Militia, the National Guard, and the Naval Militia, when called into the Federal service, and were separated therefrom under honorable conditions, who have no adequate means of support and by reason of diseases or wounds, are either temporarily or permanently incapacitated from earning a living. (Mar. 4, 1927, ch. 504, §2, 44 Stat. 1421; July 3, 1930, c. 863, § 2, 46 Stat. 1016; Omitted)

§132 Assignment to different branches of classes eligible to admission

To increase the comfort of the members, the Board of Managers, National Home for Disabled Volunteer Soldiers, is authorized to make such rules governing the assignment to the different branches of the home as it deems advisable and best for the public service. (June 5, 1920, ch. 235, §1, 41 Stat. 905, Repealed. Pub. L. 85–56, title XXII, §2202(100), June 17, 1957, 71 Stat. 166; Repeal effective Jan. 1, 1958, see section 2301 of Pub. L. 85–56, title XXIII, June 17, 1957, 71 Stat. 172)

§133 Outdoor relief; transfers from branch homes

The managers of the National Home for Disabled Volunteer Soldiers are authorized to aid persons who

are entitled to its benefits by outdoor relief, in such manner and to such extent as they may deem proper, but such relief shall not exceed the average cost of maintaining an inmate of the home. In the event that buildings at any branch of the home shall be destroyed by fire or rendered unfit for habitation because of pestilence or by the elements, then and in that event the Board of Managers shall have the authority to remove the members of said branch so afflicted or destroyed to any other branch not so affected, and to do this they may use any funds appropriated for the home, notwithstanding they may have been specifically appropriated for other purposes, to the extent that such funds shall be necessary to effect such transfer and the maintenance and support thereafter of said members so transferred, and shall report their doings therein to the Congress and their expenditures as in other cases of expenditures: *Provided*, That the appropriations for any fiscal year shall not be exceeded. (R.S. § 4833; Aug. 23, 1894, c. 316, 28 Stat. 492; May 29, 1928, ch. 901, §1(123), 45 Stat. 995; Repealed. Pub. L. 85–857, §14(1), (10), (12), (50), (52), (64), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§134 Aid to State or Territorial home

All States or Territories which have established, or which shall establish, State home for disabled soldiers and sailors of the United States who served in the Civil War or in any previous or subsequent war who are disabled by age, disease or otherwise, and by reason of such disability are incapable of earning a living, provided such disability was not incurred in service against the United States, shall be paid for every such disabled soldier or sailor who may be admitted and cared for in such home at the rate of $120 per annum.

The number of such persons for whose care any State or Territory shall receive the said payment under this section shall be ascertained by the Board of Managers of the National Home for Disabled Volunteer Soldiers under such regulations as it may prescribe, but the said State or Territorial homes shall be exclusively under the control of the respective State or Territorial authorities, and the Board of Managers shall not have nor assume any management or control of said State or Territorial homes.

The Board of Managers of the national home shall, however, have power to have the said State or Territorial homes inspected at such times as it may consider necessary, and shall report the result of each inspections to Congress in its annual report: *Provided*, That no State shall be paid a sum exceeding one-half the cost of maintenance of each soldier or sailor by such State: *Provided further*, That one-half of any sum or sums retained by State homes on account of pensions received from inmates shall be deducted from the aid provided for in this section: *Provided further*, That for any sum or sums collected in any manner from inmates of such State or Territorial homes to be used for the support of said homes a like amount shall be deducted from th aid provided for in this section, but this proviso shall not apply to any State or Territorial home into which the wives or widows of soldiers are admitted and maintained. (Aug. 27, 1888, c. 914 § 1, 25, State. 450; Mar. 2, 1889, c. 411, 25 Stat. 975; Jan. 27, 1920, c. 56, 41 Stat. 399; Feb. 12, 1925, ch. 225, 43 Stat. 933; Apr. 15, 1926, ch. 146, 44 Stat. 294; Feb. 23, 1927, c. 167, 44 Stat. 1145; Dec. 22, 1927, c. 5, §1, 45 Stat. 39; Mar. 23, 1928, c. 232, §1, 45 Stat. 363; Feb. 28, 1929, c. 366, 45 Stat. 1385; May 28, 1930, c. 348, 46 Stat. 466; July 3, 1930, c. 863, §2, 46 Stat. 1016; Feb. 23, 1931, c. 281, §1, 46 Stat. 1375; June 30, 1932, c. 330, §1, 47 Stat. 472; Aug. 1, 1939, c. 408, §1, 53 Stat. 1145; Dec. 17, 1943, c. 347, §1, 57 Stat. 603; Dec. 17, 1943, c. 347, §2, 57 Stat. 603; May 18, 1948, ch. 299, §2, 62 Stat. 237; Sept. 23, 1950, c. 1003, 64 Stat. 981; Aug. 21, 1954, ch. 782, §2, 68 Stat. 757; Repealed by Pub. L. 85–857, §14(74), (85), (95), (106), Sept.

