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The Independent Budget

for the Department of Veterans Affairs

Fiscal Year 2010

A Comprehensive Budget & Policy Document
Created by Veterans for Veterans

Prologue

As the global war on terrorism enters its eighth year and the conflict in Iraq approaches its sixth year, servicemen and -women continue to experience traumatic effects as they are placed in harm's way. Since fighting began in Afghanistan in October 2001, and in Iraq in March 2003, more than 4,000 service members have made the ultimate sacrifice and more than 40,000 more have been wounded. The sacrifices these brave soldiers, sailors, airmen, marines, and coast-guardsmen have made will leave them dealing with a lifetime of both visible and invisible wounds. It is for these men and women and the millions who came before them that we set out each year to assess the health of the one federal department whose sole task it is to care for them and their families.

The Independent Budget is based on a systematic methodology that takes into account changes in the size and age of the veteran population, cost-of-living adjustments, federal employee staffing, wages, medical care inflation, construction needs, the aging health-care infrastructure, trends in health-care utilization, benefit needs, efficient and effective means of benefits delivery, and estimates of the number of veterans and their spouses who will be laid to rest in our nation's cemeteries.

As it becomes more and more likely that the global war on terrorism will be long, with dangers from unexpected directions and enemies who are creative and flexible in planning and executing attacks on our citizens and on our friends, our nation must continue to provide for those who serve in our defense. Additionally, we must be cognizant of the current fiscal realities in a time of turbulent and rapidly fluctuating economic conditions that may compel veterans of past service to seek health care and benefits from the Department of Veterans Affairs (VA).

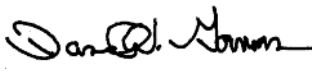
With this reality ever present in our minds, we must do everything we can to ensure that VA has *all* the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners of the world, keeping the forces of anarchy, hatred, and intolerance at bay, need to know that they will come home to a nation that respects and honors them for their service, while also providing them with the best medical care to make them whole, the best vocational rehabilitation to help them overcome employment challenges created by injury, and the best claims processing system to deliver education, compensation, and survivors' benefits in a minimum amount of time with the greatest accuracy to those most harmed by their service to our nation.

(Continued)

We are proud that *The Independent Budget* has gained the respect that it has over its 23-year history. The coauthors of this important document—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States—work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

We hope that each reader approaches this document with an open mind and a clear understanding that America's veterans should not be treated as the refuse of war, but rather as the proud warriors they are.

James B. King
National Executive Director
AMVETS



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Supporters

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United States Federation of Korea Veterans Organization
US-Korea Allies Council
Veterans Affairs Physician Assistant Association
Vietnam Veterans of America
Washington State, Office of the Governor
Wisconsin Department of Veterans Affairs

Guiding Principles

- Veterans must not have to wait for benefits to which they are entitled.
- Veterans must be ensured access to high-quality medical care.
- Veterans must be guaranteed timely access to the full continuum of health-care services, including long-term care.
- Veterans must be assured burial in state or national cemeteries in every state.
- Specialized care must remain the focus of the Department of Veterans Affairs (VA).
- VA's mission to support the military medical system in time of war or national emergency is essential to the nation's security.
- VA's mission to conduct medical and prosthetic research in areas of veterans' special needs is critical to the integrity of the veterans' health-care system and to the advancement of American medicine.
- VA's mission to support health professional education is vital to the health of all Americans.

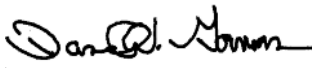
Dedication

The veterans service organizations that collectively author *The Independent Budget* wish to acknowledge and express our deep appreciation to Mr. Richard Fuller for his guidance and many contributions to this document over the years. Richard, who worked for Paralyzed Veterans of America for almost 20 years, died in February 2008 after a prolonged illness.

A tireless advocate for veterans, Richard dedicated himself to ensuring that all men and women who have served in the uniform of this nation have access to the highest quality health care and receive the benefits to which they are entitled. For many years as the lead author of the Medical Care section of *The Independent Budget*, Richard worked to ensure the document reflected the highest degree of professionalism, technical expertise, and compassion.

Richard embodied the true meaning of "citizen soldier." A graduate of Duke University; a veteran of the United States Air Force with service in Vietnam, Thailand, and Okinawa as a Vietnamese linguist; and as an advocate for his fellow service members his entire professional life, he set a standard for excellence and dedication that will remain at the heart of *The Independent Budget*.

James B. King
National Executive Director
AMVETS



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Special Thanks to:

Kelly Saxton, PVA, for editorial assistance
AMVETS' Communication Department under the supervision of Jay Agg for the cover design

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Introduction

Once again, the four veterans service organizations who coauthor *The Independent Budget (IB)*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—offer budget and program recommendations for the Department of Veterans Affairs (VA) based upon our unique expertise and experience concerning the resources that will be necessary to meet the needs of America's veterans in fiscal year (FY) 2010. In fact, this FY 2010 issue of the *IB* represents the 23rd consecutive year that this partnership of veterans service organizations has joined together to produce a comprehensive budget document that highlights the needs of elderly veterans and those of the younger men and women who join their ranks each year as they return from the conflicts in Afghanistan and Iraq and other hostile areas around the world.

Thousands of men and women who have sacrificed themselves in the global war on terrorism are returning home. These brave men and women are relying on VA health-care and benefits systems to help rebuild their lives and become productive members of society. Currently, according to information released by the VA on October 29, 2008, America's current veteran population is projected to be 23,442,000, which includes 1,802,000 females. Of the 23,442,000, 7.8 million veterans are enrolled in the VA health-care system. According to VA data, 5.5 million veterans are identified as unique individual patients who actually received care in VA facilities in 2007. Also, 2.95 million veterans receive disability compensation for injuries they received while on active duty. In addition, 333,196 spouses of deceased veterans rely on VA's dependency and indemnity compensation for the costs of everyday life.

The Veterans Health Administration, similar to private sector health-care providers and other federal health-care programs, including Medicare, Medicaid, and TRICARE, is facing growing demand for services, as the country ages and medical treatment and administrative costs spiral upward. In addition to increasing medical operational costs, almost 40 percent of America's veterans are 65 years of age or older. This group of elderly veterans has an increased demand for VA health and long-term-care services. Additionally, the influx of new, and often severely disabled, veterans entering the VA system brings new demands for care. These age-related, economic, and new patient factors make accurate resource forecasting difficult but more important each year.

Year after year, the coauthors of *The Independent Budget* review VA workload information and medical and administrative cost data and then call upon Congress to provide funding necessary to meet the health-care needs of veterans and to do so in a timely manner. Unfortunately, Congress historically has been unable to complete the VA appropriation process prior to the beginning of the new fiscal year. The *IB* offers reasonable solutions to this serious budget-timing problem—through either a mandatory or an advance appropriation process. The *IB*'s goal is to secure sufficient, timely, and predictable funding that allows VA to conduct effective planning and provide quality services.

With regard to veterans' benefits, the *IB* recommends that VA fast-track real steps that will help ameliorate nagging barriers to claims processing. Continuing studies to find solutions must be replaced by real action plans that produce positive results. These action steps must be implemented before VA's claims system becomes further mired in its own red tape and ultimately collapses under its own weight. Veterans and their families deserve prompt decisions regarding the benefits for which they have shed their blood. These benefits are part of a covenant between our nation and the men and women who have defended it. Veterans have fulfilled their part of the covenant; now VA must avoid further delay and move forward to meet its obligations in a timely manner.

The Independent Budget for Fiscal Year 2010 provides recommendations for consideration by our nation's decision makers that are based on rigorous and rational methodology designed to support the Congressionally authorized VA programs that serve our nation's veterans. *The Independent Budget* veterans service organizations are proud that more than 60 veteran, military, medical service, and disability organizations have signed on in support of this *IB*. Our primary purpose is to inform and encourage the United States government to provide the necessary resources to care for the men and women who have answered the call of our country and taken up arms to protect and defend our way of life.

VA Accounts FY 2010 (Dollars in Thousands)

	FY 2009 Appropriation	FY 2010 IB
Veterans Health Administration		
Medical Services	30,969,903	36,572,421
Medical Support and Compliance	4,450,000	4,584,964
Medical Facilities	5,029,000	5,402,015
Subtotal Medical Care, Discretionary	**40,448,903**	**46,559,400**
Medical Care Collections	2,544,000	
Total, Medical Care Budget Authority *(including Medical Collections)*	**42,992,903**	**46,559,400**
Medical and Prosthetic Research	510,000	575,000
Total, Veterans Health Administration	**40,958,903**	**47,134,400**
General Operating Expenses		
Veterans Benefits Administration	1,466,095	1,629,230
General Administration	335,772	353,552
Total, General Operating Expenses	**1,801,867**	**1,982,782**
Departmental Admin and Misc. Programs		
Information Technology	2,489,391	2,713,058
National Cemetery Administration	230,000	291,500
Office of Inspector General	87,818	90,719
Total, Dept. Admin. and Misc. Programs	**2,807,209**	**3,095,277**
Construction Programs		
Construction, Major	923,382	1,123,000
Construction, Minor	741,534	827,000
Grants for State Extended-Care Facilities	175,000	250,000
Grants for Construction of State Veterans Cemeteries	42,000	52,000
Total, Construction Programs	**1,881,916**	**2,252,000**
Other Discretionary	158,926	163,217
Total, Discretionary Budget Authority *(Including Medical Collections)*	**50,152,821**	**54,627,676**
Cost for Priority Group 8 Veterans Denied Enrollment	**375,000***	**544,200****

*The FY 2009 Appropriations Bill provided $375 million to expand enrollment for Priority Group 8 veterans by 10 percent.

**Cost for Priority Group 8 veterans based on known total cumulative number denied enrollment since 2003 (approximately 565,000 veterans) and a utilization rate of approximately 25 percent.

Benefit Programs

Through the Department of Veterans Affairs (VA), our nation's veterans are provided a comprehensive range of benefits. Included are disability compensation, dependency and indemnity compensation (DIC), pensions, vocational rehabilitation and employment, education benefits, housing loans, ancillary benefits for service-connected disabled veterans, life insurance, and burial benefits.

Disability compensation payments fulfill our primary obligation to attempt to make up for the economic and other losses veterans suffer as a result of the effects of service-connected diseases and injuries. When service members are killed on active duty or veterans' lives are cut short by service-connected injuries or following a substantial period of total service-connected disability, eligible family members receive DIC. Veterans' pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled as a result nonservice-connected causes or who have reached 65 years of age. Death pensions are paid to needy eligible survivors of wartime veterans. Burial benefits assist families in meeting a portion of the costs of veterans' funerals and burials and provide for burial flags and grave markers. Miscellaneous assistance includes other special allowances for smaller select groups of veterans and dependents and attorney fee awards under the Equal Access to Justice Act. Congress has also authorized special programs to provide a monthly financial allowance, health care, and vocational rehabilitation for the children of some Vietnam and Korean war veterans who suffer from spina bifida and other birth defects.

In recognition of the disadvantages that result from a life of military service, Congress has authorized various benefits to assist veterans in their readjustment to civilian life. These readjustment benefits provide veterans financial assistance for education or vocational rehabilitation programs and provide seriously disabled veterans financial assistance for specially adapted housing and automobiles. Education benefits are also available for children and spouses of those who die on active duty, of those are permanently and totally disabled, or of those who die as a result of service-connected disability. Qualifying students pursuing VA education or rehabilitation programs may receive work-study allowances. For temporary financial assistance to veterans undergoing vocational rehabilitation, loans are available from the vocational rehabilitation revolving fund.

Under its home loan program, VA guarantees commercial home loans for veterans, certain surviving spouses of veterans, certain service members, and eligible reservists and National Guard members. VA also makes direct loans to supplement specially adapted housing grants and direct housing loans to Native Americans living on trust lands.

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserve. A group plan also covers service members and members of the Ready Reserve and their family members. Mortgage life insurance protects veterans who have received VA specially adapted housing grants.

COMPENSATION AND PENSIONS

Compensation

ANNUAL COST-OF-LIVING ADJUSTMENT:

Congress should provide a cost-of-living adjustment (COLA) for compensation and dependency and indemnity compensation (DIC) benefits.

On average, veterans with service-connected disabilities earn less than those who were not disabled in service to America. Compensation is intended to replace lost earning capacity. However, each year increasing consumer prices erode the value of compensation and increase the hardship on those who have already sacrificed much for our nation. Further, the families of those who died in service or from service-connected disabilities depend on the small monthly stipend granted them by a grateful nation.

Compensation and DIC rates are modest—inflation erodes this fixed income and has a detrimental impact on its recipients. These benefits must therefore be regularly adjusted to keep pace with increases in the cost of living. Observant of this need, Congress has traditionally adjusted compensation and DIC rates to be equal to the annual adjustment for Social Security benefits. However, timely action by Congress is not guaranteed.

Recommendation:

Congress should enact legislation that automatically adjusts compensation and dependency and indemnity compensation by a percentage equal to the increase received by Social Security recipients in order to offset the rise in the cost of living.

FULL COST-OF-LIVING ADJUSTMENT FOR COMPENSATION:

Congress must provide cost-of-living adjustments (COLAs) equal to the annual increase in the cost of living without rounding down such increases to the next whole dollar.

Congress increases disability compensation and dependency and indemnity compensation (DIC) rates each year in an attempt to keep pace with the cost of living. However, as a temporary measure to reduce the budget deficit, Congress enacted legislation in 1978 to round monthly payments down to the nearest whole dollar after adjustment for increases in the cost of living. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress refuses to break its recurring habit of extending this provision, even in the face of prior budget surpluses. Inexplicably, VA has recommended that Congress make round-down monthly payment increases a permanent part of the law.

The cumulative effect of this practice over 30 years has eroded and will continue to substantially erode the value of compensation and DIC. This continued practice is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and their dependents and survivors who have no choice but to rely on modest VA compensation for life's necessities.

Recommendations:

Congress should reject any recommendations to permanently extend provisions for rounding down compensation cost-of-living adjustments and allow the temporary round-down provisions to expire on their statutory sunset date.

In the alternative, Congress should enact a one-time adjustment to ensure that veterans and the survivors of those who gave the ultimate sacrifice in service to our nation again receive the full value of benefits intended by a grateful nation.

STANDARD FOR SERVICE CONNECTION:

Standards for determining "service connection" should remain grounded in current law.

A member of the armed forces on active duty is at the disposal of military authority and, in effect, serves on duty 24 hours a day, 7 days a week.

Under many circumstances, a service member may be directly engaged in performing various duties for far more extended periods than a typical eight-hour workday and may be on call or standing by for duty the remainder of the day. Other circumstances require service members to live with their unit 24 hours a day, such as when on duty on naval vessels or at remote military outposts. There is no distinction between "on duty" and "off duty" for purposes of legal status in America's military service, nor is there any clear demarcation between the two. In the overall military environment, there are rigors, physical and mental stresses, known and unknown risks, and hazards unlike and far beyond those seen in civilian occupations.

Compensation for "service-connected" disabilities or death is the core of veterans' benefits. When disability or death results from injury or disease incurred or aggravated in the "line of duty," the disability or death is service connected for purposes of entitlement to these benefits. "Line of duty" means "an injury or disease incurred or aggravated during a period of active military, naval, or air service unless such injury or disease was the result of the veteran's own willful misconduct or, for claims filed after October 31, 1990, was a result of his or her abuse of alcohol or drugs."[1] Accordingly, *any* such occurrence during service that meets the current requirements of law satisfies the criteria for service connection.

These principles are expressly set forth in law. The term "service connected" means, with respect to disability or death, "that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in the line of duty in the active military, naval, or air service." The term "active military, naval, or air service" contemplates, principally, "active duty," although duty for training qualifies when a disability is incurred during such period. The term "active duty" means "full-time" duty in the armed forces of the United States.

For these reasons, current law requires only that an injury or disease be incurred or aggravated coincident with military service. There is no requirement that the veteran prove a causal connection between military service and a disability for which service-connected status is sought.

In spite of these long-standing principles, some Congressional members have proposed the abolishment of these rules by replacing the "line of duty" standard with a strict "performance of duty" standard, under which service connection would not generally be granted unless a veteran could offer proof that a disability was caused by the actual performance of military duty.

Congress created the Veterans' Disability Benefits Commission (VDBC) to carry out a study of "the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service, and to produce a report on the study." After more than 30 months of meetings, study, analysis, and debate, the VDBC, in October 2007, unanimously endorsed the current standard for determining service connection.
The Independent Budget veterans service organizations believe that current standards governing service connection for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. We urge Congress to reject any revision of this long-standing policy.

Recommendation:

Congress should reject all suggestions from any source to change the terms for service connection of veterans' disabilities and deaths.

[1] 38 C.F.R. § 3.1(m).

Standard for Determining Combat-Veteran Status:

Veterans should be presumed to have engaged in combat while serving in an active combat zone.

Current law provides a relaxed evidentiary standard for those veterans who incurred disability or experienced an event that causes a disability, while in combat with the enemy. This standard helps both veterans and the Department of Veterans Affairs. It helps veterans because it is often impossible to prove through documentary evidence that a disease or injury occurred while in combat. The law requires VA to accept as true a veteran's statement that a particular injury or event occurred in combat. (This only relieves the burden of showing service incurrence. Medical evidence must still demonstrate that a disability currently exists and that it is related to service.) It helps VA because it relieves it from spending months or even years researching military records trying to prove that a disease, injury, or event occurred.

Although VA states that evidence of combat is not limited to certain documents, in practice, VA claims processors accept only evidence showing receipt of a certain military decoration[2] or military unit records. Unfortunately, many veterans who were in combat never received a medal on VA's list. Further, unit records, if existent, are notoriously incomplete, vague, or both. These two factors (no combat medal or no accurate unit records) make it impossible for many combat veterans to obtain service connection for disabilities incurred in or caused by combat.

If VA applied 38 U.S.C.A. section 1154 properly, these problems, and others, would be resolved. Section 1154(a) reads in part: "[I]n each case where a veteran is seeking service-connection for any disability due consideration shall be given to the places, types, and circumstances of such veteran's service...."[3] Likewise, section 1154(b) states:

> In the case of any veteran who *engaged in combat with the enemy* in active service...the Secretary shall accept as sufficient proof of service-connection of *any* disease or injury alleged to have been incurred in or aggravated by such service satisfactory lay or other evidence of service incurrence or aggravation of such injury or disease, if consistent with the circumstances, conditions, or hardships of such service, *notwithstanding the fact that there is no official record of such incurrence or aggravation in such service,* and, to that end, shall resolve every reasonable doubt in favor of the veteran.[4]

Specific to post-traumatic stress disorder (PTSD) resulting from combat, VA has determined that service connection requires (1) medical evidence of the condition; (2) credible supporting evidence that a claimed in-service stressor occurred; and (3) a link, established by medical evidence, between the diagnosis and the in-service stressor.[5] Section 3.304(f) appears on its face to be consistent with the statute by stating:

> If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.[6]

It is evident that the provisions of the foregoing statute and regulation do not require validation by official military records of an in-service combat stressor. The law merely requires, absent "clear and convincing evidence to the contrary," " 'credible,' satisfactory lay or other evidence" of an in-service stressor "consistent with the circumstances, conditions, or hardships of the veteran's service." Congress made clear its intent of not requiring such proof to be in the form of official military records when it stated, "notwithstanding the fact that there is no official record of such *incurrence* or aggravation in such service." In cases of combat-related PTSD, the *incurrence* of the disability is the actual exposure to the event; therefore, requiring proof through official records of the *incurrence* violates the law.

Notwithstanding the plain language of the foregoing statute and regulation, VA has circumvented the law by conducting improper rulemaking through its general counsel and its adjudication procedures manual, M21-1MR. Specifically, veterans are required to prove they engaged in combat as shown through official military records, thus contradicting the intent of the statute. VA Office of General Counsel Opinion 12-99 reads in part:

> In order to determine whether VA is required to accept a particular veteran's "satisfactory lay or

> other evidence" as sufficient proof of service connection, an initial determination must be made as to whether the veteran "engaged in combat with the enemy." That determination is not governed by the specific evidentiary standards and procedures in section 1154(b), which only apply once combat service has been established.[7]

This general counsel opinion requires veterans to establish by official military records or decorations that they "personally participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality." Further, VA has promulgated internal instructions that arguably go beyond the general counsel's opinion by instructing rating authorities as follows:

> Credible supporting evidence that an in-service stressor actually occurred includes not only evidence that specifically documents the veteran's personal participation in the event, but evidence that indicates the veteran served in the immediate area and at the particular time in which the stressful event is alleged to have occurred, and supports the description of the event.[8]

The M21-1 manual gives the following two "examples" to VA adjudicators considering whether a veteran has submitted sufficient evidence of an in-service combat stressor:

- When considered as a whole, evidence consisting of a morning report, radio log, and nomination for a Bronze Star may be sufficient to corroborate a veteran's account of an event, even if it does not specifically include mention of the veteran's name.
- Unit records documenting the veteran's presence with a specific unit at the time mortar attacks occurred may be sufficient to corroborate a veteran's statement that she/he experienced such attacks personally.

These examples exceed statutory and regulatory requirements. By requiring official records to prove the "incurrence" of a disease or injury—the in-service stressor serving as the incurrence, or injury, in the case of PTSD—VA has effectively read "satisfactory lay or other evidence" out of the law, thereby exceeding its authority.

For decades VA has required such proof before recognizing a claimant as a "combat veteran." As a result, those who suffer a disease or injury resulting from combat are forced to provide evidence that may not exist or must wait a year or more while VA conducts research to determine whether a veteran's unit engaged in combat. Many claims that satisfy the requirements of the statute are improperly denied.

Congress should amend title 38, United States Code, section 1154(b) to clarify when a veteran is considered to have engaged in combat for purposes of determining combat-veteran status. In the alternative, Congress could amend title 38, section 1101, and define who is considered to have engaged in combat with the enemy. It is hoped that such clarification would allow for utilization of nonofficial evidence—such as a veteran's statement alone if the statement is "credible" and "consistent with the circumstances, conditions, or hardships" of the veteran's service and is otherwise not contradicted by clear and convincing evidence—as proof of an in-service occurrence of a combat-related disease or injury, to include PTSD.

This type of legislation would remove a barrier to the fair adjudication of claims for disabilities incurred or aggravated by military service in a combat zone. This legislation would follow the original intent of the law by requiring VA to accept as sufficient proof lay or other evidence that a veteran engaged in combat with the enemy as well as suffered a disease or injury as a result of that combat, if consistent with that veteran's service.

Many veterans disabled by their service in Iraq and Afghanistan, and those who served in earlier conflicts, are unable to benefit from liberalizing evidentiary requirements found in the current version of the applicable statute, section 1154; and regulation, section 3.304(f). This results because of difficulty, even impossibility, in proving by official military documents personal participation in combat.

Congressional staff conducting oversight visits in VA regional offices found claims that had been denied under this policy because those who served in combat zones had not been able to produce official military documentation of personal participation in combat via engagement with the enemy. The only possible resolution to this problem, without amending section 1154 or otherwise defining who is considered to have engaged in combat, is for the military to record the names and personal actions of every single soldier, sailor, airman, marine, or coastguardsman involved in every single event—large or small—that constitutes combat

and/or engagement with the enemy on every battlefield. Such recordkeeping is impossible.

In numerous cases, extensive delays in claims processing occur while VA adjudicators attempt to obtain official military documents showing participation in combat—documents that may never be located. Without codifying whom VA considers to have engaged in combat, the VA will continue to apply criteria that unlawfully exceed regulatory and statutory authority.

Congress and VA must understand that the change requested herein would not open the proverbial floodgates by forcing VA to accept every unsupported claim made by any veteran who served in a combat zone. With specific regard to occurrences of combat injuries and/or combat stressors, the law would still require a claimant to satisfy some evidentiary burden. Albeit, that evidentiary burden *may,* in some circumstances, solely be a lay statement. For example, if a military truck driver who served in Iraq stated, with clarity and detail, that his convoy came under attack, absent evidence to the contrary, such a statement may be accepted without additional proof because the conditions and circumstances of the veteran's service would have placed him or her directly in the line of fire for that type of attack. However, a unit mailroom clerk's statement of the same would require additional proof of the event because the nature of that veteran's service *normally* may not include such circumstances.

The legislative amendment requested herein would overturn VA's internal requirement—a requirement inconsistent with the original intent of Congress in liberalizing the requirements for proof of service connection in cases involving veterans who served in combat areas. The Senate noted in 1941, in the report on the original bill providing special consideration for combat veterans: "The absence of an official record of care or treatment in many of such cases is readily explained by the conditions surrounding the service of combat veterans."

It was emphasized in the hearings that the establishment of records of care or treatment of veterans in other than combat areas, and particularly in the states, was a comparatively simple matter when compared to that of veterans who served in combat. Either the veterans attempted to carry on despite their disability to avoid having a record made lest they be separated from their organization, or, as in many cases, the records themselves were lost. Likewise, many records are simply never generated. Nowhere in the *law* has Congress ever required proof of combat exposure through official military records.

Recommendation:

Congress should clarify its intent by amending title 38, United States Code, section 1154(b), with respect to defining a veteran who engaged in combat for all purposes under title 38.

In the alternative, Congress should enact legislation that extends 38 U.S.C. section 1154(b) to anyone who served in a war zone. This action would ease the evidentiary burden on veterans and time-consuming development by VA while leaving in place the need for the veteran to prove the existence of a disability and medical evidence connecting the disability to service.

[2]Air Force Achievement Medal with "V" Device; Air Force Combat Action Medal; Air Force Commendation Medal with "V" Device; Air Force Cross; Air Medal with "V" Device; Army Commendation Medal with "V" Device; Bronze Star Medal with "V" Device; Combat Action Badge; Combat Action Ribbon (before February 1969, the Navy Achievement Medal with "V" Device was awarded.); Combat Aircrew Insignia; Combat Infantry/Infantryman Badge; Combat Medical Badge; Distinguished Flying Cross; Distinguished Service Cross; Joint Service Commendation Medal with "V" Device; Medal of Honor; Navy Commendation Medal with "V" Device; Navy Cross; Purple Heart; Silver Star. VA Manual M21-1MR, Part IV, Subpart ii.1.D.13.d.
[3]38 U.S.C. § 1154(a) (West 2002).
[4]Ibid., § 1154(b) (emphasis added).
[5]38 C.F.R. § 3.304(f) (2007).
[6]Ibid., § 3.304(f)(1).
[7]VA Gen. Coun. Prec. 12-99, October 18, 1999.
[8]VA Manual M21-1MR, Part IV, Subpart ii, 1.D.13.

Concurrent Receipt of Compensation and Military Retired Pay:

All military retirees should be permitted to receive military retired pay and VA disability compensation concurrently.

Many veterans, retired from the armed forces based on longevity of service, must forfeit a portion of their retired pay earned through faithful performance of military service before they receive VA compensation for service-connected disabilities. This is inequitable—military retired pay is earned by virtue of a veteran's career of service on behalf of the nation, careers of no less than 20 years.

Entitlement to compensation, on the other hand, is paid solely because of disability resulting from military service, regardless of the length of service. Most nondisabled military retirees pursue second careers after serving in order to supplement their income, thereby justly enjoying a full reward for completion of a military career with the added reward of full civilian employment income. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential. Their earning potential is reduced commensurate with the degree of service-connected disability.

To put retirees disabled from service on equal footing with nondisabled retirees, VA should provide full military retired pay and compensation to account for reduction of their earning capacity. To the extent that military retired pay and VA disability compensation now offset each other, the disabled retiree is treated less fairly than a nondisabled military retiree. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing a service obligation can receive full VA compensation and full civilian retired pay—including retirement from any federal civil service. A veteran who performed 20 or more years of military service should have that same right.

A disabled veteran should not suffer a financial penalty for choosing military service as a career rather than a civilian career, especially where in all likelihood a civilian career would have involved fewer sacrifices and greater rewards. Disability compensation to a disabled veteran should not be offset against military longevity retired pay. While Congress has made progress in recent years in correcting this injustice, *The Independent Budget* veterans service organizations believe the time has come to finally remove this prohibition completely.

Recommendation:

Congress should enact legislation to totally repeal the inequitable requirement that veterans' military retired pay be offset by an amount equal to their rightfully earned VA disability compensation. To do otherwise results in the government compensating disabled retirees with *nothing* for their service-connected disabilities. *The Independent Budget* veterans service organizations urge Congress to correct this continuing inequity.

Continuation of Monthly Payments for All Compensable Service-Connected Disabilities:

Lump-sum settlements of disability compensation should be fully rejected.

The government pays disability compensation monthly to eligible veterans on account of, and at a rate commensurate with, diminished earning capacity resulting from the effects of service-connected diseases and injuries. By design, compensation provides relief from service-connected disability for the life of the condition's disabling effects. The severity of disability determines the rate of compensation, which usually warrants reevaluation when changes in severity occur.

Lump-sum payments have been suggested as a way for the government to avoid the administrative costs of reevaluating service-connected disabilities and as a way to avoid future liabilities to qualified veterans when their disabilities worsen or cause secondary disabilities. Under such a scheme, the Department of Veterans Affairs would use the immediate availability of a lump-sum settlement to entice veterans to bargain away future benefits. Lump-sum payments are not in the best interests of disabled veterans.

In its final report, the Veterans' Disability Benefits Commission rejected the concept of paying a lump sum in lieu of recurring compensation because the "complexity of lump sum payments would likely be excessive and difficult for veterans to understand and accept...[b]e difficult and costly to administer...would have significant short-term impact on the budget of the United States[,] and the break-even point when the up-front costs would be offset by future savings would be many years in the future.... "[9] *The Independent Budget* veterans service organizations strongly oppose any change in law to provide for lump-sum payments of compensation.

Recommendation:

Congress should reject any recommendation to permit VA to discharge its future obligation to compensate service-connected disabilities through payment of lump-sum settlements to veterans.

[9]*Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century,* Veterans' Disability Benefits Commission, October 2007, p. 278.

Mental Health Rating Criteria:

The Department of Veterans Affairs should compensate mental health disabilities on parity with physical disabilities.

Two recent studies, the first by the Center for Naval Analysis, Inc. (commissioned by the Veterans' Disability Benefits Commission)[10] and second by the Econ-Systems (commissioned by the Department of Veterans Affairs),[11] found that veterans who suffer from service-connected psychiatric disabilities suffer greater lost earnings at all levels than do veterans with nonpsychiatric disabilities. VA should update its mental health rating criteria to ensure that those veterans with service-connected psychiatric disabilities are equitably and appropriately evaluated.

Recommendation:

VA should propose a rule change in the *Federal Register* that would update the mental health rating criteria to more accurately reflect the severe impact that psychiatric disabilities have on veterans' average earning capacity.

[10]Ibid., pp. 233, 473.
[11]*A Study of Compensation Payments for Service-Connected Disabilities,* vol. 1. Economic Systems, Inc., September 2008, p. 31.

More Equitable Rules for Service Connection of Hearing Loss and Tinnitus:

For combat veterans and those with military occupations that typically involved acoustic trauma, service connection for hearing loss or tinnitus should be presumed.

Many veterans exposed to acoustic trauma during service, who are now suffering from hearing loss or tinnitus, are unable to prove service connection because of inadequate testing procedures, lax examination practices, or poor recordkeeping. The presumption requested herein would resolve this long-standing injustice.

The Institute of Medicine (IOM) issued a report in September 2005 titled "Noise and Military Service: Implications for Hearing Loss and Tinnitus." The IOM found that patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel. Because large numbers of people have served in the military since World War II, the total number who experienced noise-induced hearing loss by the time their military service ended may be substantial.

Hearing loss and tinnitus are common among combat veterans. The reason is simple: Combat veterans are typically exposed to prolonged, frequent, and exceptionally loud noises from such sources as gunfire, tanks and artillery, explosive devices, and aircraft. Exposure to acoustic trauma is a well-known cause of hearing loss and tinnitus. Yet many combat veterans are not able to document their in-service acoustic trauma nor can they prove their hearing loss or tinnitus is due to military service. World War II veterans are particularly at a disadvantage because testing by spoken voice and whispered voice was universally insufficient to detect all but the most severe hearing loss.

Audiometric testing in service was insufficient, and testing records are lacking for a variety of reasons. Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control. Congress should do the same for veterans exposed to acoustic trauma, including combat veterans. Congress should instruct VA to develop a list of military occupations that are known to expose service members to noise. VA should be required to presume noise exposure for anyone who worked in one of those military occupations and grant service connection for those who now experience documented hearing loss or tinnitus. Further, this presumption should be expanded to anyone who is shown to have been in combat.

Recommendation:

Congress should enact a presumption of service-connected disability for combat veterans and veterans whose military duties exposed them to high levels of noise and who subsequently suffer from tinnitus or hearing loss.

Compensable Disability Rating for Hearing Loss Necessitating a Hearing Aid:

The VA disability-rating schedule should provide a minimum 10 percent disability rating for hearing loss that requires use of a hearing aid.

The VA *Schedule for Rating Disabilities* does not provide a compensable rating for hearing loss at certain levels severe enough to require hearing aids. The minimum disability rating for any hearing loss warranting use of a hearing aid should be 10 percent, and the schedule should be amended accordingly.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment and the disadvantages of artificial hearing restoration, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of

VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device. For example, a veteran receives full compensation for amputation of a lower extremity although he or she may be able to ambulate with a prosthetic limb.

Providing a compensable rating for this condition would be consistent with minimum ratings provided elsewhere when a disability does not meet the rating formula requirements but requires continuous medication. Such a change would be equitable and fair.

Recommendation:

VA should amend its *Schedule for Rating Disabilities* to provide a minimum 10 percent disability rating for any hearing loss medically requiring a hearing aid.

TEMPORARY TOTAL COMPENSATION AWARDS:

Congress should exempt temporary awards of total disability compensation from delayed payment dates.

An inequity exists in current law controlling the beginning date for payment of increased compensation based on periods of incapacity due to hospitalization or convalescence. Hospitalization exceeding 21 days for a service-connected disability entitles the veteran to a temporary total disability rating of 100 percent. This rating is effective the first day of hospitalization and continues to the last day of the month of discharge from hospital. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications or where immobilization of a major joint by cast is necessary, a temporary 100 percent disability rating is awarded effective on the date of hospital admission or outpatient visit.

The effective date of temporary total disability ratings corresponds to the beginning date of hospitalization or treatment. However, title 38, United States Code, section 5111 delays the effective date for payment purposes until the first day of the month following the effective date of the increased rating.

This provision deprives veterans of an increase in compensation to offset the total disability during the first month in which temporary total disability occurs. This deprivation and consequent delay in the payment of increased compensation often jeopardizes disabled veterans' financial security and unfairly causes them hardship.

The Independent Budget veterans service organizations urge Congress to enact legislation exempting these temporary total disability ratings, administered under title 38, Code of Federal Regulations, sections 4.29 and 4.30, from the provisions of title 38, United States Code, section 5111.

Recommendation:

Congress should amend the law to authorize increased compensation based on a temporary total rating for hospitalization or convalescence to be effective, for payment purposes, on the date of admission to the hospital or the date of treatment, surgery, or other circumstances necessitating convalescence.

Pensions

Pension for Nonservice-Connected Disability:

Congress should extend basic eligibility for nonservice-connected pension benefits to veterans who serve in combat environments, despite no declaration of war.

Veterans totally disabled from nonservice-connected conditions (or are at least 65 years old) with low income and wartime service are eligible to receive a modest pension. The amount of pension awarded is reduced for every dollar of income received from any other source. It is designed to ensure that wartime veterans do not become charges on the public welfare.

Under the Constitution, Congress is charged with declaring war. However, in the past century large numbers of service members have been sent into many hostile areas around the world to conduct operations in support of American foreign policy and to protect American interests. Typically, these military actions are not conducted under the umbrella of a declaration of war and not all are considered to be a "war" under VA regulations.[12] As a consequence, not all veterans who have been engaged in combat are eligible for a VA pension. Another factor to consider is that some expeditionary medals and combat badges are awarded to members of the armed forces who have served in hostile regions, in situations and circumstances other than those officially designated combat operations, or during a wartime era as declared by Congress.

Recommendation:

Congress should amend eligibility requirements in title 38, United States Code, chapter 15 to authorize nonservice-connected disability pension benefits to veterans who have been awarded the Armed Forces Expeditionary Medal, Navy/Marine Corps Expeditionary Medal, Purple Heart, Combat Infantryman's Badge, Combat Medical Badge, or Combat Action Ribbon for participation in military operations not falling within an officially designated or declared period of war.

[12] 38 C.F.R. § 3.2.

Dependency and Indemnity Compensation

Increase of Dependency and Indemnity Compensation for Surviving Spouses of Service Members:

Congress should increase rates of dependency and indemnity compensation (DIC) to survivors of active duty military personnel who die while on active duty.

Current law authorizes the Department of Veterans Affairs to pay an enhanced amount of DIC, in addition to the basic rate, to surviving spouses of veterans who die from service-connected disabilities after at least an eight-year period of the veteran's total disability rating prior to death. However, surviving spouses of military service members who die on active duty receive only the basic rate of DIC. This is inequitable because surviving spouses of deceased active duty service members face the same financial hardship as survivors of deceased service-connected veterans who were totally disabled for eight years prior to their deaths.

Recommendation:

Congress should authorize disability and indemnity eligibility at increased rates to survivors of deceased military personnel on the same basis as that for the survivors of totally disabled service-connected veterans.

Repeal of Offset against Survivor Benefit Plan:

The current requirement that the amount of an annuity under the Survivor Benefit Plan (SBP) be reduced on account of and by an amount equal to dependency and indemnity compensation (DIC) is inequitable.

A veteran disabled in military service is compensated for the effects of service-connected disability. When a veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive DIC from VA. This benefit indemnifies survivors, in part, for the losses associated with the veteran's death from service-connected causes or after a period of time when the veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

Career members of the armed forces earn entitlement to retired pay after 20 or more years' service. Unlike many retirement plans in the private sector, survivors have no entitlement to any portion of the member's retired pay after his or her death. Under the SBP, deductions are made from the member's retired pay to purchase a survivors' annuity. This is not a gratuitous benefit. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died of other than service-connected causes or was not totally disabled by service-connected disability for the required time preceding death, beneficiaries receive full SBP payments. However, if the veteran's death was due to service or followed from the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. Where the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose all entitlement to the SBP annuity.

This offset is inequitable because no duplication of benefits is involved. The offset penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay.

Recommendation:

Congress should repeal the offset between dependency and indemnity compensation and the Survivor Benefit Plan.

Retention of Remarried Survivors' Benefits at Age 55:

Congress should lower the age required for survivors of veterans who die from service-connected disabilities who remarry to be eligible for restoration of dependency and indemnity compensation (DIC) to conform with the requirements of other federal programs.

Current law permits the Department of Veterans Affairs to reinstate DIC benefits to remarried survivors of veterans if the remarriage occurs at age 57 or older or, if survivors have already remarried, they apply for reinstatement of DIC at age 57. While *The Independent Budget* veterans service organizations appreciate the action Congress took to allow this restoration of rightful benefits, the current age threshold of 57 years is arbitrary. Remarried survivors of retirees in other federal programs obtain a similar benefit at age 55. We believe the survivors of veterans who died from service-connected disabilities should not be further penalized for remarriage and that equity with beneficiaries of other federal programs should govern Congressional action for this deserving group.

Recommendation:

Congress should lower the existing eligibility age for reinstatement of disability and indemnity compensation to remarried survivors of service-connected veterans from 57 years of age to 55 years of age.

READJUSTMENT BENEFITS

Housing Grants

GRANT FOR ADAPTATION OF SECOND HOME:

Grants should be available for special adaptations to homes that veterans purchase or build to replace initial specially adapted homes.

Like those of other families today, veterans' housing needs tend to change with time and new circumstances. An initial home may become too small when the family grows or become too large when children leave home. Changes in the nature of a veteran's disability may necessitate a home configured differently and/or changes to the special adaptations. These evolving requirements merit a second grant to cover the costs of adaptations to a new home.

Recommendation:

Congress should establish a grant to cover the costs of home adaptations for veterans who replace their specially adapted homes with new housing.

GRANTS FOR ADAPTATION OF HOMES FOR VETERANS LIVING IN FAMILY-OWNED TEMPORARY RESIDENCES:

Grants should be increased for special adaptations to homes in which veterans temporarily reside that are owned by a family member.

The Department of Veterans Affairs may provide specially adapted housing grants for veterans who have service-connected disabilities for certain combinations of loss or loss of use of extremities and blindness or other organic diseases or injuries when those veterans reside in but do not intend to permanently reside in a residence owned by a family member. Specifically, the assistance for the first group may not exceed $14,000 for veterans who have a permanent and total service-connected disability as a result of the loss or loss of the use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair. For the second group, the assistance may not exceed $2,000 for veterans who have a permanent and total service-connected disability rating due to blindness in both eyes with 5/200 visual acuity or less and the disability includes the anatomical loss or loss of use of both hands. Unless the amounts of these grants are periodically adjusted, inflation erodes these benefits that are payable to a select few, albeit among the most seriously disabled service-connected veterans.

Recommendation:

Congress should increase the allowance from $14,000 to $28,000 for those veterans meeting the criteria of the first group and increase the allowance from $2,000 to $5,000 for veterans meeting the criteria of the second group. Then it should provide for automatic annual adjustments in the future to keep pace with inflation.

Automobile Grants and Adaptive Equipment

Increase in Amount of Automobile Grant and Automatic Annual Adjustments for Increased Costs:

The automobile and adaptive equipment grants need to be increased and automatically adjusted annually to cover increases in costs.

The Department of Veterans Affairs provides grants for the purchase of automobiles or other conveyances to certain severely disabled veterans and service members. VA also provides grants for adaptive equipment necessary for safe operation of these vehicles. Veterans suffering from service-connected ankylosis of one or both knees or hips are eligible for only the adaptive equipment. This program also authorizes replacement or repair of adaptive equipment.

Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile. However, because adjustments have not kept pace with increased costs, over the past 52 years the value of the automobile allowance has been substantially eroded. In 1946 the $1,600 allowance represented 85 percent of the average retail cost and was sufficient to pay the full cost of automobiles in the "low-price field." Comparing the Department of Energy's average price of a new vehicle to the automobile allowance that was in effect for that year, Table 1 demonstrates the dramatic decline in this benefit.

The National Automobile Dealers Association has confirmed that the $28,500 average price of a new car in 2007 is the same for 2008. The table below shows that an $11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile. To restore equity between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be $22,800.

Veterans eligible for the automobile allowance under title 38, United States Code, section 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance is only a fraction of the cost of even the most modest and smaller models, which are often not suited to these veterans' special needs. Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles.

Recommendation:

Congress should increase the automobile allowance to 80 percent of the average cost of a new automobile in 2008 and then provide for automatic annual adjustments based on the rise in the cost of living.

Price of New Vehicle vs. Auto Allowance

Year	Auto Allowance	Avg. Cost of New Car	Cost as a % of Allowance
1946	$1,600	$1,875	85%
1971	$2,800	$3,919	72%
1975	$3,300	$5,084	65%
1978	$3,800	$6,478	58%
1981	$4,400	$8,912	49%
1985	$5,000	$11,589	43%
1988	$5,500	$13,418	41%
1998	$8,000	$18,479	43%
2001	$9,000	$19,654	46%
2007	$11,000	$28,500	39%

INSURANCE

Government Life Insurance

VALUE OF POLICIES EXCLUDED FROM CONSIDERATION AS INCOME OR ASSETS:

For purposes of other government programs, the cash value of veterans' life insurance policies should not be considered assets, and dividends and proceeds should not be considered income.

For nursing home care under Medicaid, the government forces veterans to surrender their government life insurance policies and apply the amount received from the surrender for cash value toward nursing home care as a condition for Medicaid coverage of the related expenses of needy veterans. It is unconscionable to require veterans to surrender their life insurance to receive nursing home care. Similarly, dividends and proceeds from veterans' life insurance should be exempt from countable income for purposes of other government programs.

Recommendation:

Congress should enact legislation to exempt the cash value of, and dividends and proceeds from, VA life insurance policies from consideration in determining entitlement under other federal programs.

LOWER PREMIUM SCHEDULE FOR SERVICE-DISABLED VETERANS' INSURANCE:

The Department of Veterans Affairs should be authorized to charge lower premiums for Service-Disabled Veterans' Insurance (SDVI) policies based on improved life expectancy under current mortality tables.

Because of service-connected disabilities, disabled veterans have difficulty getting or are charged higher premiums for life insurance on the commercial market. Congress therefore created the SDVI program to furnish disabled veterans life insurance at standard rates.

When this program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. However, VA continues to base its rates on mortality tables from 1941. Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer provide the intended benefit for eligible veterans.

Recommendation:

Congress should enact legislation to authorize VA to revise its premium schedule for Service Disabled Veterans' Insurance to reflect current mortality tables.

INCREASE IN MAXIMUM SERVICE-DISABLED VETERANS' INSURANCE COVERAGE:

The current $10,000 maximum for life insurance under Service-Disabled Veterans' Insurance (SDVI) does not provide adequately for the needs of survivors.

When life insurance for veterans was first made available to members of the armed forces in October of 1917, coverage was limited to $10,000. At that time, the law authorized an annual salary of $5,000 for the director of the Bureau of War Risk Insurance. Obviously, the average annual wages of service members in 1917 was considerably less than $5,000. Then, a $10,000 life insurance policy provided sufficiently for the loss of income from the death of an insured in 1917.

Today, more than 90 years later, maximum coverage under the base SDVI policy remains at $10,000. Given that the annual cost of living is many times what it was in 1917, the same maximum coverage now nearly a century later clearly does not provide meaningful income replacement for the survivors of service-disabled veterans.

A May 2001 report from an SDVI program evaluation conducted for VA recommended that basic SDVI coverage be increased to $50,000 maximum. *The Independent Budget* veterans service organizations therefore recommend that the maximum protection available under SDVI be increased to $50,000.

Recommendation:

Congress should enact legislation to increase the maximum protection under base Service Disabled Veterans' Insurance policies to $50,000.

Veterans' Mortgage Life Insurance

INCREASE IN MAXIMUM VETERANS' MORTGAGE LIFE INSURANCE COVERAGE:

The maximum amount of mortgage protection under Veterans' Mortgage Life Insurance (VMLI) needs to be increased.

The maximum VMLI coverage was last increased in 1992. Since then, housing costs have risen substantially. Because of the great geographic differentials in the costs associated with accessible housing, many veterans have mortgages that exceed the maximum face value of VMLI. Thus, the current maximum coverage amount does not cover many catastrophically disabled veterans' outstanding mortgages. Moreover, severely disabled veterans may not have the option of purchasing extra life insurance coverage from commercial insurers at affordable premiums.

Recommendation:

Congress should increase the maximum coverage under Veterans' Mortgage Life Insurance from $90,000 to $150,000.

General Operating Expenses

From its central office in Washington, D.C., and through a nationwide system of field offices, the Department of Veterans Affairs administers its veterans' benefits programs. Responsibility for the various benefit programs is divided among five services within the Veterans Benefits Administration: Compensation and Pension, Vocational Rehabilitation and Employment, Education, Loan Guaranty, and Insurance. Under the direction and control of the Under Secretary for Benefits and various deputies, the program directors set policy and oversee their programs from the VA Central Office. The field offices receive benefit applications, determine entitlement, and authorize benefit payments and awards.

The Office of the Secretary of Veterans Affairs and the assistant secretaries provide departmental management and administrative support. These offices, along with the Office of General Counsel and the Board of Veterans' Appeals, are the major activities under the General Administration portion of the General Operating Expenses (GOE) appropriation. The GOE appropriation funds the benefits delivery system-VBA and its constituent line, staff, and support functions—and the functions under General Administration.

The best-designed benefit programs achieve their intended purposes only if the benefits are delivered to entitled beneficiaries in a timely manner and in the correct amounts. *The Independent Budget* veterans service organizations make the following recommendations to maintain VA's benefits delivery infrastructure and to improve VA performance and service to veterans.

VETERANS BENEFITS ADMINISTRATION

VBA Management

MORE AUTHORITY OVER FIELD OFFICES:

VA program directors should have more accountability for benefits administration in the field offices.

The Veterans Benefits Administration (VBA) has introduced several new initiatives to improve its claims processes. Besides fundamental reorganization of claims-processing methods to achieve increased efficiencies, the initiatives include several measures to improve quality in claims decisions. Among these measures are better quality assurance and accountability for technically correct decisions. The VBA's current management structure presents a serious obstacle to enforcement of accountability because program directors lack direct authority over those who make claims decisions in the field. Of VBA management, program directors have the most hands-on experience with and intimate knowledge of their benefit lines, and they have the most direct involvement in day-to-day monitoring of field office compliance. Program directors are therefore in the best position to advise the Under Secretary on enforcing quality standards and program policies within their respective benefit programs.

While higher-level VBA managers are properly positioned to direct operational aspects of field offices, they are indirectly involved in the substantive elements of the benefit programs. To enforce accountability for technical accuracy and to ensure uniformity in claims decisions, program directors logically should have more accountability for the field decision-making process and should be enabled to advise the Under Secretary to order remedial measures when variances are identified.

In its August 1997 report to Congress, the National Academy of Public Administration (NAPA) attributed many of the VBA's problems to unclear lines of accountability. NAPA found that a sense of powerlessness to take action permeates the VBA. In turn, field personnel perceived VBA's central office staff as incapable of taking firm action. NAPA said that a number of executives interviewed by its study team indicated that VBA executives have difficulty giving each other bad news or disciplining one another. NAPA concluded that until the VBA is willing to deal with this conflict and modify its decentralized management style, it will not be able to effectively analyze the variations in performance and operations existing among its regional offices. Neither will it be able to achieve a more uniform level of performance. Regarding the Compensation and Pension (C&P) Service especially, NAPA concluded that the C&P director's lack of influence or authority over its field office employees would greatly hamper any efforts to implement reforms and real accountability.

NAPA recommended that the Under Secretary for Benefits strengthen C&P influence over field operations and close the gaps in accountability. *The Independent Budget* veterans service organizations (IBVSOs) continue to agree with that assessment and urge the Under Secretary to empower the C&P director to become more involved in direct field operations. In its March 2004 "Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran," the VA Vocational Rehabilitation and Employment (VR&E) Task Force recommended that the director of the VR&E Service be given "some line-of-sight authority for the field administration of the program." The IBVSOs agree with this assessment as well.

