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DEPARTMENT OF VETERANS AFFAIRS

Brooks D. Tucker

MISSION STATEMENT

The Department of Veterans Affairs (VA) is the primary provider of health care, benefits, and memorial affairs for America's veterans and their families. The VA has the noble responsibility to render exceptional and timely support and services with respect, compassion, and competence. The veteran is at the forefront of every VA process and interaction. The VA must continually strive to be recognized as a "best in class," "Veteran-centric"[1] system with an organizational ethos inspired by and accountable to the needs and problems of veterans, not subservient to the parochial preferences of a bureaucracy.

OVERVIEW

At the end of the Obama Administration, the VA was held in low esteem both by the veterans it served and by the employees who served these former warriors. Eroding morale caused by the downstream effects of a health care access crisis in 2014 led to the resignation of Secretary Eric Shinseki and extensive oversight investigations by Congress from 2015–2016.

By 2020, however, the VA had become one of the most respected U.S. agencies. This significant progress was due in part to the leadership of Secretary Robert Wilkie (2018–2021) and his team of political appointees and career senior executives, many of them veterans, who led the effort to ensure that the VA became "Veteran-centric" in its governance decisions and fostered a more positive work environment.

This mindset translated into a department that was better attuned to employees' and veterans' needs and experiences in the daily operations of health care, benefits,

and memorial affairs. During that period, the VA received the largest number of watershed congressional authorizations to reform its health care and benefits that it had received since the post–Vietnam War years along with historic increases in annual appropriations, which have tripled since the last full year of the George W. Bush Administration.

The current VA leadership team of Biden appointees has adopted some of their predecessors' governance processes. However, they have not sustained the previous Administration's commitment to a genuine "Veteran-centric" philosophy, most notably with respect to the delivery of health care, and harbor a bias toward expanding the unionized federal employee workforce that has not always been aligned with a focus on "Veteran-centric" care. There also is growing concern in Congress and the veteran community that the VA is poorly managing and in some cases disregarding provisions of the VA MISSION [Maintaining Internal Systems and Strengthening Integrated Outside Networks] Act of 2018[2] that codify broad access for veterans to non-VA health care providers. Efforts to expand disability benefits to large populations without adequate planning have caused an erosion of veterans' trust in the VA enterprise.

Additionally, the current VA leadership is focusing very publicly on "social equity and inclusion" within departmental policy discussions toward ends that will affect only a small minority of the veterans who use the VA. For the first time, the VA is allowing access to abortion services, a medical procedure unrelated to military service that the VA lacks the legal authority and clinical proficiency to perform. In addition to continuing the grotesque culture of violence against the child in the womb, these sociopolitical initiatives and ideological indoctrinations distract from the department's core missions.

DEPARTMENTAL HISTORY

Following the Civil War, state veterans homes were established to provide medical and hospital treatment for all injuries and diseases. When the United States entered World War I in 1917, "Congress established a new system of Veterans benefits, including programs for disability compensation, insurance for service personnel and Veterans, and vocational rehabilitation for the disabled"[3] that was overseen by three different federal programs: the Veterans Bureau, the Department of the Interior's Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers. In 1921, Congress combined those programs into the Veterans Bureau. Following World War II, a national VA hospital system, much of which remains operational today, was established to care for millions of returning veterans.

Following the Vietnam War, the VA's federally owned and operated hospital network expanded again to meet the needs of the volunteer and draftee population. In the past two decades, the VA has purposely transitioned to leasing medical properties rather than building expensive new facilities that can take years to complete and often experience budget overruns. As the nature of health care has evolved

with a growth in same-day surgical procedures and outpatient care, so has the VA, and in 2018 Congress added access to private-sector urgent care outlets as one of the VA's health care benefits.

Today, the VA operates 172 inpatient VA Medical Centers (VAMCs), which are an average of 60 years old, and 1,113 Community Based Outpatient Clinics (CBOCs), which are newer facilities designed to meet the needs of veterans closer to home. The VA also manages a Community Care Network (CCN) through contracts with Optum and TriWest, third-party health care administrators responsible for building and maintaining a robust population of community providers to meet the needs of veterans referred for care outside of the VA system. Currently, approximately 6.4 million veterans out of 18 million nationally (and out of the 9.1 million who are enrolled) use the VA for health care; the remainder use employer-sponsored plans, Tricare, Medicare, and Medicaid.