2, 1958, 72 Stat. 1272, 1273; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits).

§135 Persons entitled to admission to hospital at Pacific branch

The persons who shall be entitled to the privileges of treatment in the hospital erected at the Pacific branch of the National Home for Disabled Volunteer Soldiers at Santa Monica, California, and who may be admitted thereto upon the order of a member of the Board of Managers of the National Home for Disabled Volunteer Soldiers, shall be the following: Honorably discharged officers, soldiers, sailors and marines who served in the Regular, Volunteer, or other forces of the United States in the War with Mexico, the Civil War,the War with Spain, and the World War, or in any war in which the country has been engaged, in campaigns against hostile Indians, or who served in any of the extraterritorial possessions of the United States in foreign countries, including Mexican border service, or in the Organized Militia or National Guard when called into the Federal service, and who are disabled by diseases or wounds and by reason of such disability are either temporarily or permanently incapacitated from earning a living. (June 7, 1924, c. 295, § 2, 43 Stat. 534; Repealed. Pub. L. 85–857, §14(1), (10), (12), (50), (52), (64), Sept. 2, 1958, 72 Stat. 1268, 1269, 1271, 1272; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§136 Disposition of personal property of deceased members

The application of any person for membership in the National Home for Disabled Volunteer Soldiers and the admission of the applicant thereunder shall be and constitute a valid and binding contract between such applicant and the Board of Managers of said home that on the death of said applicant while a member of such home, leaving no heirs at law nor next of kin, all personal property owned by said applicant at the time of his death, including money or choses in action held by him, and not disposed of by will, whether such property be the proceeds of pensions or otherwise derived, shall vest in and become the property of said Board of Managers for the sole use and benefit of the post fund of said home, the proceeds to be disposed of and distributed among the several branches as may be ordered by said Board of Managers, and that all personal property of said applicant shall, upon his death, while a member, at once pass to and vest in said Board of Managers, subject to be reclaimed by any legatee or person entitled to take the same by inheritance at any time within five years after the death of such member. The Board of Managers is directed to so change the form of application for membership as to give reasonable notice of this provision to each applicant, and as to contain the contain the consent of the applicant to accept membership upon the conditions provided in this section (June 25, 1910, c. 384, ·§ 1, 36 Stat. 736; Dec. 26, 1941, ch. 634, 55 Stat. 868, related to disposition of deceased veterans' personal property; Repealed. Pub. L. 85–56, title XXII, §2202(1), (85), June 17, 1957, 71 Stat. 162, 165; Repeal effective Jan. 1, 1958, see section 2301 of Pub. L. 85–56, title XXIII, June 17, 1957, 71 Stat. 172; See section 8520 et seq. of Title 38, Veterans' Benefits)

§137 Inmates subject to Articles of War

All inmates of the National Home for Disabled Volunteers Soldiers shall be subject to the Articles of War, and in the same manner as if they were in the Army. (R.S. § 4835; Repealed. July 3, 1930, ch. 863, §7, 46 Stat. 1018)