Recommendation:

To improve the management structure of the Veterans Benefits Administration for purposes of enforcing program standards and raising quality, the VA Under Secretary for Benefits should give VBA program directors more accountability for the performance of VA regional office directors.

Compensation and Pension Service

IMPROVEMENTS IN CLAIMS PROCESSING:

Congress should restore fairness to the claims process by providing solid structure and enforceable rights to claims development where too much personal discretion otherwise exists.

The Department of Veterans Affairs administers a complex set of laws and regulations designed to compensate veterans for the average impairment of earnings capacity due to disabilities (the residuals of disease or injury) incurred coincident with or as a result of military service.

The compensation program is not workers compensation, nor is it akin to Social Security Disability Insurance (SSDI). The first is intended to protect workers from lost wages as the result of disabilities related to employment. This benefit is usually limited in both amount and duration of payment. It provides basic income for a finite period to injured employees. It also protects employers by providing a limit on payments. Social Security Disability Insurance is, at its heart, an insurance program. Both employees and employers pay premiums to the federal government which, in turn, pays a monthly benefit based on a number of factors.

Both workers compensation and SSDI decisions are relatively simple. With workers compensation, the decision maker gathers information on the origins and severity of a job-related injury. Workers compensation is paid if the injury is work related and at least temporarily disabling. SSDI is simpler still. Once basic eligibility is determined, the Social Security Administration need merely decide if the disability keeps the individual from working. If it does, the benefit is paid.

The payment of veterans' disability compensation, on the other hand, requires a decision that each claimed disability be related to service; a medical examination for each service-connected disability to assess the severity or impairment of the condition; and the assignment of a numerical evaluation for each condition. Finally, the decision maker must select an effective date of service connection for each condition and the level of severity for each disability, and if the disability worsened during the pendency of the claim, determine whether higher evaluations should be assigned at different points of time during that period.

The adjudication of compensation claims is complex and time consuming. Failure to develop evidence correctly requires serial redevelopment, which delays claims resolution and increases opportunities for mistakes.

Further, inadequately trained employees fail to recognize claims that have been adequately prepared for rating purposes. As a consequence, VA routinely continues to develop many claims rather than making timely decisions.

Inadequately trained and overworked employees are not limited to the Veterans Benefits Administration (VBA). Such actions usually result in appeals, followed by needless remands by the Board of Veterans' Appeals (BVA) and/or the Court of Appeals for Veterans Claims (CAVC/the Court). In many of these cases, the evidence of record supports a favorable decision on the appellant's behalf, yet the appeal is remanded nonetheless. These unjustified remands usually do nothing but perpetuate the hamster-wheel reputation of veterans law.

In far too many cases, VA continues to develop cases, and the BVA remands appeals, solely to obtain a VA medical opinion even when the claimant's submission of a private medical opinion is adequate for rating purposes. VA's conduct in these cases violates the very purpose of its pro-claimant, nonadversarial claims process.

In order to understand the complex, procedural characteristics of the claims process—and how these characteristics delay timely adjudication of claims—one must focus on the procedural characteristics and how they affect the claims process as a whole. Whether through expansive judicial orders, repeated mistakes, or variances in VA decision making, some aspects of the claims process have become complex, loosely structured, and open to the personal discretion of individual adjudicators. By strengthening and properly structuring these processes, Congress can build on what otherwise works.

These changes should begin by providing solid, nondiscretionary structure to VA's "duty to notify." Congress

meant well when it enacted VA's current statutory "notice" language. It has nonetheless led to unintended consequences that have proven detrimental to the claims process. Many Court decisions have expanded upon VA's statutory duty to notify, in terms of both content and timing. However, with the recent passage of P.L. 110-389, the "Veterans Benefits Improvement Act of 2008," Congress, with the Administration's support, took an important step to correct this problem. However, *The Independent Budget* veterans service organizations (IBVSOs) believe VA can do more.

There is ample room to improve the law concerning medical opinions in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assistance Act (VCAA) notice letter. Under current notice requirements and in applicable cases, VA's letter to a claimant normally informs the claimant that he or she may submit a private medical opinion. The letter also states that VA may obtain a medical opinion if VA decides to do so. However, these notice letters do not inform the claimant of what elements make private medical opinions adequate for VA rating purposes.

To correct this deficiency, the IBVSOs recommend that when VA issues proposed regulations to implement the recent amendment of section 5103 its proposed regulations contain a provision that will require it to inform a claimant, in a VCAA notice letter, of the basic elements that make medical opinions adequate for rating purposes. The VA's notice requirements should be amended to include specific information concerning the basic elements that make a medical opinion adequate for rating purposes, such as a medical statement indicating what records (for example, service medical records, copy of VA claims file, treatment records, etc.) were reviewed in reaching the opinion, a medical rationale for the opinion, and a conclusion to the opinion stated in terms of "as likely as not," "more likely than not," or "less likely than not" rather than "maybe," "possibly," or "could be."

The IBVSOs believe if a claimant's physician is made aware of the elements that make a medical opinion adequate for VA rating purposes, and provides VA with such an opinion, VA no longer needs to delay making a decision on a claim by obtaining its own medical opinion. This would reduce the number of appeals that result from conflicting medical opinions—appeals that—more often than not—are ultimately decided in an appellant's favor.

If the Administration refuses to promulgate regulations that incorporate the foregoing suggestion, Congress should amend VA's notice requirements in section 5103 to require that VA provide such notice regarding the adequacy of medical opinions. As a matter of fairness, VA does relay this exact information to its own doctors when it seeks a medical opinion.

Congress should consider amending title 38, United States Code, section 5103A(d)(1) to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request such evidence from a Department provider. These suggested changes to VA's "duty to notify" and its "duty to assist" would ensure uniformity between the two procedures.

Congress has previously attempted, to a lesser degree, to fix this problem. Congress enacted title 38, United States Code, section 5125 for the express purpose of eliminating the former 38 Code of Federal Regulations, section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report prior to an award of VA benefits. Section 5125 states:

> For purposes of establishing any claim for benefits under chapter 11 or 15 of this title, a report of a medical examination administered by a private physician that is provided by a claimant in support of a claim for benefits under that chapter *may* be accepted without a requirement for confirmation by an examination by a physician employed by the Veterans Health Administration if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim.[13]

Section 5125 was therefore codified to eliminate unnecessary delays in the adjudication of claims and to avoid the costs associated with unnecessary medical examinations. In addition to unnecessary costs, this type of overdevelopment significantly adds to VA's increasing claims and appeals backlog.

In spite of the elimination of 38 Code of Federal Regulations, section 3.157, and the enactment of title 38, United States Code, section 5125, VA consistently refuses to make decisions in claims wherein the claimant secures a private medical opinion until a VA medical opinion is obtained. Such actions are an abuse of discretion, delay decisions, and prompt needless appeals. When claimants

submit private medical evidence that is competent, credible, probative, and otherwise adequate for rating purposes, Congress should mandate that VA *must* decide the case based on such evidence rather than delaying the claim by arbitrarily requesting it provide additional medical opinion. Therefore, section 5125 should also be amended to ensure harmonious law with enforceable rights that is to a lesser degree than current law open to such wide discretionary interpretations by VA employees.

Some may view these suggestions as an attempt to tie VA's hands with respect to its consideration of private medical opinions. However, they do not. The language in these recommended changes would not require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for VA rating purposes.

Recommendations:

VA should issue proposed regulations to implement the recent amendment of 38, United States Code, section 5103 as quickly as possible. VA's proposed regulations should include provisions that will require it to notify a claimant, in appropriate circumstances, of the elements that make medical opinions adequate for rating purposes.

Congress should amend section 5103A(d)(1) to provide that when a claimant submits a private medical opinion that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request another medical opinion from a Department health-care facility.

Congress should amend title 38, U.S.C., section 5125, insofar as it states that a claimant's private examination report "may" be accepted. The new language should direct that VA "must" accept such report if it is (1) provided by a competent health-care professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for adjudicating such claim.

[13] 38 U.S.C. § 5125 (West 2002) (emphasis added).

IMPROVEMENTS IN VBA TRAINING

Although the Department of Veterans Affairs has improved its training programs to some extent, more needs to be done to ensure decision makers and adjudicators are held accountable to training standards.

The Veterans Benefits Administration (VBA) has a standard training curriculum for new claims processors and an 80-hour annual training requirement for all claims processors. The training program in VBA is basically a three-stage system. First, VBA policy requires new staff to complete some orientation training, which is provided in their home offices. Second, they are required to attend a two- to three-week centralized training course that provides a basic introduction to job responsibilities. Third, new staff are required to spend several more months in training at their home offices, which includes on-the-job training and/or instructor-led training that follows a required curriculum via use of an online learning tool called the Training and Performance Support System (TPSS). VBA policy states that all claims processors are required to complete a minimum of 80 hours of training annually. VA regional offices (ROs) have some discretion over what training they provide to meet this requirement.

The first phase of training for new rating veteran service representatives (RVSRs) is prerequisite training; this begins at their home regional offices. This training is designed to lay the foundation for future training by introducing new employees to topics, such as the software applications used to process and track claims, medical terminology, the system for maintaining and filing a case folder, and the process for requesting medical records. The VBA specifies the topics that must be covered during prerequisite training; however, ROs can choose the format for the training and the time frame. New veteran service representatives (VSRs) and RVSRs

typically spend two to three weeks completing prerequisite training in their home office before they begin the second program phase.

The second phase of training is known as centralized training, wherein new VSRs and RVSRs spend approximately three weeks in classroom training. Participants from multiple ROs are typically brought together in centralized training sessions, which provide an overview of the technical aspects of the VSR and RVSR positions.

To practice processing different types of claims, VSRs work on either real or hypothetical claims specifically designed for training. Centralized training for new RVSRs focuses on such topics as systems of the human body, how to review medical records, and how to interpret medical exams. To provide instructors for centralized training, the VBA relies on senior RO staff who are trained as instructors. Centralized training instructors may be VSRs, RVSRs, supervisors, or other staff identified by RO managers as having the capability to be effective instructors.

The VBA has increased the number of training sessions because of the influx of new staff. In fiscal year 2007 the VBA increased the frequency of centralized training and its student capacity at the Veterans Benefits Academy. During FY 2007, the VBA held 67 centralized training sessions for 1,458 new VSRs and RVSRs. Centralized training sessions were conducted at 26 different ROs during FY 2007, in addition to the Veterans Benefits Academy. By comparison, during FY 2006, the VBA held 27 centralized training sessions for 678 new claims processors. Nonetheless, the VBA has not run its benefits academy near to full capacity in 2008, the reasons for which are unclear.

When new VSRs and RVSRs return to their home office after centralized training, they are required to begin their third phase of training, which is supposed to include on-the-job, classroom, and computer-based training modules that are part of the VBA's TPSS, all conducted by and at the RO. New VSRs and RVSRs typically take about 6 to 12 months after they return from centralized training to complete all the training requirements for new staff.

In addition to the foregoing three-phase training program, the VBA also requires 80 hours of annual training for all VSRs and RVSRs. The training is divided into two parts. At least 60 hours must come from a list of core technical training topics identified by the Compensation and Pension Service. The VBA specifies more core topics than are necessary to meet the 60-hour requirement, so regional offices can choose those topics most relevant to their needs. They can also choose the training method used to address each topic, such as classroom or TPSS training. The RO managers decide the specificities of the remaining 20 hours.

Despite the foregoing, training has not been a high priority in the VBA. One of the most essential resources is experienced and knowledgeable personnel devoted to training. More management devotion to training and quality requires a break from the status quo of production goals above all else. In a 2005 report from the VA Office of Inspector General, VBA employees were quoted as stating: "Although management wants to meet quality goals, they are much more concerned with quantity. An RVSR is much more likely to be disciplined for failure to meet production standards than for failing to meet quality standards," and "there is a lot of pressure to make your production standard. In fact, your performance standard centers around production and a lot of awards are based on it. Those who don't produce could miss out on individual bonuses, etc."[14] Little if anything has changed since the Inspector General issued this report.[15]

The VBA's problems caused by a lack of accountability do not begin in the claims development and rating process—they begin in the training program. There is little measurable accountability in the VBA's training program.

For example, some VA employees anonymously informed *The Independent Budget* veterans service organizations that many candidates begin centralized training without having had the opportunity to participate in and/or complete phase-one training. Additionally, candidates are not held responsible by formal testing on subjects taught during phase-one training. While oversight may exist for this portion of training, we could find none.

Without resorting to a critique of the substance of the VBA's subject matter taught during phase-two training, or any other phase for that matter, we limit our analysis again to accountability. As in phase one, the VBA refuses to test participants of phase-two training. The obvious goal is to ensure employees attend the required course—ensuring that employees achieve the VBA's learning objectives appears to have no priority.

By now, a new employee has had approximately one month of training and is supposedly prepared for phase-three training. Keep in mind that during phase three, new employees will work on real-world cases in which the outcomes affect the lives and livelihoods of disabled veterans and their families. Real cases notwithstanding, again there is no accountability, no testing, and no oversight outside that provided locally; again, that oversight is not measured nationally.

The result of such an unsupervised and unaccountable training system is that no distinction exists between unsatisfactory performance and outstanding performance. This lack of accountability during training further reduces, or even eliminates, employee motivation to excel. This institutional mind-set is further epitomized in VBA's day-to-day performance, where employees throughout VBA are reminded that optimum work output is far more important than quality performance and accurate work.

The effect of VBA's lack of accountability in its training program was demonstrated when it began offering skills certification tests to support certain promotions. Beginning in late 2002, VSR job announcements began identifying VSRs at the GS-11 level, contingent upon successful completion of a certification test. The open-book test consisted of 100 multiple-choice questions. VA allowed participants to use online references and any other reference material, including individually prepared notes in order to pass the test.

The first validation test was performed in August 2003. There were 298 participants in the first test. Of these, 75 passed for a pass rate of 25 percent. The VBA conducted a second test in April 2004. Out of 650 participants, 188 passed for a pass rate of 29 percent. Because of the low pass rates on the first two tests, a 20-hour VSR "readiness" training curriculum was developed to prepare VSRs for the test. A third test was administered on May 3, 2006, to 934 VSRs nationwide. Still, the pass rate was only 42 percent. Keep in mind that these tests were not for training; they were to determine promotions from GS-10 to GS-11.

These results reveal a certain irony, in that the VBA will offer a skills certification test for promotion purposes, but does not require comprehensive testing throughout its training curriculum. Mandatory and comprehensive testing designed cumulatively from one subject area to the next, for which the VBA then holds trainees accountable, should be the number one priority of any plan to improve VBA's training program. Further, VBA should not allow trainees to advance to subsequent stages of training until they have successfully completed such testing.

The Veterans' Benefits Improvement Act of 2008 mandated some testing for claims processors and VBA managers, which is an improvement; however, it does not mandate the type of testing during the training process as explain herein. Measurable improvement in the quality of and accountability for training will not occur until such mandates exist.

It is quite evident that a culture of quality neither exists, nor is much desired, in the Veterans Benefits Administration.

Recommendation:

VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence. In addition, to complement recent improvements in its training programs, VA should require mandatory and comprehensive testing of the claims process and appellate staff. To the extent that VA fails to provide adequate training and testing, Congress should require mandatory and comprehensive testing, under which VA will hold trainees accountable.

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[14]Department of Veterans Affairs Office of Inspector General, *Rep. No. 05-00765-137, Review of State Variances in VA Disability Compensation Payments* 61 (May 19, 2005).

[15]A survey conducted by the Center for Naval Analysis Corporation for the Veterans' Disability Benefits Commission found that "some raters felt that they were not adequately trained or that they lacked enough experience." Veterans' Disability Benefits Commission, October 2007, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century.* p. 12.

STRONGER ACCOUNTABILITY

The Veterans Benefits Administration (VBA) must overhaul its outdated and ineffective accountability mechanisms.

In addition to training, accountability is the key to quality, and therefore to timeliness as well. As it currently stands, almost everything in the VBA is production driven. Performance awards cannot be based on production alone; they must also be based on demonstrated quality. However, in order for this to occur, the VBA must implement stronger accountability measures for quality assurance.

The quality assurance tool used by the Department of Veterans Affairs for compensation and pension claims is the Systematic Technical Accuracy Review (STAR) program. Under the STAR program, VA reviews a sampling of decisions from regional offices and bases its national accuracy measures on the percentage with errors that affect entitlement, benefit amount, and effective date.

However, there is a gap in quality assurance for purposes of individual accountability in quality decision making. In the STAR program, a sample is drawn each month from a regional office workload divided between rating, authorization, and fiduciary end-products. However, VA recognizes that these samples are only large enough to determine national and regional office quality. Samples as small as 10 cases per month per office are woefully inadequate to determine individual quality.

While VA attempts to analyze quality trends identified by the STAR review process, claims are so complex, with so many potential variables, that meaningful trend analysis is difficult. As a consequence, the VBA rarely obtains data of sufficient quality to allow it to reform processes, procedures, or policies.

As mentioned above, STAR samples are far too small to allow any conclusions concerning individual quality. That is left to rating team coaches who are charged with reviewing a sample of ratings for each rating veteran service representative (RVSR) each month. This review should, if conducted properly, identify those employees with the greatest problems. In practice, however, most rating team coaches have insufficient time to review what could be 100 or more cases each month. As a consequence, individual quality is often underevaluated and employees with quality problems fail to receive the extra training and individualized mentoring that might allow them to be competent raters.

In the past 15 years the VBA has moved from a quality-control system for ratings that required three signatures on each rating before it could be promulgated to the requirement of but a single signature. Nearly all VA rating specialists, including those with just a few months' training, have been granted some measure of "single signature" authority. Considering the amount of time it takes to train an RVSR, the complexity of veterans disability law, the frequency of change mandated by judicial decisions, and new legislation or regulatory amendments, a case could and should be made that the routine review of a second well-trained RVSR would avoid many of the problems that today clog the appeals system.

The Veterans' Benefits Improvement Act of 2008 (section 226) required VA to conduct a study on the effectiveness of the current employee work-credit system and work-management system. In carrying out the study, VA is required to consider, among other things: (1) measures to improve the accountability, quality, and accuracy for processing claims for compensation and pension benefits; (2) accountability for claims adjudication outcomes; and (3) the quality of claims adjudicated. The legislation requires VA to submit the report to Congress, which must include the components required to implement the updated system for evaluating VBA employees, no later than October 31, 2009.

This is a historic opportunity for VA to implement a new methodology—a new philosophy—by developing a new system with a primary focus of quality through accountability. Properly undertaken, the outcome would result in a new institutional mind-set across the VBA—one that focuses on the achievement of excellence—and change a mind-set focused mostly on quantity-for-quantity's sake to a focus of quality and excellence. Those who produce quality work are rewarded and those who do not are finally held accountable.

Recommendation:

The VA Secretary's upcoming report must focus on how the Department will establish a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit errors while simultaneously providing employee motivation for the achievement of excellence. VA should generate the report in consultation with veterans service organizations most experienced in the claims process.

Investments in VBA Initiatives

VBA INFORMATION TECHNOLOGY AND STAFF TRAINING INITIATIVES:

To maintain and improve efficiency and accuracy of claims processing, the Veterans Benefits Administration (VBA) must continue to upgrade its information technology (IT) and training programs. Also, the VBA must be given more flexibility to install, manage, and plan upgraded technology to support claims management improvement.

To meet ever-increasing demands while maintaining efficiency, the VBA must continually modernize the tools it uses to process and resolve claims. Given the current challenging environment in claims processing and benefits administration, and the ever-growing backlog, the VBA must continue to upgrade IT infrastructure and revise its training to stay abreast of program changes and modern business practices. However, as noted in the "Centralized Information Technology Impact on VA Health Care" section of this *Independent Budget*, the centralization of all IT to one chief information officer has brought many crucial VBA IT initiatives to a halt—or at best a slow crawl—to the detriment of reforms essential to improving the claims-processing system. Also, in spite of undeniable needs, Congress has steadily reduced funding for VBA initiatives over the past several years. In FY 2001, Congress provided $82 million for VBA-identified IT initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and in 2006, $23 million.

Funding for FY 2006 was only 28 percent of FY 2001 funding, without regard to inflation. Moreover, some VBA employees who provided direct support and development for VBA's IT initiatives were transferred to the VA chief information officer when the Department centralized all IT operations, governance, planning, and budgeting. Continued IT realignment through FY 2007 and 2008 shifted more funding to VA's agency IT account, further reducing funding for these VBA initiatives in the General Operating Expenses account to $11.8 million. It should be noted that in the FY 2007 appropriation, Public Law 110-28, Congress provided $20 million to VBA for IT to support claims processing, and in 2009 Congress designated $5 million in additional funding specifically to support the IT needs of new VBA Compensation and Pension Service personnel—also authorized by that appropriations act.

The Independent Budget veterans service organizations (IBVSOs) urge the Department of Veterans Affairs to use new funds for the purposes enumerated in this section and to ensure that new VBA personnel are properly supported with necessary IT resources. With restored investments in these initiatives, the VBA could complement staffing adjustments for increased workloads with a supportive infrastructure to improve operational effectiveness. The VBA could resume an adequate pace in its development and deployment of IT solutions, as well as to upgrade and enhance training systems for staff to improve operations and service delivery to veterans. Whereas all IT initiatives are now being funded in VA's IT appropriation and tightly controlled by the chief information officer, needed and ongoing VBA initiatives include expansion of web-based technology and deliverables, such as a web portal and Training and Performance Support System (TPSS); "Virtual VA" paperless processing; enhanced veteran self-service and access to benefit application, status, and delivery; data integration across business lines; use of the corporate database; in-

formation exchange; quality assurance programs and controls; and employee skills certification and training.

The IBVSOs believe these initiatives should receive priority funding in FY 2010:

- Complete the replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with the Veterans Service Network (VETSNET) for the Compensation and Pension Service. VETSNET is a suite of applications, which include Share/Search and Participant Profile, Modern Award Processing-Development, and Rating Board Automation, that integrates several subsystems into one nationwide information system for claims development, adjudication, and payment administration;
- Enhance the Education Expert System (TEES) for the Education Service (this program will be crucial to support the new GI Bill recently enacted by Congress in Public Law 110-181). TEES provides for electronic transmission of applications and enrollment documentation along with automated expert processing; and
- Update the corporate WINRS (CWINRS) to support programs of the Vocational Rehabilitation and Employment (VR&E) Service. CWINRS is a case management and information system allowing for more efficient award processing and sharing of information nationwide.

Also, the IBVSOs believe the VBA should continue to develop and enhance data-centric benefits integration with "Virtual VA" and modification of The Imaging Management System (TIMS). All these systems serve to replace paper-based records with electronic files for acquiring, storing, and processing claims data.

Virtual VA supports pension-maintenance activities at three VBA pension-maintenance centers. Further enhancement would allow for the entire claims and award process to be accomplished electronically. TIMS is the Education Service system for electronic education claims files, storage of imaged documents, and workflow management. The current VBA initiative is to modify and enhance TIMS to make it fully interactive and allow for fully automated claims and award processing by the Education Service and VR&E nationwide.

Upgrade and Enhance Training Systems

VA's TPSS is a multimedia, multimethod training tool that applies the instructional systems development methodology to train and support employee performance of job tasks. These TPSS applications require technical updating to incorporate changes in laws, regulations, procedures, and benefit programs. In addition to regular software upgrades, a help desk for users is needed to make TPSS work effectively.

VBA initiated its skills certification instrument in 2004. This tool helps the VBA assess the knowledge base of veterans service representatives. VBA intends to develop additional skills certification modules to test rating veteran service representatives, decision review officers, field examiners, pension-maintenance center employees, and veterans claims examiners in the Education Service.

Accelerate Implementation of Virtual Information Centers

By providing veterans regionalized telephone contact access from multiple offices within specified geographic locations, VA could achieve greater efficiency and improved customer service. Accelerated deployment of virtual information centers will more timely accomplish this beneficial effect.

With the effects of inflation, the growth in veterans' programs, and the imperative to invest more in advanced IT, the IBVSOs believe a conservative increase of at least 5 percent annually in VBA's IT initiatives is warranted. Had Congress increased the FY 2001 funding of $82 million by 5 percent each year since then, the amount available for FY 2010 would be nearly $130 million. Unfortunately, these programs have been chronically underfunded, and now with IT centralization, IT funding in the VBA is even more restricted and bureaucratic.

Congress has taken notice of the chronic disconnect between VBA IT and lagging improvements in claims processing. Section 227 of Public Law 110-389 places new requirements on VA to closely examine all uses of current IT and comparable outside IT systems with respect to VBA claims processing for both compensation and pension. Following that examination, VA is required to develop a new plan to use these and other relevant technologies to reduce subjectivity, avoid remands, and reduce variances in VA regional office ratings for similar specific disabilities in veteran claimants. The act requires the VA Secretary to report the results of that examination to Congress in great detail and includes a requirement that the Secretary ensure that the plan will result, within three years of implementation, in reduc-

tion in processing time for compensation and pension claims processed by the VBA. The requirements of this section will cause heavy scrutiny on IT systems that VBA has been attempting to implement, improve, and expand for years. We believe the examination will reveal that progress has been significantly stymied as a result of a lack of directed funding to underwrite IT development and completion and lack of accountability to ensure these programs work as intended.

Recommendations:

Congress should provide the Veterans Benefits Administration adequate funding for its information technology initiatives to improve multiple information and information-processing systems and to advance ongoing, approved, and planned initiatives such as those enumerated in this section. These IT programs should be increased annually by a minimum of 5 percent or more.

VBA should revise its training programs to stay abreast of IT program changes and modern business practices.

VA should ensure that recent funding specifically designated by Congress to support the IT needs of the VBA, and of new VBA staff authorized in FY 2009, are provided to VBA as intended, and on an expedited basis.

The chief information officer and Under Secretary for Benefits should give high priority to the review and report required by Public Law 110-389 and redouble their efforts to ensure these ongoing VBA initiatives are fully funded and accomplish their stated intentions.

The VA Secretary should examine the impact of the current level of IT centralization under the chief information officer on these key VBA programs and, if warranted, shift appropriate responsibility for their management, planning, and budgeting from the chief information officer to the Under Secretary for Benefits.

SUFFICIENT STAFFING LEVELS

Recent staffing increases in the Veterans Benefits Administration (VBA) may now be sufficient to reduce the backlog of pending claims once new hires complete training. However, any move by Congress to reduce VBA staffing in the foreseeable future will guarantee a return to unacceptably high backlogs.

The Department of Veterans Affairs began making some progress in reducing pending rating claims in FY 2008. While pending rating claims remain at an unacceptably high level, with more than 386,000 pending at the end of the fiscal year, that number represents a nearly 4 percent reduction from FY 2007. Total compensation and pension (C&P) issues, both rating and nonrating, also decreased during this period by 3.2 percent. While both reductions are encouraging, an increase of 18,282 appeals (11.3 percent) to a record high of nearly 180,000 for this same period clearly indicates that VA has merely shifted resources from processing appeals to processing ratings.[16]

During FY 2008, VA hired nearly 2,000 staff authorized by Congress. This is in addition to those hired in the previous year. In the near term, this increase in claims processors is a net drain on VBA resources as experienced personnel are taken out of production to conduct extensive training and mentoring of the new hires. Historically, it takes at least two years for new nonrating claims processors to acquire sufficient knowledge and experience to be able to work independently with both speed and quality. Those selected to make rating decisions require a separate period of at least two years of training before they have the skills to accurately complete most rating claims.

The VBA has modified its training regimen in recent years in an attempt to obtain increased production from new personnel at an earlier stage in their training. While it is impossible to isolate the underlying reasons for the modest reductions in pending rating and total C&P claims, it is reasonable to assume that a part of the decrease in the backlog is due to this VBA strategy. *The Independent Budget* veterans service organizations (IBVSOs) believe that rushing trainees into production encourages managers to skimp on training and ensures

that completed work is of lower quality than it would be if it were done by fully trained personnel.

In recent years, Congress has come to recognize that staffing reductions in the VBA in the previous decades laid the foundation for the backlogs of the present. Congress' actions to dramatically increase staffing has provided VBA a major tool in stopping chronic increases in the pending claims and begin the process of regaining control of the backlog. It is vital, however, that Congress recognize that the backlog will not go away overnight: it developed through years of increasing complexity of the claims development process with an overlay of judicial review. Neither of these causes is inherently bad; in fact, both development safeguards and judicial oversight were deemed necessary to help ensure that veterans and other claimants receive every benefit to which they are entitled under the law. However, the impact of these factors was, in the view of the IBVSOs, never fully appreciated—that is, until now. Congress should recognize that it will be several years before the full impact of recent hiring initiatives is felt.

Once everyone is fully trained and reductions in the backlog are seriously under way, it would be a mistake of monumental proportions if Congress were to allow staffing levels to decline. The IBVSOs do not suggest that VBA staffing remain off limits to Congressional budget considerations. What we believe, however, is that staffing reductions should occur only after the VBA has demonstrated, through technological innovation and major management and leadership reforms, that it has the right people and the right tools in place to ensure that claims can be processed both timely *and* correctly. As with backlog reductions, these changes will also not occur overnight. Congressional oversight, therefore, is critical to buttress any real improvements in claims processing and quality decisions.

Recommendations:

Congress should continue to monitor current staffing levels and ensure that they remain in place until such time as the backlog is eliminated.

Once the backlog is eliminated, Congress could consider staffing reductions in the Veterans Benefits Administration but only after ensuring that quality problems are fully and adequately addressed.

Congress should ensure through oversight that management and leadership reforms in the VBA are completed and permanent.

[16]Monday Morning Workload Report, October 6, 2008, showing October 4, 2008, data (www.vba.va.gov/REPORTS/mmwr/index.asp).

Vocational Rehabilitation and Employment

ADEQUATE STAFFING LEVELS:

To meet its ongoing workload demands and to implement new initiatives recommended by the Secretary's Vocational Rehabilitation and Employment (VR&E) Task Force, VR&E needs to increase its staffing.

The cornerstone among several new initiatives is VR&E's Five-Track Employment Process, which aims to advance employment opportunities for disabled veterans. Integral to attaining and maintaining employment through this process, the employment specialist position was changed to employment coordinator and was expanded to incorporate employment readiness, marketing, and placement responsibilities. In addition, increasing numbers of severely disabled veterans from Operations Enduring and Iraqi Freedom (OEF/OIF) benefit from VR&E's Independent Living Program, which empowers such veterans to live independently in the community to the maximum extent possible. Independent living specialists provide the services required for the success of

severely disable veterans participating in this program. VR&E needs approximately 200 additional full-time employees (FTEs) to offer these services nationally.

Given its increased reliance on contract services, VR&E needs approximately 50 additional FTEs dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force recommended creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

In FY 2009, VR&E was authorized 1,073 FTEs. *The Independent Budget* veterans service organizations have been informed that this number has been "frozen" due to the unknown impact the implementation of chapter 33 benefits will have on the VR&E program. Last year, we recommended that total staffing be increased to manage the current and anticipated workload as stated in the Secretary's VR&E Task Force. This recommendation is still valid and VR&E staffing should be increased by 302 FTEs to total 1,375 FTEs.

Recommendation:

Congress should authorize 1,375 total full-time employees for the Vocational Rehabilitation and Employment Service for FY 2010.

VOCATIONAL REHABILITATION AND EMPLOYMENT AND CHAPTER 33 OFFSETS:

Disabled veterans who are eligible or become eligible for Vocational Rehabilitation and Employment (VR&E) and who are already entitled to chapter 33 benefits should receive the same financial assistance provided under chapter 33 in lieu of the VR&E subsistence allowance.

With the passage of the Post 9/11 Veterans Education Assistance Act of 2008 (chapter 33), veterans eligible for VR&E who are also eligible for chapter 33 face a financial disincentive to participate in VR&E because the VR&E subsistence allowance is significantly lower than the monthly housing allowances provided under chapter 33. Consequently, disabled veterans who choose to receive the higher amount under chapter 33 will be deprived of the other significant advantages provided by VR&E, including counseling, employment services, independent living services, etc.

The Independent Budget veterans service organizations do not believe that Congress intended chapter 33 benefits to replace those of VR&E. It is imperative that veterans with employment handicaps or serious employment handicaps have access to the wide array of services provided through VR&E. In fact, that is the very purpose of its existence.

Given the unique services required to enable disabled veterans to return to the workforce, we believe that veterans eligible for both programs should receive the full benefit of VR&E with the same level of housing allowance as the chapter 33 housing allowance.

Recommendation:

Congress should amend title 38, United States Code, section 3108 (f)(1)(A) to include recipients of chapter 33 benefits.

Education Service

ADEQUATE STAFFING LEVELS:

To meet its increasing workload demands, the Education Service must increase direct program full-time employees.

As it has with its other benefit programs, the Department of Veterans Affairs has been striving to provide more timely and efficient service to its claimants for education benefits. Given the fact that Congress has authorized the Post 9/11 Veterans Education Assistance Act (chapter 33) with benefits beginning in August of 2009, *The Independent Budget* veterans service organizations are concerned that VA's Education Service will find itself severely understaffed. Chapter 33 benefits are extremely complex to administer, and VA has reported that it is unlikely that the software technology will be developed by the August 2009 deadline, so processing will have to be done manually. While we do not know at this time what this will mean in terms of the manpower necessary to manage this workload, we believe that it is obvious that VA will need a significant increase in resources to begin benefit processing in a timely manner and at a productivity level sufficient to prevent an instant backlog of claims.

Recommendation:

Congress should support VA requests for additional full-time employees at a level sufficient to minimize current claims backlogs and to fully manage the new workload they will incur with the addition of chapter 33 claims.

Judicial Review

In 1988, Congress recognized the need to change the situation that existed throughout the modern history of veterans' programs, in which claims decisions of the Department of Veterans Affairs were immune to judicial review. Congress enacted legislation to authorize judicial review and created what is now the United States Court of Appeals for Veterans Claims (CAVC) to hear appeals from VA's Board of Veterans' Appeals (BVA). Until Congress acted, the BVA enjoyed, and took advantage of, its decision making—what the Supreme Court once referred to as "splendid isolation" from the law.

Now the VA's administrative decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This provides a course for an individual to seek a remedy for an erroneous decision and a means by which to settle questions of law for application in other similar cases. When Congress established the CAVC, it added another beneficial element to appellate review: It created oversight of VA decision making by an independent, impartial tribunal from a different branch of government. Veterans are no longer without a remedy for erroneous BVA decisions.

Judicial review of VA decisions has, in large part, lived up to the positive expectations of its proponents. Nevertheless, based on past recommendations in *The Independent Budget,* Congress has made some important adjustments to the judicial review process based on lessons learned through experience over time. More precise adjustments are still needed to conform judicial review to Congressional intent. Accordingly, *The Independent Budget* veterans service organizations make the following recommendations to improve the processes of judicial review in veterans' benefits matters.

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review: Enforce Fairness in the Appeals Process

ENFORCE THE BENEFIT-OF-THE-DOUBT RULE:

To achieve the law's intent that the Court of Appeals for Veterans Claims (CAVC/Court) enforce the benefit-of-the-doubt rule on appellate review, Congress must enact more precise and effective amendments to the statute setting forth the Court's scope of review.

The conclusion regarding this recommendation is explained by the story of James Halvatgis. Mr. Halvatgis served approximately 25 years of honorable service. He was diagnosed with a right lumbar strain following a lifting injury during service in February 1963. Mr. Halvatgis also hurt his back when he fell approximately 20 feet while rappelling and then again in a jeep accident when he was thrown from the vehicle while swerving to avoid a landmine in Vietnam. He reported low back pain during service in July 1966, December 1968, September through November 1973, September through October 1974, and again in 1976. Many of these symptoms spanned months at a time and were accompanied by neurological symptoms indicating nerve involvement. X-rays of the veteran's low back taken *prior* to military discharge clearly revealed early signs of spinal deterioration.

Numerous private treatment records following discharge continued to document a definite back disability. A board-certified orthopedic surgeon, who was also an associate professor of orthopedic surgery, diagnosed degenerative joint disease of the lumbar spine with spinal stenosis. VA subsequently received a medical opinion from this same orthopedic surgeon wherein he stated that he felt that the veteran had had symptoms since the 1960s with respect to his low back and opined that in all likelihood, the Vietnam War injuries contributed to his early onset of arthritis and spinal stenosis.

Mr. Halvatgis filed a claim of service connection for his low back condition in January 2002. Further, he submitted a statement to VA that all doctors who provided statements regarding his claims were afforded one complete copy of his service medical records. In April 2002, VA received another opinion from a second board-certified orthopedic surgeon, who, again, was an associate professor of orthopedic surgery. This was the veteran's treating physician, who stated that he had reviewed the veteran's service medical records and then opined that the veteran's "condition is a continuation of the difficulties he developed in the service."

The veteran submitted a second medical opinion (totaling three) from one of the surgeons that stated the low back pain complained of while in the military "gradually progressed to the point where he now has post-traumatic arthritis of the lumbar spine." A second opinion from the other surgeon (totaling four) was submitted that stated, "[h]e had problems dating back to 1974 when...he was noted to have collapse, narrowing, and degeneration at the L5-S1 level. I have reviewed his medical service record which indicates this difficulty to that point in time."

In developing the claim, VA examined Mr. Halvatgis and asked for another medical opinion. The opinion was rendered by a noncertified physician assistant. Without referring to all of the treatment records in service, and without acknowledging the evidence that included four opinions presented by the two orthopedic surgeons, the physician assistant opined that Mr. Halvatgis's condition was congenital *and* otherwise age related, and therefore not related to his service. Based on the physician assistant's opinion, VA denied the claim.

Mr. Halvatgis appealed to the Board of Veterans' Appeals (BVA/Board). The Board found that there was "no competent evidence linking the veteran's low back disorder with his service...." The Board arbitrarily provided that the physician assistant's opinion was of more probative value despite that fact that all opinions were based on the same information.

Mr. Halvatgis appealed to the Court. *See Halvatgis v. Mansfield*, No. 06-0149, 2007 WL 4981384 (U.S. Vet.App., November 02, 2007). Because of the Board's nearly unreviewable authority to assign probative value (a factual finding) as arbitrarily as it sees fit, regardless of how abusive, and because of the Court's refusal to

reverse such ludicrous decisions if they contain the slightest scintilla of plausibility, the Court denied Mr. Halvatgis's claim.

Unfortunately, because the Board has such authority, cases such as this are not at all uncommon. The Board is fully aware that its power to assign such value to evidence is practically untouchable; therefore, rather than using that power to ensure fairness and objectivity when reviewing evidence, it consistently yields it as a proverbial double-edged sword to marginalize and minimize evidence to fit its own subjective view. A combination of reasons explains the inherent unfairness displayed in Mr. Halvatgis's case. Part of the problem is that a claimant's statutory right to the benefit of the doubt in cases like this has been interpreted as a "finding of fact" and subsequently converted by the Court's jurisprudence to nothing more than meaningless window dressing.

The CAVC upholds VA findings of "material fact" unless they are clearly erroneous and has repeatedly held that when there is a "plausible basis" for the Board's factual finding, it is not clearly erroneous.

Title 38, United States Code, section 5107(b) grants VA claimants a statutory right to the benefit of the doubt with respect to any benefit under laws administered by the Secretary of Veterans Affairs when there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter. Yet, the CAVC has been affirming many BVA findings of fact when the record contains only minimal evidence necessary to show a "plausible basis" for such finding. This renders a claimant's statutory right to the benefit of the doubt meaningless because claims can be denied and the denial upheld when supported by far less than a preponderance of evidence. These actions render Congressional intent under section 5107(b) meaningless.

To correct this situation, Congress amended the law with the enactment of the Veterans Benefits Improvement Act of 2002[17] to expressly require the CAVC to consider whether a finding of fact is consistent with the benefit-of-the doubt rule. The intended effect of section 401[18] of the Veterans Benefits Act of 2002 has not been upheld by the court.

Prior to the Veterans Benefits Act, the Court's case law provided (1) that the Court was authorized to reverse a BVA finding of fact when the only permissible view of the evidence of record was contrary to that found by the BVA and (2) that a BVA finding of fact must be affirmed where there was a plausible basis in the record for the Board's determination.

As a result of Veterans Benefits Act section 401 amendments to section 7261(a)(4), the CAVC is now directed to "hold unlawful and set aside or reverse" any "finding of material fact adverse to the claimant...if the finding is clearly erroneous."[19] Furthermore, Congress added entirely new language to section 7261(b)(1) that mandates the CAVC to review the record of proceedings before the Secretary and the BVA pursuant to section 7252(b) of title 38 and "take due account of the Secretary's application of section 5107(b) of this title...."[20]

The Secretary's obligation under section 5107(b), as referred to in section 7261(b)(1), is as follows:

> (b) BENEFIT OF THE DOUBT - The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.[21]

Prior to enactment of Veterans Benefits Act section 401, the CAVC characterized the benefit-of-the-doubt rule as mandating that "when...the evidence is in relative equipoise, the law dictates that [the] veteran prevails" and that, conversely, a VA claimant loses only when "a fair preponderance of the evidence is against the claim."[22] Nonetheless, such characterizations have historically proven to be nothing more than lip service.

Reading amended sections 7261(a)(4) and 7261(b)(1) together, which must be done in order to determine the effect of the Veterans Benefits Act section 401 amendments, reveals that the CAVC is now directed, as part of its scope-of-review responsibility under section 7261(a)(4), to undertake three actions in deciding whether BVA fact-finding that is adverse to a claimant is clearly erroneous and, if so, what the court should hold as to that fact-finding.

Specifically, the three actions to be taken as noted in the plain meaning of the amended subsections (a)(4) and (b)(1) require the Court: (1) to review all evidence

before the Secretary and the BVA; (2) to consider the Secretary's application of the benefit-of-the-doubt rule in view of that evidence; and (3) if the Court, after carrying out actions (1) and (2), concludes that an adverse BVA finding of fact is clearly erroneous and therefore unlawful, the Court must set it aside or reverse it.

Therefore, as the foregoing discussion illustrates, Congress intended the Veterans Benefits Act section 401 amendments to section 7261(a)(4) and (b) to fundamentally alter the Court's review of BVA fact-finding. This is evident by both the plain meaning of the amended language of these subsections as well as the unequivocal legislative history of the amendments.

Further, the legislative history bolsters the plain meaning of the statute by making clear that Congress intended for the Court to take a more proactive and less deferential role in its BVA fact-finding review. For example, amendments to section 7261, dealing with the same elements as did Veterans Benefits Act section 401, were included in S. 2079, introduced by Senator Rockefeller on April 9, 2002.[23] Senator Rockefeller stated in full regarding section 401:

> Section 401 of the Compromise Agreement would maintain the current "clearly erroneous" standard of review, but modify the requirements of the review the court must perform when making determinations under section 7261(a) of title 38. CAVC would be specifically required to examine the record of proceedings—that is, the record on appeal-before the Secretary and BVA. Section 401 would also provide special emphasis during the judicial process to the "benefit of the doubt" provisions of section 5107(b) as CAVC makes findings of fact in reviewing BVA decisions. The combination of these changes is intended to provide for more searching appellate review of BVA decisions, and thus give full force to the "benefit of doubt" provision. The addition of the words "or reverse" after "and set aside" in section 7261(a)(4) is intended to emphasize that CAVC should reverse clearly erroneous findings when appropriate, rather than remand the case. This new language in section 7261 would overrule the U.S. Court of Appeals for the Federal Circuit decision of *Hensley v. West,* 212 F.3d 1255 (Fed. Cir. 2000), which emphasized that CAVC should perform only limited, deferential review of BVA decisions, and stated that BVA fact-finding "is entitled on review to substantial deference." However, nothing in this new language is inconsistent with the existing section 7261(c), which precludes the court from conducting trial de novo when reviewing BVA decisions, that is, receiving evidence that is not part of the record before BVA.[24]

Perhaps the most dramatic of the three CAVC actions directed by section 401 was the mandate that the court "take due account of the Secretary's application of section 5107(b)," the "benefit-of-the-doubt rule." It is against this more relaxed standard of review that, through Veterans Benefits Act section 401, Congress has now required the Court to review the entire record on appeal and to examine the Secretary's determination as to whether the evidence presented was in equipoise on a particular material fact. The foregoing notwithstanding, the Court's equipoise review is no better after Veterans Benefits Act section 401 than it was before section 401. Congress's intent has been ignored.

In light of this background, the post–Veterans Benefits Act section 401 mandate supercedes the previous CAVC practice of upholding a BVA finding of fact unless the only permissible view of the evidence of record is contrary to that found by the Board and that a Board finding of fact must be affirmed where there is a plausible basis in the record for the determination. Yet the nearly impenetrable "plausible basis" standard continues to prevail as if Congress never amended section 7261.

The legislative history supports the plain meaning of these provisions discussed herein by strongly evidencing the intent of Congress to bring about decisive change in the scope of the Court's review of Board fact-finding. The House and Senate Committees on Veterans' Affairs described the new provisions enacted by section 401 as follows in an explanatory statement they prepared regarding their compromise agreement: [25]

Senate bill
Section 501 of S. 2237 would amend section 7261(a)(4)...to change the [Court's] standard of review as it applies to BVA findings of fact from "clearly erroneous" to "unsupported by substantial evidence." Section 502 would also cross-reference section 5107(b) in order to emphasize that the Secretary's application of the "benefit of the doubt" to an appellant's claim would be considered by CAVC on appeal.

House bill
The House bill contains no comparable provision.

Compromise agreement
Section 401 of the Compromise Agreement followed the Senate language with the following amendments:

> The Compromise Agreement would modify the standard of review in the Senate bill in subsection (a) by deleting the change to a "substantial evidence" standard. It would modify the requirements of the review the Court must perform when it is making determinations under section 7261(a) ...since the Secretary is precluded from seeking judicial review of decisions of the Board, the addition of the words "adverse to the claimant" in subsection (a) is intended to clarify that findings of fact favorable to the claimant may not be reviewed by the Court. Further, the addition of the words "or reverse" after "and set aside" is intended to emphasize that the Committees expect the Court to reverse clearly erroneous findings when appropriate, rather than remand the case. [The Committees' expectations are being ignored by the Court.] The new subsection (b) [of section 7261] would maintain language from the Senate bill that would require the Court to examine the record of proceedings before the Secretary and BVA and the special emphasis during the judicial process on the benefit-of-doubt provisions of section 5107(b) as it makes findings of fact in reviewing BVA decisions. This would not alter the formula of the standard of review on the Court, with the uncertainty of interpretation of its application that would accompany such a change. The combination of these changes is intended to provide for more searching appellate review of BVA decisions, and thus give full force to the "benefit-of-doubt" provision.[26]

At the time of the Senate's final action on S. 2237, VBA section 401 was quite extensively explained by Senator Rockefeller, who was the chairman of the Senate Committee, the floor manager of the bill in the Senate, and the principal author of VBA section 401. In explaining section 401, he emphasized, as did the two committees in their explanatory statement,[27] that the combination of the new requirements that the CAVC "examine the...record on appeal," consider the benefit-of-the doubt rule, and "make...findings of fact in reviewing BVA decisions" is "intended to provide for more searching appellate review of BVA decisions and thus give full force to the 'benefit of the doubt' provision."[28] Chairman Rockefeller concluded that the court should "reverse clearly erroneous findings when appropriate, rather than remand the case."[29] His statement is particularly significant (1) because only the Senate had passed provisions to amend the Court's section 7261 scope-of-review provisions (in S. 2237), and the Committees on Veterans' Affairs explained that section 401 generally "follows the Senate language," and (2) because there is no legislative history that is inconsistent with his statement.[30] Representative Evans, the ranking minority member of the House Committee, spoke in strong support of S. 2237 and explained that "the bill...clarifies the authority of the Court of Appeals for Veterans Claims to reverse decisions of the [BVA] in appropriate cases and requires the decisions be based upon the record as a whole, taking into account the pro-veteran rule known as the 'benefit of the doubt.' "[31]

With the foregoing statutory requirements, the Court should no longer uphold a factual finding by the Board solely because it has a plausible basis, inasmuch as that would clearly contradict the requirement that the CAVC's decision must take due account whether the factual finding adheres to the benefit-of-the-doubt rule. Yet such CAVC decisions upholding BVA denials because of the "plausible bases" standard continue as if Congress never acted.

The CAVC has essentially construed these amendments—intended to require a more searching appellate review of BVA fact-finding and to enforce the benefit of-the-doubt rule—as making no substantive change. The Court's precedent decisions now make it clear that it will continue to defer to and uphold BVA fact-finding without regard to whether it is consistent with the statutory benefit-of-the-doubt rule. Congress should not allow any federal court to scoff at its legislative power, particularly one charged with the protection of rights afforded to our nation's disabled veterans and their families.

Congress clearly intended a less deferential standard of review of the Board's application of the benefit-of-the-doubt rule when it amended 38 U.S.C. section 7261 in 2002, yet there has been no substantive change in the Court's practices. Therefore, to clarify the less deferential level of review that the Court should employ, Congress should amend 38 U.S.C. section 7261(a) by adding a new section, (a)(5), that states: "(5) In conducting review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision."

The Department of Veterans Affairs is a unique, non-adversarial forum for the adjudication of veterans' benefits claims. Proper and consistent application of the

benefit-of-the-doubt rule is critical to maintaining the unique characteristics of the Department. The above discussion proves that such application is absent more often than not; in fact, Court decisions are usually void of any meaningful discussion of the benefit-of-the-doubt rule. Whereas, when applying the companion to subsection 7261(b)(1), which is 38 U.S.C. section 7261(b)(2), requiring the Court to take due account of the rule of prejudicial error, the Court expressly states its determinations of such rule. Therefore, Congress should require the Court to consider and expressly state its determinations with respect to the application of the benefit-of-the-doubt doctrine under 38 U.S.C. section 7261(b)(1), when applicable.

Recommendations:

Congress should enact a joint resolution concerning changes made to title 38, United States Code, section 7261, by the Veterans Benefits Act of 2002, indicating that it was and still is the intent of Congress that the Court of Appeals for Veterans Claims provide a more searching review of the Board of Veterans' Appeals findings of fact, and that in doing so, ensure that it enforce a VA claimant's statutory right to the benefit of the doubt.

Congress should amend 38 U.S.C. section 7261(a) by adding a new section, (a)(5), that states: "(5) In conducting review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision."