The disability benefits system evolved significantly in the years between the Cold War era and the global war on terrorism, a period when the VA enrolled large numbers of veterans from World War II, Korea, and Vietnam who were seeking disability benefits and health care. Disability compensation is the largest VA benefit, but there also are dozens of others, the next largest of which are the GI Bill and the Home Loan Guaranty. These benefits are administered through 56 Regional Benefits Offices (RBOs) and hundreds of satellite sites around the country.

The Agent Orange Act of 1991[4] significantly expanded the scope of disability benefits for those who had deployed to Vietnam, and the cost of those benefits began to increase dramatically as the Vietnam generation of veterans aged and began to experience adverse health conditions, some of which were presumed to have been caused by defoliant chemicals used in Southeast Asia. In 2016 and 2017, a burdensome backlog of appeals of denied disability claims from multiple wartime generations—a backlog numbering in the hundreds of thousands—led to a joint effort by the VA, Veteran Service Organizations (VSOs), and Congress to pass legislation that streamlined appeal processes. Implemented in 2017, this historic "good governance" success has helped the VA to reduce the number of these appeals dramatically.

The Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022[5] addressed adverse health outcomes presumed to be the result of veterans' exposure to airborne toxins during the global war on terrorism and further expanded disability benefits to the most recent generation of veterans. These ambitious authorities, like the 1991 authorities, have the potential to overwhelm the VA's ability to process new disability claims and adjudicate appeals. Currently, the VA is seeking to hire large numbers of personnel to process these claims while exploring the use of an automated process to accelerate claims reviews and decisions. The ever-present lag in the hiring and training of new employees could result in major problems with the timely adjudication of benefits well into the next Administration in 2025.

In sum, the VA for the foreseeable future will experience significant fiscal, human capital, and infrastructure crosswinds and risks. Budgets are at historic highs, and with a workforce now above 400,000, the VA is contending with a lack of new veteran enrollees to offset the declining population of older veterans. Recruitment of medical and benefits personnel has become more challenging. Veterans are migrating from the northern states to the southern and western states for retirement and employment. Meanwhile, VA information technology (IT) is struggling to keep pace with the evolution of patient care and record keeping. Consequently, VA leaders in the next Administration must be wise and courageous political strategists, experienced managers to run day-to-day operations more effectively, innovators to address the changing veteran landscape, and agile "fixers" to mitigate and repair systemic problems created or ignored by the present leadership team.

VETERANS HEALTH ADMINISTRATION (VHA)

Needed Reforms

- Rescind all departmental clinical policy directives that are contrary to principles of conservative governance starting with abortion services and gender reassignment surgery. Neither aligns with service-connected conditions that would warrant VA's providing this type of clinical care, and both follow the Left's pernicious trend of abusing the role of government to further its own agenda.

- Focus on the effects of shifting veteran demographics. At least during the next decade, the VA will experience a significant generational shift in its overall patient population. Of the approximately 18 million veterans alive today, roughly 9.1 million are enrolled for VA health care, and 6.4 million of these enrollees use VA health care consistently. These 6.4 million veterans are split almost evenly between those who are over age 65 and those who are under age 65, but the share of VA's health care dollars is spent predominantly in the over-65 cohort. That share increases significantly as veterans live longer and use the VHA system at a higher rate.

  VHA enrollments of new users are increasingly at risk of being exceeded by the deaths of current enrollees, primarily because significant numbers of the Vietnam generation are reaching their life expectancy. The generational transition from Vietnam-era veterans to post-9/11 veterans will take several years to complete. The ongoing demographic transition is a catalyst for needed assessments of how the VA can improve the delivery of care to a numerically declining and differently dispersed national population

of veterans—a population that is more active, reaching middle age or retirement age, and migrating for lifestyle and career reasons.

At the center of the VHA's evolution during this generational transition is an ongoing tension, some of it politically contrived, between Direct Care for Veterans provided from inside the VHA system and Community Care for Veterans who are referred to private providers participating in the VHA's two Community Care Networks (CCNs). In recent years, the budget for Community Care has grown as demand from veterans has risen sharply, sometimes outpacing the budgets for Community Care at individual VAMCs.