§138 Payment of pensions of inmates of home

All pensions and arrears of pensions payable or to be paid to pensioners who are or may become inmates of the National Home for Disabled Volunteer Soldiers shall be paid to the treasurers of said home, to be disbursed for the benefit of the pensioners without deduction or fines or penalties, under the rules and regulations of said home. Said payments shall be made by the Bureau of Pensions upon a certificate of the proper officer of the home that the pensioner is an inmate thereof on the day to which said pension is drawn. The treasurers of said home, respectively, shall give security, to the satisfaction of the managers of said home, for the payment an application by them of all arrears of pension and pension moneys they may receive under the aforesaid provision. Any balance of the pension which may remain at the date of the pensioner's discharge shall be paid over to him. (Feb. 26, 1881, ch. 80, §2, 21 Stat. 350; Aug. 7, 1882, ch. 433, §1, 22 Stat. 322; Aug. 17, 1912, ch. 301, §1, 37 Stat. 312, Repealed. Pub. L. 85–857, §14(4), (5), (26), Sept. 2, 1958, 72 Stat. 1269, 1270; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

§139 Disposition of balance of pension money due deceased inmate

Any balance of pension money due a member of the National Home for Disabled Volunteer Soldiers at the time of his death shall be paid to his widow, minor children or dependent mother or father in the order named, and should not widow, minor child, or dependent parent be discovered within one year from the time of the death of the pensioner, said balance shall be paid to the post fund of the branch of said national home of which the pensioner was a member at the time of his death, to be used for the common benefit of the members of the home under the direction of the Board of Managers, subject to future reclamation by the relatives designated in this section upon application filed with the Board of Managers within five years after the pensioner's death. (July 1, 1902, ch. 1351, §1, 32 Stat. 564; Repealed. Pub. L. 85–857, §14(4), (5), (26), Sept. 2, 1958, 72 Stat. 1269, 1270; Repeal effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as a note preceding Part I of Title 38, Veterans' Benefits)

SUBCHAPTER V—BATTLE MOUNTAIN SANITARIUM RESERVE

§151 Battle Mountain Sanitarium Reserve; establishment; rights to lands, not affected

There are reserved from settlement, entry, sale, or other disposal all those certain tracts, pieces, or parcels of land lying and being situated in the State of South Dakota and within the boundaries particularly described as follows: Beginning at the southwest corner of section 18, township 7 south, range 6 east, Black Hills meridian; thence east to the southeast corner of said section 18; thence south to the southwest corner of the northwest quarter of section 20; thence east to the southeast corner of the northeast quarter of section 21; thence north to the northeast corner of the southeast quarter of section 9; thence west to the center of section 7; thence south to the southwest corner of the southeast quarter of section 7; thence west to the northwest corner of section 18; thence south to the place of beginning, all in township 7 south, range 6 east, Black Hills meridian, in Fall River County, South Dakota: Provided, That nothing herein contained shall be construed to affect any valid rights acquired in connection with any of the lands embraced within the limits of said reserve. (Mar. 22, 1906, ch. 1127, §1, 34 Stat. 83)

§152 Name; control, rules and regulations

Said reserve shall be known as the Battle Mountain Sanitarium Reserve, and shall be under the

exclusive control of the Secretary of Veterans Affairs in connection with the Battle Mountain Sanitarium at Hot Springs, South Dakota, whose duty it shall be to prescribe such rules and regulations and establish such service as the Secretary may consider necessary for the care and management of the same. (Mar. 22, 1906, ch. 1127, §2, 34 Stat. 83; Pub. L. 102–54, §13(i)(2), June 13, 1991, 105 Stat. 276 substituted "Secretary of Veterans Affairs" for "Board of Managers of the National Home for Disabled Volunteer Soldiers" and "as the Secretary may consider necessary" for "as they may deem necessary")