Congress should require the Court to consider and expressly state its determinations with respect to the application of the benefit-of-the-doubt doctrine under 38 U.S.C., section 7261(b)(1), when applicable.

[17]P.L. 107-330, § 401, 116 stat. 2820, 2832.
[18]Section 401 of the *Veterans Benefits Act*, effective December 6, 2002; 38 U.S.C. §§ 7261(a)(4) and (b)(1).
[19]38 U.S.C. § 7261(a)(4). See also 38 U.S.C. § 7261(b)(1).
[20]38 U.S.C. § 7261(b)(1).
[21]38 U.S.C. § 5107(b).
[22]*Gilbert v. Derwinski* 1 Vet. App. 49, 54–55 (1990).
[23]See S. 2079, 107th Cong., 2d sess. § 2.
[24]148 *Congressional Record* S11334 (remarks of Sen. Rockefeller).
[25]148 *Congressional Record* S11337, H9007.
[26]148 *Congressional Record* S11337, H9003 (daily ed. November 18, 2002) (emphasis added). (Explanatory statement printed in *Congressional Record* as part of debate in each body immediately prior to final passage of compromise agreement.)
[27]148 *Congressional Record* S11337, H9007.
[28]148 *Congressional Record* S11334.
[29]Ibid.
[30]147 *Congressional Record* S11337, H9003.
[31]148 *Congressional Record* H9003.

THE COURT'S BACKLOG:

Congress should require the Court to amend its Rules of Practice and Procedure so as to preserve its limited resources.

Congress is aware that the number of cases appealed to the U.S. Court of Appeals for Veterans Claims (CAVC/Court) has increased significantly over the past several years. Nearly half of those cases are consistently remanded back to the Board of Veterans' Appeals (BVA/Board).

The Court has attempted to increase its efficiency and preserve judicial resources through a mediation process, under Rule 33 of the Court's Rules of Practice and Procedure, to encourage parties to resolve issues before briefing is required. Despite this change to the Court's rules, VA general counsel routinely fails to admit error or agree to remand at this early stage, yet later seeks a remand, thus utilizing more of the Court's resources and defeating the purpose of the program.

In this practice, the Department of Veterans Affairs usually commits to defend the Board's decision at the early stage in the process. Subsequently, when VA general counsel reviews the appellant's brief, VA then changes its position, admits to error, and agrees to or requests a remand. Likewise, VA agrees to settle many cases in which the Court requests oral argument, suggesting acknowledgment of an indefensible VA error through the Court proceedings. VA's failure to admit error, to agree to remand, or to settle cases at an earlier stage of the Court's proceedings do not assist the Court or the vet-

eran; it merely adds to the Court's backlog. Therefore, Congress should enact a Judicial Resources Preservation Act. Such an act could be codified in a note to section 7264. For example, the new section could state:

(1) Under 38 U.S.C. section 7264(a), the Court shall prescribe amendments to Rule 33 of the Court's Rules of Practice and Procedure. These amendments shall require the following:

(a) If no agreement to remand has been reached before or during the Rule 33 conference, the Department, within seven days after the Rule 33 conference, shall file a pleading with the Court and the appellant describing the bases upon which the Department remains opposed to remand opposed.

(b) If the Department of Veterans Affairs later determines a remand is necessary, it may only seek remand by joint agreement with the appellant.
(c) No time shall be counted against the appellant where stays or extensions are necessary when the Department seeks a remand after the end of seven days after the Rule 33 conference.

(d) Where the Department seeks a remand after the end of seven days after the Rule 33 conference, the Department waives any objection to and may not oppose any subsequent filing by appellant for Equal Access to Justice Act fees and costs under 28 U.S.C. section 2412.

(2) The Court may impose appropriate sanctions, including monetary sanctions, against the Department for failure to comply with these rules.

Recommendation:

Congress should enact a Judicial Resources Preservation Act as described herein to preserve the Court's limited resources and reduce the Court's backlog.

APPOINTMENT OF JUDGES

Congress should ensure that any new judges appointed to the Court of Appeals for Veterans Claims are themselves a veteran's advocate and skilled in the practice of veterans law.

The United States Court of Appeals for Veterans Claims received well over 4,000 cases during FY 2008. According to the Court's annual report, the average number of days it took to dispose of cases was nearly 450. This period has steadily increased each year over the past four years, despite the Court having recalled retired judges numerous times over the past two years specifically because of the backlog.

Veterans law is an extremely specialized area of the law that currently has fewer than 500 attorneys nationwide whose practices are primarily in veterans law. Significant knowledge and experience in this practice area would reduce the amount of time necessary to acclimate a new judge to the Court's practice, procedures, and body of law. A reduction in the time to acclimate would allow a new judge to begin a full caseload in a shorter period, thereby benefiting the veteran population. Congress should therefore consider appointing new judges to the Court from the selection pool of current veterans law practitioners.

Recommendation:

Congress should enact a joint resolution indicating that it is the sense of Congress that any new judges appointed to the Court of Appeals for Veterans Claims be selected from the knowledgeable pool of current veterans law practitioners.

Court Facilities

COURTHOUSE AND ADJUNCT OFFICES:

The Court of Appeals for Veterans Claims (CAVC) should be housed in its own dedicated building, designed and constructed to its specific needs and befitting its authority, status, and function as an appellate court of the United States.

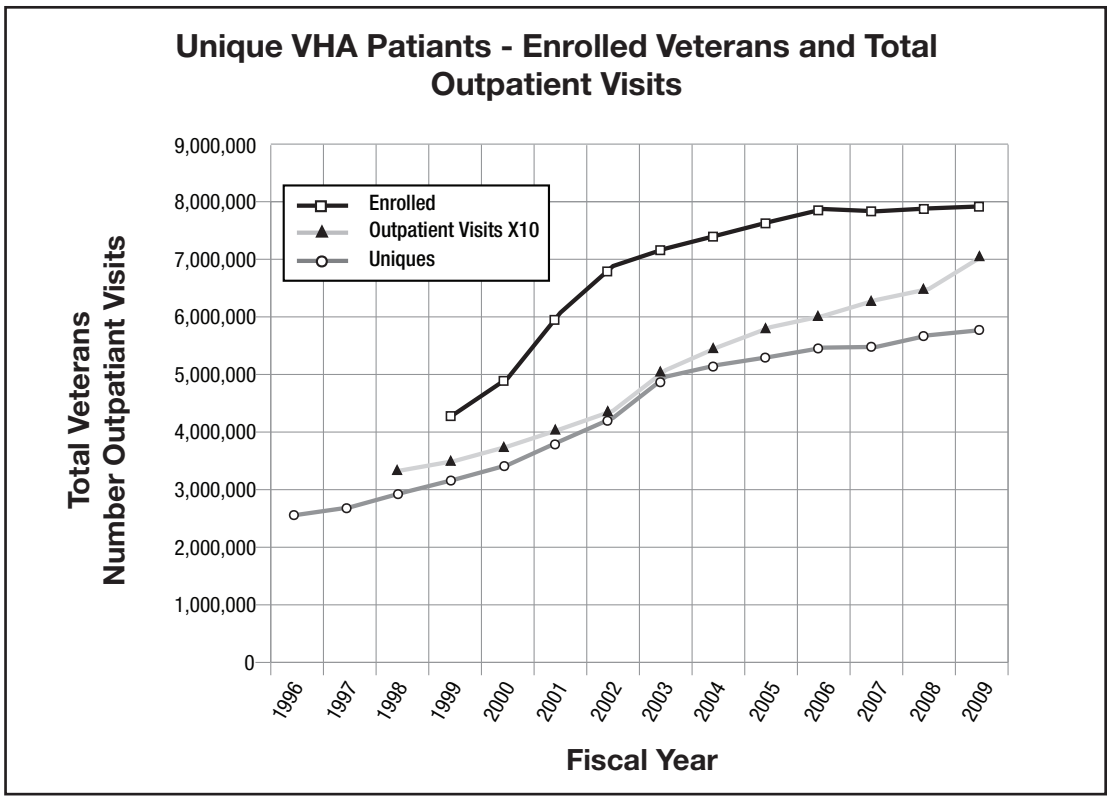
During the nearly 16 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse. The "Veterans Court" should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Rather than being a tenant in a commercial office building, the court should have its own dedicated building that meets its specific functional and security needs, projects the proper image, and concurrently allows the consolidation of VA general counsel staff, court practicing attorneys, and veterans service organization representatives to the court in one place. The CAVC should have its own home, located in a dignified setting with distinctive architecture that communicates its judicial authority and stature as a judicial institution of the United States. Construction of a courthouse and justice center requires an appropriate site, authorizing legislation, and funding.

Recommendation:

Congress should enact legislation and provide the funding necessary to construct a courthouse and justice center for the Court of Appeals for Veterans Claims.

Medical Care

The Veterans Health Administration (VHA) is the largest direct provider of health-care services in the nation. The VHA provides the most extensive training environment for health professionals and is the nation's most clinically focused setting for medical and prosthetics research. Additionally, the VHA is the nation's primary backup to the Department of Defense (DOD) in time of war or domestic emergency. Of the nearly 8 million veterans that the Department of Veterans Affairs anticipates enrolling in the health-care system in fiscal year 2010, the VHA will provide health care to nearly 75 percent of them—approximately 6 million unique patients. It is a well-established fact that the quality of VHA care is at least equivalent to, and in most cases better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any other system in the United States or worldwide. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors.



Unique VHA Patients and Enrolled Veterans—This chart shows the trend toward the increasing number of patients treated in VHA facilities and the increase of veterans enrolled for care.

Although the VHA makes no profit, buys no advertising, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private-sector health-care systems, it is the most efficient and cost-effective health-care system in the nation. The VHA sets the standards for quality and efficiency, and it does so at or below Medicare rates, while serving a population of veterans that is older, sicker, and has a higher prevalence of mental and related health problems.

Whereas, historically, VA has faced inadequate appropriations, Congress and the Administration have shown some desire to correct this trend in the past couple of years. But more work remains to be done. More often than not, appropriations are delayed beyond the start of the fiscal year on October 1, placing the VHA at a competitive disadvantage for health-care professionals. In fact, in 19 of the past 21 years VA did not receive its appropriations prior to the start of the new fiscal year. This creates a domino effect wherein the VA is unable to hire enough quality professionals, which leads to longer waits for health-care appointments. It also creates significant access problems for veterans. As a result of these occurrences, *The Independent Budget* continues to advocate for a method to ensure that VA receives adequate funding in a timely manner in order to continue providing timely, quality health care to all veterans.

With this in mind, the coauthors of *The Independent Budget,* in conjunction with the Partnership for Veterans' Health Care Budget Reform, will advocate for Congress to reform VA's medical care appropriation to give it an advance appropriation status, to provide funding for veterans' health care one year or more in advance of the operating year. This would ensure funding becomes timely and predictable, without converting it to mandatory status or requiring it to meet Congressional PAYGO (pay-as-you-go) rules for mandatory accounts. Moreover, we believe Congress should require VA's internal budget model to be shared publicly to provide accurate estimates for VA health-care funding, with the information audited by the Government Accountability Office.

We also recognize that VA must continue to meet the demands of the newest generation of veterans as they turn to VHA for their care. The difficulties in this crossover between VA and the DOD have elevated seamless transition to the top of concerns for both departments. As such, it is critically important for VA and DOD to implement the systems needed to make this transition, particularly from one health-care system to the other, as smooth as possible.

Ultimately, the policy proposals we present and the funding recommendations we make serve to enhance and strengthen the VA health-care system. It is our responsibility, along with Congress and the Administration, to vigorously defend a system that has set itself above all other major health-care systems in this country. For all of the criticism that the VA health-care system receives, it continues to outperform, both in quality of care and patient satisfaction, every other health-care system in America.

FINANCE ISSUES

SUFFICIENT, TIMELY, AND PREDICTABLE FUNDING FOR VA HEALTH CARE:

The Department of Veterans Affairs must receive sufficient funding for veterans' health care and Congress must reform the funding process to ensure sufficient, predictable, and timely funding.

As in years past, the FY 2008 appropriations process was neither seamless nor efficient. *The Independent Budget* veterans service organizations (IBVSOs) were very disappointed when, for the 13th time in the past 15 years, VA did not receive its appropriation at the start of the new fiscal year, October 1. Although the appropriations bill was eventually enacted, it included budgetary gimmicks the IBVSOs have long opposed. The maximum appropriation available to VA matched or exceeded the *IB's* recommendations; however, the vast majority of this increase was contingent upon the Administration making an emergency funding request for the additional money Congress approved. Fortunately, the Administration recognized the importance of this critical funding and triggered its release to VA. This emergency request provided VA with $3.7 billion more than the Administration had sought for VA in FY 2008.

The process leading up to FY 2009 was equally challenging. For the second year in a row, VA received historic funding levels that matched, and in some cases exceeded, the recommendations of the *IB*. Moreover, for only the third time in the past 20 years, VA received its budget prior to the start of the new fiscal year. However, this funding was provided through a combination continuing resolution/omnibus appropriations act. The underlying Military Construction and Veterans Affairs appropriations bill for FY 2009 was not actually completed by Congress in the regular order. While the House passed the bill in the summer, the Senate never brought its bill up for a floor vote. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past two years, the larger appropriations process is completely broken.

Although significant strides have been made to increase the level of VA health-care funding during the past several years, the inability of Congress and the Administration to agree upon and enact veterans' health-care appropriations legislation on time continues to hamper and threaten VA health care. When VA does not receive its funding in a timely manner, it is forced to ration health care. Much-needed medical staff cannot be hired, medical equipment cannot be procured, waiting times for veterans increase, and the quality of care suffers.

Only through a comprehensive reform of the budget and appropriations process, such as advance appropriations, will Congress be able to ensure the long-term viability and quality of VA's health-care system. A review of the past two budget cycles makes it evident that even when there is strong support for providing sufficient funding for veterans' medical care programs, the systemic flaws in the budget and appropriations process continue to hamper access to and threaten the quality of VA's health-care system.

On February 4, 2008, the President's budget submission for the Department of Veterans Affairs for FY 2009 was released, which included a total funding request of $41.2 billion for VA medical care, an increase of $2.1 billion over the FY 2008 funding level. This request included $38.7 billion in discretionary funding and $2.5 billion in medical care collections. *The Independent Budget for Fiscal Year 2009* recommended approximately $42.8 billion in total funding for medical care—an increase of $3.7 billion over the FY 2008 approved funding level and approximately $1.6 billion over the Administration's request. In the end, Congress provided approximately $43 billion for total medical spending in VA. This included $40.5 billion in discretionary budget authority and an additional $2.5 billion in medical care collections.

Although the IBVSOs have long opposed the use of collections in establishing the VA operating budget, we recognize that a significant amount of funding is available to the Department each year from these collections. However, we urge Congress to review the actual collection rates VA achieves each year if it continues to use collections to increase its operating budget. Our own analysis suggests that VA has only collected about 79 percent of its estimated collection rates dating back to FY 2004. This would suggest that VA will likely only collect approximately $2 billion for FY 2009, even though the Office of Management and Budget and the appropriators will credit VA's estimate of $2.5 billion to offset budgetary needs.

For FY 2010, *The Independent Budget* recommends approximately $46.6 billion for total medical care, an in-

crease of $3.6 billion over the FY 2009 operating budget level established by P. L. 110-329, the "Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009." Our recommendation reinforces the long-held policy that medical care collections should be a supplement to, not a substitute for, operating funds. Therefore, until Congress and the Administration fairly address the inaccurate estimates for medical care collections, the VA operating budget should not include inflated estimates as a component.

The Medical Care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2010, *The Independent Budget* recommends approximately $36.6 billion for Medical Services, as outlined in the table below.

Medical Services Recommendation	
Current Services Estimate	$34,608,814,000
Increase in Patient Workload	$1,173,607,000
Policy Initiatives	$790,000,000
Total FY 2010 Medical Services	$ 36,572,421,000

The increase in patient workload is based on a projected increase of 93,000 new unique patients—priority group 1–8 veterans and covered nonveterans. The IBVSOs estimate the cost of these new unique patients at approximately $639 million. The increase in patient workload also includes a projected increase of 90,000 new Operation Enduring Freedom and Operation Iraqi Freedom veterans at a cost of approximately $279 million. Finally, the increase in workload includes a projected increase in the number of new veterans who will use the VA health-care system as a result of the recent decision to expand priority group 8 enrollment by 10 percent. The VA estimated that this policy change would allow approximately 265,000 new enrollees. Based on a historic enrolled priority group 8 utilization rate of 25 percent, we estimate approximately 66,250 of these new enrollees will become users of the system. This translates to a cost of approximately $255 million.

Our policy initiatives include a continued investment in mental health and related services, returning the VA to its mandated long-term care capacity, and meeting prosthetics needs for current and future generations of veterans. For mental health and related services, the *IB* recommends an additional $250 million. In order to restore the VA's long-term care average daily census to the level mandated by P. L. 106-117, the "Millennium Health Care Act," we recommend $440 million more. Finally, to meet the increase in demand for prosthetics, the *IB* recommends an additional $100 million.

For Medical Support and Compliance, the *IB* recommends approximately $4.6 billion. This new account was established by the FY 2009 appropriations bill, replacing the Medical Administration account. Finally, for Medical Facilities, the *IB* recommends approximately $5.4 billion. This amount includes an additional $150 million for nonrecurring maintenance for VA to begin addressing its massive backlog of infrastructure needs.

The IBVSOs contend that despite the recent increases in VA health-care funding VA does not have the resources necessary to remove the prohibition on enrollment of priority group 8 veterans, who have been blocked since January 17, 2003. In response to this continuing policy, Congress included additional funding to begin opening the VA health-care system to some priority group 8 veterans. In fact, the final approved FY 2009 appropriations bill included approximately $375 million to increase enrollment of priority group 8 veterans by 10 percent. This will allow the lowest income and uninsured priority group 8 veterans to begin accessing VA health care.

The IBVSOs believe that providing a cost estimate for the total cost to reopen VA's health-care system to all priority group 8 veterans is a monumental task. That being said, our estimate is based on projected new users and on second-hand information received regarding numbers of priority group 8 veterans who have actually been denied enrollment into the VA system. We have received information suggesting that VA has actually denied enrollment to approximately 565,000 veterans. We estimate that such a policy change would cost approximately $545 million in the first year, assuming that about 25 percent (141,250) of these veterans would actually use the system. If, assuming a worst-case scenario, all of these veterans previously denied enrollment were to become users of the VA health-care system, the total cost would be approximately $2.2 billion. These estimates reflect a total cost that does not consider the offset of any medical care collections. We believe it is time for VA and Congress to develop a workable solution to allow all eligible priority group 8 veterans to enroll in the system.

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations, has advocated reform in the VA health-care budget process. The Partnership

has worked with both House and Senate veterans' leaders to craft legislation that would change VA's health-care funding process from a discretionary to a mandatory system. If enacted, such a change would be intended to guarantee that VA health-care funding would be sufficient, timely, and predictable. This technique would guarantee funding is made available on time every year, with automatic adjustments to account for medical inflation and enrollment changes. However, despite the fact that legislation has been introduced in recent years to shift VA health-care funding to mandatory status, to date, Congress has not shown interest in moving this legislation forward. As a result, the Partnership worked with Committees on Veterans' Affairs to develop an alternative proposal (S. 3527/H. R. 6939) that would change VA's medical care appropriation to an "advance appropriation," guaranteeing funding for the health-care system up to one year in advance of the operating year. This alternative proposal would ensure that the VA received its funding in a timely and predictable manner. Furthermore, it would provide an option the IBVSOs believe to be politically more viable than mandatory funding and unquestionably better than the current process. Moreover, to ensure sufficiency, our advance appropriations proposal would require that VA's internal budget actuarial model be shared publicly with Congress to reflect the accuracy of its estimates for VA health-care funding, as determined by a Government Accountability Office audit, before political considerations take over the process. This feature would add transparency and integrity to the VA health-care budget process.

Recommendations:

The Administration and Congress must provide sufficient funding for VA health care to ensure that all eligible veterans are able to receive VA medical services without undue delays or restrictions. When VA has calculated the cost to reopen the system to all veterans, it should receive full funding to accommodate priority group 8 veterans who choose to use the VA system for their health-care needs.

Congress should reform VA's medical care appropriation to give it an advance appropriation status, to provide funding for veterans' health care one year or more in advance of the operating year. This would ensure funding becomes timely and predictable, without converting it to mandatory status or requiring it to meet Congressional PAYGO (pay-as-you-go) rules for mandatory accounts.

Congress should require VA's internal budget model to be shared publicly to provide accurate estimates for VA health-care funding, with the information audited by the Government Accountability Office.

Advance Appropriations for VA Health Care:

Congress should enact and implement legislation reforming the VA budget and appropriations process to fund veterans' medical care through a one-year advance appropriation, and require the Government Accountability Office (GAO) to audit and publicly report on VA's budget methodology and estimates.

On September 30, 2008, legislation providing appropriations for the Department of Veterans Affairs was enacted into law one day before the start of the new fiscal year, the first time the VA budget had been approved on time in more than a decade, and just the third time in the 22-year history of *The Independent Budget*. Despite the commitment of the current Congress to provide sufficient and timely funding for veterans' health care, there is a consistent record of late and insufficient funding for veterans' health care over the past two decades, which has occurred under the Congressional and Presidential leadership of both political parties. Even with the large increases of the past few years, veterans continue to wait to receive medical services and VA is still unable to enroll all veterans seeking care, including more than 600,000 priority group 8 veterans who have been turned away by VA over the past five years.

VA is the largest integrated health-care system in the United States, employing more than 200,000 personnel who provide medical care to more than 5.5 million veterans at more than 1,400 access points across the country. As a direct provider of services, VA is especially vulnerable to the inherently unpredictable nature of the annual discretionary appropriations process. Effectively managing such a large enterprise requires sufficient, timely, and predictable funding. Without reform of the budget process, the veterans' health-care system will face greater challenges and pressures that could threaten the long-term quality of care provided to veterans.

To ensure the long- term viability and quality of the VA health-care system, Congress should approve legislation enabling one-year advance appropriations for veterans' medical care programs and subsequently approve both the regular FY 2010 VA appropriations bill and an advance appropriations bill for FY 2011 veterans' medical care accounts during the FY 2010 budget cycle. To enhance Congress's ability to provide accurate and sufficient appropriations levels for VA medical care, the GAO should audit, assess, and publicly report to Congress an assessment of the accuracy and sufficiency of VA's budget forecasting methodology, as well as the budget projections derived from it.

On September 18, 2008, the chairmen of Committees on Veterans' Affairs introduced legislation (S. 3527/H.R. 6939) to reform the VA budget process by providing advance appropriations for veterans' health care. The legislation was developed in consultation with the Partnership for Veterans Health Care Budget Reform (Partnership), which includes the four *Independent Budget* veterans service organizations (IBVSOs). The Military Coalition, composed of 35 military and veterans organizations, has also endorsed this proposal as a top legislative priority. S. 3527 and H.R. 6939 have been supported by a bipartisan group of Senate and House cosponsors, including then-Senator Barack Obama and Sen. John McCain. In a recent letter to the American Federation of Government Employees, then-candidate Obama stated clearly that he would "...recommend passage of advance appropriation legislation for the FY 2010 appropriations cycle...." The IBVSOs call on Congress to work with the President to fulfill this promise.

For more than a decade the Partnership has worked to achieve a sensible and lasting reform of the funding process for veterans' health care. With today's economic crisis further exacerbating the federal government's budget outlook, such a change may be even more difficult to achieve. Over the past two years, the Partnership has explored several other budget reform options that would achieve the same goals for which mandatory funding was proposed—sufficient, timely, and predictable funding—while taking into account the political and economic changes that have occurred since the Partnership was first formed.

Despite the significant, and in some cases historic, funding increases for veterans programs that occurred over the past couple of years, the long-term funding outlook for veterans' health care remains uncertain. There is an unfortunate historical trend that when wars wind down, so, too, does the public's interest, and by extension Congress's attention to providing sufficient funding. With the potential for a long recession or worse on the horizon, veterans can be expected to rely more heavily on VA to meet their health-care needs. In addition, the scale and complexity of the wounds and disabilities suffered by our newest veterans, and the costly cutting-edge treatments available to help them recover, are likely to require increasing levels of funding far into the future, even if the veterans' population continues to contract over the next decade.

Unlike government grant or transfer payment programs, VA is a direct provider of services, and, as such, suffers more when funding is late and unpredictable. Testimony submitted to a Senate Veterans' Affairs Committee hearing on VA health-care funding quoted three former VA medical center (VAMC) directors. One stated, "For the past 13 years, I served as the Director of the Spokane VA Medical Center...(and)...in all but one year of my tenure as Director, we began the budget cycle in a continuing resolution." Another longtime VAMC director stated that because of "...the uncertainty of sufficient resources to meet the needs of the veteran population...[d]ecisions were made based on the availability of funds daily." Another person, who served both as a VAMC director and as VHA's chief business officer, summed it up best when he said, "...VA funding and the appropriations process is a process that no effective business could tolerate."[32]

For the past two decades, VA has been forced to operate without knowing when or what amount of funding would be available for its health-care programs. This unpredictability is a hindrance for VA directors as they seek to recruit and hire new doctors, nurses, and other health-care professionals, a process that already takes months in the best of circumstances. And even if their budget is approved a few days or weeks before the start of the new

fiscal year, VA directors are not able to hire the medical personnel necessary to provide expanded care to new veterans or begin new specialized care programs for several months into the new fiscal year. Negotiating equipment purchases or facility leases also takes time to ensure fiscally responsible contracts, further delaying the provision of expanded health care, for which funding increases are intended. Until VA can have some assurance that its funding will arrive in a timely and predictable manner, these types of inefficiencies will continue to hinder VA's provision of health care.

The Veterans Health Care Budget Reform Act (S. 3527/H.R. 6939) would address these problems by authorizing advance appropriations for VA medical care. Advance appropriations are different from biennial budgeting, in which Congress approves a full two-year appropriations bill every two years, providing funding that can be spent throughout the entire two-year period. It is also different from forward funding and advance funding, which provide the flexibility to spend some appropriated funds in the preceding or next fiscal year. With advance appropriations, funding would be appropriated for each fiscal year to be spent only during that fiscal year; it is only the law that is done in advance. The benefit of advance appropriations is that when the law is approved a year in advance, VA has the statutory authority to plan how best to spend the approved funding on the first day of the fiscal year, regardless of what happens with the rest of the federal budget process.

Unlike mandatory funding proposals, advance appropriations is a discretionary funding process, and therefore Congress and the Administration maintain their role in setting funding levels for each fiscal year. Advance appropriations do not have to comply with Congressional PAYGO budget rules because there is no mandatory scoring to be offset by matching spending cuts or tax increases. Nor is there any reasonable argument to be made that Congressional oversight is weakened, as Congress retains its full discretion to set the level of funding for all medical care accounts for each fiscal year. Furthermore, Congress can reconsider or amend any advance appropriations bill prior to the start of the fiscal year, to increase it to provide sufficient funding or to limit spending for certain programs or purposes. Congress also retains authority to approve emergency supplemental appropriations for VA medical care, just as it can for any program, if unforeseen circumstances warrant additional spending.

Advance appropriations are regularly used for a number of other federal programs, including the Low Income Home Energy Assistance Program, Head Start, Special Education programs, Employment and Training Administration, Job Corps, Section 8 Housing Vouchers, and the Corporation for Public Broadcasting (CPB). The most recent budget resolutions have contained provisions that provide waivers against points of order against these specified advance appropriations and also have included an overall dollar limitation on all of them except for the CPB. Historically, advance appropriations have been used to make a program function more effectively, better align with funding cycles of program recipients, or provide insulation from annual partisan political maneuvering. By moving to advance appropriations, veterans' health-care programs would accrue all three of these benefits. Veterans' health care could no longer be used as political bargaining chip, either to "bust" budget caps or to carry unrelated spending or legislative provisions. With advance appropriations, veterans' health care could not be held hostage during future federal budget showdowns, which often result in continuing resolutions, emergency spending designations, and other budget gimmicks.

To enhance the budget process even further, the proposed legislation includes provisions to add transparency and oversight of VA's internal budget forecasting model. In recent years, VA has developed a new methodology to estimate its resource needs for veterans' health care, called the Enrollee Health Care Projection Model (model). Developed in collaboration with a leading private sector actuarial firm (Milliman, Inc.) over the past several years, the model has substantially improved VA's ability to estimate its budgetary needs for future years. The model has been thoroughly reviewed by the Office of Management and Budget and approved for use in developing VA's budget. In addition, RAND's Center for Military Health Policy Research recently completed a study on VA's model, concluding that it is "...likely to be valid for short-term budget planning...[and]...represents a substantial improvement over the budgeting methodologies used by the VA in the past...." RAND cautioned that the model's validity and accuracy for short-term budget estimation does not necessarily translate into long-term policy planning and analysis.

The model estimates VA health-care's resource needs by combining estimates of enrollment levels, utilization rates, and unit costs for 58 medical services and more than 40,000 separate enrollee groups, or "cells." Each of the 40,000 cells represents a combination of one geographic sector, age range, and priority level. The model incorporates additional usage trends—such as reliance on and intensity of services—and then separates out spe-

cial populations (such as veterans of Operations Enduring and Iraqi Freedom) and services (such as mental health care) for additional adjustments. While the model relies heavily on Milliman's proprietary Health Cost Guidelines, substantial adjustments are made to account for the unique characteristics of the veteran enrollee population and the VA health-care system. The final result produced by the model provides the most comprehensive, robust, and accurate estimate of what it will cost VA in future years to provide current services authorized in law to the veterans expected to seek those services.

Because of the complex nature of VA's actuarially based model, the proposed legislation would require the GAO to conduct an annual audit and assessment of the model to determine its validity and accuracy, as well as assess the integrity of the process and the data upon which it is based. The GAO would submit public reports to Congress each year at the same time the President submits his budget request. Each report would assess the model and include an estimate of the budget needs for VA's medical care accounts for the next two fiscal years. These GAO reports would provide a valuable tool for Congress as it applies its expertise to considering the President's budget request.

Furthermore, by making the model's data-driven estimates publicly available, Congress and the Administration would be forced to conduct an honest debate on the funding needs of veterans' health care, rather than the political priority of fully funding veterans' medical care programs. The GAO reports would also provide the IBVSOs and other veterans service organizations and interested parties a greater ability to objectively judge whether Congress and the Administration were proposing funding levels for veterans' health care sufficient to meet actual need. In addition, providing Congress with access to the model and its estimates of VA health care's resource needs would provide greater confidence in the accuracy of advance appropriations for veterans' medical care, as well as validate future requests for emergency supplemental appropriations.

Recommendations:

Congress should approve legislation that reforms the VA health-care budget process by authorizing one-year advance appropriations for VA Medical Care Accounts: Medical Services, Medical Support and Compliance, and Medical Facilities. The legislation should also require the Government Accountability Office to regularly audit, assess, and report publicly to Congress on the integrity and accuracy of VA's budget forecasting model and its estimates.

Congress should include language in the budget resolution that provides a waiver for points of order against advance appropriations for VA Medical Care Accounts without setting a dollar limitation on those accounts.

Congress should approve both the FY 2010 appropriations for all VA accounts and an FY 2011 advance appropriations bill for the three VA Medical Care Accounts during the FY 2010 budget cycle.

[32]Testimony submitted before the Sentate Committee on Veterans' Affairs, July 25, 2007.

Accountability:

The Department of Veterans Affairs must hold its leaders accountable for running high-quality health-care programs and ensure that accountability systems that measure accomplishment of goals are synchronized with the needs of veterans.

Like the private sector, government organizations have seen the need for developing systems of accountability. Accountability is simplified when everyone's goals are shared—for example, goals of for-profit corporations align with maximizing profits and cost savings. However, the process of identifying goals that meet the needs of a government program, such as the Veterans Health Administration (VHA), and satisfy a variety of stakeholders, establishing objectives and measures and assigning responsibility for their suc-

cessful completion, can be extremely challenging.

The federal government has committed to the establishment of practices that demonstrate its effectiveness to taxpayers. For example, the Office of Management and Budget (OMB) has reengineered its operations to focus more resources on managing federal government programs (reviewing performance) and the General Accounting Office has been renamed the Government Accountability Office (GAO) to more accurately reflect the current mission focused on improving the performance and assuring the accountability of the federal government for the benefit of the American people.[33]

Congress has also demonstrated interest in ensuring that the programs it funds are meeting their goals. In 1993, Congress enacted the Government Performance and Results Act (GPRA), which established the framework for the development of strategic plans and performance measurement for the federal government agencies. The GPRA requires each agency to develop a five-year strategic plan, which is to be reviewed every three years. Both the OMB and the GAO attempt to ensure that federally funded programs use resources effectively to meet strategic goals.

The OMB Performance Assessment Rating Tool (PART) for Veterans Health Care found that the VA medical care system was "adequate" in terms of meeting its goals. Goals assessed included targeting resources at lower-income, service-disabled, and veterans with special eligibilities; collecting data to demonstrate effective care, such as use of performance measures, widely accepted clinical indices for managing chronic conditions and preventive measures; and linking medical care budget requests to performance.

Managerial accountability systems encompass several important components: clearly defined, measurable goals that affected parties agree are in the best interest of the organization, accurate tools to measure the goals, and the appropriate and fair assignment of responsibility for achieving the goals.

In accordance with the GPRA, VA developed four broad strategic goals to accomplish the following:

1. Restore to the greatest extent possible the capabilities of veterans with disabilities and improve the quality of their lives.
2. Ensure a smooth transition for veterans from active military service to civilian life.
3. Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the nation.
4. Contribute to the public health, emergency management, socioeconomic well-being, and history of the nation.
5. Deliver world-class service to veterans and their families by applying sound business principles that result in effective management of people, communications, technology, and governance.

The final goal is an "enabling goal," which, if fulfilled, allows VA to meet the first four. Each goal is followed by a series of objectives and each objective by measures that relate to those objectives' fulfillment.

To measure its performance toward fulfilling its mission, VA uses a five-tier performance measurement framework. To achieve its four strategic goals listed above, VA employs 21 strategic objectives, which are broad operational focus areas. In order to evaluate performance and measure progress toward achieving strategic objectives a collective summit was held that included the OMB, GAO, and Congress. VA ultimately identified 138 specific measurable indicators called performance measures that fall under three broad categories: *efficiency* (effective use of time and resources), *outcome* (achieves the desired result), or *output* (numbers produced). Of the 138 performance measures, 25 were identified by VA senior leadership as mission critical.

VA also identified performance and strategic targets associated with specific performance measures to be achieved during a fiscal year. Ideally, quality systems want to ensure that "outcomes" goals are met—for example, rather than counting how many medical records indicated that veterans had been advised not to smoke (an output measure), ideally, an overall reduction in smoking among VA users (an outcome measure) would be a goal.

The Independent Budget veterans service organizations (IBVSOs) agree with the broadly defined strategic goals but have some concern with the objectives or the measures and targets VA used to define success. For example, under strategic goal 3 (Honoring, Serving, and Memorializing Veterans) Objective 3.1 (Delivering Health Care), one key measure is a targeted annual percent increase of noninstitutional long-term care as expressed by the average daily census (ADC). While VA acknowledges that a more accurate measure than using

ADC is needed because it does not accurately measure the amount of care veterans receive, it continues to do so. In fact, VA had planned to report in FY 2005 a combination of workload measures for home-based primary care to include the number of patients treated and the number of visits veterans receive in addition to enrolled days.[34] Currently, this key measure only uses ADC and the number of veterans being cared for under the Care Coordination/Home Telehealth settings.[35]

According to VA, this key performance measure drives expansion of Home and Community Based Care (HCBC), the variety of services, and expansion of geographic access to increase the number of veterans receiving these services. ADC data are used to project the need for services, evaluate existing services, and promote access to required services. In addition, the data are used to establish Veterans Integrated Service Network (VISN) targets and evaluate VISN performance in meeting assigned workload levels in the HCBC area. The IBVSOs believe the current data reporting undermines the Secretary's statement that the performance data presented in VA's FY 2007 and 2008 Performance and Accountability Report are complete and reliable. Equally important, it undermines enforcing accountability at all levels of the VHA in providing noninstitutional long-term-care services and in doing so directly minimizes disabled veterans' opportunity to improve their quality of lives.

Another key measure of success that VA continues to claim it has achieved is access to medical care. In FY 2007 this included measuring the percentage of primary and specialty care patients seen within 30 days of a requested appointment time. This measure tracks the time between when the primary or specialty care appointment request is made (entered using VA's scheduling software) and the date for which the appointment is actually scheduled. The percentage is calculated using the numerator, which is all appointments scheduled within 30 days of desired date (includes both new and established patient experiences), and the denominator, which is all appointments in primary care clinics posted in the scheduling software during the review period. Despite the Office of Inspector General's assertion that VA's data for calculating the percentage are suspect,[36] VA continues to report that there are no data limitations.[37] Two additional key measures were included for FY 2008, and the accuracy of these measures also remains suspect since they share the same data source as the aforementioned key measures. Further, when an individual patient is waiting for more than one appointment, the calculation for one of the new 2008 measures counts only the appointment with the longest wait time.[38] This is particularly important because, in addition to the key measure above, both of these measures constitute half of the reported key performance measures for VA medical care programs.

VA also uses performance measures to assess its leadership's effectiveness in programs, networks, and facilities. It also links their performance to financial bonuses. In 2007 this practice came under scrutiny when some VA officials received financial rewards for "superior" service based on performance measures but had a record of continuing adverse outcomes within their responsibilities. In a government health-care setting, however, it is difficult to assign credit or blame for some outcomes because the officials' authority is limited—often they are not empowered to change factors, such as beneficiary demand, revenues, copayments, hiring practices, or facility design, which they may believe are obstructing the successful execution of their goals and objectives. For example, a facility manager might believe that a new outpatient clinic would increase the efficiency of clinicians and improve waiting times and patient satisfaction ratings. Generally, that manager, however, has no authority over whether that outpatient clinic would be approved and funded.

In government programs, there are often many "uncontrollables" that hinder individuals' ability to achieve desired results—for example, resources are limited, laws and regulations proscribe managerial actions, and demand from beneficiaries may be more or less than systems can accommodate. Additionally, if a network director treats a population of veterans that has increased rates of growth in demand relative to other networks along with a static fiscal year budget, is it fair to expect the director to meet the corporate standard waiting time for primary and specialty care? What if the veterans treated are older and sicker? These are factors that are generally out of the medical center directors' control. Finding the right measures to link "controllable" outcomes to managerial actions, then, is a delicate balance.

The IBVSOs support continued emphasis on establishing greater accountability in government programs. We want to ensure that VA leaders are accountable and that accountability systems measure VA's accomplishment of goals that are synchronized with the needs of veterans.

Recommendations:

The Office of Management and Budget must continue to ensure that beneficiaries' access to high-quality service, benefits, and programs is paramount in all strategic goals, objectives, and measures. Efficiency and cost-effectiveness are also appropriate goals but should be secondary to fulfillment of the mission of the agency.

VA should ensure that objectives and performance measures are directly related to each other and the strategic goal they support.

The Inspector General should periodically audit databases used to manage key performance measures and take steps to ensure that VA confirms the accuracy of its performance measures and, thereby, the integrity of its accountability systems.

VA should replace output measures with outcome measures, and Congress should charge the Government Accountability Office with review of key VA managers' performance to ensure that they are accountable for performance of functions over which they have direct control.

[33]H. Rept. 108-880.
[34]GAO-04-913.
[35]*Fiscal Year 2008 Performance and Accountability Report,* Department of Veterans Affairs, p. 443.
[36]DVA OIG Report No. 07-00616-199, September 10, 2007; DVA OIG Report No. 07-03505-129, May 19, 2008.
[37]*FY 2007 Performance and Accountability Report, Department of Veterans Affairs,* p. 209; *FY 2008 Performance and Accountability Report,* Department of Veterans Affairs, p. 231.
[38]*Fiscal Year 2008 Performance and Accountability Report,* Department of Veterans Affairs, p. 230.

Seamless Transition from the DOD to VA:

The Department of Defense and the Department of Veterans Affairs must ensure that all service members separating from active duty have a seamless transition from military to civilian life.

As servicemen and -women return from the conflicts in Afghanistan and Iraq, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service to successfully integrate into the civilian community as veterans. Though improvements have been made, the transition from the DOD to VA continues to be a challenge for newly discharged veterans. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The problems with transition from the DOD to VA were never more apparent than during the controversy that occurred at Walter Reed Army Medical Center in 2007. While much of the media coverage misrepresented the problems at Walter Reed as being a problem with care for injured service members, the real problems reflected many of the administrative difficulties associated with transitioning from the DOD to VA.

The IBVSOs continue to stress the points outlined by the report of President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), released in May 2003 and reinforced by the President's Commission on Care for America's Returning Wounded Warriors in September 2007, as well as four other major studies[39] regarding transition of soldiers to veteran status. One of the 20 recommendations made by the PTF and those made by the President's Commission is increased collaboration between the DOD and VA for the transfer of personal and health information. Great progress has been made in this area by VA; however, this recommendation remains only partially implemented. A September 2008 Government Accountability Office (GAO) report noted that the DOD and VA are not sharing all electronic health information and that information is still being captured in paper records at many DOD facilities.

Health Information

The IBVSOs believe that the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and bidirectional allowing for a two-way real-time electronic exchange of health information and occupational and environmental exposure data. Such an accomplishment could increase health information sharing between providers, laboratories, pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary

testing; improve patient safety by reducing medical errors; and increase our knowledge and understanding of the clinical, safety, quality, financial, and organizational value and benefits of health information technology. Lessons learned from previous wars also indicate that the DOD must continue collecting medical and environmental exposure data electronically while personnel are still in theater, and we applaud the DOD for doing so. But it is equally important that this information be provided to VA.

Electronic health information should also include an easily transferable electronic Certificate of Release or Discharge from Active Duty (DD 214) forwarded from the DOD to VA. This would allow VA to expedite the enrollment into its health-care system and claims process, giving the service member faster access to health care and benefits. According to DOD officials, the Defense Integrated Military Human Resources System (DIMHRS), a Congressionally mandated program with self-service capabilities to improve the delivery of military personnel and pay services is being developed to provide the electronic, computable interface between VA and DOD systems for transmittal and use of an electronic DD 214. The self-service aspects allow service members "view-only" access to their DD 214. According to Defense Secretary Robert M. Gates, the Army is scheduled to implement DIMHRS in March 2009, followed by the Air Force in October. Dates for transitioning by the Navy have not been set; the Marine Corps already has its own integrated pay and personnel system.

The Joint Electronic Health Records Interoperability plan, as agreed to by both VA and the DOD through the Joint Executive Council and overseen by the Health Executive Council, is a progressive series of exchange of related health data between the two departments, culminating in the bidirectional exchange of interoperable health information. While this has occurred on a limited and truncated basis, the current need is for a common standard and governmentwide implementation. In May 2007, the DOD established a Senior Oversight Committee (SOC), chartered and cochaired by the Deputy Secretaries of VA and the DOD, with the goal to identify immediate corrective actions and to review, implement, and track recommendations from a number of external reviews. Because of the recognized need, one of the lines of action identified to be addressed was DOD-VA data sharing. The SOC approved initiatives to ensure health and administrative data are made available. The September 2008 GAO report indicates the DOD and VA have agreed to numerous common standards and are working with federal groups to ensure adherence to such standards and align with emerging standards.

For example, VA and the DOD are sharing selected health information at different levels of interoperability, such as pharmacy and drug allergy data on nearly 19,000 patients that seek care from both agencies. Such information is computable to warn clinicians of a possible drug allergy with a to-be-prescribed medication. The Laboratory Data Sharing Interface Project is a short-term initiative that has produced an application used to electronically transfer laboratory work orders and retrieval of results between the departments in real time. Nonetheless, questions remain regarding the extent to which the VA and the DOD will achieve full interoperability by next year as neither department has yet to articulate an interoperability goal.

According to the GAO,[40] the DOD-VA Information Interoperability Plan that the departments recently completed is supposed to address these and other issues, including the establishment of schedules and benchmarks for developing interoperable health record capability. While the plan is an important accomplishment, on preliminary review, however, the plan's high-level content provides only a limited basis for understanding and assessing the department's progress toward full interoperability by the September 30, 2009, date mandated by the National Defense Authorization Act for FY 2008. Moreover, when fully established, a new interagency program office is to play a crucial role in accelerating efforts. Unfortunately, this office is not expected to be fully operational until the end of 2009, and some milestones in the office's plan for achieving interoperability have yet to be determined.

Care Coordination

Severely injured service members and veterans whose care and rehabilitation are being provided by both VA and the DOD, or are transferring from one health-care system to the other, must have a clear plan of rehabilitation and the necessary resources to accomplish the plan's goals. In response to the provisions of VA's Office of Inspector General (VAOIG) recommendations in a 2006 report examining the rehabilitation of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans suffering from traumatic brain injury (TBI), the Under Secretary for Health stated, "...case managers will provide long-term case management services and coordination of care for polytrauma patients and will serve as liaisons to their families." In October 2007, VA and the DOD partnered to create the Federal Recovery

Coordination Program to improve care management by identifying and integrating care and services between VA and DOD health-care systems, and it subsequently served to satisfy provisions of the Wounded Warrior Act, title XVI of Public Law 110-181. With such resources as the newly developed Federal Individual Recovery Plan, National Resource Directory, Family Handbook, MyeBenefits, and Veterans Tracking Application, the IBVSOs are cautiously optimistic that these coordinators will be able to provide greater oversight for the seamless transition of severely injured service members. While there are only eight federal recovery coordinators serving about 120 severely injured service members across military treatment facilities,[41] and one newly assigned at Dwight D. Eisenhower Army Medical Center, the President's Commission on Care of America's Returning Wounded Warriors reported that more than 3,000 seriously wounded veterans might need the assistance of these coordinators.

For service members and veterans whose injuries allow for more outpatient recovery and rehabilitation, a more extensive network has been created spanning the entire VA health-care system.[42] The Veterans Health Administration (VHA) has assigned part-time and full-time social workers to major military treatment facilities (MTFs) to serve as VHA liaisons between the MTF and VHA facilities. Each VHA facility has selected a point of contact and alternate who work closely with VA-DOD social work liaisons detailed to MTFs and Veterans Benefits Administration (VBA) representatives to ensure a seamless transition and transfer of care. While this initiative pertains primarily to military personnel returning from Iraq and Afghanistan having served in Operations Enduring and Iraqi Freedom, it also includes active duty military personnel returning from other combat theater assignments. It does not include active duty military personnel who are serving in noncombat theaters of operation.

Moreover, in March 2007, VA introduced the concept of transition patient advocates, who focus specifically on the needs of severely wounded veterans from operations in Iraq and Afghanistan. Since then, the VA OIG issued a follow-up report on May 1, 2008, to assess the extent to which VA maintains involvement with service members and veterans who had received inpatient rehabilitative care in VA facilities for traumatic brain injury (TBI). According to the report, VA case management was determined to have improved, while long-term case management is not uniformly provided for these patients, and significant needs remain unmet.

Disability Evaluation

The Independent Budget likewise concurred with the President's Commission recommendation that the DOD and VA implement a single comprehensive medical examination, and the IBVSOs believe that this must be absolutely done as a prerequisite of promptly completing the military separation process. However, we would like to reiterate our belief that if and when a single separation physical becomes the standard, VA should be responsible for handling this duty. VA simply has the expertise to conduct a more thorough and comprehensive examination as part of its compensation and pension process. Moreover, the inconsistencies with the physical evaluation board process from the different branches of the service can be overcome with a single physical administered from the VA's perspective and not the DOD's.

In addition to the President's Commission findings and recommendations, the Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center (IRG) found serious difficulties in administering the Physical Disability Evaluation System caused by a significant variance in policy and guidelines within the military health system. The IRG recommended the Physical Disability Evaluation System be completely overhauled to include changes in the U.S. Code, Department of Defense policies, and service regulations, resulting in one integrated solution.

Consequent to the recommendations from the reports of the Task Force on Returning Global War on Terrorism Heroes, the IRG, the President's Commission, and the Commission on Veterans' Disability Benefits, a single disability pilot project launched by the DOD and VA in November 2007 for service members from Walter Reed Army Medical Center, National Naval Medical Center at Bethesda, and Malcolm Grow Medical Center has more than 200 participants and is a step toward developing this single separation physical. A year after its inception, VA announced, on November 7, 2008, the expansion of the Disability Evaluation System (DES) Pilot Program to 19 military installations, representing all military departments. The initial phase of the expansion began October 1 at Fort Meade, Maryland, and Fort Belvoir, Virginia. The remaining 17 installations[43] will begin upon completion of site preparations and personnel orientation and training, during a seven-month period from November 2008 to May 2009.

By law, the DOD can consider only conditions that deal with "fitness for service" when determining disability ratings, whereas VA determines disability ratings for all service-connected conditions, even those that would not result in a finding of unfitness for service. The DOD uses the VA disability percentages for each condition, but may have a different combined disability rating than VA. While this separation physical is being put into practice in the DES Pilot Program, it is targeted primarily at those considered for medical discharge from the military. It should be considered for all separations. Moreover, issues remain regarding other components of the DES Pilot Program. The IBVSOs were not consulted for feedback or included in deliberations and design of the program and, more important, service members are not being properly educated about their right to counsel by individuals not employed by the DOD or VA or encouraged to seek such counsel throughout the program. Such a situation is aggravated by the current appellate process, which requires a service member to make an immediate decision regarding counsel.

The problem with separation physicals identified for active duty service members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists and in some cases reservists are not made aware of the possibility. Although the physical examinations of demobilizing reservists have greatly improved in recent years, there are still a number of soldiers who "opt out" of the physicals, even when encouraged by medical personnel to participate. Although the expense and manpower needed to facilitate these physicals might be significant, the separation physical is critical to the future care of demobilizing soldiers. We cannot allow for insufficient information to be gathered in separation physicals, particularly among our National Guard and reserve forces, because they do not have the same structure and program for a seamless transition that exist for the active duty force. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

In the last several years, the DOD and VA have made good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) handled by the Veterans Employment and Training Service (VETS) is generally the first service that a separating service member will receive. In particular, local military commanders, through the insistence of the DOD, began to allow their soldiers, sailors, airmen, and marines to attend far enough in advance to take greatest advantage of the program. The programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then seek answers prior to discharge.