The Trump Administration made Community Care part of its "Veteran-centric" approach to ensure that veterans would be able to participate more fully in their health care decisions and have options if or when the VHA was unable to meet their needs. The Biden Administration has watered down that effort, has sought various procedural ways to slow the rate of referrals to private doctors, and at some facilities is reportedly manipulating the Community Care access standards required by the VA MISSION Act of 2018. If the makeup of Congress is favorable in 2025, the next Administration should rapidly and explicitly codify VA MISSION Act access standards in legislation to prevent the VA from avoiding or watering down the requirements in the future.

First and foremost, a veterans bill of rights is needed so that veterans and VA staff know exactly what benefits veterans are entitled to receive, with a clear process for the adjudication of disputes, and so that staff ensure that all veterans are informed of their eligibility for Community Care. Currently, veterans are not routinely and consistently told that they are eligible for Community Care unless they request information or are given a referral.

- To strengthen Community Care, the next Administration should create new Secretarial directives to implement the VA MISSION Act properly. Sections for consideration and areas for reform include the following:

    1. Sections 101 and 103 (Community Care eligibility for access standards and the best medical interest of the veteran).

    2. Section 104 (Community Care access standards and standards for quality of care).

3. Section 121 (developing and administering an education program that teaches veterans about their health care options available from the Department of Veterans Affairs).

4. Section 152 (returning the Office for Innovation of Care and Payment to the Office of Enterprise Integration with a joint governance process set up with the VHA).

5. Section 161 (overhauling Family Caregiver Program expansion, which has gone poorly, so that it focuses on consistency of eligibility and awareness that the most severely wounded or injured may require the program indefinitely).

- Require the VHA to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost-effectiveness, using standards similar to those in the Medicare Accountable Care Organization program so that the government may monitor and achieve continuous improvement in the VA system more effectively.

- Encourage VA Medical Centers to seek out relevant academic and private-sector input in their communities to improve the overall patient experience.

Budget

- Conduct an independent audit of the VA similar to the 2018 Department of Defense (DOD) audit to identify IT, management, financial, contracting, and other deficiencies.

- Assess the misalignment of VHA facilities and rising infrastructure costs. The VHA operates 172 inpatient medical facilities nationally that are an average of 60 years old. Some of these facilities are underutilized and inadequately staffed. Facilities in certain urban and rural areas are seeing significant declines in the veteran population and strong competition for fresh medical staff.

  In 2018, Congress authorized an Asset Infrastructure Review (AIR) of national VHA medical markets to provide insight into where the VA health care budget should be responsibly allocated to serve veterans most effectively. However, the Senate Veterans Affairs Committee lacked the political will to act on the White House's nominations of commission members, and this ultimately led to termination of the AIR process. The next Administration should seek out agile, creative, and politically acceptable operational solutions to this aging infrastructure status quo,

reimagine the health care footprint in some locales, and spur a realignment of capacity through budgetary allocations. Specifically:

1. Embrace the expansion of Community Based Outpatient Clinics (CBOCs) as an avenue to maintain a VA footprint in challenging medical markets without investing further in obsolete and unaffordable VA health care campuses.

2. Explore the potential to pilot facility-sharing partnerships between the VA and strained local health care systems to reduce costs by leveraging limited talent and resources.

Personnel

- Extend the term of the Under Secretary for Health (USH) to five years. Additionally, authority should be given to reappoint this individual for a second five-year term both to allow for continuity and to protect the USH from political transition.

- Establish a Senior Executive Service (SES) position of VHA Care System Chief Information Officer (CIO), selected by and reporting to the chief of the VHA Care System with a dotted line to the VA CIO.

- Identify a workflow process to bring wait times in compliance with VA MISSION Act–required time frames wherever possible.

    1. Assess the daily clinical appointment load for physicians and clinical staff in medical facilities where wait times for care are well outside of the time frames required by the VA MISSION Act.

    2. Require VHA facilities to increase the number of patients seen each day to equal the number seen by DOD medical facilities: approximately 19 patients per provider per day. Currently, VA facilities may be seeing as few as six patients per provider per day.

    3. Consider a pilot program to extend weekday appointment hours and offer Saturday appointment options to veterans if a facility continues to demonstrate that it has excess capacity and is experiencing delays in the delivery of care for veterans.