§153 Perfecting bona fide claims to lands; exchange of private lands

In all cases of unperfected bona fide claims lying within the said boundaries of said reserve, which claims have been properly initiated prior to September 2, 1902, said claims may be perfected upon compliance with the requirements of the laws respecting settlement, residence, improvements, and so forth, in the same manner in all respects as claims are perfected to other Government lands: Provided, That to the extent that the lands within said reserve are held in private ownership the Secretary of the Interior is authorized in his discretion to exchange therefor public lands of like area and value, which are surveyed, vacant, unappropriated, not mineral, not timbered, and not required for reservoir sites or other public uses or purposes. The private owners must, at their expense and by appropriate instruments of conveyance, surrender to the Government a full and unencumbered right and title to the private lands included in any exchange before patents are issued for or any rights attached to the public lands included therein, and no charge of any kind shall be made for issuing such patents. Upon completion of any exchange the lands surrendered to the Government shall become a part of said reserve in a like manner as if they had been public lands at the time of the establishment of said reserve. Nothing contained in this section shall be construed to authorize the issuance of any land scrip, and the State of South Dakota is granted the privilege of selecting from the public lands in said State an equal quantity of land in lieu of such portions of section sixteen included within said reserve as have not been sold or disposed of by said State and are not covered by an unperfected bona fide claim as above mentioned. (Mar. 22, 1906, ch. 1127, §3, 34 Stat. 83)

§154 Unlawful intrusion, or violation of rules and regulations

All persons who shall unlawfully intrude upon said reserve, or who shall without permission appropriate any object therein or commit unauthorized injury or waste in any form whatever upon the lands or other public property therein, or who shall violate any of the rules and regulations prescribed hereunder, shall, upon conviction, be fined in a sum not more than $1,000, or be imprisoned for a period not more than twelve months, or shall suffer both fine and imprisonment, in the discretion of the court. (Mar. 22, 1906, ch. 1127, §4, 34 Stat. 83)

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National Park Service Organic Act of 1916 16USC§1 to §18f-3 National Suicide Hotline Designation Act of 2020 Public Law No: 116-172 October 17, 2020

Notice of Claimed Investigational Exemption for a New Animal Drug 21CFR§511.1

Office of National Drug Control Policy 21USC§1701 *et seq*. repeal

Office of National Veterans Sports Programs and Special Events 38USC§322

Office of Rural Health 38USC§7308

Perfecting bona fide claims to land; private exchange 24USC§153

Persons required to register; requirement of modification of registration authorizing activity as an online pharmacy 21CFR§1301.11

Postal Policy 39USC§101

Procedures for classifying OTC drugs as generally recognized as safe and effective and not misbranded, and for establishing monographs 21CFR§330.10

Program Responsibilities and Authorities Section 110 of the National Historic Preservation Act 54USC§306101 - §306114

Prohibited Acts, Food Drug and Cosmetics Act (FD&CA) 21USC§331 et seq.

Prohibition against any federal interference Sec. 1801 of the Social Security Act 42USC§1395

Protection of the individual right to bear arms 16USC§1a-7b transfer to end of the chapter on obstruction of lawful hunt at 16USC§5208

Purpose of Veterans' Canteen Service 38USC§7801

Receiving consideration for appointment to or employment in public office – Misdemeanor SD-22-12A-2

Regulations for State Programs 42USC§300h

Renunciation of criminal intent – Requirements 22-4A-4

Rules and regulations for Army and Navy Hospital 24USC§18
Rules for administration, management, and development of state park system – Violation as misdemeanor SD-41-17-1.1

Schedules of Controlled Substances 21USC§812

Sharing arrangements with Federal agencies 25USC§1645

Sharing of health resources 38USC§8153

Sherman Anti-Trust Act 26 Stat. 209 Monopolizing trade a felony; penalty 15USC§2

Sherman Anti-Trust Act 26 Stat. 209 Trusts, etc., in restraint of trade illegal; penalty 15USC§1

Standard for Demolition and Renovation 40CFR§61.145

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Unlawful appointments or employments void – Official acts not invalidated by subsequent conviction SD-22-12A3

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