The TAP and DTAP programs continue to improve, but challenges remain at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service members who want to file a claim for VA compensation benefits and other ancillary benefits are dissuaded by the specter of assignment to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in providing this information. Though individuals are receiving the information, the haphazard nature and quick processing time may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center or other specialized health-care services despite still being on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. DTAP has not had the same level of success as TAP, and it is critical that coordination be closer among the DOD, VA, and VETS to improve this function.

Though the achievements of the DOD and VA have been good with departing active duty service members, there is a much greater concern with the large numbers from the reserve and National Guard moving through the discharge system. As a result of the number of troops that are on "stop-loss"—a DOD action that prevents military service personnel from leaving the military at the end of their enlistments during deployments—large numbers of personnel rapidly transition to civilian life upon their return. Both the DOD and VA seem ill prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life.

Unless these soldiers are injured, they may clear the demobilization station in a few days. Little of this time is dedicated to informing them about veterans' benefits and services. Additionally, DOD personnel at these sites are most focused on processing service members with efficiency and dispatch. Lack of space and facilities often allow for limited contact by VA representatives with the demobilizing personnel.

In October 2008, the DOD released its new "Compensation and Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces." This handbook is designed to help service members who are wounded, ill, and injured, as well as their family members, navigate the military and veterans' disability system. The IBVSOs applaud this informative booklet as one more method for service members to understand the transition, but now it will be critical for the DOD to ensure it gets into the hands of transitioning service members.

The IBVSOs believe the DOD and VA have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. If we are to ensure that the mistakes of the first Gulf War are not repeated during this extended global war on terrorism, it is imperative that a truly seamless transition be created. With this, it is imperative that proper funding levels be provided to VA and the other agencies providing services for the vast increase in new veterans from the National Guard and Reserves. Servicemen and -women exiting military service should be afforded easy access to the health care and benefits that they have earned. This can only be accomplished by ensuring that the DOD and VA improve their coordination and information sharing to provide a seamless transition.

Recommendations:

The DOD and VA must ensure that service members have a seamless transition from military to civilian life.

The DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. These electronic exchanges should also include an easily transferable electronic DD214.

The DOD and VA must fully establish the Joint Interagency Program Office with permanent staff and clear lines of responsibility, and finalize the draft implementation plan with set milestones and timelines for defining requirements to support interoperable health records.

VA and the DOD must outline the requirements for assigning new or additional federal recovery coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service members' medical conditions.

Severely injured service members and veterans receiving treatment from the DOD and VA must have a clear plan of rehabilitation and the necessary resources to accomplish its goals.

VA and the DOD should make changes to the Disability Evaluation System Pilot Project to meet the needs and protect the rights of severely injured service members.

Congress and the Administration must provide adequate funding to support the Transition Assistance Program and Disabled Transition Assistance Program managed by the Department of Labor's Veterans Employment and Training Service to ensure that active duty, as well as National Guard and reserve, service members do not fall through the cracks while transitioning.

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[39]Veterans' Disability Benefits Commission, DOD Task Force on Mental Health, Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, and Task Force on Returning Global War on Terror Heroes.
[40]GAO-08-954.
[41]Walter Reed Army Medical Center, Bethesda National Naval Medical Center, Brooke Army Medical Center, and Naval Medical Center Balboa are being actively recruited as of this writing.
[42]VHA DIRECTIVE 2006-017 April 3, 2006.
[43]Army: Fort Carson, Colorado, Fort Drum, New York; Fort Stewart, Georgia; Fort Richardson, Alaska; Fort Wainwright, Alaska; Brooke Army Medical Center, Texas; and Fort Polk, Louisiana. Navy: Naval Medical Center (NMC) San Diego and Camp Pendleton, California; NMC Bremerton, Washington; NMC Jacksonville, Florida; and Camp Lejeune, North Carolina. Air Force: Vance Air Force Base, Oklahoma; Nellis Air Force Base, Nevada; MacDill Air Force Base, Florida; Elmendorf Air Force Base, Alaska; and Travis Air Force Base, California.

INAPPROPRIATE BILLING:

Service-connected and nonservice-connected veterans and their insurers are continually frustrated by inaccurate and inappropriate billing for services related to conditions secondary to their disability.

The Veterans Health Administration (VHA) continues to bill veterans and their insurers for care provided for conditions directly related to service-connected disabilities. Reports continue to surface of veterans with service-connected amputations being billed for the treatment of associated pain and veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers. Inappropriate billing for secondary conditions forces veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden to both veterans and an already backlogged claims system. Additionally, veterans with more than six service-connected disability ratings are frequently billed improperly as a result of VA's inability to electronically store more than six service-connected conditions in the Compensation and Pension (C&P) Benefits Delivery Network (BDN) master record and the lack of timely and/or complete information exchange about service-connected conditions between the Veterans Benefits Administration (VBA) and the VHA.

VBA has undertaken a five-step approach to change the process by which it electronically shares C&P eligibility and benefits data with the VHA, particularly information about service-connected conditions that exceed the six stored in the C&P BDN. According to VA, because of difficulties in the development and implementation of the first two steps, the plan for improving VBA-VHA sharing of information about veterans' service-connected conditions has been delayed. Furthermore, VA acknowledges that not all these cases, with six service-connected conditions, have been identified under the new plan; however, it will determine the best course of action to take to further address the cases with incomplete service-connected disability information.

Nonservice-connected veterans are also continually frustrated with VA's billing process. Overbilling and inappropriate charging for copayments is becoming the norm rather than the exception. Veterans are experiencing multiple billing episodes for a single medical treatment or health-care visit.

Inappropriate bill coding is causing major problems for veterans subject to VA copayments. Veterans using VA specialized services, outpatient services, and VA's Home Based Primary Care programs are reporting multiple billings for a single visit. Often these multiple billing instances are the result of follow-up medical team meetings at which a veteran's condition and treatment plan are discussed.

These discussions and subsequent entries into a veteran's medical record trigger additional billing. In other instances simple phone calls from VA health-care professionals to individual veterans to discuss their treatment plan or medication usage can also result in copayment charges when no actual medical visit has even occurred.

Recommendations:

The Under Secretary for Health should firmly establish and enforce policies that prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that relate to an original service-connected disability rating.

The Under Secretary for Health should establish specific deadlines for the action plan to develop methods to improve the electronic exchange of information about service-connected conditions that exceed the maximum of six currently captured in the Compensation and Pension Benefits Delivery Network master record.

VA's cost-recovery system must be reviewed to determine how multiple and inappropriate billing errors are occurring. Billing clerk training procedures must be intensified and coding systems must be altered to prevent inappropriate billing.

Homeland Security/Funding for the Fourth Mission:

The Veterans Health Administration (VHA) is playing a major role in homeland security and bioterrorism prevention. This vital statutory fourth mission will require a budget of more than $300 million in FY 2010.

The Department of Veterans Affairs has four critical health-care missions. The primary mission is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission is to conduct medical research. VA's fourth mission is to "serve as a backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters[.]"

VA has statutory authority, under title 38, United States Code, section 8111A, to serve as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed into law an "Authorization for Use of Military Force," which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. This resolution, P.L. 107-40, satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the DOD.

As part of its fourth mission, VA has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System (NDMS), created by P.L. 107-188 (the Public Health Security and Bioterrorism Preparedness Response Act of 2002), has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters. These disasters include natural disasters, technological disasters, major transportation accidents, and acts of terrorism including weapons of mass destruction events, in accordance with the National Response Plan.

The NDMS is a partnership comprising the Department of Homeland Security (DHS), VA, the DOD, and the Department of Health and Human Services (HHS). According to the VA website, www.va.gov, some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance, and evaluation of the local NDMS program. VA has also assigned "area emergency managers" to each Veterans Integrated Service Network (VISN) to support this effort and assist local VA management in fulfilling this responsibility.

In addition, P.L. 107-188 required VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other emergency supplies. In response to this mandate, VA created 143 internal pharmaceutical caches at VA medical centers. Ninety of those stockpiles are large and can supply medications to 2,000 casualties for two days, and 53 stockpiles can supply 1,000 casualties for two days. VA's national acquisition center manages four pharmaceutical and medical supply caches for the DHS and the Federal Emergency Management Agency (FEMA) as a part of their NDMS requirements, and two additional special caches for other federal agencies. The Secretary was also directed to enhance the readiness of medical centers and provide mental health counseling to individuals in communities affected by terrorist activities.

In 2002, Congress also enacted P.L. 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002. This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and would develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons, or devices posing threats to the public health and safety. In addition, the centers would provide education, training, and advice to health-care professionals. They would also provide laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or responding to a disaster or emergency. These centers, although authorized by law, have not received any funding, and have not been established.

The disasters caused by Hurricanes Katrina and Rita in 2005 more than met the criteria for the fourth mission. VA proved to be fully prepared to care for veterans in the Gulf Coast region affected by the hurricanes. Nearly

10,000 VA employees around the country received recognition for their actions during the hurricanes. This included 73 Valor Awards presented for risking personal safety to prevent the loss of human life or government property and 3,000 official commendations.

In 2004 nearly 800 VA employees from around the country volunteered and were on standby to assist Florida communities damaged by Hurricane Frances. More than 120 VA employees, mostly medical personnel, were dispatched directly to the stricken areas to help with relief efforts in support of FEMA.

As a result of lessons learned during and after Hurricanes Katrina and Rita, VA developed three valuable new assets for deployment during a catastrophe: the deployable medical unit (DMU), the deployable pharmacy unit (DPU), and the response support unit (RSU). The DMU is a self-contained medical unit that can be on the site of an emergency within 24-48 hours. It contains examination and treatment areas and emergency power generation capacity and can withstand category 3 hurricane-force winds. The DPU permits VA pharmacists to fill commonly prescribed medications during an emergency. The unit obtains data on patient prescriptions via satellite communications with the VA prescription database. The RSU serves as a platform to assist a VISN to manage an emergency or support VA personnel deployed as part of a federal response.

The Independent Budget veterans service organizations are concerned that VA lacks the resources to properly fulfill its fourth mission responsibilities. In FY 2002 the funding for homeland security initiatives was $84.5 million. Since that time, VA's expenditures on emergency preparedness and homeland security missions have nearly quadrupled. As such, *The Independent Budget* recommends approximately $325 million for these responsibilities for FY 2010. Without additional funding and resources, VA will have difficulties in becoming a resource in a time of national crisis. VA has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not specifically received any funding to support the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. Homeland security funding—estimated to be more than $300 million in FY 2008—is simply taken from the Medical Care account. This leaves VA with fewer resources with which to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, already scarce resources will continue to be diverted from direct health-care programs.

VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. In light of the natural disasters that have recently wreaked havoc on this country, this fact has never been more apparent. These important roles once again reiterate the importance of maintaining the integrity of the VA system and its ability to provide a full range of health-care services.

Recommendations:

Congress should provide funds necessary in the Veterans Health Administration's FY 2010 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, funding for the fourth mission should be included as a separate line item in the Medical Care appropriation.

MENTAL HEALTH ISSUES

MENTAL HEALTH SERVICES:

The Department of Veterans Affairs must deliver on its promise to transform its mental health and substance-use care programs and rise to the challenge of increasing access and quality of care for veterans of prior eras and the latest generation of combat veterans from Afghanistan and Iraq.

VA Mental Health Strategic Plan

This year marks the sixth anniversary of the release of the President's New Freedom Commission on Mental Health Report. Based on the commission's recommendations, the Veterans Health Administration (VHA) undertook a comprehensive and critical review of its mental health and substance use disorder programs and produced its own road map for the future of veterans' mental health care, the Mental Health Strategic Plan (MHSP). The old model of care for mental health focused on management of symptoms and accepted long-term disability as being inevitable. In 2004, VA's MHSP gave veterans hope that mental illness would be treated with the same seriousness as medical illnesses and that care would become more veteran and family-centered. We are pleased that the focus of VA mental health programs is now on recovery.

The VA MHSP includes a number of action items that build on the recommendations of the President's New Freedom Commission and the VA Secretary's Mental Health Task Force. Funding for these actions has been provided through a mental health initiative that supports implementation in four key areas: (1) enhancing capacity and access for mental health services; (2) integrating mental health and primary care; (3) transforming mental health specialty care to emphasize recovery and rehabilitation; and (4) implementing evidence-based care. Funding for the initiative is provided outside of the routine Veterans Equitable Resource Allocation (VERA) model and augments the capitated funding for mental health programs. Changes in guaranteeing *ongoing* funding of these programs occurring in FY 2010 are potentially problematic. We understand that $557 million was allocated to the Mental Health Enhancement Initiative (MHEI) for FY 2009 to continue funding for positions and programs initiated during 2005–2008 from both the initiative and supplemental funding, and to provide support for the implementation of the Uniform Mental Health Services (UMHS) handbook. Also, additional funding has been allocated to each Veterans Integrated Service Network (VISN) to support the implementation of the handbook, and further additional funding will be allocated to support the Secretary's initiative to add substance-use providers to post-traumatic stress disorder (PTSD) programs, and to support both Homeless Grant and Per Diem program staff and Housing and Urban Development VA Supportive Housing case managers. Without a guarantee of these fenced funds beyond the current fiscal year to ensure continuous support and perpetuate these newly established programs, these fledgling programs are in danger of failure. We recommend that the Under Secretary's Office appoint a task group to study funding of mental health programs and whether the VERA model will provide adequate funding for the full continuum of services mandated by the MHEI and UMHS handbook and make recommendations for future funding.

The Independent Budget veterans service organizations (IBVSOs) applaud progress made under these initiatives, including improvements in capacity and access through expansion of mental health services in community-based outpatient clinics, expanded use of telemental health, and enhancements in both treatment and outreach for PTSD. Particularly important are efforts to foster the integration of mental health and primary care programs in more than 100 pilot program sites and the integration of mental health care services for older veterans within home-based primary care. Recovery and rehabilitation programs are being facilitated by developing additional psychosocial rehabilitation programs, expanding residential rehabilitation services, increasing the number of beds and the degree of coordination in homeless programs, enhancing mental health intensive case management, and funding a recovery coordinator in each medical center. These developments are encouraging, and the IBVSOs are hopeful that their promise will be actualized in the near future. We note that integration of mental health into primary care is currently only a series of demonstrations and in some cases involves only one integrated clinic in a facil-

ity. The IBVSOs believe this initiative should be implemented as expeditiously as possible and include all service lines including integration of mental health in geriatrics, women's health programs, Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) programs and all other areas. The UMHS handbook, published in September 2008, requiring a common set of standards for mental health services throughout the VA health-care system, is also a major milestone.

Tracking Progress on the VA Mental Health Strategic Plan

While we congratulate the VHA for the progress in mental health services made to date, we note that recovery programs have had a slow, prolonged start-up period, and program managers have not made consistent efforts to involve veterans and family members locally. Despite clear progress, the current level of effort and provision of services remains inadequate in making treatment planning a true partnership between the veteran, family members, and provider. Additionally, a sustained effort toward reducing stigma and addressing PTSD, concurrent substance abuse and mental health treatment in a wide variety of conditions and settings, and family and marriage counseling, all pointed toward recovery goals, remains inadequate. Therefore, Congress should increase its oversight to ensure that veterans' needs for quality, comprehensive mental health care are met, and the promise of recovery is finally achieved.

Furthermore, the recovery transformation process has some regulatory impediments that need to be addressed. At the heart of the recovery effort is the need to have veterans with mental illness be partners in determining their goals and the interventions necessary to achieve them. This requires a major shift away from the historically paternalistic approach of having clinical providers determine the treatment plan and expecting veterans to adhere to it, with only nominal input from them. This is a major challenge—and transformation of a vast system, such as VHA mental health care, to recovery-oriented services is an unprecedented effort. To make this credible, it is critical to develop recovery partnerships between VA planners, managers, clinicians, and the veteran users themselves. Such partnership groups should exist at every level to ensure proper development of programs that are centered on the needs of veterans so they can effectively meet them. The current interpretations of the Federal Advisory Committee Act (FACA) regulations within VA have made this problematic, as such work groups are now seen as needing to be independently organized by veterans themselves, with VA staff serving only in a liaison function. Many veteran consumer councils have existed for years at the national, VISN, and facility and program levels (i.e., the Committee on Care of Veterans with Serious Mental Illness Liaison Council). Almost every consumer council was initiated by VA staff. If current FACA interpretation had then held sway, few of these groups would exist. Since such FACA interpretation has not prevented the development of general stakeholder groups at the VISN and facility level, organized by VA, it is not clear why mental health stakeholders receive disparate treatment by the VHA under FACA. VHA policy and applicable federal regulations should be modified to encourage VA-veteran health partnerships and recognize the importance of veterans' involvement in their health-care system, especially recovery-based mental health services.

Furthermore, Section 7321 of title 38, United States Code, requires VA to appoint a Committee on Care of Veterans with Serious Mental Illness with clearly defined duties: to identify systemwide problems and specific VA facilities at which program enrichment is needed to improve treatment and rehabilitation and to promote model programs that should be implemented more widely within VA's mental health practice. Since 2006, this committee—a committee that at one time displayed inspired leadership and effectiveness in meeting this Congressional mandate—has seemingly become a functional arm of VA Central Office (VACO) leadership and is no longer an independent voice for better services for the most vulnerable enrolled patient population: the chronically mentally ill.

Progress in VA's crucial mental health reform initiatives is dependent on incorporation of best practices and effective oversight. Oversight is needed to ensure that veterans, family members, and their representatives and advocates are an integral part of a continuous improvement feedback loop: reviewing the effectiveness and satisfaction with current programs; evaluating the development and deployment of new programs; recommending changes in current services; and providing constructive feedback on how to transform these services to provide the highest quality, most veteran-centered programs possible. A formalized, empowered oversight system with consumer representation is urgently needed to replace the current above-noted committee, and therefore the IBVSOs recommend a Secretary of Veterans Affairs–level oversight committee be authorized by law.

The new committee should include experts from both within and outside VA; consumers and consumer advocates, such as veterans service organizations (including the IBVSOs); and mental health associations concerned about VA programs and the veterans they serve. The committee must be adequately staffed and empowered to conduct ongoing reviews of efforts to improve and sustain mental health services in VA, covering the full range of programming from transitional and readjustment primary care to the treatment of chronic mental illnesses. The committee should be required to report periodically and independently to Congress on its evaluations and recommendations, including providing testimony at oversight and legislative hearings of the Committees on Veterans' Affairs. Constructive oversight and feedback to both VA and Congress can help ensure that the finite resources available from Congressional mental health appropriations make the greatest contribution to the recovery and humane care of veterans experiencing the often-devastating mental health effects resulting from their military service to the nation.

VA Mental Health Budget

Final calculations of total spending for VA mental health services for FY 2008 were not available at the time of this writing. However, at the beginning of FY 2009, spending for FY 2008 was estimated to be between $3.4 billion and $3.5 billion, mostly to be derived through VERA. This figure was higher than the "no less than $2.9 billion" spending requirement for mental health services in the FY 2008 Appropriations Act. Prior to the start of FY 2009, mental health spending was estimated to be $3.86 billion, modestly above the "no less than $3.8 billion" requirement that was subsequently included in the FY 2009 Appropriations Act. For FY 2009 and FY 2010, VA's challenge will be to execute the budget increases effectively and allocate its resources wisely. VA's Office of Mental Health has undertaken a monumental transformation of its programs and services and is under tremendous pressure to ensure implementation of the MHSP and UMHS package; fill existing gaps in mental health and substance-use disorder care; integrate mental health services throughout primary care and other service lines; and enhance targeted mental health services. It must be noted that since the MHSP was first drafted, before the current OEF/OIF operations, many circumstances have changed and the challenge to provide comprehensive mental health services continues to grow in scope and complexity. For these reasons, the IBVSOs urge Congress to provide concentrated oversight of spending on mental health services and require VA to provide a full accounting and breakdown of resource allocation, distribution and outcomes of the initiative goals discussed above. We are concerned there is great possibility for manipulation of data and "creative accounting" that can reflect a picture that is not truly representative of the status of this agenda.

Oversight of these programs will be critical to their success. In November 2006, the Government Accountability Office (GAO) issued a report on resources allocated to VA's MHSP initiatives. The GAO documented that VA did not spend the entire allocated budget planned for new FY 2005 mental health initiatives. Additionally, the GAO found that VACO did not inform network and medical center officials that funds were to be used for specific mental health priorities and therefore it is likely that the funding was spent on other health-care needs. The VHA noted that it is aware of concerns about spending of funds from the mental health initiative in FY 2005 and FY 2006 and has made adjustments to its processes to better track the use of these funds. According to the Mental Health Strategic Health Care Group, these funds have been used to improve capacity and approve the hiring of 4,000 new mental health providers to date. However, the IBVSOs continue to hear reports from mental health practitioners in the field that the difficulty of recruiting and retaining behavioral health staff is a major contributing factor for the delay in spending mental health funding. The lengthy, burdensome hiring process, which includes advertising, recruiting, interviewing, and problematic credentialing and privileging requirements, in some cases can take four or five months between tentative offer and on-duty status.

There is a national shortage of behavioral health personnel that makes these issues doubly important. VA needs to improve its succession planning in mental health to address the professional field shortages, recruitment, and retention challenges. VA should also establish a new employee education and mentoring program to overcome the practical problems new staff have in establishing and implementing new programs and policies, when they are unfamiliar with VA or federal procedures. VACO has been slow to develop new policies and procedures to manage these programs while maintaining the flexibility needed to make adjustments. Past experience indicates that it will take several years to fully implement even relatively straightforward changes and longer when more complex culture change is required. Congressional scrutiny is vital to ensure effective and efficient use of these dedicated mental health funds, continuous progress on all facets of the MHSP, and improvements in mental health services and outcomes.

Although the IBVSOs are extremely pleased about the UMHS initiative, we are extremely concerned about the estimated timeline, resources, and staffing levels necessary to establish the initiative. The IBVSOs were informed by VA mental health leadership that the field facilities were consulted about the staffing needed to fulfill the goals outlined in the UMHS handbook. We understand the number of full-time employee equivalents reported necessary by each VISN to carry out the initiative was significantly higher than the level approved by mental health leadership. Field sources also noted that even if all the funds were to appear in their budgets on day one of FY 2009, there would be no practical way all the staff could be hired and programs developed and put in place by the end of the fiscal year as expected. In addition, there are many features of the UMHS package that require transformations, such as recovery-oriented care that clinicians believe will take years to accomplish. Another critical concern to the IBVSOs is the apparent lack of development of a population based demand model, with projections of impact on VA mental health resource requirements presented by returning veterans from Afghanistan and Iraq. It is recognized that these newly returning veterans are challenged by a number of post-deployment mental health issues requiring specialized and evidence-based treatments for a variety of combat-related conditions, including depression, anxiety, PTSD, substance-use disorders, relationship counseling, and risk of suicide. To our knowledge there is no official VA estimate of this impact, other than a generalized number in the budget. It is disconcerting that VA officials often describe this increase as easily able to be absorbed within existing resources, without any adequate data to support their claims. Such a population-based demand model, combined with a set of realistic productivity standards for the various disciplines within specific program settings, would seemingly help to ensure the field has adequate resources to meet the mental health needs of *all* enrolled veterans, including the newest generation of war veterans.

In November 2007, the Institute of Medicine (IOM) published *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress, vol. 6.*[44] The IOM committee studied literature covering World War II, the Korean War, the Vietnam War, the 1991 Persian Gulf War, and OEF/OIF. Potential health effects considered included both physiological and psychological effects, including PTSD, anxiety disorders, depression, substance abuse, and psychosocial effects, such as marital conflict and incarceration.

In reviewing the scientific evidence, the IOM found the evidence to be sufficient to conclude an association between deployment to a war zone and the following conditions: PTSD, anxiety disorders, depression, alcohol abuse, suicidal ideation, and accidental death in early years after deployment, as well as marriage and family conflict. In addition, the committee found that there was suggestive evidence of an association between deployment stress and drug abuse, chronic fatigue syndrome, fibromyalgia and other pain syndromes, gastrointestinal symptoms and functional disorders, skin disorders, increased symptom reporting, and unexplained conditions, as well as incarceration. The IOM committee noted that there was insufficient investigation by VA or the Department of Defense (DOD) to allow them to draw cause-and-effect conclusions regarding the effects of deployment stress on physiological, psychological, and psychosocial conditions. To remedy this problem, the committee recommended further epidemiologic studies and enhanced predeployment screening to identify exposures most stressful to the veteran and regular longitudinal reassessments at five-year intervals thereafter to identify long-term health and psychosocial health effects. Considering the importance of these findings to all combat veterans and the urgency to develop effective programs for OEF/OIF veterans, the IBVSOs strongly urge VA and the DOD to move rapidly to develop health policy and research inquiries that are responsive to these important recommendations. Additionally, we urge VA to review and propose regulations to establish presumptive service connection based on the above noted findings for the conditions that meet the threshold established by VA for other previously established presumptive conditions.

VA's Specialized PTSD Programs

According to VA data, the Department operates a network of more than 190 specialized PTSD outpatient treatment programs nationwide, including specialized PTSD teams or a PTSD specialist at each VA medical center (VAMC). VA has indicated that treating PTSD among returning veterans is one of its highest priorities. VA and DOD studies have indeed verified that veterans with combat exposure in Afghanistan and Iraq had the expected increased risk for PTSD and other mental health concerns postdeployment. Since the beginnings of OEF/OIF, 868,717 service members have been discharged and become eligible for VA health care. Through August 2008, VA reported that of the 347,750 separated OEF/OIF veterans who have sought VA health care since FY 2002 a total of 147,744 unique patients had received a diagnosis of a possible mental health disorder (not including in-

formation on PTSD from VA Vet Centers or data from veterans not enrolled for VHA health care). Nearly 76,000 enrolled OEF/OIF veterans had a probable diagnosis of PTSD; nearly 60,000 OEF/OIF veterans have been diagnosed with depression; and nearly 13,000 received a diagnosis of alcohol dependence syndrome.[45] These data are generally consistent with DOD and other studies of U.S. military service members who served in Iraq. However, VA data does not track early indications of alcohol and other drug misuse, hazardous use, and early abuse, which DOD studies indicate are a problem in between 11 percent and 23 percent of service members surveyed.

An IOM expert committee studied the evidence for treatments proven effective for PTSD and reported that there is sufficient evidence to conclude that exposure to cognitive behavior therapies is effective in treatment of PTSD.[46] The IOM noted that there may be important treatment response differences between civilians and veteran populations with PTSD, as well as differences between older and younger veterans. The IOM committee was not convinced that the evidence is sufficient regarding efficacy of the currently used pharmacological interventions and cautioned that evidence regarding the effectiveness of group therapy is inadequate. The committee made important recommendations to improve VA's ability to provide evidence-based treatments. Of particular note is the committee's finding that available research has significant gaps in evaluation of the efficacy of treatment interventions in the subpopulation of veterans with comorbid traumatic brain injury, major depression, and substance abuse and in women, racial and ethnic minorities, and older individuals. The IBVSOs are pleased with the increased federal investments in PTSD research, and we commend Congress for providing those funds and the mandate to do so; however, we believe there should be greater attention to these specific areas of study as recommended by the IOM. It is disheartening to learn that despite widespread recognition of the importance of deployment stress and PTSD in veterans the committee found "it striking that so few of the studies were conducted in populations of veterans."[47]

VA has been a leader in research on efficacious interventions for severe PTSD, but, as documented by the IOM report, these effective approaches are complex, expensive, and time consuming. Prolonged exposure therapy, an intensive specialized counseling treatment, was highlighted in the IOM report as being one of the few proven effective treatments supported by evidence-based research studies. The IBVSOs are concerned that VA does not currently have the capacity to deliver these intensive exposure therapy programs in every VAMC and to all appropriate veterans with PTSD across the nation. VA needs to immediately increase its funding for such programs and conduct more translational research on how best to disseminate this state-of-the-art care across the VA mental health system. This translational research must include an analysis of the barriers to dissemination, including resources and structural and cultural barriers. Translation of research studies to ready availability of effective treatment programs across the VA healthcare system is a daunting task, but the need is urgent and early intervention is critical to prevent diminished quality of life and well-being for those who have served their country in combat. Prevention of chronic PTSD and recovery should be among the highest priorities for the VHA as it serves the mental health needs of veterans of recent and prior wars.

In 2007 investigators published a study using VA administrative data indicating that between 1997 and 2005 total patients served by VA mental health programs increased by almost 300,000 unique veterans, a 56 percent increase. In addition, the number of veterans diagnosed with PTSD doubled, while the number who received mental health diagnoses other than PTSD increased by 40 percent. The largest numbers of veterans (80 percent) were from earlier eras; however, the largest proportionate increases occurred in veterans who were born after 1972. During this period the number of clinic contacts per veteran per year declined steadily, resulting in a cumulative decline of 37.5 percent. Declines were observed in both PTSD and other mental health diagnoses. The total number of mental health clinic visits showed real number reductions of 2.7 percent from 10.18 visits in FY 1997 to 9.91 visits in FY 2005. The study noted that during the period after the beginning of combat in Iraq, the rate of increase in PTSD and other mental health patient workloads grew further. Mental health service use among both Gulf War era and older veterans increased progressively while service intensity declined steadily. This suggests that increasing demand was met by compressing the allowable number of visits per veteran. Clinicians believe these changes cannot be explained by improvements in evidence-based treatment protocols; therefore, it is likely that the reported declines were accompanied by reductions in continuity of care.[48]

Although VA has increased funding to specialized care programs, the IBVSOs are extremely concerned that care be taken to immediately reverse the above-reported trends so that veterans may benefit from the highest quality men-

tal health care available. We recognize that counseling and evidence-based therapies require intensive training and mentorship to be effectively delivered. Additionally, these treatments are labor intensive and require numerous sessions and increased time with clinicians. In the absence of real-time field experience with these evidence-based PTSD treatments, it is often assumed by VACO planners that the 12-session cognitive processing therapy and the equally brief prolonged exposure therapy will result in veterans no longer requiring ongoing supportive services for PTSD. This is contrary to what clinicians in the field have been observing. These intensive services result in new clinicians having their caseloads rapidly filled, with ongoing need for additional staff, which is not possible with the resources allocated for new mental health providers this year. This yet again points to the need for realistic productivity standards and population-based demand models for these key interventions. Given the likelihood of a surge in combat veterans returning to their communities in the next 12 to 24 months, this needs to happen immediately. We believe these data justify a rigorous study of whether VA has, indeed, purposefully reduced the intensity of care for certain of its enrolled patients in mental health programs in order to generate capacity to absorb newer arrivals with more acute needs. If this study corroborates these observations, VA should be required to shift this trend back toward higher quality and more continuous care for *all* the veterans it serves in mental health programs.

Readjustment Counseling Service

The Readjustment Counseling Service (RCS) currently provides counseling and readjustment services to veterans at 232 Vet Centers, located throughout the nation. The RCS will be expanding the number of Vet Centers to 271 by the end of 2009. Vet Centers provided more than 1.1 million visits by more than 167,000 unique combat veterans from all service eras in FY 2008, including more than 69,000 veterans that were seen through outreach efforts.

In addition to the expansion of Vet Center sites already noted, these centers have also expanded the depth and range of services provided. Vet Centers have been innovative in using technology to expand services, including use of telehealth linkages with VA medical centers. Use of telehealth has increased geographic access to mental health service delivery in remote areas to underserved veteran populations. Since their inception, Vet Centers have provided a recovery focus and an alternative to conventional access for mental health care that some veterans may be reluctant to seek in traditional VA medical centers and clinics. They serve as a model for veterans' psychosocial readjustment and rehabilitation, and support ongoing enhancements under the VA Mental Health Strategic Plan. Also, since 2003, the Vet Centers have provided bereavement services to surviving family members of service members killed while serving on active duty. This successful new program has provided support to more than 2,100 family members of more than 1,400 fallen warriors, most of whom were killed in action in OEF/OIF. Some of these family members may require treatment for depression or anxiety in response to their grief reactions, but there is no current legislative authority for the provision of such care. We urge VA to establish collaborative relationships with community providers for those family members who do not qualify for TRICARE and needed mental health benefits.

The Vet Center program is one of the few VA programs to address a veteran's full range of readjustment and reintegration needs with their families and communities. Family counseling is provided when needed for the readjustment of the veteran. Families provide the "front line" of support network for returning veterans. Spouses are often the first to identify readjustment issues and facilitate veterans' evaluation and treatment when concerns are identified. Repeated deployments, financial hardships, long absences from home, and the stresses of reintegration with family routines have put a tremendous strain on OEF/OIF veterans' marriages. The most recent survey of more than 3,000 soldiers, conducted while they were serving in Afghanistan and Iraq, indicates that by the midpoint of deployment 30 percent were considering divorce.[49] We are pleased that Public Law 110-387 clarified VA's authority to provide marriage and family counseling and establish a limited pilot program to assess the feasibility and advisability to provide readjustment and transition assistance to veterans and their families in cooperation with Vet Centers. We encourage VA to expand this program to provide routine support and relationship counseling services for all combat veterans and their families. We believe these services should be made available in all major VA care sites. Vet Center staff and VA mental health professionals in VA medical centers should work to improve collaboration between their respective program services to ensure appropriate care coordination and quality care for veterans. In the near term, VAMCs should increase their coordination with Vet Center staff to increase access and referrals for veterans needing

family counseling; increase distribution of outreach materials to family members with tips on how to better manage the dislocation and improve reintegration of combat veterans who are returning from a deployment; and provide information on identifying warning signs of suicidal ideation so veterans will be more likely to seek help with readjustment issues. Also, in cases of referrals from Vet Centers to VA medical centers, information of record on patient counseling at Vet Centers should be made available to mental health practitioners to aid them in the continuing care of these veterans.

Substance-Use Disorders Treatment

In the past, population-based surveys have strongly confirmed that veterans report higher rates of alcohol abuse than nonveterans and are more likely to meet criteria for alcohol abuse and dependence. Recent studies have demonstrated no reduction in overall veteran need for substance-use disorder services and have shown an increase in alcohol concerns expressed by or about OEF/OIF veterans.

Army investigators recently published the first longitudinal study of health concerns among soldiers serving in Iraq. The study found that questionnaires administered immediately after completing redeployment underestimate the physical health, mental health, and substance-use burden on service members who served in Iraq. Surveys conducted later showed increased reporting of both physical health and mental health concerns and increased referrals to care. In this particular study, although 11.8 percent of soldiers reported alcohol misuse, only 0.2 percent of those individuals were subsequently referred for treatment. Moreover, of those referred, only a small number received care within 90 days of screening.[50]

The number of veterans who received specialized outpatient substance abuse treatment services in VA declined between FY 1998 and FY 2005 by 18 percent. The IBVSOs believe the overall decline in supply of substance-use disorder services occurred despite stable or increasing veterans' demand for such services. However, we note that during the past year VA conducted an analysis of gaps in service for substance abuse care and has begun to fund new programs, particularly intensive outpatient treatment programs, to fill critical gaps in access to care. This is an important first step in rebuilding VA substance abuse treatment programming and assuring equity of access across the system to critical services. However, VA data show that the numbers of veterans who received specialty care for substance-use disorders during FY 2006 as 121,926, but in FY 2007 it was a mere 127,402.[51] These minimal increases do not begin to address veterans' treatment requirements or reverse the 15 percent to 18 percent decreases in VA substance abuse treatment in the decade between 1996 and 2006.

In its UMHS handbook, the VHA mandates that all VA health-care facilities develop a full continuum of care for substance-use disorders, including more consistent and universal periodic screening of OEF/OIF combat veterans in all its health-care facilities and programs. Screening, especially in primary care clinics and Vet Centers, is essential for early intervention and prevention of chronic substance-use disorders. The IBVSOs are pleased with the new policy and look forward to its speedy implementation across all VA sites of care. Outpatient substance misuse counseling and pharmacotherapy should be available at all larger VA community-based outpatient clinics at a minimum. At more extensive VA medical centers, short-term outpatient counseling including motivational interventions, intensive outpatient treatment, residential care for those most severely disabled, detoxification services, ongoing aftercare and relapse prevention, self-help groups, opiate substitution therapies, and newer drugs to reduce cravings should be made more widely available. We note that, traditionally, VA substance abuse services have been primarily focused on service for veterans who have a severe and chronic substance abuse or dependence. This has resulted in neglect of programs that could help veterans early and prevent consequent disruption of family, employment, and community relationships. We believe this is a significant issue, especially with respect to the newest generation of war veterans exhibiting these early symptoms of alcohol and other drug misuse. For these reasons, we strongly recommend that VA focus intensive efforts to improve and increase early intervention and the prevention of substance abuse in the veteran population.

Recovery and Disability Compensation

In the 110th Congress, legislation was proposed that attempted to link the disability compensation system with "recovery." The use of the term recovery created unnecessary confusion with mental health recovery concepts and the VHA's focus of transforming its mental health services through recovery-based programs and principles. The legislative proposal, which would have delayed veteran access to VA's Disability and Compensation claims process, created a sense of suspicion and fear among service-connected veterans who believed that the government's focus on the hope of recovery from se-

rious mental illness was simply a cynical effort to reduce or eliminate their entitlement benefits. The IBVSOs do not believe this to be the case; however, to truly achieve the greatest outcome for disabled veterans, this issue must be addressed. We acknowledge that fear of loss of compensation benefits (and reality of the current regulations) is a serious barrier to some of the most important aspects of recovery transformation. The urgent need to realign the disability regulations with recovery transformation is particularly compelling due to the large numbers of veterans returning from OEF/OIF, who are frequently torn between competing priorities of seeking treatment and recovery, returning to work and self-sufficiency (which almost all want to do), and having disability compensation that provides financial security to them during their difficult journey to recovery. First, there should be an adjustment to the disability compensation rating schedule that ensures parity between mental health disabilities and physical disabilities. Second, it is critical that compensation and treatment not be contingent or linked. These issues should be decoupled to eliminate the potential barriers and conflicts for maximizing employment under the recovery/rehabilitation model of care. Veterans service organizations (VSOs) and disabled veterans should be involved in all efforts to realign the disability rating system for mental health disorders to ensure that programs are designed to maximize every veteran's ability to fully participate in the recovery/rehabilitation model of care without being denied the ability to file a claim for benefits and without fear of loss of established disability compensation. A task force, composed of experts from the Veterans Benefits Administration (VBA), VHA mental health staff, VSOs, and disabled veterans should be assembled to appropriately align the disability compensation system with recovery-oriented care.

Designation of Seriously Ill and Injured Veterans and Case Management

Over the past decade, the VHA has emphasized the critical importance of a coordinated continuum of care for seriously ill and injured veterans. This includes the initial transition between the DOD and VA health-care systems. After managing the initial "hand-off" between federal health-care programs, VA has developed systems of care to ensure that high-quality, accessible health-care services continue to be provided to these individuals.

The President's Commission on Care for America's Returning Wounded Warriors made many recommendations for improvements in VA care. The commission recognized the importance of integrated care management to provide "...patients with the right care and benefits at the right time in the right place by leveraging all resources appropriate to their needs. For injured service members—particularly the severely injured—integrated care management would build bridges across health-care services in a single facility and across health-care services and benefits provided by DOD and VA."

To implement the commission's recommendations and ensure every veteran receives the care he or she requires, VA created the OEF/OIF Case Management Program for veterans and service members with serious injuries or illnesses. VA has professed that its case management and coordination strategy has allowed it to meet the needs of returning seriously injured veterans. This case management program is designed to provide lifelong care to those individuals who are designated as seriously ill and injured veterans. However, the IBVSOs have become aware that the case management programs treat veterans with physical injuries and mental health injuries and illness in a disparate manner. OEF/OIF combat veterans being discharged with serious mental illness without an accompanying physical injury are not included in this program. Because of this disparity, case managers and mental health staff are left to cobble together locally developed databases and programs for OEF/OIF veterans with serious or complex mental health problems that clinically require case management. Because the programs are unique to each VAMC, there is no national tracking or monitoring of this important patient population. VAMCs have no means to report case management workload or resources to the national program office required for these efforts. We recommend that VA immediately correct case management program deficiencies and begin to treat psychological injury and illness in veterans with the same intensity that it treats serious physical injuries.

Suicide Prevention

The IBVSOs are pleased that over the past year VA has stepped up its efforts and made suicide prevention a priority. VA has developed a broad program based on increasing awareness, prevention, and training of health-care staff to recognize suicide risk. A national suicide prevention hotline has been established and suicide prevention coordinators have been hired in each VA medical center. Research into the risk factors associated with suicide in veterans and prevention strategies is under way. While recognizing the advances in suicide prevention programs made by VA, the IBVSOs believe

strongly that the most effective investments will be those that VA makes to improve the screening, diagnosis, and treatment for PTSD, depression, substance abuse, and other mental health disorders. Evidence is clear that those conditions, left untreated or poorly treated, can lead to increases in suicide attempts and suicide rates. For these reasons we believe VA must redouble its efforts to reduce the stigma associated with seeking mental health care and to encourage veterans to seek treatment. Case management for veterans at high risk for suicide should be sized adequately to meet the needs, and when the veteran also has a care manager for OEF/OIF issues, that care manager needs to be equally well trained in suicide risk management to avoid duplication or working at cross purposes. There should be clearly delineated role functions for OEF/OIF case managers since they may naturally cross over into clinical management.

OEF/OIF Veterans

There is growing concern that the special needs of new veterans of the conflicts in Afghanistan and Iraq have received insufficient advance planning and inconsistent attention since the first deployments began in Afghanistan in October 2001. Because of the importance of stepping up efforts directly on behalf of OEF/OIF veterans, the IBVSOs have included a separate section in this *Independent Budget*, titled "The Challenge of Caring for Our Newest War Veterans."

Summary

The IBVSOs recognize the unprecedented efforts made by VA to improve the safety, timeliness, and effectiveness of mental health-care programs for veterans. We are especially pleased that VA has expressed its intent and commitment through the national Mental Health Strategic Plan to reform its mental health programs, moving from the traditional treatment of symptoms to embrace potential recovery of every patient under VA care. We also appreciate the will of Congress in continuing to insist that VA dedicate sufficient resources in pursuit of full VA coverage of the mental health needs of veterans. The IBVSOs have concerns, nevertheless, that these laudable goals will be unfulfilled unless VA adopts and enforces mechanisms to ensure its policies at the top are reflected as results in the field. In that regard we are deeply concerned that substance-use disorder programs in VA, currently focused on chronic and severe addictions, are woefully inadequate given that there are consistent indications of substance-use disorder problems in the OEF/OIF population.

We believe the conflicts inherent in VA's disability compensation system for mental health disorders and recovery-based care for mental illness need to be addressed by VA. No veteran should fear compensation penalty from health improvement. The current practices between the VBA and the VHA may be working at cross purposes and should be more closely examined by a VA benefits-health task group involving veterans organizations, including the IBVSOs. We also urge closer cooperation and coordination between VA medical centers and Vet Centers within their areas of operations. We recognize that the Readjustment Counseling Service is independent from the VHA by statute and conducts its readjustment counseling programs outside the traditional "medical model." We respect that division and do not intend to undermine it. However, in addition to having concerns about VA's ability to coordinate with community providers in caring for veterans at VA expense, we believe veterans will be best served if better ties and mutual goals govern the relationship of Vet Centers to VA medical centers.

The development of the MHSP and the new Uniform Mental Health Services package provide an excellent road map for the VHA's transformation of its mental health services to veterans. However, throughout this section, the IBVSOs have expressed continued concern about the pace of implementation of the mental health clinical, education, and research programs. There are also significant gaps that need to be closed, especially in oversight of mental health programs and in the case management programs for OEF/OIF combat veterans. VA needs to fulfill its promises to treat mental illness with the same intensity as physical illness and to deliver on veterans' hope for recovery from mental illness.

The IBVSOs urge strong oversight by the Committees on Veterans' Affairs to ensure VA's mental health programs and the reforms we have outlined in this *Independent Budget* meet their promise—not only for those coming back from war now, but for those already here.

Recommendations:

Congress should provide oversight to ensure that VA maintains a full continuum of mental health-care services across the system and enhance its efforts for oversight of VA's mental health transformation and implementation of VA's National Mental Health Strategic Plan and Uniform Mental Health Services delivery initiative.

VA should appoint a task group to study and recommend a budget appropriate to support the UMHS. The task group should determine whether the Veterans Equitable Resource Allocation model will provide adequate funding for the full continuum of services mandated by the UMHS handbook and make recommendations for future funding of mental health services.

VA should provide frequent periodic reports that include a facility-level accounting of the use of mental health enhancement funds, as well as an accounting of overall mental health expenditures, to Congressional staff, veterans service organizations, and the Consumer Liaisons Council of the VA Advisory Committee on the Care of Veterans with Serious Mental Illness.

In keeping with the National Mental Health Strategic Plan, Medical Services funding to support the Mental Health Enhancement Initiative should be provided on a recurring "earmarked" basis, outside of the VERA system, until such time that VA is confident that the programs within the initiative are sustainable. At a minimum, *The Independent Budget* veterans service organizations believe a five-year period for such protection is necessary.

Given the urgency of ensuring the implementation of the UMHS package, consideration should be given to holding Congressional oversight hearings as soon as possible on the implementation strategy employed by the VA Central Office for this initiative. Congress should require VA to provide an assessment of resource requirements, as well as a completion date for full implementation of the UMHS package.

VA must increase access to veteran and family-centered mental health-care programs, including family therapy and marriage counseling. These programs should be available at all VA health-care facilities.

Veterans and family consumer councils should become routine standing committees at all VA medical centers. These councils should include the active participation of veteran health-care consumers, their families, and their representatives.

A task force, composed of experts from the Veterans Benefits Administration, Veterans Health Administration mental health staff, veterans service organizations, and disabled veterans, should be assembled to explore potential barriers and disincentives to mental health care and the VA disability compensation system.

VA and the Department of Defense should track and publicly report performance measures relevant to their mental health and substance use disorder programs. VA should focus intensive efforts to improve and increase early intervention and the prevention of substance abuse in the veteran population.

The VA Advisory Committee on the Care of Veterans with Serious Mental Illness should be redesignated as a secretarial-level committee on mental health, armed with independent reporting responsibility to Congress.

VA and the Department of Defense must ensure that veterans and service members receive adequate screening for mental health needs. When problems are identified with screening, providers should use nonstigmatizing approaches to enroll them in early treatment in order to mitigate the development of chronic illness and disability.

VA should invest in research on effective stigma reduction, readjustment, prevention, and treatment of acute post-traumatic stress disorder in combat veterans; increase its funding for evidence-based PTSD treatment programs; and conduct translational research on how best to disseminate this state-of-the-art care across the system. VA should conduct an assessment of the current availability of evidence-based care, including for PTSD, identify shortfalls by site of care, and calculate the resources necessary to provide universal access to evidence-based care.

VA should conduct an assessment of the current availability of evidence-based care for PTSD, identify shortfalls by site of care, and calculate the resources necessary to provide universal access to these specialized treatments.

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[44] *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress*, vol. 6 (Washington, DC: National Academies Press, 2007).
[45] DVA, VHA Office of Public Health and Environmental Hazards, Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans: Operation Enduring Freedom, Operation Iraqi Freedom, August 2008.
[46] *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence* (Washington, DC: National Academies Press, 2007).
[47] Ibid.
[48] R. A. Rosenheck and A. F. Fontana, "Recent Trends in VA Treatment of Post-Traumatic Stress Disorder and Other Mental Health Disorders," *Health Affairs* 26(6) (2007): 1720–27.
[49] Office of the Surgeon, Multi-National Force-Iraq; Office of the Command Surgeon; and Office of the Surgeon General; United States Army Medical Command, Mental Health Advisory Team V Final Report; Operation Iraqi Freedom 06-08: Iraq; Operation Enduring Freedom 06-08: Afghanistan, February 14, 2008.
[50] C. S. Milliken, J. L. Auchterlonie, and C. W. Hoge, "Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War," *JAMA* 298(18) (2007): 2141–48.
[51] Unpublished briefing by the Veterans Health Administration to veterans service organizations on status of VA substance-use disorder programs, November 2008.

OEF/OIF ISSUES

The Challenge of Caring for Our Newest War Veterans

The Departments of Defense and Veterans Affairs face unprecedented challenges in meeting the needs of a new generation of war veterans and their families, including those who suffer from postcombat readjustment challenges and cognitive impairments as a result of traumatic brain injury (TBI).

Since October 2001, approximately 1.8 million military service members have deployed to Afghanistan and Iraq in Operations Enduring and Iraqi Freedom (OEF/OIF). Many service members have participated in multiple deployments and been subjected to a number of serious threats, including mortar attacks, suicide bombs, and exposure to repeated blasts from improvised explosive devices (IEDs). Current studies indicate that multiple exposures to IED blasts and the stress of these deployments in general are exacting a toll on the fighting force, resulting in a variety of seemingly "invisible" wounds, including post-traumatic stress disorder (PTSD), major depression, and cognitive impairments as a result of milder forms of traumatic brain injury. Military medicine has advanced to unprecedented levels of excellence that have resulted in a 90 percent survival rate among wounded veterans.[52] However, within the DOD and VA health-care systems, gaps remain in the recognition, diagnosis, treatment, and rehabilitation of these less-visible injuries.

The DOD and VA share a unique obligation to meet the health-care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from postdeployment readjustment problems as a result of combat exposure. The DOD, VA, and Congress must remain vigilant to ensure that federal programs aimed at meeting the needs of the newest generation of combat veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts. Congress must also remain apprised of how VA spends the significant new funds that have been provided and earmarked specifically for the purpose of meeting postdeployment mental health and physical rehabilitation needs.

The Independent Budget veterans service organizations (IBVSOs) are grateful that VA has adopted the principles of the President's New Freedom Commission on Mental Health. The commission's ultimate goal is the eradication of the stigma that surrounds mental health challenges and the opportunity for full recovery for people facing those challenges. The commission's framework for achieving this important goal should be the guiding beacon for VA mental health planning, programming, budgeting, and clinical care for veterans of OEF/OIF service and of all military service periods. Optimal recovery is also the goal for those with severe physical injuries.