    4. Identify clinical services that are consistently in high demand but require cost-prohibitive compensation to recruit and retain talent, and examine exceptions for higher competitive pay.

5. Assess the medical facilities where Community Care is readily available but referrals for Community Care are below the averages in other similar markets, referrals expiring are above the average, and/or canceled appointments are above the average. Identify reasons and factors and consider possible ways to improve timeliness and responsiveness for veterans.

6. Further explore how to leverage telehealth to reduce personnel costs across the enterprise and serve veterans. Continue to pursue expansion of broadband services to remote and rural areas.

7. Assess recruitment and retention in highly competitive medical markets to identify common limiting factors for attracting high-demand, specialized occupations.

8. Consider aggressively recruiting retired physicians who desire to serve veterans.

9. Consider expanding VA tuition assistance in exchange for reciprocal service in rural or understaffed VAMCs.

10. Examine the surpluses or deficits in mental health professionals throughout the enterprise, recognizing that the department needs a blend of social workers, therapists, psychologists, and psychiatrists with a focus on attracting high-quality talent.

- Conduct a high-priority assessment of Electronic Health Record (EHR) transition delays and functionality problems. VA innovation in health care for the next 20 years and beyond will rest squarely on the timely implementation of the new VHA EHR in coordination with the DOD's parallel pacing effort. The VA's EHR rollout has been blocked by technical delays at local facilities where personnel have raised safety concerns and infrastructure has not been modernized to accept the new system.

VETERANS BENEFITS ADMINISTRATION (VBA)

Needed Reforms

The most evident and ongoing concern is the complexity of benefits, which can lead to confusion for the veteran and, if not mitigated early in the veteran's interactions, long-term distrust of and animosity toward the VA. Wholesale benefits reform is unnecessary and politically a "third rail," but effective managerial

approaches and technology tools that currently exist in the private sector could be employed to improve existing VBA activities.

This problem is most pronounced in the disability claims process, which needs more and better management attention focused on streamlining the procedures involved in processing claims and administering benefits. The VA must improve timeliness of claim adjudication and benefits delivery: Veterans want the VBA to provide timely responses to requests for benefits support, render empathetic customer service and understandable explanations of those benefits, and deliver those benefits without frustrating delays (weeks, not months).

- Identify performance targets for benefits, report publicly on actual performance each quarter, and use these metrics to drive consistent improvement.

- Develop a new pilot "Express 30" commitment for a veteran's first fully developed disability compensation claim and organize the VBA to complete the first claim in 30 days.

- Hire more private companies to perform disability medical examinations. Delays in completing the examinations could be eliminated with more external capacity.

- Increase automation. Hiring additional staff to process claims is costly, is inflexible, and has yielded mixed results. Attempting to change laws and regulations simply to adjudicate claims would be a herculean effort given their complexity. The best way to provide benefits faster and more accurately is by using technology to perform most of the work. Technology currently exists in the private sector, but the VBA lacks the expertise to use it. This would be more of an organizational challenge than a technology hurdle.

- Reduce improper payment and fraud. About $500 million is improperly paid out each year. Better tools, training, and management could reduce this substantially, but rule changes at the departmental level would be needed.

Budget

The VA's Schedule for Rating Disabilities (VASRD) has assigned disability ratings to a growing number of health conditions over time; some are tenuously related or wholly unrelated to military service. The further growth in presumptive service-connected medical conditions pursued by Congress and Veteran Service Organizations, begun with Agent Orange and most recently for Burn Pits/Airborne

Toxins, has led to historic increases in mandatory VBA spending in recent years. The VA has a time-phased plan to reassess the VASRD and its ratings for compensation, but this internal process can be slow and laborious, requires Office of Management and Budget (OMB) approvals, and can become politically charged both in Congress and with VSOs.

- The next Administration should explore how VASRD reviews could be accelerated with clearance from OMB to target significant cost savings from revising disability rating awards for future claimants while preserving them fully or partially for existing claimants.

- The VBA's Information Technology top-line budget should be reexamined and reassessed in light of the need for expanded automation across the enterprise.

- Traditionally, VHA captures the large majority of VA IT funding. The VBA needs to make the case for a larger IT budget with clear requirements to support that request.