Invisible Wounds of War

The RAND Corporation Center for Military Health Policy Research recently completed a comprehensive study titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* RAND found that the effects of TBI are still poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it.[53] The study evaluated the prevalence of mental health and cognitive problems of OEF/OIF service members; the existing programs and services available to meet the health-care needs of this population; the gaps that exist in these programs and what steps need to be taken to improve these services; and the costs of treating or not treating these conditions.

The study found rates of PTSD, major depression, and probable TBI are relatively high when compared to the U.S. civilian population.[54] RAND estimated that approximately 300,000 of the 1.64 million OEF/OIF service members who had been deployed as of October 2007 suffer from PTSD or major depression, and that about 320,000 individuals experienced a probable TBI during deployment.[55] Additionally, about one-third of those previously deployed have at least one of those three conditions, and about 5 percent report symptoms of all three.

According to RAND, 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. About 53 percent of those who met the criteria for PTSD or major depression had sought help from

a physician or mental health provider in the past year.[56] It was noted, however, that even when individuals sought care, few received *quality* care—with only half having received what was considered minimally adequate treatment. A number of barriers to care were identified by survey participants as reasons for not getting treatment. RAND concluded there is a need for increased access to confidential, evidenced-based psychotherapy and that the prevalence of PTSD and major depression will likely remain high unless efforts are made to enhance systems of care for these conditions.[57]

Finally, the study evaluated the costs of these mental health and cognitive conditions to the individual and society. Suffering from these conditions can impair relationships, disrupt marriages, affect parenting, and cause problems in children of veterans.[58] RAND determined the estimated financial costs associated with mental health and cognitive conditions related to OEF/OIF service would be substantial ($4 billion to $6 billion over a two-year period for PTSD and major depression, and $591 million to $910 million for TBI within the first year of diagnosis).[59]

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, DOD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these powerful detonations and that signs and symptoms are often not readily recognized but can include chronic headache, irritability, behavioral disinhibition, sleep disorders, confusion, memory problems, and depression.

Emerging literature (including the RAND study) strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DOD and VA mental health experts, mild TBI can also produce behavioral manifestations that mimic PTSD or other mental health conditions. Additionally, TBI and PTSD can be coexisting conditions in one individual. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. The IBVSOs believe VA should conduct more research into the long-term consequences of brain injury and development of best practices in its treatment; however, we suggest that any studies undertaken include veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. The medical and social histories of previous generations of veterans could be of enormous value to VA researchers interested in the likely long-term progression of brain injuries. Likewise, such knowledge of historic experience could help both the DOD and VA better understand the policies needed to improve screening, diagnosis, and treatment of mild-to-moderate TBI in combat veterans of the future.

On July 12, 2006, the VA Office of the Inspector General (OIG) issued *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation.* The report found that better coordination of care between DOD and VA health-care services was needed to enable veterans to make a smooth transition. The OIG Office of Health Care Inspections conducted follow-on interviews to determine changes since the initial interviews conducted in 2006. The OIG concluded that three years after completion of initial inpatient rehabilitation, many veterans with TBI continue to have significant disabilities and, although case management has improved, it is not uniformly provided to these patients.[60]

Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, and progress is being made, uniformity and identified gaps in services are troubling. The authors of *The Independent Budget* remain concerned about whether VA has fully addressed the long-term needs and the emotional and behavioral problems that are often associated with TBI, as well as the devastating impact on both veterans *and* their families.

Research is urgently needed to identify the most sensitive and specific screening tools for TBI: improved TBI classification and prognostic tools; effective prevention, neuroprotective agents, and treatment programs; and enhanced understanding of the natural history of multiple concussions. While VA and the DOD are investing heavily in research related to blast injury and mild TBI, the quality and outcome of this research is being negatively affected by lack of exposure data concerning the blast magnitude and the circumstance of the service member's injury. The DOD should declassify this information and make it available to federally funded researchers doing Institutional Review Board–approved studies.

Polytrauma System of Care

As a result of the conflicts in Afghanistan and Iraq, VA has coordinated the transfer of more than 6,800 OEF/OIF severely injured or ill active duty service members and veterans from DOD to VA care and services—many with multiple injuries, including TBI, amputations,

serious burns, spinal cord injury, and blindness.[61] VA's terminology for the care to veterans with multiple and serious injuries is "polytrauma" care. Veterans with injuries to more than one physical region or organ system generally require extensive rehabilitation and lifelong personal and clinical support, including neurological, medical, and psychiatric services, as well as physical, psychosocial, occupational, and vocational therapies. VA has four established polytrauma rehabilitation centers (PRCs) collocated with lead centers for TBI in Tampa; Richmond, Virginia; Palo Alto, California; and Minneapolis, and announced last year it will also provide specialized polytrauma care in San Antonio. In addition, each of VA's networks has established a lead center for follow-up care of polytrauma and TBI patients referred from the four lead centers or directly from military treatment facilities. The goal of the polytrauma rehabilitation centers is to offer a comprehensive, interdisciplinary approach to meeting the goals of an individualized treatment plan to return each injured veteran to optimal function. VA has not yet met its goal of comprehensive services at each PRC and should enhance the PRC programs to ensure that each center can provide at least care for spinal cord injury, amputation, and TBI, as well as blind rehabilitation and specialized mental health services for both men and women.

Just as other "special emphasis" rehabilitation programs (e.g., spinal cord injury, blind rehabilitation, and amputation care programs) have evolved their acute care programs for newly injured veterans into comprehensive programs that provide a full continuum of lifelong care and services, VA's polytrauma centers must likewise ensure that they offer a coordinated continuum of follow-up care, rehabilitation, respite, and long-term care to address the lifetime care needs of seriously injured veterans. The IBVSOs plan to carefully monitor the evolution of these special programs to ensure that they continue to meet the needs of this vulnerable population of veterans throughout their lifetimes.

Caregivers of Traumatically Injured Veterans

While a miraculous number of our veterans are surviving what surely would have been fatal wounds in earlier periods of warfare, some are grievously wounded and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal supports. Eventually most of these veterans will be able to return to their families, at least on a part-time basis, or be moved to an appropriate therapeutic residential setting, but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them substitute for the dramatic loss of physical, mental, and emotional capacities as a consequence of their injuries. Immediate families of newly and severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical and emotional problems of the severely injured veteran, deal with the complexities of the systems of care on which these veterans must rely—all while struggling with disruption of their family life, interruptions of personal goals and employment, and often the dissolution of other "normal" support systems most people take for granted.

The IBVSOs believe a strong case management system is necessary to ensure a smooth and transparent handoff of severely injured and ill veterans and their family caregivers between DOD and VA programs of care. This case management system should be held accountable to ensure uninterrupted support as these veterans and family caregivers return home and attempt to rebuild their lives. A severely injured veteran's spouse is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. Spouses must often give up their personal plans (resign from employment, withdraw from school, etc.) to care for, attend, and advocate for the veteran. They often fall victim to bureaucratic mishaps in the shifting responsibility for conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation), upon which they must rely for subsistence in absence of other personal means. For many younger, unmarried veterans who survive their injuries, their primary caregivers remain their parents, who have limited eligibility for military assistance and have virtually no current eligibility for VA benefits or services of any kind.

Research shows that family members suffer from a number of negative health consequences associated with the caregiver role. The 1996 National Caregiver Survey documented that caregivers report great impacts on employment, caregiver strain, mental and physical health problems, time for leisure and other family members, and family conflict. Family caregivers who provide 36 or more hours of care per week are more likely than noncaregivers to experience symptoms of depression or anxiety; for spouses the symptom rate is six times as high.[62] Studies also demonstrate that family caregivers report having a chronic health condition at more than twice the rate of noncaregivers.[63] In addition, studies indicate that when family caregivers experience extreme stress, they age prematurely and this level of stress can take as much as 10

years off a family caregiver's life.[64] This research suggests that VA and the DOD should do more to mitigate the health effects and provide care for the family caregivers of seriously injured veterans.

VA has limited authorization and capacity to provide mental health and relationship counseling services to family members—an important component of the rehabilitation process for veterans and their families. However, the IBVSOs have been informed by a few local VA officials that they are providing a significant amount of training, instruction, counseling, and other services to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the possible absence of legal authority to provide these services and that scarce resources are being diverted to these needs without recognition of their cost within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency and validity of this need.

The IBVSOs believe Congress should authorize, and VA should provide, a full range of psychological counseling and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum this benefit should include relationship and marriage counseling, family counseling, training of family members in skills to care for and maximize the recovery of the seriously injured family member, and related assistance for the family coping with the stress and continuous burden of caring for a severely injured and permanently disabled veteran. Also, we believe VA should establish a new national program to make periodic respite services more readily available to all severely injured veterans and caregivers. The IBVSOs believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days available for use, providing overnight and weekend respite care to veterans and their caregivers, and eliminating applicable long-term-care copayments. A separate section on caregivers, "Family and Caregiver Support Issues Affecting Severely Injured Veterans," discusses these complex issues in greater detail.

VA's Specialized PTSD Programs

Without question, the Veterans Health Administration (VHA) has the most comprehensive mental health program in the nation to treat veterans with readjustment problems stemming from military combat, including combat stress and acute and chronic PTSD. The VHA employs a cadre of highly skilled, dedicated clinicians and researchers who specialize in and are dedicated to helping veterans deal with the unique mental health challenges they face as they return to civilian life from a military combat deployment.

However, a recent analysis of current research on the effectiveness of treatment for PTSD conducted by the Institute of Medicine (IOM) underscores how much still needs to be done to ensure that all veterans with PTSD receive state-of-the-art treatment for this problem, which was a direct result of their military service. VA has led in researching the most efficacious interventions for severe PTSD, but as documented in the Institute of Medicine report, these effective approaches are complex, expensive, and time consuming. Intensive programs, such as those in the successful efficacy studies noted by the IOM, are not readily available to many veterans across the nation.[65] VA needs to immediately increase its funding for such programs, and to conduct more translational research on how to best disseminate this state-of-the-art care across the system. This translational research must include an analysis of the barriers to dissemination, including resources and structural barriers. Translation of effective treatment methods from research studies to ready availability across the system is a daunting task, but the need is now and early intervention is critical for the recovery and well-being of those who have served.

Stigma and Outreach

Currently no comprehensive data are collected from returned OEF/OIF veterans on their personal perceptions of barriers to care. However, one of the most serious hurdles OEF/OIF veterans face in getting mental health care is overcoming the stigma associated with mental health problems. More than 50 percent of soldiers and marines in Iraq who test positive for a mental health problem are concerned that they will be seen as weak by their fellow service members, and almost one in three of these troops worries about the effect of a mental health diagnosis on his or her career.[66] To help reduce stigma associated with seeking mental health services, the DOD should develop a screening tool to assess cognition, psychological functioning, and overall psychological readiness for every active duty service member, reservist, and guardsman as part of a routine annual primary care examination. VA has already adopted a screening tool that is part of its primary care preventive health assessment process. We con-

cur that in both settings trained mental health technicians should be accessible to interpret responses and mental health professionals should be immediately available to receive appropriate referrals.[67]

The DOD has acknowledged its need to incorporate some of the recommendations of its Task Force on Mental Health, including conducting appropriate screenings in private environments, identifying options for screening active duty, Reserve, and National Guard annually, and ensuring that its mental health assessment tools are valid and reliable. The IBVSOs will continue to monitor progress of this initiative.

The barriers to seeking mental health care are formidable; however, there is much that we do not currently know about these barriers. While VA's current patient satisfaction data provide some information on those who have successfully entered care, patient satisfaction data tell us little about those who were frustrated in their attempts to access services. VA should conduct comprehensive surveys of samples of all OEF/OIF veterans—not just those who have successfully accessed VA care—to identify barriers to care and formulate solutions to eliminate these barriers. Although VA has taken some steps to improve outreach to veterans, it must continue to proactively identify this population's unmet needs for postdeployment mental health services. In addition to making phone calls, sending letters, and conducting debriefings at demobilization sites following deployments, VA must initiate an aggressive outreach campaign to inform veterans and their families of risk factors for mental health problems post deployment and programs available to meet veterans' needs. The IBVSOs believe this should involve modernizing the VA website and developing listservs to communicate with veterans through email, electronic bulletin boards, sponsored chat rooms, and other innovative means of communicating to the ".com" generation, in addition to traditional methods, such as telephone calls and letters.

The DOD has recently instituted a number of anti-stigma measures and resiliency programs for active duty members. The IBVSOs applaud the courage of a high-ranking Army official, injured during his 2004 and 2005 tours in Iraq, who recently came forward to speak of his experiences. In so doing, he broke the military's code of silence in seeking psychiatric counseling for PTSD and then publically spoke out about it. In a recent interview he said that he is promoting open attitudes in both the Reserves and the National Guard "...to reduce the stigma associated with soldiers coming forward. We want them to come forward early, before problems are even greater."[68] The IBVSOs recognize the fortitude it took for him to do this and encourage other military leaders to follow his example. VA also needs to embrace this open attitude, treat mental health with the same seriousness that it treats physical health, and enhance its anti-stigma messages to veterans.

VA clinicians believe outreach efforts should emphasize that it is normal to have a psychological reaction to intense or repeated stress, that some people may need help in readjusting, and that it is good to seek such help. Media outreach campaigns in particular should attempt to normalize the process, and not overly stress mental health diagnoses or focus on pathology. The goal should be to get the veteran to seek immediate assistance, at which time further evaluations can be conducted if more severe problems are suspected. Such an outreach program must be viewed as a crucial early prevention effort, an effort to identify problems before they compound and exact a high social and economic price on the veteran, his or her family, and society. These efforts can only succeed if VA offers readily accessible services for the type of problems that are often the first sign of trouble, including marital and relationship counseling and interventions for hazardous use of alcohol and other drugs. Upgrading current prevention efforts and user-friendly access to early intervention services must be an immediate priority for VA.

Substance-Use Disorder Treatment

Another issue having an impact on newly returning service members, veterans, and their families is substance-use disorders. There are multiple consistent indications from both the DOD and VA that the misuse of alcohol and other substances will continue to be a significant problem for many OEF/OIF service members and veterans. An untreated substance-use disorder can result in a number of health consequences for the veteran and family, including a marked increase in health-care expenditures, additional stresses on families, social costs from loss of employment, and additional, avoidable costs to the legal system. We urge VA and the DOD to continue research into this critical area and to identify the best treatment strategies to address substance abuse and other mental health and readjustment issues collectively.

Over the past decade VA drastically reduced its substance-use treatment and related rehabilitation services; however, during the past year VA conducted an analysis of gaps in service for substance abuse care, and has begun to fund new programs, particularly intensive outpatient treatment programs, to fill critical gaps in access to care. This is an important first step in rebuilding VA substance abuse

treatment programming and ensuring equity of access across the system to these critical services. Because substance misuse is often the first symptom of even greater psychological problems to be evident to veterans and their families and employers, access for early intervention services will help ensure that problems are identified at an early stage and reduce the negative impact on veterans and their families. The IBVSOs urge VA to closely monitor the implementation phase of its newly approved Uniform Mental Health Services policy to ensure a full continuum of care for substance-use disorders and include additional screening in all its healthcare facilities and programs, especially in primary care. Congress must provide continued oversight to ensure these specialized programs are fully restored, readily accessible, and focused on meeting the unique needs of this population.

The IBVSOs are pleased that VA has developed a comprehensive strategy to address suicides and suicidal behavior in the veteran population, but we encourage Congress to provide oversight to ensure proper focus and attention are paid to this issue. It is clear that without proper screening, diagnosis, and treatment, postdeployment mental health problems can lead distressed individuals to attempt to take their own lives. VA must focus on delivering comprehensive, high-quality, timely mental health and substance-use disorder care to all appropriate veterans. Ready access to robust mental health and substance abuse treatment programs, which must include screening and early intervention, is the most critical component of any effective suicide prevention effort.

Specialized Readjustment Counseling Service

The Readjustment Counseling Service (RCS) currently provides counseling and readjustment services to veterans at 232 Vet Centers, located throughout the nation. Since their inception, Vet Centers have provided a recovery focus and an alternative to traditional access for mental health care that some veterans may be reluctant to seek in VA medical centers and clinics that used traditional medical models of care focused on symptom reduction. According to VA, the RCS will be expanding the number of Vet Centers to 271 by the end of 2009. Vet Centers provided more than 1.1 million visits to more than 167,000 unique combat veterans from all service eras in FY 2008, including more than 69,000 veterans that were seen through outreach efforts.

Since 2003, the Vet Centers have provided bereavement services to surviving family members of service members killed while serving on active duty. This successful new program has provided support to more than 2,100 family members of more than 1,400 fallen warriors, most of whom were killed in action in OEF/OIF. However, some of these family members may require treatment for depression or anxiety in response to their grief reactions, but there is no current legislative authority for the provision of such care. We urge VA to establish collaborative relationships with community providers for family members who do not qualify for TRICARE and needed mental health benefits.

The Vet Center program is the one of the few VA programs to address the veteran's needs within family and community. Families provide the "front line" of a support network for returning veterans, and spouses are often the first to identify readjustment issues and facilitate veterans' evaluation and treatment when concerns are identified. Repeated deployments, financial hardships, long absences from home, and the stresses of reintegration with family routines have put a tremendous strain on OEF/OIF veterans' marriages. The most recent survey, conducted of more than 3,000 soldiers while they were serving in Afghanistan and Iraq, indicates that by the midpoint of deployment, 30 percent were considering divorce.[69] We are pleased that Public Law 110-387 clarified VA's authority to provide marriage and family counseling and established a pilot program to assess the feasibility and advisability to provide readjustment and transition assistance to veterans and their families in cooperation with Vet Centers. We encourage VA to expand its support and counseling services for veterans and families, and we believe that optimally this expansion should occur in all major VA care sites.

Vet Center staff and VA mental health professionals in VA medical centers (VAMCs) should work to improve collaboration between their respective program services to ensure appropriate care coordination and quality care for veterans. The Vet Center and VAMC programs are synergistic, and there can be great benefit to veterans from increased coordination of services. In the near term, VAMCs should increase coordination with Vet Centers to obtain consultations for family counseling; increase distribution of outreach materials to family members with tips on resiliency; improve the reintegration process of returning combat veterans into their family, civilian job, and community; and provide information on identifying warning signs of readjustment problems, including suicidal ideation so veterans will more likely seek early help.

Work Life Rehabilitation Services

Veterans suffering from mental and substance-use disorders often experience disruptions in their work life. Comprehensive rehabilitation must include assistance in successfully reentering the workforce. This is needed not only by those eligible for rehabilitation services due to service-connected disabilities, but also for many other veterans seeking care. While some VA facilities offer comprehensive rehabilitation services for patients recovering from mental disorders, many do not. The goal of recovery/rehabilitation must be to return the veteran to a productive family, social, and work life. VA should carefully assess the availability of complete rehabilitation services across the system and take action to assure that all veterans have access to this critical portion of the rehabilitation process. This is especially important since OEF/OIF veterans today are returning to an economic environment that is unusually challenging.

Women Veterans

The numbers of women now serving in our military forces are unprecedented in U.S. history, and today women are playing extraordinary roles in the conflicts in Afghanistan and Iraq. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, and military police officers and serve in many military occupational specialties that expose them to the risk of combat, serious injury, and death. To date, more than 100 women have been killed in action, and women service members have suffered grievous injuries including multiple amputations. The current rate of enrollment of women in VA health care constitutes the second most dramatic growth of any subset of veterans. In fact VA projects the number of women veterans coming to the Department for health-care services is likely to double in two to four years. According to VA, since 2002, more than 42 percent of women who deployed in OEF/OIF and have since been discharged from military service have enrolled in VA health care.

As the population of women veterans undergoes exponential growth over the next decade, VA must act now to prepare to meet the specialized needs of the women who served. Overall, the culture of VA needs to be transformed to be more inclusive of women veterans and must adapt to the changing demographics of its women veteran users—taking into account their unique characteristics as young working women with child care and elder care responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care are equal for women and men. A separate section on women veterans, "Women Veterans Health and Health-Care Programs," is included in this *Independent Budget* for further discussion on this issue.

Summary

Emerging evidence suggests that the health-care burden for OEF/OIF veterans will be heavy and that the current wars are presenting new challenges to the DOD and VA health-care systems. Utilization rates for health-care and mental health services presage an increasing requirement for such services in the future. The devastating effects of polytrauma, PTSD, TBI, blindness, limb loss, burns, sexual assault, and other postdeployment mental health injuries can lead to serious health catastrophes, including occupational and social disruption, personal distress, and even suicide if not treated. A stable, robust VA health-care system dedicated to the unique needs of the nation's veterans—one that is there now for aging veterans of World War II, Korea, and Vietnam, and that will remain viable for the newest generation of veterans who will need specialized medical and mental health care for decades to come—must be ensured. Congress must remain vigilant to ensure that research and treatment programs are authorized and sufficiently funded.

The DOD and VA have taken the first steps toward improving mental health services for active duty members and veterans of OEF/OIF. The IBVSOs do commend the DOD and VA for attempting to deal with the issue of suicide, stigma, and the barriers that prevent service members and veterans from seeking mental health services. Although we recognize and acknowledge both agencies' efforts, the DOD and VA are still far from meeting the mental health needs of OEF/OIF veterans and achieving the universal goal of "seamless transition."

The unprecedented challenges of the protracted war on terror, including increasing, frequent deployments by an all-volunteer force; the heavily utilization of reserve components; and unprecedented proportions of women service members in harm's way, demand swift and comprehensive change in how we deliver health-care services to veterans. This change must be fully informed by the targeted recipients of care and their representatives. The changing needs of veterans and their families must drive VA's ongoing efforts to modernize its services for veterans. This can only occur if veterans, family members, and their representatives are an integral part of an active feedback loop: recommending changes in current services and new services; evaluating the development and de-

ployment of these changes; and providing feedback on how best to adjust these services over time.

To accomplish this goal, a formalized, empowered oversight system with consumer representation is needed. A Secretary of Veterans Affairs–level oversight committee that includes experts from both within and outside of VA, consumers, and consumer advocates, such as veterans service organizations, is needed. The committee should be adequately staffed and empowered to conduct ongoing reviews of efforts to improve mental health services in VA and required to report periodically to Congress on its evaluations and recommendations. Constructive oversight and feedback will ensure that the finite resources available have the greatest impact on the recovery of veterans experiencing psychological aftermaths of their service to the country.

Meeting the challenges of delivery of mental health-care to our nation's veterans will require an unprecedented level of interagency cooperation. Nevertheless, the IBVSOs believe with proper resources, clearly defined goals, and determination to overcome stigma and other institutional, cultural, and social barriers, our government can fulfill its commitment to providing the best available health-care and rehabilitation services to service members and veterans with combat-related physical and mental health injuries.

Recommendations:

The Departments of Defense and Veterans Affairs must invest in research for individuals who suffer from postdeployment mental health challenges and traumatic brain injury, to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of TBI and develop best practices in its screening, diagnosis, and treatment.

VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance-use disorders, in returning service members.

Congress should formally authorize, and VA should provide, a full range of psychological and social support services, including strong, effective case management, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.

The VA system must continue to improve access to specialized services for veterans with mental illness, posttraumatic stress disorder, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

VA should initiate surveys and other research to assess the variety of barriers to VA care for veterans of Operations Enduring and Iraqi Freedom, with special emphasis on reservists and guardsmen returning to veteran status after combat deployments, rural and remote veterans, and women veterans. These surveys should assess barriers among *all* OEF/OIF veterans—not only the subset who actually enroll or otherwise contact VA for health care or other services.

The DOD and VA must increase the number of providers who are trained and certified to deliver evidenced-based care for postcombat PTSD and major depression.

The DOD and VA should increase outreach efforts to include Internet options and amend current policies to encourage service members and veterans to seek the care they need without fear of stigma.

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on women who have served in OEF/OIF.

The DOD and VA should align policies and procedures to maximize information sharing while protecting the privacy and confidentiality of service members' and veterans' health records.

The DOD should declassify information on military occupational exposures, especially those experienced during combat deployments. The DOD should immediately release data on blast events and injuries that could result in TBI.

The President and Congress should sufficiently fund DOD and VA health-care systems to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans and continue to address the needs of previous generations of veterans with PTSD and other combat-related postdeployment mental health challenges.

[52]Goldberg, M.S., "Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan," Congressional Budget Office testimony before the House Committee on Veterans Affairs, October 17, 2007 (www.cbo.gov/ftpdocs/87xx/doc8710/10-17-VA-Admin_Testimony.pdf).

[53]T. Tanielian and L. Jaycox, eds., Executive Summary, in *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corp., Center for Military Health Policy Research, 2008), p. xx.
[54]Ibid., p. xxi.
[55]Ibid.
[56]Ibid.
[57]Ibid., p. xxii.
[58]Ibid.
[59]Ibid., p. xxiii.
[60]DVA OIG, *Follow-up Health Care Inspection: Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans After Traumatic Brain Injury Rehabilitation,* Report No. 08-01023-119, May 1, 2008, p. 8.
[61]Daniel Cooper, VA Under Secretary for Benefits, "DOD and VA Disability Rating Systems and the Transition of Service Members from DOD to VA," testimony before the U.S. Senate, Committees on Veterans' Affairs and Armed Services, April 11, 2007.
[62]C. C. Cannuscio, C. Jones, et al., "Reverberation of Family Illness: A Longitudinal Assessment of Informal Caregiver and Mental Health Status in the Nurses' Health Study," *American Journal of Public Health* 92 (2002): 305–11.
[63]Department of Health and Human Services (DHHS), *Informal Caregiving: Compassion in Action* (Washington, DC: DHHS, 1998); (http://aspe.hhs.gov/daltcp/Reports/carebro2.pdf).
[64]Peter S. Arno, "Economic Value of Informal Caregiving" (paper presented at the DVA Care Coordination and Caregiving Forum, Bethesda, Maryland, January 25–27, 2006).
[65]Institute of Medicine, NIH,*Treatment of PTSD: An Assessment of the Evidence,* October 2007.
[66]Office of the Surgeon, Multi-National Force-Iraq; Office of the Command Surgeon; and Office of the Surgeon General; United States Army Medical Command; Mental Health Advisory Team IV Final Report; Operation Iraqi Freedom 05-07: Iraq; Operation Enduring Freedom 05-07: Afghanistan, November 17, 2006.
[67]Ibid.
[68]Rod Lamkey Jr., "Military Marches Toward Mental Health," *Washington Times,* December 2, 2008.
[69]Office of the Surgeon, Multi-National Force-Iraq; Office of the Command Surgeon; and Office of the Surgeon General; United States Army Medical Command, Mental Health Advisory Team V Final Report; Operation Iraqi Freedom 06-08: Iraq; Operation Enduring Freedom 8: Afghanistan, February 14, 2008.

ACCESS ISSUES

Timely Access to VA Health Care:

The Veterans Health Administration (VHA) needs to improve data systems that record and manage waiting lists for VA primary care and improve availability of some clinical programs to minimize unnecessary delay in scheduling specialty VA health care.

In 1996, Congress passed the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104-262, which changed eligibility requirements and the way health care was provided to veterans. As a result of this landmark legislation and a number of other factors, greater numbers of veterans chose to access the VA health-care system. The shift allowed VA to close thousands of unnecessary hospital beds while establishing new facilities called community-based outpatient clinics to provide greater numbers of veterans with more convenient access to care. VA outreach, through its Veterans Integrated Service Networks, encouraged veterans to enroll in a reformed VA health-care system. As a result, millions of veterans enrolled in VA health care for the first time in their lives. A decade later, VA health care has become a remarkable success story.

In 2002, VA placed a moratorium on its facilities' marketing and outreach activities to veterans and determined there was a need to give the most severely service-connected disabled veterans a special priority for care. This was necessitated by VA's realization that demand was seriously outpacing available funding and other resources and that service-connected veterans were being pushed aside rather than being VA's highest priority. At its zenith, in the summer of 2002, VA reported that 310,000 veterans were waiting at least six months for their first appointment for primary care. On January 17, 2003, the VA Secretary announced a "temporary" exclusion from enrollment of veterans whose income exceeded geographically determined thresholds and who were not enrolled before that date. This decision denied health-care access to 164,000 so-called "priority group 8" veterans in the first year alone. Since 2003, VA notes that more than 400,000 priority group 8 veterans had sought access to VA health care but were denied.

According to the Agency for Healthcare Research and Quality, access is a measure of patients' ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Access to medical care depends greatly on whether the VA health-care system has the capacity to meet the demand. The time to "third next available" appointment is the preferred measure of capacity and is used to determine how long patients have to wait for an appointment. The third appointment is featured be-

cause the first and second appointments may reflect openings created by patients canceling appointments, working patients into the schedule, or other events, and this does not accurately measure true accessibility.[70]

Several years ago, in an attempt to better manage patient access to care, VA began a process of reengineering its clinic patient flow through the "Advanced Clinic Access Initiative" developed by the Institute for Healthcare Improvement (IHI). The strategy emphasizes managing demand in order to improve patient flow and thus access to services. The core principle of Advanced Clinic Access is that patients calling to schedule a physician visit are offered an appointment the same day. Notably, Advanced Clinic Access is not sustainable if patient demand for appointments is permanently greater than physician capacity to offer appointments. Three key concepts supported by10 elements of advanced access are important in its application: shape the demand (work down the backlog, increasing system ability to reduce demand); match supply and demand (understand supply and demand, reduce appointment types, plan for contingencies); and redesign the system to increase supply (manage the constraint; optimize the care team; synchronize patient, provider, and information; predict and anticipate patient needs at time of appointment; and optimize rooms and equipment).

More specifically, the IHI principles identify "bottlenecks," such as limited clinical staff, care space, clerical staff, and equipment) in order to ensure that the process was optimally efficient. One important element of the IHI strategy is to allow patients to always see the same care provider. This allows a personal relationship to develop between the patient and provider, thus dispensing with the need to repeat medical background at each visit. The strategy apparently yielded good results in reducing waiting times; however, questions remain about the accuracy of data collected to confirm these reductions. Moreover, although these principles are powerful, they are counter to deeply held beliefs and established practices in health-care organizations. Accordingly, adopting these principles requires strong leadership investment and support.

To assess its success in reducing waiting times, the VHA used scheduling software developed in the 1970s, supplemented by electronic waiting lists. Initially, the VHA produced data for six monitored clinic stops nationwide (primary care, urology, cardiology, audiology, orthopedics, and ophthalmology) that demonstrated steady declines in waiting times. Today the Veterans Health Information Systems and Technology Architecture (VistA) collects waiting time data from 50 high-volume clinic stops throughout the system. Since FY 2002, the VHA has measured waiting times for primary and specialty care separately.

Over time, new functionality and enhancements were made to scheduling software.[71] The VHA maintains a number of reports to track and manage outpatient waiting times under three major categories: Missed Opportunities Report, which includes cancellations and no-shows; Completed Appointments Report; and the Electronic Waiting List Report. VA's FY 2007 Performance and Accountability Report[72] contains key performance measures to track its progress in accomplishing its overall mission. Under VA's third strategic goal, VA measures the percentage of primary and specialty care appointments scheduled within 30 days of a patient's desired date with a target of 96 and 95 percent, respectively.

However, the IHI recommends utilizing four outcomes measured in concert with Advanced Access: (1) third next available appointment; (2) future capacity (used for primary care only), the percentage of appointment slots that are open and available for booking patients over the next four weeks; (3) office visit cycle time, the amount of time in minutes that a patient spends at an office visit where the cycle begins at the time of arrival and ends when the patient leaves the office; and (4) percentage of no-show appointments. Of these four measures the VHA is measuring and reporting systemwide the percentage of no-show appointments through its "Missed Opportunities Report." Also, the VHA is tracking the third next available appointment but not publicly reporting it, which would foster consistency and allow performance comparison using external benchmarks.

There is a lot of truth to the old adage, "You can't improve what you can't measure." Furthermore, the quality of resulting data can influence the ability to improve. Unfortunately, the data the VHA utilizes to report to the public remain suspect as the Department has repeatedly failed to ensure that established protocols for scheduling appointments are followed. VA Office of Inspector General (OIG) reports in 2005, 2007, and 2008 found reported outpatient waiting times to be unreliable because of data integrity concerns associated with VHA's scheduling system. The September 2007 report "Audit of the Veterans Health Adminis-

tration's Outpatient Waiting Times" challenges VA's assertion that in FY 2006, 96 percent of all veterans seeking primary care and 95 percent of all veterans seeking specialty care were seen within 30 days of their desired appointment time. The VHA claimed even better results for FY 2007 and 2008: 97.2 and 98.7 percent of primary care, and 95 and 97.5 percent of specialty care patients, respectively, fall within the 30-day time frame.

The OIG is particularly concerned that the VHA has repeatedly failed to accurately document the "desired date"—the baseline of calculating a "waiting time"—for an appointment. The discrepancies found by the OIG between requested appointment times documented in medical records and in the databases, and incomplete waiting lists are attributed to patient preference or the scheduler's use of inappropriate scheduling procedures. This occurs despite the explicit policy prescribed by VHA Directive 2006-055 for schedulers to maintain documentation for every patient who requests a specific appointment date that is different than the date specified by the provider in the medical records. Specifically, the scheduler should annotate why the date was used in the "Other Info" section in the VistA scheduling package. This discrepancy of unsupported documentation to validate the "desired date" led the OIG to report that the VHA waiting times are significantly understated.

The VHA non-concurred with the 2007 findings due to disagreements with the OIG's methodology and consequently contracted with Booz Allen Hamilton in December 2007 to perform a thorough analysis and assessment of its scheduling and wait times reporting system. Its analysis revealed what was peripherally discussed during the December 12, 2007, joint hearing before the House Committee on Veterans' Affairs Subcommittee on Health and Oversight and Investigation on Outpatient Waiting Times. Specifically, due to VHA's archaic scheduling software and its cumbersome administration, Booz Allen Hamilton found VHA's measurement of outpatient care waiting times, "not sufficiently accurate for public reporting on system-wide performance."[73]

Since the first *Independent Budget* issue article in 2002, *The Independent Budget* veterans service organizations (IBVSOS) have consistently recommended that the VHA "identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide." Starting at its zenith in 2002 when more than 310,000 veterans were waiting six months or more for care,[74] to a high in January 2008 of 109,970 veterans waiting more than 30 days to be seen, the VHA's measurement system for outpatient waiting times has always lacked credibility.

The IBVSOs believe the VHA has made tremendous effort to significantly reduce waiting times over the last several years and is in the forefront by even attempting to measure clinical waiting times for such a vast healthcare enterprise, whereas most providers only use proxies, such as patient satisfaction or clinicians' estimates, to determine patient dissatisfaction and adverse clinical outcomes affecting quality of care. However, the VHA both developed its own measures and compared itself to no one else but itself, which weakens external perceptions regarding quality of care. Further, the IBVSOs and VA's OIG have raised questions about the validity of the VHA's reportable data, one of which concerns the metrics used that have been redefined over the years.

The IBVSOs believe VHA made a progressive step forward having contracted Booz Allen Hamilton to conduct an independent review of its scheduling process and metrics. The report made 52 strategic recommendations (including 9 regarding measurement) to improve the timeliness of care, supported by 78 action items that describe intermediate steps to achieve the goals articulated by the major recommendations. We disagree with some but agree with many of these recommendations. For example, we disagree with the report's recommendation for VA to discontinue the measurement of follow-up wait times for established patients citing the "desired date" of an appointment to be the main culprit (as indicated by VA's OIG reports) and aggravated by lack of compliance despite training efforts. Another reason for the recommendation is that "patient panels effectively match supply to demand, making delays less likely."

First and foremost, the OIG report highlighting weaknesses in VA data due to the ambiguity of the "desired date" included recommendations[75] that the VHA has yet to complete, which address, among other things, training, compliance, monitoring, and oversight of use of correct procedures. Regarding the basis for the recommendation about patient panel size meeting the demand, the IBVSOs believe if capacity indeed matches the demand, making delays less likely, the monthly average number of patients waiting longer than 30 days would not exceed 76,000. Moreover, as indicated

above, access is a measure of the patients' ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit, such as a routine follow-up.

The VHA has indicated it will eventually address all the recommendations of the Booz Allen Hamilton report. In the short-term, only 7 of the 52 strategic recommendations and 3 of the 72 action items will be implemented.[76] Notably, despite numerous questions raised regarding the validity of VHA's data, the report only makes nine major recommendations for modifying and improving the measurement and reporting of care timeliness. Further, of the seven strategic recommendations to be implemented by the VHA, only one will address the future measurement of the timeliness of care.

Equally disturbing is that despite the OIG's assertion that VA's data for calculating the percentage are suspect,[77,78] VA continues to report that there are no data limitations.[79] Compounding the issue further, two more key measures were added in FY 2008 that also use the same questionable data. Moreover, one of the new measures by design would depress actual waiting times by calculating only the longest wait time even if the patient has multiple appointments.[80]

The concern of the veteran community remains unmet, having identified such barriers as inadequate funding, unaddressed infrastructure capacity, limited human capital, poor communication with stakeholders and veteran patients, archaic technology, and unmanageable business processes. The IBVSOs believe timely access is the VHA health-care system's capacity to provide health care quickly after a need is recognized and is crucial to the quality of care delivered. Prevalent delays for appointments result in patient dissatisfaction, higher costs, and possible adverse clinical consequences.[81] As the Institute of Medicine identified "timeliness" as one of the six key "aims for improvement" in its major report on quality of health care,[82] we believe the VHA must take a more aggressive stance than currently to ensure veterans are receiving timely access to care. The VHA must make external comparisons to measuring its success because the perception of VHA's quality is important to its very existence.

Recommendations:

The Veterans Health Administration should make external comparisons to measuring its performance in providing timely access to care.

The VHA should fully implement complementary aspects of the Institute for Healthcare Improvement's Advanced Clinic Access principles and measures for primary and specialty care to maximize productivity of clinical care resources by identifying additional high-volume clinics that could benefit.

VA should consider implementing complementary recommendations contained in the Booz Allen Hamilton "Patient Scheduling and Waiting Times Measurement Improvement Study."

The VHA should certify the validity and quality of waiting time data from its 50 high-volume clinics to measure performance of networks and facilities.

The VHA should complete implementation of the eight recommendations for corrective action in the July 8, 2005, report by VA's Office of Inspector General.

VA must ensure that schedulers receive adequate annual training on scheduling policies and practices in accordance with the Inspector General's recommendations.

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[70]Thomas Bodenheimer and Kevin Grumbach, *Improving Primary Care: Strategies and Tools for a Better Practice,* (New York: Lange Medical Books/McGraw Hill, 2006), p. 104.
[71]VHA Directive 2002-068, November 13, 2002; *Primary Care Management Module Unassign Inactive Patient Primary Care Providers, Release Notes,* December 2006; *Electronic Wait List for Scheduling and Primary Care Management Module User Manual,* November 2002 (revised October 2008).
[72]P.L. 103-62, *Government Performance and Results Act of 1993; P.L. 106-531, Reports Consolidation Act of 2000.*
[73]Executive Summary, *Final Report on the Patient Scheduling and Waiting Times Measurement Improvement Study* (Washington, DC: Booz Allen Hamilton, July 22, 2008).
[74]VHA survey conducted in July 2002. Senate Report 107-222, 107th Cong., 2nd Sess. (2002).
[75]DVA OIG Report No. 04-02887, July 8, 2005; DVA OIG Report No. 07-00616-199, September 10, 2007; and DVA OIG Report No. 07-03505-129, May 19, 2008.
[76]Strategic Recommendations A1, B1, C1, C2, C3, L1, M2; Action Items L1a, E1b, E1c.
[77]DVA OIG Report No. 07-00616-199, September 10, 2007.
[78]DVA OIG Report No. 07-03505-129, May 19, 2008.
[79]*FY 2007 Performance and Accountability Report,* p. 209; *FY 2008 Performance and Accountability Report,* Department of Veterans Affairs, p. 231.
[80]*FY 2008 Performance and Accountability Report,* Department of Veterans Affairs, pp. 230, 445.
[81]M. Murray and C. Tantau, "Must Patients Wait?" *Journal on Quality Service Improvement* 24(8) (1998): 423–25.
[82]Institute of Medicine, NIH, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press, 2001).

Community-Based Outpatient Clinics:

While* The Independent Budget *veterans service organizations (IBVSOs) support VA-operated community-based outpatient clinics (CBOCs), if the Department of Veterans Affairs finds it necessary to contract for CBOC operations, these contracts should be consolidated at either the medical center or network level.

Veterans Health Administration (VHA) community-based outpatient clinics provide a VHA presence in the communities where veterans live. These free-standing clinics are an integral part of the host VA medical center (VAMC) of which they are a part, whether staffed by VA employees or those of a contractor. Since first authorized, CBOCs have expanded in number and in services offered. As of the third quarter of FY 2008, VA was operating 745 CBOCs with plans to establish 44 new ones in 21 states. Of that number, 353 CBOCs are doing real-time video conferencing (predominantly telemental health), while 130 CBOCs are performing teleretinal imaging, which greatly enhances patient care and drastically cuts down on patient travel. The IBVSOs applaud the VHA for improving veterans' access to quality care.

Although the IBVSOs applaud the VHA's intention to spread primary and limited specialty care access for veterans to more areas, enabling additional veterans access to a convenient VA primary care resource, we urge that the business plan guiding these decisions generally first emphasize the option of VA-operated and staffed facilities. When geographic or financial conditions warrant (e.g., rural, scarceness, remoteness, etc.), we do not oppose the award of contracts for CBOC operations or leased facilities, but we do not support the general notion that VA should rely heavily or primarily on contract CBOC providers to provide providing care to veterans.

While all CBOCs provide similar capabilities and services to veterans, each serves as an extension of a particular VA medical center. Therefore, each VAMC establishes its own clinical requirements for its CBOCs, based on the VAMC's capabilities and community-based needs.

Regarding the contracted CBOCs, this growth has been achieved primarily through separate solicitations and multiple contracts, often with different performance measures and pricing models within an individual catchment area. The result is a more complex, less efficient contract administration structure, creating extra work for already overburdened contracting officials and delivering an uneven benefit to those veterans who access those CBOCs for their primary care.

As the need for veterans' health-care access continues to grow, the ability to address those needs in an efficient, effective, and consistent manner also will grow. As many organizations, including VA, have already realized, consolidation of contracts at the medical center or network levels is one strategy that can create efficiencies and improve performance. Consolidating VA CBOC contracts would offer many benefits to both VA and the veterans its serves, offering VA a way to standardize the health-care benefits to veterans served by individual VAMCs and providing greater efficiencies and cost savings to help meet the ever-increasing health-care needs of veterans in both rural or underserved areas and areas not directly served by a VA medical facility.

Specific benefits of consolidated CBOC contracting include the following:

- *Greater continuity of care and uniformity of benefit.* Because a single contractor would operate these consolidated CBOCs, similar practices and procedures would be utilized at each CBOC and, in some cases, even the same providers. This consistent treatment would help to provide veterans with greater continuity of care and ensure all veterans served by a specific VAMC would receive the same health benefit options in all contracted CBOCs serving their VAMC.
- *Simplified contract administration and oversight.* Contracting officers spend much of their time dealing with multiple contracts and different points of contact for each contracted CBOC. Under a consolidated approach, VA would have a single contract and a single point of contact to handle all issues related to multiple (two to four) CBOCs in a defined area.
- *More efficient contracts.* A consolidated approach to CBOC contracting would minimize duplication of resources and services, driving contract efficiencies. Consolidation would enable the contractor to share appropriate resources across multiple CBOCs. For example, the contractor could use a regional registered nurse (RN) supervisor to provide oversight of each CBOC instead of having an

individual RN manager at each separate location, or the contractor could hire floating providers or staff to address surge or backfill requirements.
- *Easier access*. In times of heavy volume, the CBOC could move staff from one location to another to address the need most efficiently.
- *Consistent, uniform services*. Having a single contractor operate multiple CBOCs would result in consistent policies and procedures at each location, which can conform to the policies and procedures of VA-run CBOCs within the same VAMC.
- *Procurement efficiencies*. Many Veterans Integrated Service Networks have well more than 20 CBOCs, which translates to several under each VAMC. In most cases, there is a separate procurement and contract for each CBOC. This process limits the opportunity to benefit from efficiencies from both an operations and a contracting perspective. Depending on the number of CBOCs associated with a VAMC, significant efficiencies would be realized by combining these procurements into a single request for proposals.
- *Consolidated training on VA programs and procedures, including use of Veterans Health Information Systems and Technology Architecture (VistA)*. Under a consolidated model, post-award training and such tasks as VistA training could be completed for all sites in one catchment area on a single day, rather than VA having to conduct separate training sessions for each new CBOC.
- *Standardized CBOC reporting*. Reporting requests, both from VA and the contractor, could be standardized for the region, making it easier for VA to review the reports and to track performance at each CBOC.
- *Mental health providers*. By using a consolidated model, each CBOC could have a licensed clinical social worker, with a regional psychiatrist who travels from CBOC to CBOC for oversight and pharmaceutical prescribing. Using one psychiatrist would offer consistency to the mental health model for each VA medical center.

Additionally, VA still needs to increase access to care in underserved geographic areas. With ever-growing demand for health-care services in rural areas, particularly as the result of the redeployment of so many National Guard and Reserve service members, CBOCs will have to be a critical component to VA's meeting this demand. VA can also further explore sharing initiatives with Department of Defense health-care facilities and coordinating services with other health-care providers.

The IBVSOs also remain concerned that many CBOCs do not comply with Section 504 of the Rehabilitation Act, regarding physical accessibility to medical clinics. This is a common complaint among veterans who receive their care in VA CBOCs. In some cases, severely disabled veterans are completely unable to access basic services in the CBOCs because of this problem. VA needs to take more active steps to overcome this barrier to access, both in its own CBOCs and in those for which VA contracts.

Recommendations:

The Veterans Health Administration should consider consolidating contracted community-based outpatient clinics at the VA medical center or network levels. This would ensure consistent requirements, pricing, and performance measurements, along with simplified contract administration. Aggregating CBOC contracting would allow VAMCs and the VHA to derive increased efficiencies within the CBOC program while simultaneously furthering VHA efforts to ensure clinical excellence in contracted CBOCs. Moreover, this approach would deliver a number of benefits to veterans including enhanced access, greater continuity of care, and a more standardized primary care benefit.

The VHA must ensure that CBOCs are staffed by clinically appropriate providers capable of meeting the needs of veterans.

The VHA must develop and use clinically specific referral protocols to guide patient management in cases in which a patient's condition calls for expertise or equipment not available at the facility at which the need is recognized.

The VHA must ensure that all CBOCs fully meet the accessibility standards set forth in Section 504 of the Rehabilitation Act.

Veterans' Rural Health Care:

The Department of Veterans Affairs should continue to improve access to VA health-care services for veterans living in rural areas, without diminishing existing internal VA health-care capacities to provide specialized services.

The Independent Budget veteran service organizations (IBVSOs) believe that after serving their country veterans should not experience neglect of their health-care needs by VA because they live in rural and remote areas far from major VA health-care facilities. In the previous year's *Independent Budget,* we detailed pertinent findings dealing with rural health care, disparities in health, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). Those conditions remain relatively unchanged:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and concerns for stress, depression, suicide, and anxiety disorders as major rural health concerns.[83]
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.[84] The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services.[85]
- Nearly 22 percent of our elderly live in rural areas; rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term-care systems. In rural areas some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care.[86]

Given these general conditions of scarcity of resources it is not surprising or unusual, with respect to those serving in the U.S. military and to veterans, that—

- There are disparities and differences in health status between rural and urban veterans. According to the VA's Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have worse physical and mental health related to quality of life scores. Rural/Urban differences within some VISNs [Veterans Integrated Service Networks] and U.S. Census regions are substantial."
- More than 44 percent of military recruits, and those serving in Iraq and Afghanistan, come from rural areas.
- More than 44,000 service members have been evacuated from Iraq and Afghanistan as a result of wounds, injuries, or illness, and tens of thousands have reported readjustment or mental health challenges following deployment.
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health-care users, 40.1 percent (nearly 2 million) reside in rural areas, including 79,500 from "highly rural" areas as defined by VA.

Currently VA operates 153 hospitals and more than 750 community-based outpatient clinics (CBOCs). In June 2008, VA announced plans to activate 44 additional CBOCs during FY 2009. VA staffs 540 clinics, and the remainder of these CBOCs are managed by contractors. At least 333 of VA's CBOCs are located in rural or highly rural areas as defined by VA. In addition, VA is expanding its capability to serve rural veterans by establishing rural outreach clinics. Currently 12 VA outreach clinics are operational, and more are planned.

In August 2008, VA announced the establishment of three "Rural Health Resource Centers" for the purpose of improving understanding of rural veterans' health issues; identifying their disparities in health care; formulating practices or programs to enhance the delivery of care; and developing special practices and products for implementation VA systemwide. According to VA these centers will serve as satellite offices for VA's Office of Rural Health. They are sited in VA medical centers in White River Junction, Vermont; Iowa City, Iowa; and Salt Lake City.

In the FY 2009 appropriations act, Congress provided VA additional funding to increase the beneficiary travel mileage reimbursement allowance authorized under section 111 of title 38, United States Code, and intended to benefit certain service-connected and poor veterans as an access aid to VA health care. VA recently announced it has issued this higher rate, at 41.5 cents per mile. While we

appreciate this development and applaud both Congress and the VA for raising the rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by private conveyance, and provides only limited relief to those who have no choice but to travel long distances by automobile for VA health care.

The IBVSOs understand that VA's intended strategic direction in rural care is of necessity to enhance noninstitutional care solutions. VA provides home-based primary care as well as other home-based programs and is using telemedicine and telemental health—but on a limited basis in our judgment—to reach into veterans' homes and community clinics, including Native American tribal clinics. Expansion of telehealth would allow VA to directly evaluate and follow veterans without their needing to personally travel great distances to VA medical centers. VA has reported it has also begun to use a special Internet site providing information to veterans in their own homes, including up-to-date research information, access to their health records, and online ability to refill prescription medication. The IBVSOs believe that the use of technology, including the World Wide Web, telecommunications, and telemetry, offer VA a great but still unfulfilled opportunity to improve rural veterans' access to VA care and services. We urge VA management, through the VISNs, the Office of Patient Care Services, the Office of Rural Health (ORH), and other appropriate entities, to pursue additional ways of using technology to reach and care for rural veterans.

As described by VA, the mission of the ORH is to develop policies and identify and disseminate best practices and innovations to improve health-care services to veterans who reside in rural areas. VA maintains that the office is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VA also attests that the ORH will conduct, coordinate, promote, and disseminate research on issues important to improving health care for rural veterans. With confirmation of these stated commitments and goals the IBVSOs believe the Veterans Health Administration (VHA) would be beginning to incorporate the unique needs of rural veterans as new VA health-care programs are conceived and implemented; however, the ORH is a relatively new function within the VA Central Office (VACO), and it is only at the threshold of tangible effectiveness, with many challenges remaining. Given the lofty goals, we are concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning rather than closer to the operational arm of the VA system. Having to traverse the multiple layers of the VHA's bureaucratic structure could frustrate, delay, or even cancel initiatives established by this staff office. Rural veterans' interests would be better served if the ORH were elevated to a more appropriate management level in VACO, with staff augmentation commensurate with these stated goals and plans.

The VHA has established VA rural care designees in all its VISNs to serve as points of contact and liaisons with the ORH. While the IBVSOs appreciate that the VHA designated the liaison positions within the VISNs, we remain concerned that they serve these purposes only on a part-time basis, along with other duties as assigned. We believe rural veterans' needs, particularly those of the newest war veteran generation, are sufficiently crucial and challenging to deserve full-time attention and tailored programs. Therefore, in consideration of other recommendations dealing with rural veterans' needs put forward in this *Independent Budget,* we urge VA to establish at least one full-time rural liaison position in each VISN and more if appropriate, with the exception of VISN 3 (urban New York City).

Without question, section 213 of Public Law 109-461 could be a significant element in meeting the health-care needs of veterans living in rural areas, especially those who have served in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, VA is required to collaborate with employers, state agencies, community health centers, rural health clinics, Critical Access Hospitals (as designated by Medicare), and local units of the National Guard to ensure that returning veterans and Guard/Reserve members, after completing their deployments, can have ready access to the VA health benefits they have earned by that service. Given this mandate is more than two years old, the IBVSOs urge VA's Office of Intergovernmental Affairs to move forward aggressively on this outreach effort—and that any outreach under this authorization be closely coordinated with VA's ORH to avoid duplication and to maintain consonance with VA's overall policy on rural health care. To be fully responsive to this mandate, VA should report to Congress the degree of its success in conducting effective outreach and the result of its efforts in public-private and intergovernmental coordination to help rural veterans.

Stimulated by concerns about the health status of OEF/OIF veterans, several legislative proposals were introduced during the 110th Congress to provide rural veterans more access to VA-sponsored care, but exclusively through private providers. One such proposal, an

amended form of H.R. 1527, was enacted as a demonstration project in Public Law 110-387, the Veterans' Mental Health and Other Care Improvements Act of 2008. The act directs the Secretary of Veterans Affairs to conduct a three-year pilot program under which a highly rural veteran who is enrolled in the system of patient enrollment of the Department of Veterans Affairs and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health-care provider at VA expense. The act defines a "highly rural veteran" as one who (1) resides more than 60 miles from the nearest VA facility providing primary care services, more than 120 miles from a VA facility providing acute hospital care, or more than 240 miles from a VA facility providing tertiary care (depending on which services a veteran needs); or (2) otherwise experiences such hardships or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of the veteran. During the three-year demonstration period the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

While we applaud the sponsors' intentions, measures such as this one could result in unintended consequences for VA, unless carefully administered. Chief among these is the diminution of established quality, safety, and continuity of VA care for rural and highly rural veterans. It is important to note that VA's specialized health-care programs, authorized by Congress and designed expressly to meet the specialized needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably impacted by the loss of veterans from those programs. Also, the VA's medical and prosthetic research program, designed to study and, hopefully, cure the ills of injury and disease consequent to military service, could lose focus and purpose were service-connected and other enrolled veterans no longer physically present in VA health care. Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when Public Law 104-262 was enacted in 1996. Unfortunately some of that capacity has dwindled.

We believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with sophisticated health problems such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health-care programs may only exacerbate the problems currently encountered.

In light of the escalating costs of health care in the private sector, to its credit VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected veterans might seek care in the private sector as a matter of personal convenience as a result of enactment of vouchering and privatization bills, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic health record, and bar code medication administration. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, ones that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

As stated elsewhere in this *Independent Budget*, in general, current law places limits on VA's ability to contract for private health-care services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits, there is no general authority in the law (with the exception of the new demonstration project described above) to support broad-based contracting for the care of populations of veterans, whether rural or urban.

The IBVSOs urge Congress and the VA ORH to closely monitor and oversee the development of the new rural pilot demonstration project from Public Law 110-387, especially to protect against any erosion or diminution of VA's specialized medical programs and to ensure participating rural and highly rural veterans receive health-care quality that is comparable to that available within the VA health-care system. Especially we ask VA in implementing this demonstration project to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state or other federal

agencies) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health professions' academic affiliates. We recommend the principles of our recommendations from the "Contract Care Coordination" section of this *Independent Budget* be used to guide VA's approaches in this demonstration and that it be closely monitored by VA's Rural Veterans Advisory Committee. Further, we believe the ORH should be designated the overall coordinator of this demonstration project, in collaboration with other pertinent VHA offices and local rural liaison staff in VHA's rural VISNs selected for this demonstration.

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IBSVOs believe that these veterans, too, should have access to specialized services offered at VA's Vet Centers. Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives readjustment and psychological counseling related to their military experiences. Building on the strength of the Vet Centers program, VA should establish a pilot program for mobile Vet Centers that could help reach veterans in rural and highly rural areas where there is no other VA presence.

Health workforce shortages and recruitment and retention of health-care personnel are a key challenge to rural veterans' access to VA care and to the quality of that care. *The Future of Rural Health* report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health-care professionals working in rural areas. To this end, VA's deeper involvement in education in the health professions for future rural clinical providers seems appropriate in improving these situations in rural VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health sciences students from 1,000 schools, including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners, receive training in VA facilities. These relationships of VA facilities to health profession schools should be put to work in aiding rural VA facilities with their health personnel needs. The VHA Office of Academic Affiliations, in conjunction with ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

VA should examine and establish creative ways to collaborate with ongoing efforts by other agencies to address the needs of health care for rural veterans. VA has executed agreements with the Department of Health and Human Services (HHS), including the Indian Health Service and the HHS Office of Rural Health Policy, to collaborate in the delivery of health care in rural communities, but we believe there are numerous other opportunities for collaboration with Native American tribal organizations, state public health agencies and facilities, and some private practitioners as well, to enhance access to services for veterans. The ORH should pursue these collaborations and coordinate VA's role in participating in them.

The Independent Budget for FY 2009 expressed the concern that rural veterans, veterans service organizations, and other experts needed a seat at the table to help VA consider important program and policy decisions such as those described here, ones that would have positive effects on veterans who live in rural areas. The IBVSOs were disappointed that Public Law 109-461 failed to include authorization of a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans service organizations, and other rural health experts to recommend policies to meet the challenges of veterans' rural health care. Therefore, we applaud the Secretary of Veterans Affairs for having responded to the recommendation in the FY 2009 *Independent Budget* to use VA's existing authority to establish such a committee. That new federal advisory committee has been formed and has held its initial meeting. We hold high expectations that the new Rural Veterans Advisory Committee will be a strong voice of support for many of the ideas we have expressed here, in testimony before Congress, and in previous *Independent Budgets*.

The IBVSOs believe VA is working in good faith to address its shortcomings in rural areas but still faces major challenges. In the long term its methods and plans offer rural and highly rural veterans potentially the best opportunity to obtain quality care to meet their specialized

health-care needs. However, we vigorously disagree with proposals to privatize, voucher, and contract out VA health care for rural veterans on a broad scale because such a development would be destructive to the integrity of the VA system, a system of immense value to veterans and to the IBVSOs. Thus, we remain concerned about VA's new statutory mandate to privatize services in selected rural VISNs and will closely monitor those developments.

Recommendations:

VA must ensure that the distance veterans travel, as well as other hardships they face, be considered in VA' s policies in determining the appropriate location and setting for providing direct VA health-care services.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.

The Office of Rural Health should seek and coordinate the implementation of novel methods and means of communication, including use of the World Wide Web and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health-care facilities, providers, technologies, and therapies, including greater access to their personal health records, prescription medications, and primary and specialty appointments.

The ORH should be organizationally elevated in VA's Central Office and be provided staff augmentation commensurate with its responsibilities and goals.

The Veterans Health Administration should establish at least one full-time rural liaison position in each Veterans Integrated Service Network, and more if appropriate, with the exception of VISN 3 (urban New York City).

In cognizance of section 213 of Public Law 109-461, VA should be required to report to Congress the degree of its success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans.

VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with the ORH.

Additional mobile Vet Centers should be established to provide outreach and counseling for veterans in rural and highly rural areas.

Through its affiliations with schools of the health professions, VA should develop a policy to help supply health profession clinical personnel to rural VA facilities and practitioners to rural areas in general. The VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

Recognizing that in areas of particularly sparse veteran population and absence of VA facilities, the VA ORH should sponsor and establish demonstration projects with available providers of mental health and other health-care services for enrolled veterans, taking care to observe and protect VA's role as coordinator of care. The projects should be reviewed and guided by the Rural Veterans Advisory Committee. Funding should be made available to the ORH to conduct these demonstration and pilot projects outside of the Veterans Equitable Resource Allocation system, and VA should report the results of these projects to the Committees on Veterans' Affairs.

At highly rural VA community-based outpatient clinics, VA should establish a staff function of rural outreach worker to collaborate with rural and frontier non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available or VA-authorized care by other agencies.

Rural outreach workers in VA's rural CBOCs should receive funding and authority to enable them to purchase and provide transportation vouchers and other mechanisms to promote rural veterans' access to VA health-care facilities that are distant to their rural residences. This transportaion program should be inaugurated as a pilot program in a small number of facilities. If successful as an effective access tool for rural and highly rural veterans who need access to VA care and services, it should be expanded.

[83]L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010,* vol. 2 (College Station, Texas: Texas A&M University System health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003).
[84]President's New Freedom Commission on Mental Health, "Achieving the Promise: Transforming Mental Health Care in America," July 2003 (www.mentalhealthcommission.gov/reports/FinalReport/downloads/downloads.html).
[85]Institute of Medicine, NIH, Committee on the Future of Rural Health Care, *Quality Through Collaboration: The Future of Rural Health* (Washington, DC: the National Academies Press, 2005).
[86]L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010,* vol. 3. (College Station, Texas: Texas A&M University System, Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003).

VA's New Health-Care Facility Leasing Program:

The Independent Budget *veterans service organizations remain skeptical of the VA's intentions with regard to the proposed Health Care Center Facility Leasing Program because it could have significant long-term negative impacts on the provision of health care to veterans.*

In the spring of 2008, VA announced a new Health Care Center Facility (HCCF) leasing initiative to obviate the need for major construction of new and replacement facilities. The rationale for the HCCF initiative is that it reflects changes in medical care from an inpatient model to an outpatient model. Additionally, VA admitted to the existing and growing backlog of unmet construction requirements that are the result of past years' underfunding for improvements and replacements of VA health-care facilities. This initiative has caused deep concern within the veterans' community and is viewed as a major step in moving VA from being a health-care provider to a purchaser of medical care for veterans.

The initial project targeted by the HCCF initiative is the replacement hospital slated for construction in Veterans Integrated Service Network (VISN) 19 at Denver. This project, identified as a priority under the Capital Asset Realignment for Enhanced Services (CARES) plan, was in its design phase when abruptly halted in early 2008, and an entirely new plan was unveiled in April. The new plan called for the construction of a greatly expanded ambulatory care center and the leasing of inpatient beds from the University of Colorado Medical Hospital located on the former Fitzsimmons Army Medical Center campus. The proposal was put forth without adequate notification of either Congress or the local veterans' community and was met with strong opposition.

Subsequent inquiries as to the origins and reasons for the revised approach by both members of Congress and the veterans' community have resulted in unsatisfactory responses. Assurances that all stakeholders will be involved have yet to be fulfilled, leading to continued uncertainty and deep concern for the future direction of the VA health-care system. VA has revealed that an additional 22 locations were considered for the application of leasing rather than construction to maintain needed infrastructure.

Specific issues continue to remain unresolved to the satisfaction of veterans, among them: What priority will veterans have in access to care in leased facilties? How will lines of authority be maintained from the Under Secretary of Health through non-VA health-care providers and management? What procedures are in place for the maintenance of privacy and confidentiality of electronic medical records? How will VA guidance specified in directives and handbooks be implemented, ensuring continuity throughout the health-care system? The status of current VA employees in locations that may be shifted to leased facilities also remains unresolved.

The announced HCCF initiative is viewed with skepticism and concern because it appears to replace the established CARES program that was the result of years of consideration and study in addressing the future facility needs of the VA health-care system. The failure of VA to be transparent in developing this future direction for the health-care system can only lead to additional delays in needed infrastructure replacement and modernization.

Recommendations:

Congress must exercise its oversight authority in determining the rationale for the departure from the Capital Asset Realignment for Enhanced Services and the implementation of the Health Care Center Facility initiative.

Congress must continue to adequately fund needed VA construction projects and work to eliminate the existing backlog of projects that are the result of previous years' underfunding.

VA must establish a more transparent and open system that involves all stakeholders in addressing future construction initiatives.

Waiver of Health-Care Copayments and Fees for Catastrophically Disabled Veterans:

Veterans in priority group 4 should not be subject to copayments.

In the current VA health-care system, priority group 4 includes veterans who have been catastrophically disabled from nonservice-connected causes and who have incomes above means-tested levels. Catastrophically disabled veterans were granted this heightened priority for VA health-care eligibility in recognition of the unique nature of their circumstances and need for complex, specialized health care. The higher priority 4 enrollment category also protects these veterans from being denied access to the system should VA health-care resources be curtailed and they, under usual circumstances, be considered to be in the lower priority group 8 or priority group 7.

The addition of nonservice-connected catastrophically disabled veterans to priority group 4 was in recognition of the distinct needs of these veterans and the VA's vital role in providing their care. However, access to VA services is only part of the answer to providing quality health care to catastrophically disabled veterans. Exempting these veterans from all health-care copayments and fees completes this quality health-care equation. Current VA regulation stipulates that catastrophically disabled veterans are to be considered priority 4, for the purpose of enrollment, because of their specialized needs; however, they still have to pay all health-care fees and copayments as though they were still in the lower eligibility category.

Catastrophically disabled veterans are not casual users of VA health-care services; they require a great deal of care and a lifetime of services because of the nature of their disabilities. Private insurers do not offer the kind of sustaining care for spinal cord injuries found in the VA system even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. In most instances, VA is the only, as well as the best, resource for a veteran with a catastrophic disability; yet these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they had no priority at all. This creates great financial hardship on the catastrophically disabled veterans who need to use far more VA health-care services to a far greater extent than the average VA health-care user. The catastrophically disabled most often fall within lower income brackets among veterans, while incurring the highest annual health-care costs. In many instances, fees for medical services equipment and supplies can climb to thousands of dollars per year.

The hardship endured by a catastrophic injury or disease is unique and devastating to the veteran and the family who may be responsible for his or her care. At a time when the veteran is in need of specialized assistance to regain some independence and quality of life, the financial burden of medical bills should be lifted. Any veteran determined by VA to be catastrophically disabled and therefore placed in priority group 4 should be afforded Aid and Attendance benefits to eliminate medical/prescription copayments and should be provided assistance with travel for his or her care.

Financial Income Thresholds for VA Health Care Financial Test Year 2008

Veteran with:	Free VA prescription and travel benefits	Free VA health care: 0% and nonservice-connected	Medical expense deductible: 5% of maximum allowed pension rate from previous year
0 dependents	$ 11,180	$ 28,429	$ 559
1 dependent	$ 14,642	$ 34,117	$ 732
2 dependents	$ 16,551	$ 36,026	$ 828
3 dependents	$ 18,460	$ 37,935	$ 923
4 dependents	$ 20,369	$ 39,844	$ 1,019
For each additional, add	$ 1,909	$ 1,909	5% max. allowable pension rate
Medicare deductible	$ 1,024	Income & Asset (I&A) net worth: $80,000	I&A net worth: $80,000

The need for this policy change was recognized in 2008 with the introduction of H.R. 6445, the Veterans' Health Care Policy Enhancement Act of 2008, a bill that would have prohibited the collection of copayments and other fees from catastrophically disabled veterans. This legislation even had the support of the Department of Veterans Affairs. However, while the House of Representatives overwhelmingly approved the measure, the Senate failed to act, leaving these veterans to continue to bear this financial burden.

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and other federal and state support systems. In so doing, they fall within the complete definition of priority group 4 health-care enrollment and are exempt from all fees and copayments. Yet, because of a veteran's ambition and employment, which brings annual income above means-test levels, he or she is unduly penalized by exorbitant fees (see table previous page). The current VA regulation that requires catastrophically disabled veterans to pay all health-care fees and copayments does little to reward or provide an incentive for these veterans to maintain employment and a productive life.

NOTE: VA health-care debates and arguments for health-care rationing decisions consistently refer to veterans above the means-test threshold levels as "high-income" veterans. *The Independent Budget* veterans service organizations believe it is important to recognize that even though some veterans have incomes above means-test levels many of these veterans should certainly not be considered as "high-income" individuals.

Recommendation:

Veterans designated by VA as being catastrophically disabled veterans for the purpose of enrollment in health-care eligibility priority group 4 should be exempt from all health-care copayments and fees.

Non-VA Emergency Services:

Enrolled veterans are being denied reimbursement for non-VA emergency medical services as a result of restrictive eligibility requirements.

Recently enacted legislation[87] amended sections 1725 and 1728 of title 38, United States Code, which now requires the Department of Veterans Affairs to reimburse for emergency treatment of VA patients outside VA facilities when these veterans believe a delay in seeking care will seriously jeopardize their lives or health. In addition, VA's definition of "emergency treatment" under both statutes now conforms to a term commonly known as the "prudent layperson" standard, which has been widely used in the health-care industry.

This long overdue change is intended to reverse VA's current practice of denying payment for emergency care to the veteran or emergency care provider based on the "prudence" in seeking emergency care. Oftentimes the diagnosis at discharge rather than the admitting diagnosis is used by VA to judge whether the emergency treatment provided to the veteran meets the "prudent layperson" standard.

Intended to complete a VA health-care benefits package comparable to that of many managed-care plans, Congress initially directed this benefit at "regular users" of VA facilities: Veterans who were enrolled, had used some kind of VA care within the past two years, and had no other claim to coverage for such care. Congress intended, after the veteran has been stabilized, VA to follow up with these veterans and transfer them to the nearest VA medical facility for any necessary care following episodes of emergency care.

Many veterans have filed claims for reimbursement of emergency treatment and for the post-stabilization care that is often necessary in the wake of medical emergencies. However, the strict conditions of eligibility for reimbursement have prohibited VA from paying many veterans who file claims. Moreover, *The Independent Budget* veterans service organizations (IBVSOs) understand that there have also been significant delays in VA's reimbursement of approved claims. Delayed reimbursements can damage veterans' credit—by definition of the eligibility criteria,[88] the veteran is liable for these costs—with no means of redress. The IBVSOs believe all enrolled veterans should qualify for reimbursement for non-VA emergency care when necessary without the caveat of having been seen at VA facilities within the past 24 months.

Recommendations:

Congress should eliminate the requirement for veterans to have used VA health-care services within the past 24 months to trigger reimbursement of emergency treatment claims of enrolled veterans who would otherwise be eligible.

Congress should provide oversight on the claims processing for non-VA emergency care reimbursement to determine if claims are generally paid timely and if rates of denials for such claims are adjudicated similar to the claims applicable to the policies of the Centers for Medicare and Medicaid Services and other payers who operate under "prudent layperson" standards.

[87]P.L. 110-387, *Veterans' Mental Health and Other Care Improvements Act of 2008*, § 402.
[88]38 U.S.C. § 1725(b).

SPECIALIZED SERVICES

Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

Continuation of centralized prosthetics funding is imperative to ensuring that the Department of Veterans Affairs meets the specialized needs of veterans with disabilities.

The protection of Prosthetics and Sensory Aids Service (PSAS) funding by a centralized budget for the PSAS continues to have a major positive impact on meeting the specialized needs of disabled veterans. *The Independent Budget* veterans service organizations (IBVSOs) applaud Veterans Health Administration (VHA) senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the PSAS budget, to meet the prosthetics needs of veterans with disabilities and is available for current and future expansion of services.

The IBVSOs fully support the decision to distribute FY 2009 prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures, utilization reporting, and expansion of programs, such as surgical implants funding. This decision continues to improve the budget reporting process.

The IBVSOs believe the requirement for increased managerial accountability through extensive oversight of the expenditures of centralized prosthetics funds through data entry and collection, validation, and assessment has had positive results and should be continued. This requirement is being monitored through the work of VHA's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetics budget expenditures at all levels, primarily utilizing data generated from the National Prosthetics Patients Database (NPPD). As a result, many VISN prosthetic representatives are now aware that proper accounting procedures will result in a better distribution of funds.

NPPD Expense Costs		
Prosthetic Item	**Total Cost Spent in FY 08**	**Projected Expenditure in FY 09**
Wheelchairs & Access	$ 163,217,275	$ 182,803,348
Artificial Legs	$ 89,393,059	$ 100,120,226
Artificial Arms	$ 6,491,050	$ 7,269,976
Orthosis/Orthotics	$ 43,633,076	$ 48,869,045
Shoes/Orthotics	$ 34,937,778	$ 39,130,311
Sensori-Neuro Aids	$ 218,940,274	$ 245,213,106*
Restorations	$ 4,329,151	$ 4,848,649
Oxygen & Respiratory	$ 206,505,755	$ 231,286,445
Medical Equip & Supplies	$ 203,207,497	$ 227,592,396
Medical Supplies	$ 19,588,142	$ 21,938,719
Home Dialysis	$ 1,282,400	$ 1,436,288
HISA	$ 6,013,390	$ 6,734,996
Surgical Implants	$ 387,045,033	$ 445,101,787**
Other Items	$ 19,358,422	$ 21,681,432
Total	**$ 1,403,942,302**	**$ 1,584,026,724**

*DALC data now added to NPPD, no longer a separate line item.
**15% increase since biological implants will be purchased by PSAS in FY 2009.

The IBVSOs support senior VHA officials implementing and following the proper accounting methods while holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate prediction of the prosthetics needs for the future.

FY 2008 expenditures exceeded the projected budget of $1.36 billion by $42.6 million. The 2009 proposed budget allocation for prosthetics is $1.6 billion. Funding allocations for FY 2009 were based primarily on FY 2008 NPPD expenditure data, coupled with Denver Acquisition and Logistics Center (DALC) billings, and other pertinent items, such as expansion of funding for the addition of biological implants to the existing program of surgical implants, the Amputation System of Care, and advancements in new technology.

Listed in the table above are NPPD costs in FY 2008 with projected new and repair equipment costs for FY 2009.

Recommendations:

The Veterans Health Administration must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including the latest advances in technology so that funding shortfalls do not compromise other programs. The Administration must allocate an adequate portion of its appropriations to prosthetics to ensure that the prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

The VHA should continue to utilize the Prosthetics Resources Utilization Workgroup to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the National Prosthetics Patient Database, as well as program expansion needs.

VHA senior leadership should continue to hold field managers accountable for ensuring that data are properly entered into the NPPD.

Assessment of "Best Practices" to Improve Quality and Accuracy of Prosthetic Prescriptions:

National contracts for single-source prosthetic devices may potentially lead to inappropriate standardization of prosthetic devices.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our concern with the PCMP is that this program could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

The IBVSOs are concerned with the procedures that are being used as part of the PCMP process to award single-source national contracts for specific prosthetic devices, primarily the high compliance rates contained in the national contracts. The typical compliance rate, or performance goal, in the national contracts awarded thus far as a result of the PCMP has been 95 percent. This means that for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased "off-contract" (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such high compliance rates is that inappropriate pressure may be placed on clinicians to meet these goals due to a counterproductive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe national contract awards should be multiple sourced. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from VHA standardization efforts because a "one-size-fits-all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. Yet despite this directive, the PCMP process is being used to standardize the majority of prosthetic items through the issuance of high compliance rate national contracts. This remains a matter of grave concern for the IBVSOs, and we remain opposed to the standardization of prosthetic devices and sensory aids.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that VA routinely purchases threatens future advances. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market.

A 2008 VA quality report card identified some disparities in services and treatment for women veterans. Based on these findings, the IBVSOs believe measures should be taken to address the special needs of female veterans within all VA programs, including the Prosthetics and Sensory Aids Service (PSAS). We are pleased to learn that VA has taken a proactive approach regarding this matter with the formulation of a Prosthetics Women's Workgroup to address the unique needs of our deserving female veterans.

Another problem with the issuance of prosthetic items relates to surgical implants. Although funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device, coronary stints, cochlear implants), the surgical costs associated with implanting the devices come from local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule the implant surgeries or are limiting the number of surgeries because of the costs involved. If true, the consequences to those veterans would be devastating and possibly life threatening.

Currently, the PSAS must compete with all other information technology (IT) requests within the VHA for funding. This has resulted in delaying numerous critcal IT projects and inadequate funding for the PSAS with IT applications and enhancements required to support the ever-changing requirements and needs to maintain

health information of this special emphasis group. This has not improved under the centralization of IT.

Recommendations:

The Veterans Health Administration should continue the Prosthetics Clinical Management Program provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

The VHA must continue to exempt certain prosthetic devices and sensory aids from standardization efforts. National contracts must be designed to meet individual patient needs, and single-item contracts should be awarded to multiple vendors/providers with reasonable compliance levels.

The VHA should ensure that clinicians are allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, not based on costs associated with equipment and services. VHA clinicians must be permitted to prescribe devices that are "off-contract" without arduous waiver procedures or fear of repercussions.

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent with standard practices of care and defined services including prescribing, ordering, and purchasing items based on patient's needs—not cost considerations.

The VHA must ensure that new prosthetic technologies and devices that are available on the market are appropriately and timely issued to veterans.

The VHA should continue ongoing evaluation of the purchasing and inventory guidelines necessary to provide timely and appropriate appliances for female veterans.

Congress should investigate any reports of VHA facilities withholding surgeries for needed surgical implants because of cost considerations.

VA should increase funding for Prosthetics and Sensory Aids Service IT systems projects. VA should consider dedicating full-time resources to PSAS IT systems to ensure these functions are enhanced in a timely manner.

Restructuring of Prosthetics Programs:

The Prosthetics program continues to lack consistent administration of prosthetics services throughout the Veterans Health Administration (VHA).

The VHA must require all Veterans Integrated Service Networks (VISNs) to adopt consistent operational standards in accordance with national prosthetics policies. The current organizational structure has resulted in the VHA national prosthetics staff trying to respond to various local interpretations of VA policy. This leads to inconsistent administration of prosthetics services throughout the VHA. VISN directors and VHA central office staff should be accountable for implementing a standardized prosthetics program throughout the health-care system.

To improve communication and consistency, VA must ensure that every VISN has a qualified VISN prosthetics representative (VPR) to be the technical expert responsible for ensuring implementation and compliance with national goals, objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetics policies, including administration and oversight of VHA's Prosthetics and Orthotics Laboratories. With the VPR serving as the main source of direction and guidance for implementation and interpretation of prosthetics policy and services, prosthetics staff can focus on delivering quality care and services.

Recommendations

VA must make certain that Veterans Integrated Service Network prosthetics representatives have a direct line of authority over all prosthetics' employees throughout the VISN, including all prosthetics and orthotics personnel.

The Veterans Health Administration should ensure that VISN prosthetics representatives do not have collateral duties as prosthetics representatives for local VA facilities within their VISNs.

The VHA must provide a single VISN budget for prosthetics and ensure that the VPR has control of and responsibility for that budget.

The VHA should set and enforce a five-day notification for a denial of prosthetics requests to the veteran.

Failure to Develop Future Prosthetics Staff:

The Veterans Health Administration (VHA) continues to experience a shortage in the number of qualified and trained prosthetics staff available to fill current or future vacant positions.

In 2004 the VHA developed and requested 12 training slots for the National Prosthetics Representative Training Program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program provides training for prosthetic representatives responsible for management of all prosthetics services within their assigned health-care system. With only 12 training slots in the national program, vacancies within the VHA continue to grow. As a result of this ongoing shortage, there are Veterans Integrated Service Networks (VISNs) that have developed their own prosthetics representative training programs. Although *The Independent Budget* veterans service organizations (IBVSOs) support local VISNs conducting prosthetics representative training to enhance the quality of health-care services within the VHA system and increase the number of qualified applicants, we believe that local VISNs must also support and strongly encourage participation in the annual National Prosthetics Representative Training Conference for a one-week intense prosthetics forum. The IBVSOs believe that local VISN prosthetics training should be a supplement to and consistent with the national training program.

Additionally, each prosthetics service within the Department of Veterans Affairs must have trained certified professionals that can advise other medical professionals on appropriate prescription, building/fabrication, maintenance, and repair of all devices. This is extremely important as new programs in polytrauma, traumatic brain injury, and amputation system of care are implemented in the VHA.

As the conflicts continue in Afghanistan and Iraq, service members are returning home with complex injuries and in need of highly technological prosthetic devices. The IBVSOs believe the future strength and viability of VA's prosthetics program depends on the selection of high caliber leaders in the Prosthetics and Sensory Aids Service. To do otherwise could lead to grave outcomes and the inability to understand the complexity of the prosthetics needs of veterans.

Recommendations:

VA must fully fund and support its National Prosthetics Representative Training Program, expanding the program to meet current shortages and future projections, with responsibility and accountability assigned to the chief consultant for Prosthetics and Sensory Aids.

VA must establish a full-time national training coordinator for the PSAS to ensure standardized training and development of personnel for all occupations within the Prosthetics service line. This will ensure successful career path development.

The Veterans Health Administration must work to increase the number of training slots in the National Prosthetics Training Program to keep pace with the number of

vacancies within the VHA for prosthetics representatives. The VHA and its Veterans Integrated Service Network directors must ensure that prosthetics departments are staffed by certified professional personnel or contracted staff who can maintain and repair the latest technological prosthetic devices.

The VHA must require VISN directors to reserve sufficient training funds to sponsor prosthetics training conferences, meetings, and online training for all service line personnel.

The VHA must ensure that the PSAS Program Office and VISN directors work collaboratively to select candidates for vacant VISN prosthetic representative positions who are competent to carry out the responsibilities of these positions.

The VHA must assess functional statements of all hybrid title 38 prosthetics employees to meet the complexities of programs throughout the VHA and must attract and retain qualified individuals.

PROSTHETICS SENSORY AIDS AND RESEARCH:

VA Research and Development (R&D) should maintain a comprehensive research agenda to address the deployment-related health issues of the newest generation of veterans while continuing research to help improve the lives of previous generations of veterans needing specialized prosthetics and sensory aids.

Many of the wounded soldiers returning from the conflicts in Afghanistan and Iraq have sustained polytraumatic injuries requiring extensive rehabilitation periods and the most sophisticated and advanced technologies, such as hearing and vision implants and computerized or robotic prosthetic items, to help them rebuild their lives and gain independence.

According to VA's R&D program, approximately 6 percent of wounded soldiers returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids has increased by more 70 percent since 2000.

Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. The Veterans Health Administration (VHA) is still competitive in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are made available to all veterans with a prescription and that funding is available for timely issuance of such items.

Recommendation:

The Department of Veterans Affairs must maintain its role as a world leader in prosthetics research and ensure that VA Research and Development and the Prosthetics and Sensory Aids Service work collaboratively to expeditiously apply new technology development and transfer to maximally restore a veteran's quality of life.

AMPUTATION SYSTEM OF CARE:

The Independent Budget ***veterans service organizations (IBVSOs) strongly support full implementation of VA's new amputation system of care and encourage Congress to provide adequate resources for staffing and training of this specialized program.***

In September 2006, the Department of Veterans Affairs formed an interdisciplinary amputation care working group with the primary objective to rebuild and improve its amputation care. The working group developed a proposed system of care made of four major components: regional amputation centers, polytrauma amputation network sites, amputation clinic teams, and amputation point of contacts. The goal was to create a system of care that would improve access to and the quality of amputation care.

The proposal was approved for funding in June 2008, and plans are under way to develop and implement the system of care proposed by the working group. Ultimately, the plan includes seven regional amputation centers (RACs) located in Bronx, New York; Denver; Minneapolis; Palo Alto, California; Richmond, Virginia; Seattle; and Tampa.

The RACs will provide expertise in clinical care and prosthetic concepts, and work closely with polytrauma rehabilitation centers and military treatment facilities. The amputation network sites will coordinate amputation care across Veterans Integrated Service Network sites, and provide surgical support, long-term-care needs, and case management. There will be 15 network sites located across the country, and the seven RACs will dually serve as polytrauma/amputation network sites. The proposal includes creation of a veteran amputation registry and utilization of new telehealth technology to monitor the amputation rehabilitation process. For example, the amputation clinic teams will use telehealth technology to coordinate veterans' amputation care with the RACs.
The amputation care plan also includes 100 amputation clinic teams that will provide rehabilitation and prosthetic care within network sites with implementation and management of the amputation system of care overseen by an amputation rehabilitation coordinator. When facilities do not have expertise or the capacity to provide amputation rehabilitation, amputation point of contacts will serve as resource guides to direct veterans to community facilities that can best provide the specific amputation care that is needed. The overall goal of this initiative is to provide consistent quality amputation care to veterans throughout the VA health-care system and ensure that all veterans in need of amputation care have access to the proper services.

Recommendations:

The Independent Budget veterans service organizations strongly support full implementation of VA's new amputation system of care and encourage Congress to provide adequate resources for staffing and training of this important program.

VA should expeditiously implement the proposed system of amputation care providing proper staffing levels and training to ensure VA provides superior health services for aging and newly injured veterans who need these unique services.

Hearing Loss and Tinnitus:

The Veterans Health Administration (VHA) needs to provide a full continuum of audiology services.

As our brave men and women in uniform return from the conflicts in Afghanistan and Iraq, they are facing adversity in returning to civilian life. Many have been wounded by roadside bombs leaving them with both visible and unseen injuries, such as loss of limbs, traumatic brain injury (TBI), and spinal cord injury. The federal government has recognized the need for improved healthcare services for these members of the military. Although the medical care component of the VA budget has increased by 83 percent since President Bush took office,[89] it still does not cover the urgent growing needs of our veterans—past, present, and future. Estimates for long-term health care for this new generation of veterans are in the trillions and increase by the week.

Acoustic trauma has been part of military life since muskets and cannons were part of the arsenal, and Operations Enduring and Iraqi Freedom (OEF/OIF) are some the noisiest battlegrounds yet. Roadside bombs—the signature weapon of the insurgency—regularly hit patrols, rupturing eardrums, which leads to hearing loss and tinnitus. In addition, TBI, one of the signature wounds of these conflicts, is producing a whole new generation of soldiers with both mild and severe head injuries that are often accompanied by tinnitus.

The VA Polytrauma Center in Tampa reports that even those soldiers with no measurable hearing loss have tinnitus in conjunction with milder forms of TBI. Head and neck trauma is the second most frequently reported cause of tinnitus. Additionally the VA's own statistics show that tinnitus is currently the *most prevalent* service-connected disability of OEF/OIF veterans.[90] One of the newest research findings from VA, conducted at the James H. Quillen Veterans Affairs Medical Center Tinnitus Clinic, in Mountain Home, Tennessee, noted the increasing association between those with tinnitus and post traumatic stress disorder (PTSD). Of the first 300 patients enrolled at the clinic, 34 percent also carried a diagnosis of PTSD.[91]

These indications of the direct connections between tinnitus and TBI, as well as tinnitus and PTSD, point to the urgent need to address any gaps in research and treatment modalities provided by both the Department of Defense (DOD) and VA, to military personnel and veterans sustaining blast injuries. It is also indicative of the increasing incidence and severity of these conditions caused by combat injuries. It is imperative that all polytraumatic injuries be researched and treated in tandem to provide state-of-the-art care for America's veterans sustaining auditory system and related injuries that can lead to a life of debilitation from combat.

Invisible Injury

Many service members returning from war are physically disabled. Those types of injuries are easily seen by a physician and are often easily diagnosed and treated. Soldiers exposed to blasts from roadside bombs often suffer internal injuries that are not as easy to detect and treat. One of the most prevalent disabilities from exposure to IEDs (improvised explosive devices) and the many other faces of combat is an injury that is one of the hardest to detect—and even harder to treat—"tinnitus."

Tinnitus is defined as the perception of sound in the ears where no external source is present. Some who have tinnitus describe it as "ringing in the ears," but people report hearing all kinds of sounds, such as crickets, whooshing, pulsing, ocean waves, or buzzing. For millions of Americans, tinnitus becomes more than an annoyance. Chronic tinnitus can leave an individual feeling isolated and impaired in their ability to communicate with others. This isolation can cause anxiety, depression, and feelings of despair. Tinnitus affects an estimated 50 million, or more, people in the United States to some degree. Ten million to 12 million are chronically affected and 1 to 2 million are incapacitated by their tinnitus.[92] It is estimated that 250 million people worldwide experience tinnitus.[93]

Adding to the Rolls Every Year

The number of veterans who are receiving disability compensation for tinnitus has risen steadily over the past 10 years and spiked sharply in the past 5. Since 2001, service-connected disability for tinnitus has increased alarmingly by 18 percent per year. Based on that five-year trend, the total cost of veterans receiving service-connected disability compensation for tinnitus will be near $1 billion by year 2011. Veterans with tinnitus may be awarded up to a 10 percent disability, which currently equals about $117 a month. Though it is considered a

"disease of the ear" according to title 38, United States Code, only one "ear" is considered in determining disability rating for tinnitus.

Noise Levels—Common Military Operations		
Type of Artillery	**Position**	**Decibel Level (dBA) (Impulse Noise)**
105mm Towed Howitzer	Gunner	183
Hand Grenade	At 50 Feet from Target	164
Rifle	Gunner	163
9 mm Pistol	N/A	157
F18C Handgun	N/A	150
Machine Gun	Gunner	145

Translated into economic terms, the government paid out nearly $600 million in disability compensation for tinnitus in 2007. If you couple that dollar amount with what was paid out for hearing loss disability compensation, the total is more than $1.6 billion for FY 2007. If tinnitus continues on the upward trend seen over the past five years, which as of 2006 was $539 million, the cost to taxpayers for tinnitus disability claims will reach $1.1 billion annually by 2011 and top $2 billion annually by 2020, if not sooner. This is one of the many reasons why the federal government needs to begin addressing this epidemic from an effective medical research and prevention standpoint. With an already existing patient pool of veterans there needs to be a collaborative and robust research effort on the part of VA, the DOD, and the National Institutes of Health.

Noise-Induced Hearing Loss and Tinnitus

Although tinnitus has a number of different causes, one of the primary causes among military personnel is noise exposure. Service members are exposed to extreme noise conditions on a daily basis during both war and peacetime. During present-day combat, a single exposure to the impulse noise of an IED can cause tinnitus and hearing damage immediately. An impulse noise is a short burst of acoustic energy, which can be either a single burst or multiple bursts of energy. Most impulse noises, such as the acoustic energy emitted from an IED, occur within one second. However, successive rounds of automatic weapon fire are also considered impulse noise.

According to the National Institute for Occupational Safety and Health prolonged exposure from sounds at 85+ decibel levels (dBA) can be damaging, depending on the length of exposure. For every 3-decibel increase, the time an individual needs to be exposed decreases by half, and the chance of noise-induced hearing loss and tinnitus increases exponentially. A single exposure at 140+ dBA may cause tinnitus and damage hearing immediately. The chart shows a few common military operations and associated noise levels, all exceeding the 140 dBA threshold.[94]

It's no surprise that service members using weaponry that emits such high decibel levels, in training or combat, are at greater risk of this type of disability than their civilian counterparts. So what's being done to help our military? Hearing conservation programs have been in place since the 1970s to protect and preserve the ears of our soldiers. However, a study released by the Institute of Medicine in 2005 reviewed these hearing conservation programs and concluded they were not adequately protecting the auditory systems of service members.

Additional studies conducted to assess the job performance of those exposed to extremely noisy environments in the military concluded that the noise not only caused disabilities, but put the overall safety of the service member and their team at risk. Reaction time can be reduced as a result of tinnitus, thus degrading combat performance and the ability to understand and execute commands quickly and properly.

Many soldiers develop tinnitus and other hearing impairments prior to active combat as a result of training. If a soldier is disabled prior to combat, his or her effectiveness already may be compromised at the beginning of active duty. A study in *Tank Gunner Performance and Hearing Impairment* concluded that hearing impairments may delay a soldier's ability to identify their target by as much as 50 seconds.[95]

The same study concluded that people with hearing impairments who were operating tank artillery were 36 percent more likely to hear the wrong command, and 30 percent less likely to correctly identify their target. Further, service members with hearing impairments only hit the enemy target 41 percent of the time, whereas those without hearing impairments hit the enemy target 94 percent of the time. Finally, the article stated that those with hearing impairments were 8 percent more likely to take the wrong target shot and 21 percent more likely to have their entire tank crew killed by the enemy. According to the study, hearing impairments, such as tinnitus, can very much be a life-or-death situation in the military.

The Role of Medical Research

Research has increased our knowledge on hearing loss and how it occurs, while less has been discovered about tinnitus. Tinnitus is a condition of the auditory system, originating in the brain. This points to the connection between TBI and tinnitus and may help explain why this population of veterans is experiencing tinnitus in record numbers. Of 692 TBI patients at Walter Reed Army Medical Center between January 2003 and March 2006, nearly 90 percent had nonpenetrating head injuries.[96] The extent and epidemiology of how tinnitus and TBI are affecting each other will remain unknown unless the federal government funds more medical research as encouraged by *The Independent Budget*.

Even though tinnitus research has come a long way, especially in recent years, much more needs to be learned. With so many veterans being added to the rolls every year for service-connected tinnitus, VA and the DOD need to continue working collaboratively to emerge as leaders in tinnitus research.

As of November 2007, nearly 70,000 OEF/OIF veterans had been awarded service-connected disability for tinnitus. Prior to that, there were nearly half a million veterans from previous conflicts already on the rolls for tinnitus. VA estimates show that it is likely that the actual number of veterans who have tinnitus sustained from combat and active duty injuries is more like 3–4 million,[97] showing the condition is more prevalent than records actually show.

Recommendations:

The Veterans Health Administration must rededicate itself to the excellence of program for hearing loss and tinnitus as well as other auditory processing disorders.

The VHA must continue its work with networks, to restore clinical staff resources in both inpatient and outpatient audiology programs, and develop tinnitus components to existing audiology facilities.

Congress must continue to work for increased funding for VA and the Department of Defense to prevent, treat, and cure tinnitus.

[89](www.gpoaccess.gov/usbudget/fy08/pdf/budget/veterans.pdf).
[90]VBA Office of Performance and Analysis, Audiology Care in the VA. Presented by Dr. Lucille Beck, chief consultant, Rehabilitation Services and Director, Audiology and Speech Pathology Service, November 2007, Washington, D.C.
[91]Marc A. Fagelson, "The Association between Tinnitus and Posttraumatic Stress Disorder," *American Journal of Audiology* 16 (2007): 107–17.
[92]Scott Campbell Brown, edited by Robert C. Johnson and Dorothy L. Smith *Older Americans and Tinnitus: A Demographic Study and Chartbook*, 1990.
[93]Munna Vio and Ralph H. Holme, "Hearing Loss and Tinnitus: 250 million people and a U.S. $10 Billion Potential Market." *Drug Discovery Today.* 10(19):1263–5, Oct 1, 2005.
[94]U.S. Army Center for Health and Preventative Medicine. (http://chppm-www.apgea.army.mil/)
[95]Georges Garinther and Leslie Peters, "Tank Gunner Performance and Hearing Impairment," *Army RD&A Bulletin* January-February (1990):1–5.
[96]Neil Shea, "Iraq War Medicine—The Heroes, The Healing: Military Medicine from the Front Lines to the Home Front," *National Geographic* [archives], December 2006 (nationalgeographic.com).
[97](ncrar.research.va.gov).

Special Needs Veterans

BLINDED VETERANS:

A full continuum of vision rehabilitation services is needed from the Veterans Health Adminstration.

The VA Blind Rehabilitation Service (BRS) is well known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. Currently VA operates 10 comprehensive residential blind rehabilitation centers (BRCs) with plans for three new BRCs in Biloxi, Mississippi; Long Beach, California; and Cleveland, but these are now pending construction projects with openings not expected until 2011. Approximately 46,877 blind veterans were enrolled in FY 2007 with the Visual Impairment Service Team (VIST) coordinators' offices, and projected demographic data estimate that by 2012 the VA system could sustain a rise to approximately 53,000 enrolled blind or low-vision-impaired veterans, according to the VHA Blind Rehabilitation Service. National demographic studies estimate that there are 158,000 blinded veterans in America.

Age-related eye diseases, however, affect more than 35 million Americans age 40 and older. The most common eye diseases in that age group are macular degeneration, glaucoma, diabetic retinopathy, and cataracts; of these an estimated 1 million Americans over the age of 40 are legally blind.[98] While only 4.3 percent of the 65 and older population live in nursing homes, 16 percent of those who are visually impaired and 40 percent of those who are blind reside in nursing homes. Training programs that allow safe daily independent living functions reduce these long-term-care costs and prevent injuries from falls and other accidents.

The Independent Budget emphasizes that in addition to the previously mentioned blinded veterans from previous wars and conflicts already enrolled, recent data compiled by both the Department of Defense (DOD) and VA sources reported that 13.9 percent of all wounded and evacuated from Iraq had experienced eye injuries. As of December 2008, more than 1,348 eye injured or eye wounded (395 blinded in one eye) had sustained serious enough wounds requiring evacuation, but this grew to more than 1,500 by July 2008.[99] The VA article "Putting Polytrauma Care 'On the Map'" reported that in reviewing all Operating Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans enrolled in the VHA, the most common traumatic injury affecting some 63 percent of them was hearing loss, followed by vision injuries, with 27.9 percent of all OEF/OIF veterans identified; these range from mild, to moderate, to severe visual injuries.[100] Approximately 80 blinded OEF/OIF service members have attended one of the 10 blind rehabilitation centers, with VIST tracking 112 total, and some of these are in the process of being referred for BRC admission. Nevertheless, *The Independent Budget* veterans service organizations (IBVSOs) fear that some reserve members with severe eye injuries are unaccounted for and have not been tracked while in the DOD TRICARE system.

As of September 14, 2008, the VHA reported 8,774 traumatic brain injury (TBI) cases diagnosed, with another 7,390 cases having further diagnostic and specialty screening,[101] but by several estimates this number is probably low for TBI exposure. Although VA has been stepping up their TBI screening of all OEF/OIF service members entering the VA system, those who are diagnosed with TBI should have specialized vision screening to determine if they have vision impairments related to the blasts.

TBI vision research published from the Palo Alto VA Medical Center Poly Trauma Center showed that 75 percent of veterans treated there have visual complaints and have been diagnosed with the following types of disorders: diplopia, field loss, accommodation insufficiency, convergence disorder, and ocular-motor dysfunction. Of those, 55 percent are unable to interpret print, and 4 percent of all disorders result in legal blindness.[102] Other sites have found similar results in TBI screening, of between 68 percent to 70 percent incidence of patients complaining of visual disorders, again ranging from mild, to moderate, to severe.[103] Similar to the returning wounded with hearing loss complaining of tinnitus, reports are that some 70 percent of TBI patients complain of photophobia (light sensitivity), and for those patients experiencing both symptoms, visual dysfunction screening must occur. Various complications of these traumatic eye injuries include traumatic cataracts, glaucoma, and retinal detachments, and more follow-up research is needed on all of these. The IBVSOs request that Congress exercise greater oversight on tracking of these combat-wounded eye injured veterans. Those with duel sensory hearing and vision loss must have outcome studies.

According to the Office of VA Research, serious combat eye trauma from OEF/OIF has climbed to the second most common injury from these conflicts behind only hearing loss. The IBVSOs are frustrated that long delays occurred in establishing the military Vision Centers of Excellence during this past year because the necessary $5 million was never included by Congress in the Defense appropriations for FY 2009 to begin staffing at all four designated military Vision Centers of Excellence medical centers. We request that Congress include in the Defense appropriations for FY 2010 $6.5 million for the continued implementation of the joint DOD/VA Vision Centers of Excellence as intended in the National Defense Authorization Act (NDAA) of FY 2009, section 1623, P.L. 110-181.

Historically, the residential BRC program has been the primary option for severely visually impaired and blinded veterans to receive services. The VHA this past year transitioned to approximately 44 more VA outpatient continuum of care programs, improving health-care delivery going into 2010.[104] VHA Ophthalmology, Optometry, and BRS need to continue to make the same effort for veterans in the next couple years to complete the plans for all new services.[105] For those catastrophically disabled non-service-connected veterans who require residential services at a blind rehabilitation center, they often cannot afford the copayments for their admissions, plus beneficiary travel is also not provided for those who are not a direct transfer from one VA medical center to a blind rehabilitation center, adding another burden.

Currently, approximately 1,144 blinded veterans are waiting an average of 12 weeks for entrance into 1 of the 10 VA BRCs—progress from 2004 when 2,400 blinded veterans waited almost 5 months. The IBVSOs encourage directed funding of an additional $9.5 million in FY 2010 for these new models of blind rehabilitation outpatient services and low-vision optometric programs. By encompassing the full spectrum of visual impairment services, blind rehabilitative outpatient specialists (BROS), and intermediate and advanced low-vision outpatient programs, these new services could screen service members with TBI for visual complications while serving the eye disease population of aging blinded and low-vision veterans.

Congressionally mandated capacity must be maintained, and the BRS must continue to provide for critical full-time employee equivalents within each BRC to increase capacity to provide comprehensive residential blind rehabilitation services. Other critical BRS positions—such as the 98 full-time VIST coordinators and the current number of 45 BROS, with 35 currently vacant—must be increased. VIST and BROS teams are essential full-time positions, which, in addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a BRC or a new continuum of care outpatient program, also facilitate blind rehabilitation training support in veterans' homes and provide new technology when veterans return from a BRC.