Personnel

- Pursue reforms of the Human Capital Management process and operations within the VBA to build a more blended workforce with more contractors to process claims. This would free federal employees to perform other duties and be involved solely with the final decision to award benefits.

- Improve the VBA acquisition workforce. The VBA needs more world-class contractor support. Currently, few of the top companies have contracts with the VBA, and the VBA needs to conduct more outreach to the private sector through senior leader engagement and industry conferences.

- To identify more effective and efficient ways to complete claims, establish a knowledge exchange program with top-tier private-sector companies that do similar work. The VBA is fundamentally a financial services organization. A significant amount of its work has a private-sector analogue that could be leveraged to improve service to veterans.

- For most of its existence, the VBA has been a risk-averse, insular, paper-based organization, implementing technology only over the past decade. This insularity has led to a predominantly "build it ourselves" approach, partly because VBA staff has limited experience or insight into current private-sector tools and methods and partly because the VBA struggles to compete

with the VHA for IT funding. Senior executive leadership needs more innovators and trail blazers—qualities that have sometimes been lacking in the VBA's senior ranks. Recruiting a more relevantly knowledgeable and technologically savvy team, along with robust political control of the VA, could bring about better solutions to the VBA's workflow challenges.

HUMAN RESOURCES AND ADMINISTRATION (HRA)

Needed Reforms

- Rescind all delegations of authority promulgated by the VA under the prior Administration.

- Transfer all career SES out of PA/PAS-designated positions on the first day and ensure political control of the VA.

- Take a close and analytically critical look at where hybrid and remote work is a net positive as a functional necessity and where in-person collaboration and presence will help to instill a strong work ethic and a more cohesive environment for productivity from the Office of the Secretary across the headquarters enterprise.

The COVID-19 pandemic spurred a significant shift to hybrid and telework options for large segments of the staff in the Washington headquarters, in its satellites, and at some VBA Regional Offices. The "remote work" expectation has been amplified and formalized within the Biden Administration team at VA to the extent that the current Secretary, Deputy Secretary, and their staffs are not "in office" as a matter of a routine presence while VA staff in Washington, D.C., have limited in-person meetings, relying more frequently on video conference calls. The short-term and long-term effects of this policy on the department are unknown, but generally, the policy may be undermining the cohesiveness and competencies of some staff functions and diluting general organizational accountability and responsiveness.

Budget

- Expedite the acquisition of a new Human Resources Information Technology (HRIT) system. The current system is not user-friendly; has minimal fusion, middle-ware capacity; and is not conducive to data driven personnel decisions. Personnel data needs to be organized and managed to its full potential. The HRIT system, associated databases, and other "shadow" personnel systems have no shortage of data; the problem comes with effective management of the data.

- Broaden pay and benefits in critical VA skill sets (beyond medical care occupations) to be more competitive with private-sector industry. IT, acquisition, cyber, and economists are some examples of skill sets that are difficult for the VA to recruit, largely because of the limitations of federal pay scales.

- Continue to maximize the use of new VA hiring and pay authorities provided by Congress in the RAISE Act[6] and PACT Act[7] as well as existing authorities in student loan forgiveness and the Public Service Loan Forgiveness program.

Personnel

- Foster a culture that is mission (veteran) driven, alert, engaged, and habitually responsive to the veteran, and structure an environment that promotes a flexible and agile workplace.

- Increase employee satisfaction/experience to improve recruitment and retention of VA personnel. Go beyond the traditional focus on the extrinsic (monetary pay and bonuses) and seek creative ways to instill teamwork, loyalty, and pride.

- Train leaders and managers to promote an energized and productive workplace culture and reward those who do it well. Ensure that senior leaders (SES) set the proper example.

- Focus more attention on hiring veterans and military spouses. The percentage of veterans employed at VA has been declining.

- Support the White House Office of Presidential Personnel (PPO) in identifying a fully vetted roster of candidates to assume all key positions at VA well ahead of formal nominations. The VA is the second-largest federal agency, yet it is authorized a woefully small number of PA/PAS positions when compared to other agencies of lesser size. Congress and the Office of Personnel Management should be engaged on ways to provide authorities for a higher number of non-career PA positions. The White House PPO can be inclined to discount the VA's importance, but given the political attention that VA can generate for Congress and the media, PPO should understand the importance of finding talented political appointees to serve at VA.