Recommendations:

The Veterans Health Administration must restore the bed capacity and full staffing levels in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

The VHA must continue its three-year plan for full continuum of care outpatient programs for blinded and low-vision veterans that Secretary Nicholson promised in January 2007. Congress should ensure the program's implementation by providing $9.5 million in FY 2010 for completion of 54 new sites.

In implementing DOD/VA Vision Centers of Excellence and the joint eye trauma registry created by the National Defense Authorization Act of 2008, the Department of Defense and VA must ensure electronic exchange of essential information between all eye care professionals in order to establish a seamless transition of eye care and improve long-term outcomes through vision research. As it included in FY 2009 MILCON-VA appropriations to establish this registry, Congress should again provide $2 million for FY 2010 to complete this eye trauma registry.

In implementing DOD/VA Vision Centers of Excellence and the joint eye trauma registry created by the National Defense Authorization Act of 2008, the Department of Defense and VA must ensure electronic exchange of essential information between all eye care professionals in order to establish a seamless transition of eye care and improve long-term outcomes through vision research.

Defense appropriations for FY 2010 must include $6,780,000 for further implementation of the four Vision Centers of Excellence located at Bethesda National Naval Medical Center, Brooke Army Medical Center, Madigan Army Medical Center, and San Diego NNMC, and Armed Services/VA Committee hearings on this joint program for eye injured and hearing impaired must be held.

The Congressionally directed Peer Medical Research Program must continue to include eye and vision research in Defense appropriations, and DOD research funding on eye trauma must be increased in FY 2010 to $8 million.

The VHA must require the networks to restore clinical staff resources in inpatient blind rehabilitation centers and increase the number of full-time Visual Impairment Services Team coordinators.

Although the House of Representatives passed H.R. 6445 in the 110th Congress, Congress should reintroduce and enact legislation amending title 38, United States Code to prohibit the VA Secretary from collecting certain copayments from veterans who are catastrophically disabled.

Congress should amend title 38 to provide beneficiary travel reimbursement for catastrophically disabled veterans who need to attend an inpatient rehabilitation center.

[98]www.silverbook.org/visionloss; Silver Book@agingresearch.org.
[99]"Pentagon Numbers U.S. Military OIF/OEF Warriors Eye Injuries (JTTR, Oct 2002–Aug 2007). Internal report.
[100]Diane Cowper Ripley, "Putting Polytrauma Care on the Map," *VA Research Currents,* October 2008, p. 5.
[101]Barbara Sigford, "Update on Health Care: VA Traumatic Brain Injury (TBI) Screening Program, PowerPoint presentation to veterans service organizations, September 2008.
[102]Greg Goodrich, *Summary of Polytrauma Eye Research and Treatment Study Seen at VA Palo Alto Rehabilitation Network Site,* VA Palo Alto Center report, March 2008.
[103]Hines VA Medical Center, Low Vision Screening, TBI Clinic, August 2008. Unpublished report.
[104]Visual Impairment Advisory Board Minutes, VHA Blind Rehabilitation Service Office, October 2008.
[105]VA Visual Impairment Advisory Board Full Continuum of Care Recommendations," VHA briefing to veterans service organizations, September 2007.

Spinal Cord Dysfunction:

The continuum of care model for quality health care delivered to the patient with spinal cord dysfunction continues to be hindered by the lack of trained staff to support the mission of the spinal cord injury/dysfunction (SCI/D) program.

SCI/D Leadership

The continuum of care model for the treatment of veterans with SCI/D has evolved over a period of more than 50 years. SCI/D care in the Department of Veterans Affairs has been established in a "hub-and-spokes" model. This model has shown to work very well as long as all patients are seen by qualified SCI/D trained staff. Because of staff turnover and a general lack of understanding in outlying "spoke" facilities, however, not all SCI/D patients have the advantage of referrals, consultations, and annual evaluations in an SCI/D center.

This situation is further complicated by confusion as to where to treat patients with spinal cord disorders, such as multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease). Some SCI/D centers treat these patients while others deny admission. It is recognized that there is an ongoing effort to create a continuum of care model for MS and that this model should be extended to encompass MS and other diseases involving the spinal cord, such as ALS. Although admission in an SCI/D center may not be appropriate for all veterans with spinal cord disorder, a care model must be developed to follow these veterans through their illness with a protocol that meets the treatment needs of the patient.

Nursing Staff

VA is experiencing delays in admission and bed reductions based upon availability of qualified nursing staff. *The Independent Budget* veterans service organizations continue to contend that basic salary for nurses who provide bedside care is not competitive with community hospital nurses. This results in high attrition rates as these individuals leave VA for more attractive compensation in the community.

Recruitment and retention bonuses have been effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans and nursing staff morale. Unfortunately, facilities are faced with the local budget dilemma when considering the offering of any recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus shorting other needed medical programs. Because these efforts have only been used at local or regional facilities, there is only a partial improvement of a systemwide problem.

A consistent national policy of salary enhancement should be implemented across the country to ensure that qualified staff is recruited. Funding to support this initiative should be made available to the medical facilities from the network or VA Central Office to supplement their operating budgets.

Patient Classification

VA has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of injury, amount of time spent with the patient, technical expertise, and clinical needs of each patient. A category III patient, in the middle of the scoring system, is the "average" SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of full-time employee equivalents (FTEEs) needed for continuous coverage. This formula covers *bedside nursing care hours* over a week, month, quarter, or year. It is adjusted for net hours of work with annual, sick, holiday, and administrative leave included in the formula.

The emphasis of this classification system is based on *bedside nursing care*. It does not include administrative nurses, non-bedside specialty nurses, or light-duty nursing personnel because these individuals do not or are not able to provide full-time labor-intensive bedside care for the SCI/D patient. According to the *California Safe Staffing Law,* dealing with registered nurses (RN)-to-patient staffing ratios, "Nurse administrators, nurse supervisors, nurse managers, and charge nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those administrators are providing direct patient care."

Nurse staffing in SCI/D units has been delineated in Veterans Health Administration (VHA) Handbook 1176.1 and VHA Directive 2005-001. The figure was derived on 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. Currently, nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2005-001 mandates 1,347.6 bedside nurses to provide nursing care for 85 percent of the available beds at the 23 SCI/D centers across the country. This nursing staff consists of RNs, licensed vocational/practical nurses, nursing assistants, and health technicians.

At the end of FY 2007, nurse staffing was 1,315. This number is 32.6 FTEEs short of the mandated requirement of 1,347.6. Considering that some facilities are staffed to meet the actual acuity level (above minimum levels), the real shortage is 67.9 nursing staff for the remaining centers to meet minimum staffing levels. The 1,315 FTEE includes nursing administrators and non-bedside RNs (79.5) and light duty staff (39). Removing the administrators and light duty staff makes the total number of nursing personnel 1,183.2 FTEEs to provide *bedside nursing care*. This coupled with the shortage of 67.9 FTEEs reveals a shortfall of 186.4 nursing FTEEs.

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio, however. There are 509.9 RNs working in SCI/D. Out of that, 79.5 are in non-bedside or administrative positions, leaving 430.4 RNs providing bedside nursing care. With 1,315 nursing personnel and 509.9 of those RNs, this leaves an RN ratio of 39 percent to provide bedside nursing care. If the non-bedside RNs were excluded, the percentage of RNs drops to 35 percent. These numbers are well below the mandated 50 percent RN ratio.

SCI/D facilities recruit only to the minimum nurse staffing required by VHA Directive 2005-001. As shown above, when the minimal staffing levels include non-bedside nurses and light-duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of nurses.

The low percentage of professional RNs providing bedside care and the high acuity of SCI/D patients puts SCI/D veterans at increased risk for complications secondary to their injuries. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

This nursing shortage is manifested in the fact that VA facilities have begun to restrict admissions to SCI/D wards. Reports of bed consolidations or closures have been received due to nursing shortages. Such situations create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

Proposed Bifurcated Spinal Cord Injury Center in Denver

In the spring of 2008, VA announced a revised plan for replacing the Denver VA Medical Center. Under the Capital Asset Realignment for Enhanced Services (CARES) plan, the existing, antiquated VA hospital in Denver was scheduled to be replaced with a new tertiary care facility that included a 300-bed spinal cord injury center needed to serve veterans in the Rocky Mountain region. The revised plan drastically modified the proposed CARES-driven project calling for an expanded ambulatory care center and the leasing of bed space at the to-be-constructed new University of Colorado Medical School hospital (see the section "VA's New Health-Care Facility Leasing Program in this *Independent Budget*). Included in this proposal was the division of the 30-bed SCI center between the two facilities with 12 beds designated as acute care to be located in the university hospital and 18 beds designated as rehabilitative to be located in the ambulatory care center.

This proposal has met with great opposition, most notably from the perspective that it contradicts the VA internal guidance regarding SCI care contained in VA Handbook 1176.1. The proposed split center creates obstacles to coordinated patient care, will lead to inefficient and/or ineffective utilization of staff, and create undue burdens and risks for patients being required to move from one facility to the other for necessary care. It is the position of the IBVSOs that this new approach is not in

the best interest of veterans with SCI/D and is, in fact, untenable and will lead to the diminution of quality care.

Recommendations:

The Veterans Health Administration should ensure that the spinal cord injury/dysfunction continuum of care model is available to all SCI/D veterans across the country. VA must also continue mandatory national training for "spoke" facilities.

VA should develop a comprehensive continuum of care model for SCI/D patients that includes other diseases of the neurological system, such as multiple sclerosis and amyotrophic lateral sclerosis.

The VHA needs to centralize policies and funding for systemwide recruitment and retention bonuses for nursing staff.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses.

Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.

VA should cease work on the revised plan involving the division of the SCI service in Denver and continue moving forward with the plan outlined by the CARES process.

Persian Gulf War Veterans:

The Department of Veterans Affairs must aggressively pursue answers to the health consequences of veterans' Gulf War service. VA cannot reduce its commitment to Veterans Health Administration (VHA) programs that address health care and research or Veterans Benefits Administration (VBA) programs in order to meet other important and unique needs of Gulf War veterans.

In the first days of August 1990, in response to the Iraqi invasion of Kuwait, U.S. troops were deployed to the Persian Gulf in Operations Desert Shield and Storm. The air assault was initiated on January 16, 1991. On February 24, 1991, the ground assault was launched, and after 100 hours, combat operations were concluded. Approximately 697,000 U.S. military service members served in Operations Desert Shield or Desert Storm. The Gulf War was the first time since World War II in which reserve and National Guard members were activated and deployed to a combat zone. For many of the 106,000 who were mobilized to Southwest Asia, this was a life-changing event.

After their military service, Gulf War veterans reported a wide variety of chronic illnesses and disabilities. Many Gulf War veterans have been diagnosed with chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, and gastrointestinal problems. The multisyptom condition or constellation of symptoms has often been referred to as Gulf War syndrome, Gulf War illness, or Gulf War veterans' illnesses; however, no single unique illness has been definitely identified that explains the complaints of all veterans who fit this description. According to the VA's most recent study, 25 to 30 percent of Gulf War veterans suffer from chronic multisymptom illness above the rate in other veterans of the same era. This confirms five earlier studies showing similar rates. Thus, 18 years after the war approximately 175,000 to 200,000 veterans who served remain seriously ill.

Both the Department of Defense (DOD) and VA have invested in conducting research and providing health care and benefits to address the concerns of Gulf War veterans and their families. These efforts have flagged in the past months as other veterans' issues have captured the attention of Congress and the federal agencies. However, because many Gulf War veterans remain ill, *The Independent Budget* veterans service organizations (IBVSOs) stand firm and urge the DOD and VA not to abandon their search for answers to Gulf War veterans' unique health problems and exposure concerns.

Building a Base of Evidence

Since the Gulf War, federal agencies have sponsored numerous research projects related to Gulf War illnesses. A July 26, 2007, hearing before the House Committee on Veterans' Affairs Subcommittee on Health, reported that VA and the DOD had together spent $260 million on Gulf War illness research. Combined with the Department of Health and Human Services, more than 340 research projects related to Gulf War illnesses have been conducted, totaling more than $340 million. However, Gulf War illness research is handled exclusively by VA and the DOD, and very little money has been invested in treatment research.

As troops in Southwest Asia continue to fight in the same areas as Gulf War veterans, VA's response to this unique situation was to open the Gulf War Registry to Operations Enduring and Iraqi Freedom (OEF/OIF) veterans,[106] and broaden the scope of Gulf War illness research to include "deployment-related health research." The Research Advisory Committee on Gulf War Veterans' Illnesses (RAC-GWVI) appointed by the VA Secretary in 2002 was directed to evaluate the effectiveness of government research in addressing central questions on the nature, causes, and treatments of Gulf War–related illnesses. In reviewing VA-funded research on Gulf War illnesses, the RAC-GWVI has raised questions on the nature of some VA-funded research as to whether these research projects will directly benefit veterans suffering from Gulf War illnesses by answering questions most relevant to their illnesses and injuries. Heightening this concern is a critical need for a comprehensive and well-planned program to actually solve the problems disabled Gulf War veterans face instead of studying peripheral sections.

The IBVSOs are concerned that changing the direction of Gulf War illness research will dilute its focus and divert attention to the, admittedly, urgent issues faced by veterans of OEF/OIF. While it is unclear whether veterans of the current conflicts should be categorically grouped with veterans of the first Gulf War for purposes of VA research on Gulf War illnesses, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of the other, particularly in light of news reports about an open-air "burn pit" at the largest U.S. base in Balad, Iraq, which has been described as an acute health hazard and may have exposed thousands of service members to cancer-causing dioxins; poisons; and hazardous medical waste.[107] Accordingly, the IBVSOs believe the federal research budget needs to prioritize and coordinate investigations in a progressive manner of both postdeployment groups.

The Need for Effective Treatment

The Independent Budget position is that all combat environments are hostile and traumatic; consequently, some Gulf War veterans have suffered the consequences of combat and environmental exposures, and their bravery in dealing with the aftermath of service should be neither discounted nor stigmatized. A holistic, comprehensive investigation into the causes and the most effective treatments for all illnesses and injuries suffered by Gulf War veterans is the proper path to restoring the health and well-being of those who served.

It has been eight years since Congress mandated[108] the Department of Veterans Affairs to commission the United States National Academies' Institute of Medicine (IOM), to convene a committee,[109] which issued a report[110] to address the primary concern of whether Gulf War veterans are receiving effective treatments for their health problems. In its most recent report,[111] the RAC-GWVI states, "treatments that are effective in improving the health of veterans with Gulf War illness are urgently needed." The DOD's Office of Congressionally Directed Medical Research Programs has a program aimed at identifying diagnostic tests and treatments for Gulf War illness. As mentioned in *The Independent Budget for FY 2009,* the program funded a limited number of new treatment studies in 2007 and has invited proposals for additional studies to be funded in 2009. A similar effort, sponsored by VA, is under way at a center of excellence for Gulf War research at the University of Texas Southwestern. In light of a decline since 2001 in the overall federal funding for Gulf War illness research, the IBVSOs believe Congress, VA, and the DOD should meet this need with a renewed federal research commitment and that adequate funding be allocated to achieve the critical objectives of improving the health and lives of Gulf War veterans.

The RAC-GWVI report outlines studies that consistently indicate Gulf War illness is not significantly associated with serving in combat or other psychological stressors, further citing that Gulf War veterans have lower rates of post-traumatic stress disorder than veterans of other wars. However, pyridostigmine bromide pills and pesticides have been consistently identified as significant risk factors for Gulf War illness. Moreover, limited research on other deployment-related exposures[112] currently exists, and its association with Gulf War illness cannot therefore be ruled out. Other concerns have also been raised regarding the rates of birth defects in the children of Gulf War veterans. While no studies have provided comprehensive information on the health of Gulf War veterans' children, Phase III

of VA's large U.S. National Survey of Gulf War Era Veterans and Their Families included clinical evaluations of veterans' children for which findings have not been reported.

Effectiveness of Existing Benefits

Similar to diluting the focus of Gulf War illness research by broadening its scope, the IBVSOs are also concerned about VBA's standing practice of including OEF/OIF veterans with Gulf War veterans in the Gulf War Veterans Information System (GWVIS). The GWVIS report monitors, in part, the service members' use of VA health care and disability benefits.

While the VBA indicates that GWVIS provides the best available current data identifying the 6.5 million Gulf War service member population, it has rebuffed strong criticism to delineate OEF/OIF veterans from Gulf War veterans to provide a more meaningful and timely report. For example, the reports are distributed each quarter during the following months: March, June, September, and December; however, as of this writing, only the March 2008 report has been released. In addition, lumping compensation and pension statistics undermines any reasonable effort to analyze the effects of current regulations for compensating veterans suffering from specific Gulf War illnesses. Moreover, the report lacks any practical information on health-care utilization of Gulf War veterans particularly when compared to the report on the "Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans." Issued by the VHA Office of Public Health and Environmental Hazards, this report is provided on a fairly regular basis and provides a revealing description of the trends in health-care utilization and workload of OEF/OIF veterans, diagnostic data, and where they reside in respect to the VA health-care system they seek. Such monitoring allows VA to tailor its health-care and disability programs to meet the needs of this newest generation of OEF/OIF war veterans.

Despite the GWVIS report's lack of granularity, what can be interpreted based on the February 2008 GWVIS report is that 33 percent of Gulf War veterans have been granted service-connected disability compensation. As of January 31, 2008, just 2 percent of Gulf War veterans had filed disability claims for "undiagnosed illness" and only 0.5 percent had been service-connected for "undiagnosed illness," which suggests that these claims are difficult to prosecute and possibly to adjudicate under current regulations.

Under the direction of Congress, VA has a standing responsibility to commission the IOM to assist the Secretary in making decisions as to whether there is sufficient scientific evidence to warrant a presumption of service connection for the occurrence of a specified condition in Gulf War veterans. On October 16, 2006, the IOM issued a fifth volume of its Gulf War and health series on infectious diseases. Consequently, VA informed[113] Congress of its intent to add nine new presumptive conditions based on service in Persian Gulf War: brucellosis, campylobacter jejuni, Q fever, malaria, mycobacterium tuberculosis, nontyphoid salmonella, shigella, visceral leishmaniasis, and West Nile fever. The VA Task Force charged with reviewing this committee report to determine if new presumptive service connections are warranted has submitted its recommendations to the Office of Management and Budget. To date, no regulations have been proposed for inclusion on the current list of presumptive conditions for Gulf War veterans.

The RAC-GWVI's most recent report outlined some issues regarding the IOM's Gulf War and Health reports. The report states, "IOM's Gulf War and Health series of reports have been skewed and limited by a restrictive approach to the scientific tasks mandated by Congress, an approach directed by VA in commissioning the reports. These limitations are most notably reflected in the selective types of information reviewed and the lack of in-depth analysis of the research literature and scientific questions associated with the health of Gulf War veterans. There is a fundamental disconnect between the Congressional directive to VA and VA's charge to IOM for reviewing evidence on Gulf War exposures and their association with illnesses affecting Gulf War veterans. The reports have particularly fallen short in advancing understanding of associations between Gulf War exposures and Gulf War illness, the most prominent health issue affecting Gulf War veterans." The VA Secretary, and thus veterans suffering from Gulf War illness, depend heavily on the commissioning of the IOM by virtue of Congressional mandate. The IBVSOs believe the concerns raised by the RAC-GWVI should be formally addressed and resolved by Congress to ensure the credibility of established protocols using Gulf War and Health reports to guide VA policy and programs for Gulf War veterans.

While the IBVSOs are hopeful of the work to be done by the newly formed VA Advisory Committee on Gulf War Veterans in its review of the full spectrum of health care and benefits for Gulf War veterans, much work needs to be done to improve the lives of disabled veterans suffering from Gulf War illnesses. While the evidence base to guide policy and programs administered by VA continues to grow, we must remain vigilant to ensure progress is made.

Recommendations:

Congress should ensure that sufficient, dedicated funding is provided for research into the health consequences of Gulf War veterans' service. The unique issues faced by Gulf War veterans should not be lost in the urgency to address other issues related to armed forces personnel currently deployed.

Congress should provide funding to conduct research on effective treatments for veterans suffering from Gulf War illness.

VA should commission the National Academy of Sciences' Institute of Medicine to update the "2001 Gulf War Veterans: Treating Symptoms and Syndromes" report determine whether there are effective treatments for veterans suffering from Gulf War illness and whether these veterans are receiving appropriate care.

Congress must conduct oversight on the concerns raised in the November 2008 report by the Research Advisory Committee on Gulf War Veterans' Illnesses on the IOM's Gulf War and Health reports.

VA should change the current direction of its Gulf War illness research and separate its focus on ill Gulf War veterans and those health concerns from its focus on the health concerns of veterans of Operations Enduring and Iraqi Freedom.

VA should provide a more timely Gulf War Veterans Information System report and should delineate Operations Enduring and Iraqi Freedom veterans from Gulf War veterans.

Congress should make permanent the presumptive period for undiagnosed illnesses, which is due to expire September 30, 2011.

VA should issue regulations to add brucellosis, campylobacter jejuni, Q fever, malaria, mycobacterium tuberculosis, nontyphoid salmonella, shigella, visceral leishmaniasis and West Nile fever as presumptive conditions based on service in the Persian Gulf War.

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[106]As of August 2008, more than 106,500 have participated in VA's Gulf War Veterans' Health Registry Examination, of which more than 7,000 veterans are from the current conflicts.
[107]Kelly Kennedy, "Burn Pit Fallout; Military Official: Situation Improving; Troops Report Complications from Asthma to Cancer," *Army Times*, November 7, 2008.
[108]P.L. 105-368 § 105; P.L. 105-277 § 1603.
[109]Committee on Identifying Effective Treatments for Gulf War Veterans' Health Problems, Board on Health Promotion and Disease Prevention.
[110]"Gulf War Veterans: Treating Symptoms and Syndromes," National Academies Press, July 26, 2001.
[111]"Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations," U.S. Government Printing Office, November 17, 2008.
[112]Exhaust from tent heaters and other fuel exposures, fine sand and airborne particulates, solvents, freshly applied chemical agent resistant coating paint, nerve agents, depleted uranium, vaccinations, and petroleum smoke or vapors.
[113]Lawrence Deyton, chief public health and environmental hazards officer, VHA, statement before the Subcommittee on Health, House Committee on Veterans Affairs, July 26, 2007.

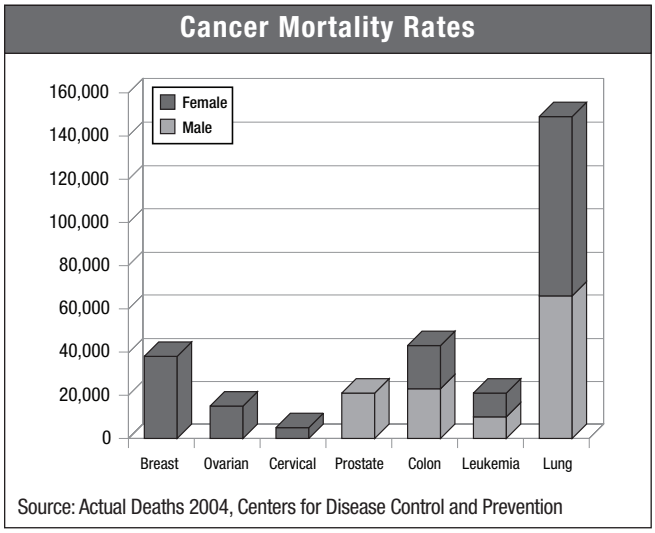
LUNG CANCER SCREENING AND EARLY DISEASE MANAGEMENT PROGRAM:

Lung cancer has a disproportionate impact on veterans, especially those exposed to carcinogens during active duty. A pilot screening program can assess those risks, improve survivability, and provide the Department of Veterans Affairs with vital cost/benefit and survival data on the efficacy of early diagnosis.

Overall Impact

Only heart disease causes more deaths per year than lung cancer. Lung cancer continues to be the number one cancer killer, causing nearly one in every three cancer deaths, more than breast, prostate, colon, kidney, melanoma, and liver cancers combined. More than half of all new cases are being diagnosed in former smokers, many of whom quit decades ago. Another 10 to 15 percent have never smoked. With higher smoking rates than the civilian population, as well as increased exposure to Agent Orange, asbestos, beryllium, nuclear emissions, propellants, and other environmental toxins, veterans, especially those exposed to these carcinogens during active duty, are at higher incidence and mortality risk. As veteran boomers enter their 60s, the decade when most diagnoses are made, the numbers of lung cancer cases will swell. Lung cancer usually re-

mains asymptomatic for 20 years or more. Given the many concerns about conditions during the Gulf War, a pilot screening program should pay particular attention to veterans who served on those battlefields.



High Mortality Rate

Since Congress passed the National Cancer Act of 1971, the five-year survival rates for the three other most common cancers—breast, prostate and colon—have risen to 88 percent, 99 percent, and 65 percent, respectively. These greatly improved survival rates are reflective of the significant federal investment in research and early detection for those cancers and widely promoted screening tests (mammograms, PSA testing, and colonoscopies). By contrast, lung cancer research and early detection has been consistently underfunded and its five-year survival rate is still only 15 percent. Lung cancer is a slow-growing cancer, the symptoms of which rarely become evident until late stage. Only 16 percent of lung cancers are being diagnosed at its earliest and most treatable stage.

Impact on Military and Veteran Populations

The Department of Defense (DOD) routinely distributed free cigarettes and included cigarettes in K-rations until 1976. The 1997 Harris Report to VA documented a higher prevalence of smoking and carcinogenic exposure among the military, with estimated costs to VA and TRICARE of billions of dollars per year. More than 70 percent of Vietnam veterans have smoked, twice the rate of 35 percent for civilians who ever smoked. Asbestos on submarines, Agent Orange, Gulf War battlefield emissions, and other toxins are also carcinogenic factors that add to the overall exposure burden. A 2004 report by the Health Promotion (HPDP) of the Institute of Medicine, titled "Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer," concluded that the presumptive period for lung cancer is 50 years or more. Another HPDP report in 2005, "Gulf War and Health, Volume 3, Fuels, Combustion Products and Propellants," concluded sufficient evidence existed for an association with lung cancer.

Given that lung cancer is an indolent cancer that takes decades to develop, the burden of treatment will fall most heavily on VA. Without screening, more than 70 percent of lung cancer is being diagnosed at late stage and most will die within a year. Late-stage lung cancer is twice as costly to treat as early stage.

The DOD and Cancer Research

In 1991, Congress initiated the Congressionally Directed Medical Research Program (CDMRP). From FY 1992 to FY 2007, appropriations have totaled $4.36 billion, including $2.1 billion for breast cancer research, $810 million for prostate cancer, $111.7 million for ovarian cancer, and $22 million for leukemia. Smaller, miscellaneous amounts have been occasionally earmarked for other cancers. In 2005, lung cancer biomarker research received $1 million in funding.

In the DOD FY 2009 appropriations bill, Congress established a line-item lung cancer research program under the CDMRP and appropriated $20 million for FY 2009. The report notes, "military personnel have heightened exposure to lung cancer carcinogens" and states that for the new program "priority shall be given to the development of the integrated components to identify, treat, and manage early curable lung cancer."

Department of Energy and Lung Cancer

Munitions plant workers have been routinely screened for lung cancer since the Worker Health Protection Program was authorized in the Department of Defense Authorization Act of 1993 and funded through the Office of Environment, Safety and Health of the Department of Energy. Expansion of the program to more plants is being planned for FY 2009.

Justification

On October 26, 2006, the *New England Journal of Medicine* published the results of a 13-year study on

screening for lung cancer with CT scanners of 31,500 asymptomatic people at high risk. The study was carried out by multidisciplinary groups at 40 centers in 26 states and 6 foreign countries. Lung cancer was diagnosed in 484 participants, 85 percent at Stage I (versus 16 percent nationally), and those treated promptly had 10-year survival rates of 92 percent (versus the national 5-year survival rate of 15 percent). The participants in the study, now expanded to 53 sites in the United States and 8 foreign countries, are still being followed to validate the data, and a new study on the diagnosis and interrelationship of chronic obstructive pulmonary disease is now in its second year.

In March 2008, the National Comprehensive Cancer Network, which sets gold standard diagnostic and treatment guidelines, interceded in the screening debate and stated that those at high risk should enter a screening research program based on the International Early Lung Cancer Action Project (I-ELCAP) protocol. Collaborating with I-ELCAP would save VA the cost of "reinventing the wheel," receive training for its staff in the established protocols, and would have access to I-ELCAP's 50,000 scan data base to make the VA pilot study more robust.

2007 Legislative History

On August 2, 2007, the Senate passed S. Res. 87, expressing the sense of the Senate that the President should declare lung cancer a public health priority and implement a comprehensive interagency task force to reduce the mortality rate for lung cancer by 50 percent by 2015. The resolution specifically cited the serious problems of tobacco addiction and exposure among military personnel and veterans, and called for the DOD and VA to develop a lung cancer screening and disease management program.

On November 13, 2007, the House of Representatives passed H. Res. 335, which also cited concerns about lung cancer risk among the military and supported the development of a screening program for the military and veterans.

In addition, Senate Report 110-85 on FY 2008 Appropriations for Military Construction and Veterans Affairs and Related Agencies included the following language:

> Lung Cancer Screening—The Committee encourages the Secretary of Veterans Affairs to institute a pilot program for lung cancer screening, early diagnosis and treatment among high-risk veteran populations to be coordinated and partnered with the International Early Lung Cancer Action Program and its member institutions and with the designated sites of the National Cancer Institute's Lung Cancer Specialized Programs of Research Excellence. The Department shall report back to the Committee on Appropriations within 90 days of enactment of this act, on the viability and plans to institute a program of this nature.

2008 Legislative History

On June 28, Sens. Dianne Feinstein and Chuck Hagel introduced S. 3187, authorizing the priority status called for in the House and Senate resolutions, setting a goal of a 50 percent mortality reduction by 2015 and requiring the Secretaries of Health and Human Services, the DOD, and VA to collaborate on a comprehensive plan of coordinated action to achieve that goal. Specifically, VA was directed to implement, with the DOD, an early detection and disease management program for veterans whose smoking history and exposure to carcinogens during active duty have increased their risk for lung cancer.

On September 30, 2008, the President signed into law (P.L. 110-329) the FY 2009 DOD appropriations bill contained in H.R. 2638, which established in law a new Lung Cancer Research Program with a $20 million appropriation for FY 2009 with report language citing the higher exposure of the military to carcinogens and specific instructions that priority be given to "the development of the integrated components to identify, treat and manage early curable lung cancer."

Recommendation:

VA should request and Congress should appropriate at least $3 million in FY 2010 to conduct a pilot screening program for veterans at high risk of developing lung cancer based on collaboration with the International Early Lung Cancer Action Program and should explore the most effective way to partner with the Department of Defense on its early detection program.

Women Veterans Health and Health-Care programs:

The number of women veterans coming to the Department of Veterans Affairs for health-care services is expected to double within two to four years. VA must reevaluate its programs and services for women veterans to ensure that consistent comprehensive, quality women's health services are delivered across the continuum of care at all VA facilities.

Women have played a vital part in the military service since the birth of our nation. In the past 50 years their roles, responsibilities, and numbers have significantly increased. Current estimates indicate that there are 1.8 million women veterans comprising nearly 8 percent of the United States veteran population.[114] According to the Department of Defense (DOD), women service members represent 15 percent of active duty forces, 10 percent of deployed forces, and 20 percent of new recruits. Thus women are a very rapidly expanding segment of the veteran population.[115]

Historically, women have represented a small numerical minority of veterans who receive health care at VA facilities. However, if women veterans from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) continue to enroll at the current rate of 42.5 percent, it is estimated that the number of women using VA health-care services will likely double within two to four years.[116] Because women will still remain a numerical minority in VA, the overall effect of these increases will be small—but the impact on the gender-specific programs and staff who serve the unique needs of women will be very heavy. Absent significant reforms, women veterans will be unable to maintain their current level of access. VA's women veterans program managers (WVPMs) are a key component to addressing the specialized needs of women veterans in the VA health-care system. *The Independent Budget* veterans service organizations (IBVSOs) were very pleased when VA announced in July 2008 that it would provide a *full-time* women veterans program manager at every VA medical center by December 1, 2008. We believe, however, that a full-time WVPM should also be present at every large multispecialty community-based outpatient clinic (CBOC) and an alternate WVPM position formally assigned to cover responsibilities when the WVPM is unavailable to ensure continuity of services and care. We urge Congress to monitor the quarterly progress reports regarding the implementation of full-time WVPM positions throughout the system.

As noted, women who served in the global war on terrorism make up an important and growing segment of the veteran population. During the past five years, 42.5 percent of women veterans who served in OEF/OIF and separated from military service have used VA health-care services, and of that group 45.6 have visited 2–10 times.[117] The top three diagnostic categories that brought these veterans to VA care were diseases of the musculoskeletal system and connective tissue; mental disorders; and signs, symptoms, and ill-defined conditions.[118] The IBVSOs are pleased that VA is attempting to address the needs of women returning from combat theaters. However, the health consequences of service by women in a combat theater are still largely unknown because no long-term women's health studies have been conducted that focus on these unique issues. Rare events, such as cancers and birth defects, cannot be investigated without a dedicated, longitudinal women's health study that has adequate sample size and a representative population. The current deployments provide a unique opportunity to address these important questions, and we strongly urge that VA and Congress oversee and ensure that these research studies are completed and appropriately translated into VA policy and programs.

Women veterans who use VA health care are younger than men, averaging 49.5 years as compared to 61 years, respectively.[119] Additionally, more than 85 percent of women who served in OEF/OIF are under the age of 40.[120] According to VA researchers women veterans are three times more likely to use fee-basis care, are more likely to have substantial mental health comorbidity, have a greater overall disease burden, and use outpatient services more heavily than men, especially middle-aged women and those with comorbid mental health conditions. In addition, women are much more likely to have experienced sexual trauma while serving in the military, which has been shown to have significant long-term effects on burden of illness and health-care utilization.[121] These demographic changes and patterns of utilization along with the dramatic increases in women veterans' enrollment in VA health care will challenge VA resources and service delivery systems.

Despite the increasing number of women coming to VA for health care, historically, women veterans have been underserved. VA indicates that market penetration for men has remained steady at 22 percent with market penetration for women now at nearly 15 percent nationally

(up from 11 percent).[122] VA accounts for the recent rise in women veteran market penetration rates from 11 percent to 15 percent as an effect of the increasing numbers of women veterans from the OEF/OIF population who are seeking care at VA.[123] Although the IBVSOs are pleased that more women are choosing VA as their preferred health-care provider, we would like to see higher market penetration rates for women equal to that of their male counterparts. VA should begin with targeted outreach to women veterans who are receiving VA disability compensation benefits but who are not enrolled in the VA health-care system. Research has shown that women who do not utilize VA health care experience a number of barriers to accessing VA care, the most significant ones being lack of knowledge about eligibility and benefits and the perception that VA's health-care system is not "welcoming" to them. The IBVSOs agree with VA researchers that these results warrant further study to better understand women's reasons for seeking care elsewhere and urge VA to increase efforts to increase overall market penetration for women veterans.

The VA system was designed to provide health care to the predominantly male population it has traditionally served. Despite concerted efforts by the Department, privacy and safety issues have not been fully resolved to date. In 2003, VA issued Handbook 1330, and mandated minimum levels of women's health services to be provided by each VA facility, independent clinic, and CBOC: Unfortunately, a loophole exists in this policy that states that these services shall be provided "where feasible." However, quality of care measures for both cervical cancer screening and breast cancer screening ensured that at least some gender-specific care is provided to women veterans at each Veterans Health Administration (VHA) facility. Today, women are receiving services in a variety of clinic settings, including physically separate, specialized comprehensive women's centers, partially integrated gender-neutral primary care settings, and gender-specific care as separate clinic stops. The IBVSOs urge VA to also explore "virtual" women's clinics to help reduce barriers to care. Many younger women coming to VA work and are primary caretakers of children and parents and often find it difficult to maintain their health. Many new technologies are now available that can help reduce travel times to appointments for established patients to continue maintenance of their health.

The availability and the quality of this care vary widely across the VA health system, creating inequities in quality and service levels. Today's reality is that women veterans cannot be assured that their needs will be consistently met. In FY 2006, VHA survey results indicated that facilities were using the following models for provision of care to women veterans:

- Separate women's health centers providing comprehensive, multidisciplinary care that includes primary care, gender-specific care, mental health services, and surgical services (i.e., breast clinic or gynecology/colposcopy clinic) within a designated space (14 percent);
- Separate women's health centers providing primary care and gender-specific care within a designated space (19 percent);
- Separate gender-specific and/or gynecology clinics, with primary care provided in a designated women's primary care team within the facility (8 percent).
- Separate gender-specific and/or gynecology clinics, with primary care provided in mixed-gender primary care teams within the facility (43 percent); and
- Integrated gender-specific and primary care provided in mixed-gender primary care teams within the facility (16 percent).

Women's health care in the private sector is also somewhat fragmented; however, the IBVSOs believe VA should create a national model for delivery of comprehensive women's health care through complete women's health-care, education, and research programs, just as it took the lead in developing the best geriatric health-care delivery system for older veterans using VA services. VA women's health researchers have also examined which models of care deliver better quality care and patient satisfaction. Results clearly indicate that women veterans are significantly more satisfied with women's health providers, especially when care is provided by a gender-specific clinic, than they are with care in mixed-gender primary care clinics. When examining the question of provider gender as a factor in satisfaction with care, women prefer a provider who has expertise in women's health over a nonexpert, female provider. However, the highest satisfaction ratings are obtained when providers combine the characteristics of primary care/women's health expertise and female gender. Given these findings, the IBVSOs strongly support VA's initiative to provide training to VA clinical staff to increase their expertise in women's health care. VA also needs to increase its efforts to identify, recruit, retain, and educate clinicians who are proficient and interested in treating women veterans. VA should have at least one provider with women's health-care expertise at every VA medical facility. One way to accomplish this goal would be to establish Women Veterans Research, Education, and Clinical Centers.

The 2008 Congressionally directed "report card" for VA looked at measurements of quality, safety, timeliness, efficiency, and "patient-centeredness" within the VA health-care system. Although the overall report gave the Department high marks, the IBVSOs were distressed to learn that VA performance data revealed that women veterans lag behind their male counterparts in some quality measures and that there are disparities in treatment and satisfaction based on gender or ethnic background. Significant gender differences in provision of clinical prevention measures and mental health screenings were identified.[124] VA has indicated that it is currently working to address the identified health-care disparities faced by women veterans and will devote additional resources and attention to this problem until it is resolved.[125] However, to give the IBVSOs, veterans, and other stakeholders' confidence that health-care quality and access issues are being addressed, VA should begin to provide Veterans Integrated Service Network (VISN) and facility-level quarterly performance reports that are stratified by gender and report them in an easily accessible, public, and transparent manner. VA has been lauded for the overall quality of its health-care services. All veterans should be active and engaged partners in their health care. Veterans should be able to compare the quality of their VHA health-care services with the care of other public and private health-care providers. In order to ensure the highest quality of care, veterans and other stakeholders must have easy access to publically reported performance measurement data.

The women veteran population is predominantly pre-retirement and of child-bearing age; therefore, birth defects and potential exposure to teratogenic agents (which cause developmental deformities) must be addressed as a critical health-care quality and safety issue for women veterans. VA health-care providers should routinely question women about sexual function and reproductive issues and be knowledgeable about health promotion, disease prevention, and current issues related to women's health and treatment regimes. VA health-care providers should make every effort to reduce unnecessary exposure to radiation and pharmaceutical teratogens. VA should facilitate providers' ability to identify compounds associated with an increased risk of birth defects (teratogens) and immediately revise the pharmacy package to provide alerts for potential teratogens prescribed to women veterans under 50 years old. The IBVSOs strongly believe that VA must immediately add functionality to its electronic health record pharmacy package so that providers receive alerts concerning potential teratogenicity of pharmaceuticals being provided, and alternative choices can be offered to women. Equally critical is that every VA facility should have the ability to obtain an urgent beta-HCG pregnancy test so that health-care decisions can be made swiftly without endangering the veteran or fetus. In addition, women veterans should be offered a sexual function and safe-sex-practices screen annually.

Women veterans are often the primary caregivers in their families and extended families. Therefore, VA health-care providers need to be sensitized to the significant health-care access barriers women face as often unmarried employed heads of households, parents, and caregivers. The IBVSOs recommend that VA develop a pilot program to provide child care services for veterans who are the primary caregivers of children, while they receive intensive health-care services for post-traumatic stress disorder (PTSD), mental health, and other therapeutic programs requiring privacy and confidentiality.

Given the increasing role of women in combat theaters and the percentage of OEF/OIF women veterans coming to VA for health care, access to quality mental health services is critical.[126] These issues are especially important for women who deployed to a combat theater or those who suffered sexual trauma during military service. According to VA, in FY 2007, 22.2 percent of women and 1.3 percent of men reported military sexual trauma (MST) when screened. However, the IBVSOs note that the size of each clinical population (men/women) that reports MST is actually similar: 45,570 women and 47,764 men, respectively.[127] VHA staff needs to be sensitive and knowledgeable and recognize the importance of environment of care delivery when evaluating veterans for their physical and mental health conditions. We encourage the VHA to develop na MST provider certification program, guarantee at least 50 percent protected time for MST coordinators to devote to position responsibilities, provide separate/secure women's subunits for inpatient mental health and residential services, and improve coordination with the DOD on transition of women veterans, especially those with complex behavioral health needs.

In 2007, VA's National Center for PTSD published the first-ever randomized controlled trial to assess PTSD treatment for active duty and veteran women. In the study the women who received prolonged exposure therapy had a greater reduction of PTSD symptoms than women who received present-centered therapy. Additionally, the prolonged exposure group was more likely than the present-centered therapy group to no longer meet the criteria for a diagnosis of PTSD and achieve total

remission. However, mental health experts report that these case-intensive treatments are not universally available at VA medical centers (VAMCs) nationwide. This study documented the importance of spreading this evidence-based practice throughout VA's system. The IBVSOs are pleased that VA has developed a program to train its mental health providers to provide the most effective treatment for PTSD due to sexual trauma and combat trauma and is examining how best to address complex combat and MST issues.[128] However, further expansion of these training programs is still needed.

The IBVSOs also urge VA to concentrate on improving services for women with serious physical disabilities, such as spinal cord injury, amputations, and blindness. The physical space, size of examination rooms, the need for specialized equipment, overall setting, and safety issues should be evaluated throughout the VA health-care system. Additionally, all VA's specialized services, including those for polytrauma rehabilitation and transitional centers, substance-use disorders, homelessness, domestic violence, and postdeployment readjustment counseling, should be evaluated to ensure women have equal access.

The IBVSOs remain concerned about the fragmentation of care and disparities in care that exist for women using the VA health-care system. According to VA, 51 percent of women veteran VA who use the VA system split their care across VA and non-VA systems of care.[129] Additionally, a substantial number of women veterans receive care in the community via fee-basis and contract care, and little is known about the quality of that care.[130] For these reasons, we believe studies are needed that evaluate the quality of care delivered and that VA should improve its case management and care coordination programs for women veterans, especially for those with comorbid mental health conditions. VA should also assess care and develop a plan to enhance the provision of integrated primary care, specialty care, and readjustment and mental health services for women veterans. Finally, collaborative care models incorporating mental health providers should be piloted in the ambulatory care clinics where women receive their care.

Summary

As the population of women veterans undergoes exponential growth in the next decade, VA must act now to prepare to meet the specialized needs of women who have served. Overall, the culture of VA needs to be transformed to be more inclusive of women veterans and must adapt to the changing demographics of its women veteran users—taking into account their unique characteristics as young working women with child care and elder care responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care are equal for women and men. We see the need for VA to reevaluate its programs and services for women veterans and to increase attention to a more comprehensive view of women's health beyond reproductive health needs to include examining cardiac care, breast cancer, osteoporosis, and colorectal cancer in women. A plan should be established that addresses the increased overall demands on ambulatory care, hospital and long-term care, gender-specific services, and mental health programs recognizing the unique and often complex health needs of women veterans. Mental health integration into primary care is also essential for provision of comprehensive women's health care.

Implementation of full-time WVPMs in every VAMC and large multispecialty CBOC, training to increase staff knowledge of the state-of-the-art in women's health, and mental health care and treatment should be fully realized this year. Women should have access to comprehensive primary care services from competent providers, including gender-specific care, at every VA facility. The IBVSOs also recommend that VA focus on improving services for women with serious physical disabilities and focus its women's health research agenda on a longitudinal health study of women who served in Afghanistan and Iraq. Such a study could prove invaluable as a source of information to help VA address a growing burden in the care of women who serve. In order to become a leader in women's health care and ensure that these goals are reached, VA should establish a new program of Women Veterans Research, Education, and Clinical Centers of Excellence.

Recommendations:

VA should conduct a comprehensive assessment of its women veterans' health programs and report the findings to Congress, along with an action plan to improve quality and reduce disparities in health-care services for women receiving VA care. The Government Accountability Office should review and report to Congress on the results of VA's assessment.

VA should redesign its women veterans care-delivery model and establish an integrated system of health-care delivery that covers a comprehensive continuum of care and serves as a best practice in the field.

VA should adopt a policy of transparent information sharing and initiate quarterly public reporting of all quality, access, and patient satisfaction data, including a report on quality and performance data stratified by gender.

VA should ensure that women veterans have access to comprehensive primary care services (including gender-specific care) at every VA facility. Collaborative care models incorporating mental health providers into women veterans' primary care teams should become the norm rather than the exception.

VA should implement and support at least one full-time women veterans program manager in women's health at every VA medical center and large multispecialty community-based outpatient clinic.

VA should fund a prospective, longitudinal long-term research study of the health consequences of women veterans' service in Afghanistan and Iraq. The research should include both telephone surveys and periodic health examinations of deployed and nondeployed women veterans.

VA should complete and report to Congress its comprehensive study of the barriers to health care experienced by recently discharged women veterans. The study should explore the perceptions and experiences of women who have tried to access health-care services at VA facilities.

VA health-care providers should make every effort to reduce women's unnecessary exposure to radiation and pharmaceutical teratogens. VA should facilitate providers' ability to identify compounds associated with an increased risk of birth defects and immediately revise the pharmacy package to provide alerts for potential teratogens to prescribe to women veterans less than 50 years of age. Women veterans should be offered a sexual function and safe-sex-practices screen annually.

VA's sexual trauma programs should be enhanced by requiring consistent training and certification of health-care personnel across all medical and mental health disciplines on techniques for screening women at risk for military sexual trauma, effective care and treatment options, and evidence-based clinical practice guidelines for sexual trauma survivors.

VA should develop a pilot program to provide child care services for veterans who are the primary caregivers of children, while they receive intensive health-care services for post-traumatic stress disorder, mental health, and other therapeutic programs requiring privacy and confidentiality.

VA should assess and develop a plan to enhance the provision of integrated readjustment and related mental health-care services for women veterans at VA's facilities, including Vet Centers.

VA should concentrate on improving services for women with serious physical disabilities and evaluate all VA's specialized services to ensure women have equal access to these programs.

VA's Women Veterans Advisory and Minority Veterans Advisory Committees should include veterans who served in Afghanistan or Iraq.

VA should expand its continuing and graduate medical education programs for women's health.

VA should establish a new program of Women Veterans Research, Education, and Clinical Centers modeled after the Geriatric Research, Education, and Clinical Centers.

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[114]DVA, Center for Women Veterans, *Women Veterans Statistics,* October 27, 2008.
[115]Defense Department Advisory Committee on Women in the Services (DACOWITS) 2007 report (www.dtic.mil/dacowits/annual_reports/DACOWITS07_Report.pdf)
[116]P.M. Hayes, "The Evolution of Women's Health Care Services in the VA," VA Office of Research & Development, Health Services R&D Service, November 2008 (www.academyhealth.org/publications/forum/nov08.pdf).
[117]H. Kang, "VA Healthcare Utilization Among 94,010 Female OIF/OEF Veterans Through 1st Qtr. FY 2008," Environmental Epidemiology Service, 2008. Not published for the public.
[118]VHA Office of Public Health and Environmental Hazards, *Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans, OEF/OIF,* August 2008.
[119]DVA, *Comprehensive Health Care for Women Veterans: You Served, You Deserve,* August 2008.
[120]H. Kang, "VA Healthcare Utilization Among 94,010 Female OIF/OEF Veterans Through 1st Qtr. FY 2008," Environmental Epidemiology Service, 2008. Not published for the public.
[121]Elizabeth Yano, "Translating Research Into Practice—Redesigning VA Primary Care for Women Veterans," PowerPoint Presentation, DAV National Convention, Las Vegas, August 2008.
[122]P.M. Hayes, "The Evolution of Women's Health Care Services in the VA," VA Office of Research & Development, Health Services R&D Service, November 2008 (www.academyhealth.org/publications/forum/nov08.pdf).
[123]H. Kang, "VA Healthcare Utilization Among 94,010 Female OIF/OEF Veterans Through 1st Qtr. FY 2008," Environmental Epidemiology Service, 2008. Not published for the public.
[124]Ibid.
[125]DVA news release, "Health Care Report Card Gives VA High Marks," June 13, 2008.
[126]H. Kang, "VA Healthcare Utilization Among 94,010 Female OIF/OEF Veterans Through 1st Qtr. FY 2008," Environmental Epidemiology Service, 2008. Not published for the public.
[127]M. Murdoch, A. Bradley, et al., "Women and War: What Physicians Should Know," *Journal of General Internal Medicine* 21, SUP 3 (March 2006): S5–10.
[128]DVA news release, "Health Care Report Card Gives VA High Marks," June 13, 2008.
[129]D. Washington, "Ambulatory Care Among Women Veterans: Access and Utilization," VA Office of Research & Development, Health Services R&D Service, November 2008 (www.academyhealth.org/publications/forum/nov08.pdf).
[130]Elizabeth Yano, "Translating Research Into Practice—Redesigning VA Primary Care for Women Veterans," PowerPoint Presentation, DAV National Convention, Las Vegas, August 2008.

Ending Homelessness among Veterans:

The Department of Veterans Affairs must expand and enhance its homeless veteran assistance programs, including preventative services, to help end and prevent homelessness among America's veterans.