- Increase the number and utilization of Limited Term Appointment Senior Executive Service positions for up to three years to work on special projects to ensure talent refreshment, talent acquisition, and flexibility.

- Manage the relationship with organized labor effectively and proactively.

    1. Ensure that any agenda that includes labor/civil service reform in the VA has a clear direction from the Secretarial level, support from the General Counsel, alignment with the Assistant Secretary for Human Resources and Administration, and a unified and strong political will to carry it out. Without those elements, labor reforms are very difficult to accomplish.

    2. Ensure that each senior leader in the process gets buy-in from reform-minded career employees willing to accept and support change. Those mid-level and senior-level managers exist, but they will need to be identified early and shown trust and confidence.

    3. Ensure that the White House communicates the labor reform agenda swiftly. Trump Administration executive orders on civil service reform (official time, government-furnished office space) were issued too late, and departments and agencies were not prepared to execute them.

    4. Anticipate the inevitable opportunities for legal challenges from organized labor, and be prepared for them to happen and be dragged out—which makes early, decisive timing all the more important.

    5. Ensure that the White House is prepared to support a concerted and deliberate effort on implementation to avoid perceptions of a disconnected strategy and disaggregated effort.

    6. Remain mindful of which labor contracts end, when they end, and what the agency's goals for renegotiation are. If not done effectively, contract end dates will be missed or lack notification. It is therefore essential to have a clear strategy with respect to what leadership wants from a new contract: Do not make the perfect the enemy of the good in contract negotiations.

- Work with Congress to sunset the Office of Accountability and Whistleblower Protection (OAWP). OAWP was well intentioned when formed, but it is redundant with the activities of supervisors as well as equal employment opportunity, Office of the Inspector General, Office of Special Counsel, and other policies, programs, and procedures for holding employees accountable. This redundancy results in lengthy investigations, gaps in coverage, and an overall ineffective method of employee and supervisor accountability.

- Consider decoupling HRA and the Office of Security and Preparedness (OSP). When Congress directed that the OAWP be established, it did not include authorities for a new Assistant Secretary position; consequently, the OSP was combined with HRA to free a PAS position. The functions of HRA and OSP are dissimilar and thus create an organization that is difficult to staff with the talent needed to execute both missions effectively.

AUTHOR'S NOTE: The preparation of this chapter was a collective enterprise of individuals involved in the 2025 Presidential Transition Project. All contributors to this chapter are listed at the front of this volume, but Darin Selnick, Paul R. Lawrence, and Christopher Anderson deserve special mention. The author alone assumes responsibility for the content of this chapter, and no views expressed herein should be attributed to any other individual.

ENDNOTES

1. U.S. Department of Veterans Affairs, Veterans Health Division, VHA Directive 1003, "VHA Veteran Patient Experience," April 14, 2020, pp. 1 and B-1.
2. S. 2372, VA Mission Act of 2018, Public Law No. 115-182, 115th Congress, June 6, 2018, https://www.congress.gov/115/plaws/publ182/PLAW-115publ182.pdf (accessed January 30, 2023).
3. U.S. Department of Veterans Affairs, VA History Office, "VA History," last updated May 27, 2021, https://www.va.gov/HISTORY/VA_History/Overview.asp (accessed January 28, 2023).
4. 38 U.S. Code § 1116, https://www.law.cornell.edu/uscode/text/38/1116 (accessed January 28, 2023).
5. S. 3373, Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics Act of 2022 (Honoring Our PACT Act of 2022), Public Law No. 117-168, 117th Congress, August 10, 2022, https://www.congress.gov/117/plaws/publ168/PLAW-117publ168.pdf (accessed January 28, 2023).
6. H.R. 2471, Consolidated Appropriations Act, 2022, Public Law No. 117-103, 117th Congress, March 15, 2022, Division S, Title I, https://www.congress.gov/117/plaws/publ103/PLAW-117publ103.pdf (accessed March 18, 2023). Known variously as the Department of Veterans Affairs Nurse and Physician Assistant Retention and Income Security Enhancement Act and the VA Nurse and Physician Assistant RAISE Act.
7. See note 5, *supra*.