Veterans are at a greater risk of becoming homeless because of many factors, including health problems, extremely low or no livable income due to unemployment or nontransferable skills, and a shortage of safe, affordable housing. Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder (PTSD) or have addictions acquired during or worsened by their military service. At least 45 percent of homeless veterans suffer from mental illness, and more than 50 percent have substance-abuse problems. Many are dually diagnosed, which especially challenges existing service-delivery systems.

While most veterans currently homeless served during prior conflicts or in peacetime, the newest generation of combat veterans of Operation Enduring Freedom and Iraqi Freedom (OEF/OIF), both men and women, are returning home and suffering from postdeployment readjustment issues and other war-related conditions, including traumatic brain injury, which may put them at risk for homelessness. The evolving gender mix of the military—women representing 15 percent of the military population—will pose new challenges for the nation's support system for returning veterans and their families. Some women veterans are reporting serious trauma histories related to combat exposure and/or episodes of physical harassment and/or sexual assault while serving in the military. VA and homeless veteran service providers are also seeing increased numbers of veterans with children seeking their assistance.

Mental and physical health problems in addition to the absence of transferable work skills can interrupt veterans' ability to keep a job, find a home, establish savings, and, in some cases, maintain family stability. Veterans' family, social, and professional networks may have been broken as a result of extensive mobility while in military service or lengthy periods away from their hometowns and their civilian jobs. Oftentimes these problems are directly traceable to their experience in military service or to their return to civilian society without appropriate transitional support.

Most Americans believe our nation's veterans are well supported, but, in fact, many go without the services they require and are eligible to receive. According to a Congressional staff analysis of 2000 U.S. Census data conducted in 2005, 1.5 million veterans—nearly 6.3 percent of the nation's veteran population—have incomes that fall below the federal poverty level, including 634,000 with incomes below 50 percent of poverty level. Neither VA nor its state and county equivalents are adequately funded to fully respond to these veterans' health, housing, and supportive services needs. Moreover, community-based and faith-based service providers also lack sufficient resources.

VA estimates 300,000 veterans will experience homelessness at some point during the year. The VA's Health Care for Homeless Veterans program serves about one-third of this population. Community-based organizations serve approximately one-third of those in need. The remaining one-third of the homeless veteran population fails to receive the help they need to transition out of homelessness and reenter society as productive citizens. Likewise, other federal, state, and local public agencies—notably housing agencies and health departments—are not adequately responding to the housing, health-care, and supportive services needs of these vulnerable veterans. Indeed, it appears veterans fail to register as a target group for these agencies in many communities.

VA reports nearly 3,000 OEF/OIF homeless veterans were treated at VA medical centers over the past four years, and, of that number, 11 percent were women. Most likely, increasing numbers of this new generation of war veterans will be coming to VA and community-based homeless veteran service provider organizations to seek services, such as health care, substance abuse prevention, disability compensation, vocational rehabilitation, affordable housing, employment training, and job placement assistance. Poverty, lack of support from family and friends, and unstable living conditions in overcrowded or substandard housing may be factors contributing to these veterans' need for assistance.

With greater numbers of women serving in combat operations, along with increased identification of and a greater emphasis on care for victims of sexual assault and trauma, new and more comprehensive services, housing, and child care services are needed. Furthermore, in the

next 10 years, significant increases in services over current levels will be needed to serve aging Vietnam veterans suffering from chronic mental health problems.

According to the VA 2007 Community Homelessness Assessment, Local Education and Networking Groups report, there were an estimated 154,000 veterans who were homeless on any given night. This estimate of homeless veterans is down 21 percent from the 2006 estimate and represents a 40 percent reduction since 2001. VA stated the decrease was due in part to its partnership with community-based homeless veteran service providers and provides evidence that its programs to help homeless veterans are effective.

The Department of Housing and Urban Development reported in its 2007 *Annual Homelessness Assessment Report to Congress* that there had been a 30 percent reduction in chronic homelessness over the past two years. Among the 1.6 million people who were homeless and found shelter during 2007, 13 percent were veterans. The authors of the report attributed the reduction in homelessness to the effectiveness of supportive housing.

If the trend toward reducing the number of homeless veterans is to continue, more funding is needed for supportive services and housing options to ensure veterans who served prior to the conflicts in Afghanistan and Iraq will continue to take control of their lives and live as productive, self-sufficient citizens. Additionally, increased appropriations to VA homeless veteran assistance programs will help prevent homelessness among the newest generation of combat veterans from Operations Enduring and Iraqi Freedom. With the help of Congress, VA will be able to develop a coordinated approach to reduce, eliminate, and ultimately prevent homelessness among all of America's veterans.

Recommendations:

Congress should increase appropriations for the VA Medical Services Account to strengthen the capacity of the VA Health Care for Homeless Veterans programs; enable VA to increase its mental health and addiction service capacity; and enable VA to increase vision and dental care services to homeless veterans as required by law.

VA should improve its outreach efforts to help ensure homeless veterans gain access to VA health and benefits programs.

Congress should authorize and appropriate funds for competitive grants to community-based, faith-based, and public organizations to provide health and supportive services to formerly homeless veterans placed in permanent housing.

Congress should increase appropriations for the Homeless Veterans Reintegration Program *to the authorized level of $50 million.* Funded by the U.S. Department of Labor Veterans Employment and Training Service, HVRP is the only federal program wholly dedicated to providing employment assistance to homeless veterans and provides competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

Congress should increase appropriations for the Veterans Workforce Investment Program. Funded by the DOL, VWIP provides competitive grants to states geared toward training and employment opportunities for veterans with service-connected disabilities, those with significant barriers to employment (such as homelessness), and recently separated veterans.

Congress should establish a Veterans Work Opportunity Tax Credit program. The program would incentivize the hiring of homeless veterans by providing employers a tax credit equal to a percentage of the wage paid to the homeless or other low-income veterans.

Congress should increase the authorization level of and appropriations for the VA Homeless Provider Grant and Per Diem (GPD) program to *$200 million* to meet the need for additional transitional housing and service center programs assistance. GPD provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans. Special needs grant funding under this program should increase for women veterans, frail and elderly veterans, veterans with chronic mental illness, and those who are terminally ill.

Congress should revise the GPD payment program to allow payments to be related to service costs rather than a capped rate. Grantees should be allowed to use GPD funds, both in capital development projects and operating per diem payments, as a match to any other federal grant source. Grantees should also be allowed to use other available sources of income besides the GPD program to furnish services to homeless veterans.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers when such services are not available within VA.

Congress should provide and appropriate funding *for an additional 20,000 Section 8 vouchers* for the HUD-Veterans Affairs Supportive Housing Program, which provides permanent housing subsidies and case management services to homeless veterans with mental and addictive disorders, by appropriating additional funds for additional housing vouchers targeted to homeless veterans.

Congress should require applicants for Department of Housing and Urban Development McKinney-Vento homeless assistance funds to develop specific plans for housing and services to homeless veterans. Organizations receiving these assistance funds should screen all participants for military service and make referrals as appropriate to VA and homeless veteran service providers. Congress should authorize and appropriate funds for a targeted permanent housing assistance program to prevent homelessness among low-income and formerly homeless veterans.

Congress should assess all service members separating from the armed forces to determine their risk of homelessness and provide life skills training to help them avoid homelessness.

Congress should ensure VA facilities—in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursement)—develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing and appropriate supportive services. Discharge planning protocols should include providing information about VA resources and assisting persons in applying for income security and health security benefits (such as Supplemental Security Income, Social Security Disability Insurance, VA disability compensation and pension, and Medicaid) prior to release.

LONG-TERM-CARE ISSUES

VA Long-Term-Care Issues

The VA Office of Geriatrics and Extended Care is responsible for meeting the diverse long-term-care (LTC) needs of America's aging veteran population. To fulfill this responsibility, the Department of Veterans Affairs must follow Congressional mandates and be responsive to organizations that represent veterans.

The Aging of America's Veterans

Changes in age composition of the veteran population will affect the needs and demand for VA health care. Further, medical care needs are not evenly divided among age groups in the population such that the projected long-term-care cost tends to rise sharply with age.

VA estimates there are 23,442,000[131] veterans living in the United States today, with more than half (12.6 million) 60 years and older. Prior estimates indicated veterans age 85 years and older would peak at 1.3 million by 2012. Notably, the segment of the veteran population age "85 or older" is projected to increase 110 percent between 2000 and 2020.[132] However, some current estimates indicate that this wave of 1.3 million of the eldest segment of the veteran population has already arrived. Historically, only a subset of the total veteran population has enrolled for VA medical care benefits and census statistics show a steady decline of the total veteran population over the next 20 years. However, the subset of veterans enrolling to use the VA health-care system is growing.

Based on a 2007 national survey[133] conducted by the Veterans Health Administration (VHA) on its enrolled

veteran population, the median age of enrollees was 63. Though 46 percent of the total enrolled veterans were 65 years and older, their numbers have steadily increased from 1.6 million in 1999 to 3.3 million in 2007. Furthermore, while there is an expected increase in the number of enrolled veterans aged 65 or older in the next decade, nearly 60 percent of the increase is projected to be among veterans aged 85 or older. Most striking is that the enrollment of all veterans aged 85 and older is projected to grow from 20 percent to 51 percent by 2013.

Historical trends show only about two-thirds of all enrolled veterans actually seek care from VA. Those who do not seek care do so for a variety of reasons such as having other private or public health-care coverage. In addition to age, another key driver for the demand for VA medical care is the reliance and dependence of enrolled veterans on the VA health-care system. Over the past few years, the rate of the total number of unique veteran patients who have sought care from VA has slowed, but is projected to peak in 2012. Furthermore, the increasing reliance on VA care of the aging World War II and Korean War veteran, median ages 83 and 76, respectively, as well as the increased use of pharmaceuticals to manage chronic conditions, is changing the demand for VA health-care services.[134] Interestingly, the largest cohort of the VA enrollee population is Vietnam-era veterans with a median age of 60. Findings based on the 2001 National Survey of Veterans published in *Military Medicine*,[135] indicate veterans under age 60 who served in Vietnam had worse self-reported health and higher rates of stroke than those who served elsewhere during that time. Vietnam veterans 60 years and older had poor self-rated health and a higher risk for cancer than their peers. Many facilities are now beginning to see Vietnam veterans in need of long-term-care (LTC) services.

VA's long-standing goal has been to provide a full spectrum of LTC services to eligible veterans. This oldest segment of the veteran population has had, and will continue to have, an increasing demand for VA health-care services, particularly those services focused on long-term care. With the influx of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans with severely disabling conditions such as traumatic brain injury, VA is challenged to meet their LTC needs, particularly in the area of residential rehabilitation care. Moreover, OEF/OIF veterans place a high value on their independence, are physically strong, and are part of a generation that was socialized differently than their older counterparts were. Although there are generational differences that pose unique challenge in the institutional and LTC environment, there is a shared preference to receive long-term care in noninstitutional settings, so they can stay connected with their community and loved ones. However, the success of such long-term care is critically dependent on the availability of local services and ability of veterans' family and friends to assist in their care. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers. *The Independent Budget* veterans service organizations (IBVSOs) believe programmatic changes can be applied, such as our recommendations from the "Family and Caregiver Support Issues Affecting Severely Injured Veterans" section of this *Independent Budget*. VA must move quickly to develop a comprehensive strategic plan, as required by Congress, to address the LTC needs of America's veterans.

Continuing Concerns on VA's Inadequate Planning for Long-Term Care

In 2003, 2004, 2005, and 2006, the Government Accountability Office (GAO) examined various aspects of VA's long-term-care programs at the direction of both the House and Senate Committees on Veterans' Affairs. The reports, which continued to find limitations with VA long-term-care program data for planning and oversight, remain a cause for great concern. In addition, the reports also describe access to a complete continuum of VA LTC services remains markedly variable from network to network.

In its November 2004 report,[136] the GAO pointed out several problems that prevent VA from having a clear understanding of its program's effectiveness. In a follow-up report[137] issued January 2006, the GAO reiterated the need for VA to estimate who will seek VA nursing home care and what their needs will be, to include estimating the number of veterans that will be eligible for nursing home care, based on law and VA policy, and the extent to which these veterans will be seeking care for long and short stays.

To help ensure that VA can conduct adequate program monitoring and planning for nursing home care and to improve the completeness of data needed for Congressional oversight, the GAO recommended that VA collect data for community and state veterans' nursing homes that is comparable to data collected on VA Community Living Centers (formerly Nursing Home Care

Units), including short-stay post-acute needs or long-stay chronic. The GAO also recommended that VA collect data on the number of veterans in these homes that VA is required to serve based on the requirements of the Veterans Millennium Health Care and Benefits Act, P.L. 106-117. VA's position is that data other than eligibility and length of stay, such as age and disability, are "most crucial" for its long-term-care strategic planning and program oversight. To best serve the veteran patient population, the IBVSOs believe Congressional oversight is equally important to VA's need to manage and plan for its long-term-care benefits package, particularly in light of shifting patient workload with 65 percent now being met by community and state veterans homes.

VA has expanded its noninstitutional long-term-care programs, such as home-based primary care, but it has not changed its reporting conventions such that it associates a day of care in a community-based or home-based program with that of a day of care in a nursing home or other institutional setting. This type of data collection and reporting is not conducive to proper oversight and may produce a distortion of activity or workload when in fact none may be present. VA's response to the GAO's 2004 report[138] that VA's workload measurement for home-based primary care does not accurately reflect the amount of care received by veterans specifies a combination of workload measures for home-based primary care and other long-term-care programs beginning in FY 2005, including days enrolled in the program, the number of patients treated, and the number of visits veterans receive.

Congress has shown its concern about VA's long-term-care planning, as evidenced by its rejection of VA's proposals to halt construction and reduce per diem funding to state veterans homes and to repeal the nursing home capacity mandate under P.L. 106-117. Most recently, Congress expanded the authorities for state veterans homes in passing the Veterans Benefits, Health Care, and Information Technology Act of 2006.[139] The law requires VA to reimburse state veterans homes for the full cost of care for a veteran with a 70 percent or greater service-connected disability rating and in need of care for service-connected conditions. It also ensures that veterans with a 50 percent or greater service-connected disability receive, at no cost, medications they need through VA. Moreover, not later than 180 days after its enactment, VA was required to publish a strategic plan for long-term care.

In light of VA's inability to meet mandated capacity requirements, coupled with its commitment to invest in alternative extended-care services, the IBVSOs are concerned about the delicate balance VA must achieve between institutional and noninstitutional long-term-care services to provide for veterans' health-care needs. We believe that the information to be collected and reported be those that are necessary to support strategic planning and program management as well as policy decisions and budget formulation.

Enrollee demand for long-term-care services, modeled by the VHA, lacks reliability, which led to a glaring gap in the Capital Asset Realignment for Enhanced Services (CARES) plan. Also, the limitation of this model was evidenced by VA's request in 2005 outside the regular appropriations process for an additional $1.997 billion, of which $600 million was to be used to correct for the estimated cost of long-term care. One of the most important underlying assumptions needed for VA's long-term-care planning model relates to understanding which enrollees choose to use VA extended-care services and why they make those choices. Until the necessary programmatic and patient population information is collected, validated, and analyzed, the IBVSOs believe VA will continue to struggle to effectively plan and provide for the immediate and future long-term-care needs of America's veterans. While VA can only advise Congress about the program requirements necessary to meet these needs, it is its duty to do so to the extent Congress is able to conduct proper oversight. VA should be the advocate for veterans' long-term-care needs, not just the provider.

VA's Long-Term-Care Programs

VA provides an array of noninstitutional (home and community-based) LTC programs designed to support veterans in their own communities while living in their own homes. Additionally, VA provides institutional (nursing home) care in three venues to eligible veterans and others as resources permit. VA provides nursing home care in VA-operated nursing homes (now termed Community Living Centers (CLCs)), under contract with private community providers, and in state veterans homes.

The long-term-care philosophy adopted by VA is to provide services in the "least restrictive setting." According to the VHA,[140] the aging veteran patient population will result in a 20–25 percent increase in use for both nursing home and home- and community-based services

through 2012. The VHA currently concentrates just over 90 percent of its long-term-care resources on nursing home care. However, among those veterans who receive long-term care from all sources, 56 percent receive care in the community. VHA's experience with providing mandatory nursing home care in its CLCs to service-connected veterans rated 70 percent or higher suggests that only 60–65 percent will choose VHA-provided care primarily due to geographical considerations and cost. These findings support the increased projected use for long-term care through home- and community-based services.

VA's current policy to increase noninstitutional services is supported by veterans, their families, and by organizations that represent them. However, the reality is that VA's own data forecast that demand for long-term-care services will increase over the next decade. Inevitably, thousands of veterans who are currently living in community settings, with the support of VA's noninstitutional services today, will need institutional services tomorrow. The IBVSOs believe the demand for VA nursing home care is increasing, not just because of the growing cohort of veterans 85 and older but also because of the complications related to the secondary conditions associated with military service that often present later in life. Accordingly, the IBVSOs are greatly concerned about VA's inability to maintain its CLC capacity at the 1998 level of 13,391 average daily census (ADC) as mandated by P.L. 106-117. In particular, the decrease in VA's CLC capacity year after year makes it more difficult to reactivate VA nursing home beds to serve veterans in need of such care.

Other equally disturbing issues exist that are aggravated by the continued decrease in CLC capacity along with the shift to provide institutional long-term care to community nursing homes (CNH) and state veterans homes. For example, VA "partnership" with the State Veterans Home program is in essence two-fold: VA's on-site inspections to ensure quality of care in state veterans homes and per diem payment to the states as they care for their veterans' long-term-care burdens. While provisions in P.L. 109-461 have enhanced this relationship, the majority of VA facilities continue to deny access to enrollment and to specialized VA care for residents of state veterans homes on the basis that the homes are responsible for comprehensive care, not VA. Moreover, most VA medical centers do not refer enrolled veterans to state veterans homes even when one is located close to the veteran's community, family, and friends. The lack of a true partnership between VA and state veterans homes affects the ability for veterans to receive patient-centric long-term care.

In addition, VA has become highly efficient at converting veterans it has placed in CNH to Medicaid status for payment purposes without establishing a formal tie to the Centers for Medicare and Medicaid Services (CMS) or with the states to oversee that unwritten policy. Clearly, much work remains to be done in VA's long-term-care program; however, Congress should conduct oversight and VA must maintain a safe margin of CLC capacity that will meet the needs of elderly veterans who can be expected to transition from VA's noninstitutional care programs to VA nursing home care in the near future.

VA Institutional Long-Term-Care Services

VA's Community Living Center (formerly nursing home care units)

VA owns and operates 133 CLCs from Puerto Rico to Hawaii, which range in size from 20 to 240 beds. As mentioned previously, VA's nursing home ADC has again dropped below that of the previous year. The projected VA nursing home ADC for 2008 is 10,538. This number continues to reflect a steady downward trend in CLC capacity despite increased need for such services (see table below).

VA's national recognition as a leader in providing quality nursing home care is being challenged by its own emphasis on post-acute care at the expense of maintaining CLC capacity. The IBVSOs believe this approach is short-sighted considering the increasing number of veterans most likely to need long-term care. Further, Congress has mandated that VA must maintain its CLC capacity at the 1998 ADC level of 13,391, but VA has not done so despite testifying in 2007 that it expects to sustain existing capacity in its own CLC.[141] The IBVSOs are concerned that the decrease in the number of long-

LTC-ADC VA's Community Living Center (Nursing Home) Care Program	
2008	10,538
2007	10,926
2006	11,434
2005	11,548
2004	12,354
1998 (PL 106-117 Mandate)	13,391
ADC Decrease from PL 106-117 Mandate: (2,853)	

stay patients and the increase in the number of short-stay patients VA treats in CLCs will continue to drain needed capacity. However, VA has chosen to ignore the Congressional mandate without adequate justification, and, to date, Congress has chosen to look the other way.

VA's Community Nursing Home Care Program

VA has contracts with more than 2,500 private CNHs located throughout the nation. In 2005, the ADC for VA's CNH program represented 13 percent of VA's total nursing home workload. VA's CNH program often brings care closer to where the veteran actually lives, closer to his or her family and personal friends. Since 1965, VA has provided nursing home care under contracts or purchase orders. The CNH Program has maintained two cornerstones: some level of veteran choice in choosing a nursing home and a unique approach to local oversight of CNHs.

The IBVSOs have ongoing concerns about the quality of contract community nursing home care in VA[142] and the abrogative relationship VA has with the veterans it places in CNHs. VA must do more to ensure that the quality of care in these facilities meets the highest standards and that VA remain the responsible party to facilitate medical information transfer and coordination of other VA benefits and services. Veterans and their families must be assured that all aspects of care meet the individual veteran's needs. For example, veterans with catastrophic disabilities, such as SCI, blindness, PTSD, and other forms of mental illness, must receive care from trained staff. Their unique medical care needs require access to physicians, nurses, and social workers who are knowledgeable about the specialized care needs of these veteran groups.

VHA Handbook 1143.2 provides instructions for initial and annual reviews of CNH and for ongoing monitoring and follow-up services for veterans placed in these facilities. First introduced in 2002, the handbook updates new approaches to CNH oversight, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

LTC-ADC VA's Community Nursing Home Program	
2008	4,787
2007	4,439
2006	4,395
2005	4,254
2004	4,302
ADC Increase over 2007: 248	

VA Nursing Home Care Provided in State Veterans Homes

The VA State Veterans Home Program currently encompasses 137 nursing homes in 50 states and Puerto Rico, with more than 28,000 nursing home and domiciliary beds for veterans and their dependents. State veterans homes provide the bulk of institutional long-term care to the nation's veterans. The GAO has reported that state homes provide 52 percent of VA's overall patient workload in nursing homes, while consuming just 12 percent of VA's long-term-care budget. VA's authorized ADC for state veterans homes was 18,349 for FY 2007 (see table below).

LTC-ADC State Veterans Homes	
2008	19,208
2007	18,349
2006	17,747
2005	17,794
2004	17,328
2008 ADC Increase over 2007: 859	

VA holds state homes to the same standards applied to the nursing home care units it operates. State homes are inspected annually by teams of VA examiners, and VA's Office of Inspector General (OIG) also audits and inspects them when determined necessary. State homes that are authorized to receive Medicaid and Medicare payments also are subject to unannounced inspections by the CMS and announced and unannounced inspections by the OIG of the Department of Health and Human Services.

VA pays a small per diem payment for each veteran residing in a state home, less than one-third of the average cost of that veteran's care. The remaining two-thirds is made up from a mix of funding, including state support, Medicaid, Medicare, and other public and private sources. In P.L. 109-461, Congress authorized VA to reimburse state homes the full cost of care for seriously disabled service-connected veterans (rated at least 70 percent disabled or more), and for veterans who receive state home care primarily for a service-connected disability at any VA rating.

Service-connected veterans should be the top priority for admission to state veterans homes, but traditionally they

have not considered state homes an option for nursing home services because of lack of VA financial support. To remedy this disincentive, Congress provided authority for full VA payment. Although regulations were not proposed until recently,[143] VA has been slow to implement this new mandate, which took effect in March 2007.

In addition to per diem support, VA helps cover the cost of construction, rehabilitation, and repair of state veterans homes, providing up to 65 percent of the cost, with the state providing at least 35 percent. Unfortunately, in FY 2007 the construction grant program was funded at only $85 million, the same amount Congress had provided in FY 2006. Based on a current backlog of nearly $1 billion in grant proposals (including $242 million in life and safety projects) and with thousands of veterans on waiting lists for state beds, *The Independent Budget for FY 2008* recommended no less than $150 million for this program. The IBVSOs are grateful Congress responded and provided $165 million for FY 2008 in the recently enacted omnibus appropriations act. For FY 2009, the *IB* recommended $200 million for the state veterans home construction grant program, and Congress provided $175 million.

For FY 2010, *The Independent Budget* recommends the construction grant program be funded at $250 million.

VA Noninstitutional Long-Term-Care Services

VA offers a wide spectrum of noninstitutional long-term-care (LTC) services to veterans enrolled in its health-care system. From 1998 to 2002, VA's ADC in home- and community-based care increased from 11,706 to 17,465. In FY 2003, 50 percent of VA's total long-term-care patient population received care in noninstitutional care settings. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, home respite care, home hospice care, and community residential care.

In recent years VA has been increasing its noninstitutional (home- and community-based) budget and services through the use of key performance measures for an annual percentage increase of noninstitutional long-term-care average daily census, using 2006 as the baseline of 43,325 ADC. As mentioned previously, simply using the percentage increase[144] is based on the ADC of veterans enrolled in home- and community-based care programs (e.g., community residential care, home-based primary care, contract home health care, adult day health care (VA and contract), homemaker/home health aide services, and care coordination/home telehealth) does not adequately capture the workload for strategic planning, program management, policy decisions, budget formulation, and oversight.

VA must also take action to ensure that these programs, mandated by P.L.106-117, are readily available in each VA network. In May of 2003, the GAO reported: "VA service gaps and facility restrictions limit veterans' access to VA noninstitutional care."[145] The report stated that of the 139 VA facilities reviewed, 126 do not offer all of the six services mandated by P.L. 106-117. In order to eliminate these service gaps, VA must survey each VA network to determine that all of its noninstitutional serv-

Table 4. LTC-ADC for VA Noninstitutional Care Programs

Programs	2004	2005	2006	2007	2008	I/D Over 2006
HHBPC	9,825	11,594	12,641	13,222	16,523	3,301
PSHC	2,606	3,075	2,490	2,656	3,319	663
HHHA	5,580	6,584	5,867	6,631	9,321	2,690
VA ADHC				15	335	320
C ADHC	1,493	1,762	1,304	1,884	2,019	135
Hospice	164	194	427	553	858	305
Respite	84	99	118	254	418	164
SCI					598	598
CRC	5,771	6,810	3,692	5,069	4,248	(821)
Total	**19,752**	**23,308**	**22,847**	**25,215**	**37,639**	**12,424**

Note: NOTE: I/D Change = Increase or (Decrease) Noninstitutional Program ADC over 2007: 12,424

ices are operational and readily available. Despite this information, VA's LTC Strategic Plan neglects to provide a clear and specific VA Action Directive to ensure systemwide compliance with P.L. 106-117.

The success of noninstitutional long-term care is critically dependent on the availability of local services and ability of veterans' family and friends to assist in their care. Family caregivers play an important role in health care, but need regular breaks to maintain their own health and well-being. VA respite care is one of the few services available with a primary focus on supporting family caregivers. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers. The IBVSOs applaud Congress for authorizing VA to conduct a pilot program on improvement of caregiver assistance services,[146] and look forward to the lessons learned to enhance caregiver services. Moreover, we believe programmatic changes can be applied, such as recommended in "Family and Caregiver Support Issues Affecting Severely Injured Veterans" in this *Independent Budget*.

The IBVSOs support the expansion of VA's noninstitutional long-term-care services and the adoption of innovative approaches to expand this type of care. Noninstitutional long-term-care programs can sometimes obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost effective and extremely popular. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

Future Directions for VA Long-Term Care

The face of long-term care is changing, and VA continues to work within resource limitations to provide variations in programming that meet veterans' needs and preferences. The IBVSOs expect VA to modify existing programs and develop new alternatives as financial resources allow. New horizons for VA long-term care include the items discussed in the following subsections.

Culture Change in VA's Community Living Centers

Concerned by the perceived devaluation of the elderly and those who care for them, formal and informal meetings of a small group of health-care providers and administrators led to the creation of a national movement within the VHA. This movement aims to engage staff and veterans across the country in transforming the culture of long-term care to a resident-centered model providing compassionate and comprehensive care to veterans in a home-like environment. The culture transformation movement is also expected to ensure increased satisfaction for both nursing home residents and staff at all 134 VA CLCs across the United States. The IBVSOs believe VA should continue the "culture change" transformation; ensure VA medical center executive staff and the CLC nurse manager and staff are involved and committed to this initiative; and issue a report measuring the expected increased satisfaction in VA CLCs.

Hospice and Palliative Care

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings for people in the last phases of incurable disease so they may live as fully and as comfortably as possible. The program emphasizes the management of pain and other physical symptoms, the management of the psychosocial problems, and the spiritual comfort of the patient and the patient's family or significant other. Services are provided by a medically directed interdisciplinary team of health-care providers and volunteers. Bereavement care is also available to the family following the death of the patient. Hospice services are available 24 hours a day, seven days a week and is provided across multiple settings, including hospital, extended-care facility, outpatient clinic, and private residence.

While hospice and palliative care is part of VA's medical benefits package, it was in recent years that this service was made into a formally structured program. Expansion and outreach was greatly assisted through the Hospice-Veteran Partnership, a local coalition of VA facilities, community hospices, veterans service organizations, and volunteers. Community agencies have been made aware of this VA benefit through the Hospice-Veteran Partnership and are actively identifying veterans within the population they serve who were not previously identified.

VA is now providing hospice and palliative care to a growing number of veterans throughout the country. Nearly 9,000 veterans were treated in designated hospice beds at VA facilities in 2007, and thousands of other veterans were referred to community hospices to receive care in their homes. The number of veterans treated in VA's inpatient hospice beds increased by 21 percent in 2007. In addition, the average daily number of veterans

receiving hospice care in their homes paid for by VA increased by 30 percent this past year.

We applaud VA for its commitment to make this service available to all veterans who require such compassionate care. Nearly half of all veterans who died in VA facilities received care from a palliative care team prior to their deaths, although such services are provided at only about one-fourth of all American hospitals. Because of the large number of World War II and Korean War era veterans and a tripling of the number of veterans over the age of 85, the increase in the need for hospice care and palliative care is expected to continue. Furthermore, the IBVSOs applaud Congress's recent efforts to improve access to VA hospice and palliative care services by prohibiting VA from collecting copayments for hospice care provided to enrolled veterans in all settings.[147]

However, some gaps remain that are a cause for concern. Through the use of palliative care consultation services at each of its medical centers and inpatient hospice care in many of its nursing homes, VA is providing hospice and palliative care to a growing number of veterans throughout the country. While VA hospice and palliative care is to be available by direct provision or by purchase in the community, VA must ensure all its medical centers have a Palliative Care Consultation Team consisting of, at a minimum, a physician, nurse, social worker, chaplain, and administrator.[148] Moreover, when a veteran who is dually eligible for VA hospice and Medicare/Medicaid hospice and is referred to a community hospice agency, the veteran is given a choice as to which will pay for hospice care.

Although the IBVSOs believe a veteran's preference should be honored, we are concerned that the choice of payer can affect the types of services provided, the quality of care, and financial expenses the veteran and dependents may incur. VA's hospice care benefit is a greater benefit as it is part of a VA's comprehensive medical care benefits package designed to be patient-centric and treat the whole patient. For example, when a veteran chooses Medicare as the payer of hospice care, Medicare will not pay for any treatment or medications not directly related to the hospice diagnosis. The community hospice would need to inform the veterans and their dependent which treatment or medications are or are not covered. Further, under the Medicare hospice benefit, all care that veterans receive for their illness must be given by the community hospice. Therefore, the veteran must be discharged out of Medicare hospice before any other treatments or medications can be given to ensure the veteran's comfort and quality of life. Finally, the IBVSOs believe both the community hospice agency and VA must ensure that when the veteran dies his or her dependents are made aware of all ancillary VA benefits to which they may be entitled.

Respite Care

According to VA, respite care is a program in which brief periods of care are provided to veterans in order to give veterans' regular caregivers a period of respite. Respite care services are primarily a resource for veterans whose caregivers are neither provided respite services through, nor compensated by, a formal care system (i.e., Community Residential Care (CRC) program agreements, Medicaid waiver programs, hospice programs, and others for which the veteran is dually eligible). The National Family Caregiver Support Program,[149] along with Aged/Disabled (A/D) Medicaid Home and Community-Based (HCBS) waivers and state-funded respite care and family caregiver support programs that provide the bulk of public financing to support family caregiving, including respite care, defines respite care as a service to provide temporary relief for caregivers from their care responsibilities.

Respite care is considered the dominant service strategy to support and strengthen family caregivers under the A/D Medicaid HCBS waiver program. In a survey conducted on A/D Medicaid waiver programs that asked respondents to choose from a list of 20 items the services their program provides specifically to family caregivers, respite care received a 92 percent response, followed by information and assistance, homemaker/chore/personal care, and care management/family consultation at 48 percent each.[150]

Even the Department of Defense (DOD) provides respite services to injured active duty service members, including National Guard/Reserve members injured in the line of duty. TRICARE now offers primary caregivers of active duty service members rest, relief, and reprieve, authorized by section 1633 of the National Defense Authorization Act for Fiscal Year 2008 (NDAA). This respite benefit helps homebound active duty service members who need frequent help from their primary caregiver. If the injured service member's treatment plan requires a caregiver to intervene more than twice in an eight-hour period, the caregiver can receive respite services for a maximum of eight hours of respite per day, five days a week. Active duty service members or their legal representatives can submit receipts for reimbursement of respite care services beginning January 1, 2008, by a TRICARE-authorized home health agency. This benefit serves to mirror other supplementary TRICARE benefits

that provide respite services to active duty family members under TRICARE Extended Care Health Option (ECHO)[151] and TRICARE ECHO Home Health Care, which are created to better align DOD's existing unlimited home health agency and skilled nursing facility benefits to mirror the benefits and payment methodology used by Medicare.

VHA Handbook 1140.02, released on November 10, 2008, seeks to address concerns about the availability of this service in both institutional and noninstitutional settings; however, additional limitations remain. While the VA policy allows respite care services to be provided in excess of 30 days, it requires unforeseen difficulties and the approval of the medical center director. Moreover, long-term-care copayments apply to respite care regardless of the setting or service that provides such care. The IBVSOs believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veterans primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days of respite care provided to veterans and their caregivers, and eliminating applicable copayments.

Special Long-Term-Care Innovations to Serve Younger Combat Veterans

VA must move forward in the development of institutional and noninstitutional care programming for young OEF/OIF veterans whose combat injuries are so severe that they are forced to depend on VA for long-term-care services.

An important factor to consider is that extraordinarily disabled veterans are coming home from Afghanistan and Iraq with levels of injury and disability unheard of in past wars. Our incredible military medical triage and its applied technology has saved them, and many of them are now in VA polytrauma centers or other acute care and rehabilitation facilities, but they present a medical and social challenge the likes of which VA has not seen before. It is fortunate that the numbers of these "polytraumatic" injured are relatively small, but we must be cognizant that some of them will need extraordinary care and shelter for the remainder of their lives. Neither VA nor these veterans' families are fully prepared today to deal with their longer-term needs, an issue we have addressed in other sections of this *Independent Budget*. In addition to establishing internal residential treatment and care capacity, the existing partnership between the states and VA may be the basis for state veterans homes to play a small but vital role in aiding some of these catastrophically injured veterans by providing them a home-like atmosphere, a caring environment, and the level of clinical services they are going to need for the remainder of their lives. Also, state veterans homes greatly increase access for services and can offer a less intensive alternative to VA medical facilities in serving as a source of respite for families of these severely injured.

VA's current nursing home capacity is designed to serve elderly veterans, not younger ones. VA must make every effort to create an environment for these veterans that recognizes they have different needs. VA leadership and VA planners must work to bring a new type of long-term-care program forward to meet these needs. To facilitate the integration of young combat injured veterans into appropriately suited VA long-term therapeutic residential care programs, VA should capitalize on the use of state veterans homes that have the capacity of providing respite services to families and other caregivers of severely injured OEF/OIF veterans.

In March 2008, VA testified before the Senate Committee on Veterans' Affairs regarding an initiative to be implemented nationally that includes the Medical Foster Home program. This program identifies families in the area who are willing to open their homes and care for veterans who need daily assistance and are no longer able to remain safely in their own home, but do not want to move into a nursing home. It is provided as an adult foster home arrangement on a permanent basis, supported by VA's Home-Based Primary Care interdisciplinary home care team providing oversight and making regular visits.

VA considers this is a long-term commitment between the veteran and the caregiver. The veteran may live for the remainder of his or her life, and the partnership between VA's Foster Care Program and Home Based Primary Care is a safeguard against abuse. The first foster home program was started in Little Rock, Arkansas, in 1999, followed by sites in Tampa and San Juan. Using New Clinical Initiative Funding in 2000, VA developed medical care foster homes and provided funding at $95,000 for two years. In 2002 VA had 35 foster homes and 45 patients. Currently, the VHA has 38 facilities in 14 Veterans Integrated Service Networks (VISNs) with medical foster home programs, and in 2008, Congress granted funds for 33 additional sites.

Medical foster homes can be owned or rented by the caregiver, and the home is limited to three or fewer res-

idents (veterans and nonveterans) receiving care. The range of fee payments to medical foster home caregivers has increased from $1,000 to $1,800 per month in 2002 to $1,500 to $2,500 based upon the level of care needed by the veteran—for example, a cost of $1,500 for someone with mild cognitive impairment who is independent in activities of daily living but requires supervision, to $2,500 for someone who is incontinent, bed-bound, and needs to be turned every four hours. This payment is made by the veteran directly to the caregiver monthly, which includes room and board, 24-hour supervision, assistance with medications, and whatever personal care is needed.

VA believes Medical Foster Homes are cost-effective alternatives to nursing home placement because veterans must pay for their medical foster care using Social Security, private pensions, and VA pensions, or service-connected disability compensation. Although under current law a veteran having neither a spouse nor a child is covered by Medicaid for nursing facility services, no pension payments exceeding $90 per month after the month of admission are to be paid to the veteran or for him or her to the facility.[152] This does not apply to veterans receiving service-connected disability benefits, however. The IBVSOs are greatly concerned that veterans living in the medical foster home are required to pay for their stay in the home using personal funds, such as their VA compensation.

The newest generation of veterans, from the Gulf War until today, exhibits different expectations than their counterparts of the past. In general, they are computer literate, well educated, want more involvement in their own care, and want to control their own destinies. As these veterans age into later life and begin to need long-term-care services, this will make VA's and our jobs much more challenging. Younger veterans with catastrophic injuries must be surrounded by forward-thinking administrators and staff who can adapt to youthful needs and interests. The entire environment must be changed for these individuals, not just marginally modified. For example, therapy programs, surroundings, meals, recreation, and policy must be changed to adapt to a younger, more vibrant resident. Unfortunately, VA's Strategic LTC Plan does not explain how VA will adjust services to care for younger OEF/OIF veterans.

MyHealtheVet

VA's Office of Geriatrics and Extended Care should aggressively promote VA's MyHealtheVet program. This VA online program can greatly enhance an aging veteran's quality of life and help ensure the quality of medical care he or she receives from VA. MyHealtheVet is a veteran-centered proactive website that encourages veterans to be involved in their own health and the care they receive from VA.

VA's Care Coordination Program

VA's intent is to provide care in the least restrictive setting that is appropriate for the veteran's medical condition and personal circumstances. Further collaboration between programs within Geriatrics and Extended Care and those of the Office of Care Coordination/Home Telehealth can continue to produce positive results by providing services that are tailored to meet individual veterans' needs.

VA has been investing in a national care coordination program for the past three years. The program applies care and case management principles to the delivery of health-care services with the intent of providing veterans the right care in the right place at the right time. Veteran patients with chronic diseases, such as diabetes, heart failure, PTSD, and chronic pulmonary disease, are now being monitored at home using telehealth technologies.

Care coordination takes place in three ways: in veterans homes, using home telehealth technologies; between hospitals and clinics, using videoconferencing technologies; and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2 percent to 3 percent of patients who are frequent clinic users and require urgent hospital admissions. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse, or a social worker, but other practitioners can provide the support necessary. There are also physicians who coordinate care for complex patients.

As veterans age and need treatment for chronic diseases VA's care coordination program has the ability to monitor a veteran's condition on a daily basis and provide early intervention when necessary. This early medical treatment can frequently reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

As America's veteran population grows older, care coordination will be a useful tool in VA's long-term-care arsenal that can enable aging veterans to remain at home or close to home as long as possible. Congress must assist VA in expanding this valuable program across the entire VA health-care system.

VA Long-Term Care for Veterans with Spinal Cord Injury/Disease (SCI/D)

Both institutional and noninstitutional VA long-term-care services designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with SCI/D are especially vulnerable and require a high degree of long-term and acute care coordination. A major issue of concern is the fact that a recent VA survey indicated that in FY 2003 there were 990 veterans with SCI/D residing in non-SCI/D designated VA nursing homes. However, VA has not identified the exact locations of these veterans in its LTC Strategic Plan. The special needs of these veterans often go unnoticed and are only discovered when the patient requires admission to a VA medical center for treatment.

VA's LTC Strategic Plan does not provide adequate and specific information to identify the location and facility of service for these veterans. The plan provides a VISN-by-VISN roll-up but does not allow for quality-of-care tracking of individual catastrophically injured veterans. VA must develop a program to locate and identify veterans with SCI/D who are receiving care in non-SCI/D designated LTC facilities and ensure that their unique needs are met. In addition, these veterans must be followed by the nearest VA SCI center to ensure they receive the specialized medical care they require. Veterans with SCI/D who receive VA institutional long-term care services require specialized care from specifically trained professional LTC providers in an environment that meets their accessibility needs.

Currently, VA operates only four designated LTC facilities for patients with SCI/D, and none of these facilities is located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility, Chicago (28 staffed beds); and Castle Point, New York (16 staffed beds). Unfortunately, these limited staffed (121 total) beds are usually filled, and there are waiting lists for admission. These four VA SCI/D long-term-care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA CARES initiative has called for the creation of additional long-term care beds in four new locations (30 in Tampa, 20 in Cleveland, 20 in Memphis, and 30 in Long Beach, California), these additional services are not yet available and would provide only 30 beds west of the Mississippi River. These new CARES long-term-care beds present an opportunity for VA to refine the paradigm for SCI/D LTC design and to develop a new SCI/D LTC staff training program.

Assisted Living

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with activities of daily living (ADLs) or the instrumental activities of daily living. Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, VA forwarded a report to Congress concerning the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by P.L. 106-117. The Assisted Living Pilot Program (ALPP) was carried out in VA's VISN 20. VISN 20 includes Alaska, Washington, Oregon, and the western part of Idaho. It was implemented in seven medical centers in four states: Anchorage; Boise; Portland; Roseburg, Oregon; White City, Oregon; Spokane; and Puget Sound Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

The VA report on the overall assessment of the ALPP stated: "The ALPP could fill an important niche in the continuum of long-term-care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."

Some of the main findings of the ALPP report include:

- ALPP veterans showed very little change in health status over the 12 months postenrollment. As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that the ALPP may have helped maintain veterans' health over time.
- The mean cost per day for the first 515 veterans discharged from the ALPP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.
- The mean cost to VA for a veteran's stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.

- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.
- The average ALPP veteran was a 70-year-old unmarried white male who was not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.
- ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment: 22 percent received assistance with between four and six ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with one to three ADLs; while 35 percent received no assistance.
- Case managers helped ALPP veterans apply for VA Aid and Attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.
- Veterans were very satisfied with ALPP care. The highest overall scores were given to VA case managers (mean: 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82).
- Veterans are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).
- Case managers were very satisfied with ALPP. (Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall in between the cracks.")

VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority to provide assisted living services, believing this is primarily a housing function. The IBVSOs disagree and believe that housing is only one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is just part of the mix. VA already provides housing in its domiciliary and nursing home programs, and an assisted living benefit should not be prohibited by VA on the basis of its housing component.

CARES and Assisted Living

VA's final CARES decision document and the VA's CARES Commission recommended utilizing VA's enhanced-use leasing authority as a tool to attract assisted living providers. The enhanced-use lease program can be leveraged to make sites available for community organizations to provide assisted living in close proximity to VA medical resources. The Fort Howard, Maryland, project is a good example of a partnership between a private developer and VA.

The IBVSOs concur with this CARES recommendation and the application of VA's enhanced-use lease program in this area. However, the IBVSOs believe that any type of VA enhanced-use lease agreement for assisted living, or any other projects, must be accompanied with the understanding that veterans have first priority for care or other use.

The IBVSOs acknowledge and appreciate that Congress recently authorized a new VA assisted living pilot project in Section 1705 of Title XVII of the NDAA. We are hopeful that VA and the Department of Defense will expedite the establishment of this program, understanding that its intent is aimed at providing alternative therapeutic residential facilities to severely injured OEF/OIF veterans. However, this new program also provides an important new opportunity to further study the feasibility and worth of assisted living as an alternative to traditional institutional services for elderly veterans.

Recommendations:

VA must develop a more robust Long-Term Care Planning Model to ensure that strategic planning, program management, policy decisions, budget formulation, and oversight are able to meet the growing need of veterans of all ages for long-term care.

Congress must hold appropriate long-term care hearings to learn the specific issues of concern for aging veterans. The information gleaned from these hearings must be used by VA as it moves forward in the development of a comprehensive strategic plan for long-term care.

VA must develop a more detailed comprehensive strategic plan for long-term care that includes milestones for oversight purposes and such a plan must ensure that it meets the current and future needs of America's veterans.

Congress must provide the financial resources for VA to implement its long-term-care strategic plan.

Congress must enforce and VA must abide by P.L. 106-117 regarding VA's nursing home average daily census capacity mandate.

VA and Congress must continue to provide the construction grant and per diem funding necessary to support state veterans homes. Even though Congress has approved full long-term-care funding for certain service-connected veterans in State Veterans Homes under P.L. 109-461, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure. To that end, Congress should provide state veterans homes $250 million in construction grant funds for FY 2010.

Congress must conduct oversight on VA's relationship and use of community nursing homes to provide long-term care to disabled veterans, and VA must do a better job of tracking the quality of care provided in VA contract CNHs. Unscheduled quality-of-care visits are a good first step but accreditation requirements are a better approach.

Given the evident growth in demand and to protect traditional VA institutional programs, Congress must provide additional resources and VA must increase its capacity for noninstitutional, home, and community-based care.

The Veterans Health Administration must update its noninstitutional extended care directive and information letter to ensure that each noninstitutional long-term-care program mandated by P.L. 106-117 is operational and available across the entire VA health-care system.

VA should continue the "culture change" transformation; ensure that VA medical center executive staff and the community living center nurse manager and staff are involved and committed to this initiative; and issue a report measuring the expected increased satisfaction in VA community living centers.

VA should ensure all veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be provided, at a minimum, all services within the VA medical benefits package regardless of the payer of services.

VA should ensure all dependents of veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be made aware of all ancillary VA benefits to which they may be entitled.

VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days of respite care provided to veterans and their caregivers, and eliminating applicable copayments.

VA should expand the care coordination program to reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

VA should not require veterans to use personal funds, such as their service-connected disability benefits, to avail themselves of the type of noninstitutional long-term care provided by the medical foster homes program.

VA's Office of Geriatrics and Extended Care should encourage veterans to use VA's MyHealtheVet website.

Serious geographical gaps exist in specialized long-term-care services (nursing home care) for veterans with spinal cord injury or spinal cord disease. As VA develops its construction plan for nursing home construction, it must provide a minimum of 15 percent bed space to accommodate the specialized spinal cord injury nursing home needs nationally. VA must start by implementing the Capital Asset Realignment for Enhanced Services spinal cord injury/dysfunction long-term-care recommendations. VA must develop a more detailed facility by facility mechanism to locate and identify veterans with SCI/D and other catastrophically injured veterans residing in non-SCI/D long-term-care facilities.

VA should develop a VA nursing home care staff training program for all VA long-term-care employees who treat veterans with SCI/D and other catastrophic disabilities.

While assisted living is not currently a benefit that is available to veterans (outside the two pilot programs discussed above), *The Independent Budget* veterans service organizations (IBVSOs) believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care.

VA's 2004 Assisted Living Pilot Program report seems most favorable and assisted living appears to be an unqualified success. However, to gain further under-

standing of how the ALPP can benefit veterans, it should be replicated in at least three Veterans Integrated Service Networks with a high percentage of elderly veterans. The IBVSOs hope the new pilot program authorized by the National Defense Authorization Act for Fiscal Year 2008 can be a means of evaluating assisted living as an innovative option for meeting long-term-care needs of elderly veterans.

[131](www1.va.gov/vetdata/docs/4X6_fall08_sharepoint.pdf).
[132]*FY 2006–2011 Strategic Plan,* Office of the Secretary of Veterans Affairs, October 2002 (www.va.gov).
[133]2007 *Survey of Veteran Enrollees' Health and Reliance Upon VA* Veterans Health Administration, May 2008 (www.va.gov/vhaeorg).
[134]VA Congressional budget submission for FY 2009.
[135]Matthew S. Brooks, Sarah B. Laditka, and James N. Laditka, "Evidence of Greater Health Care Needs Among Older Veterans of the Vietnam War," *Military Medicine* 173(8) (2008): 715–20.
[136]GAO-05-65.
[137]GAO-06-333T.
[138]GAO 04-913.
[139]P.L. 109-461 § 211.
[140]Bruce Kinosian, Eric Stallard, and Darryl Wieland, "Projected Use of Long-Term Care Services by Enrolled Veterans," *Gerontologist* 47(3) (2007): 356-64.
[141]House Committee on Veterans' Affairs, Subcommittee on Health, "State of the U.S. Department of Veterans Affairs' (VA) Long-Term Care Programs," Hearing. May 9, 2007. 100th Cong., 1st Sess., Washington: Government Printing Office, 2008. Print.
[142]GAO-01-768.
[143]Per Diem for Nursing Home Care of Veterans in State Homes, Proposed Rule. *Federal Register* 73(233) (28 November 2008): 73558–62. Print.
[144]Annual percentage increase from 2006 baseline of 43,325 average daily census of noninstitutional long-term care.
[145]GAO 03-487.
[146]Public Law 109-461, Title II, § 214.
[147]P.L. 110-387, Title IV, § 409.
[148]Additional support may be provided by pharmacists, rehabilitation therapists, recreation therapists, mental health professionals, and other specialists.
[149]Enacted under the *Older Americans Act Amendments of 2000.*
[150]L. Feinberg, L. and S. Newman. "Medicaid and Family Caregiving: Services, Supports, and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S," (New Brunswick, NJ: Rutgers Center for State Health Policy, May 1, 2005).
[151]Formerly Program for Persons With Disabilities. See *National Defense Authorization Act of 2002.*
[152]38 U.S.C. § 5503.

VA MEDICAL AND PROSTHETIC RESEARCH

VA research is a national asset. The VA Medical and Prosthetic Research program is one of the nation's premier biomedical and behavioral research endeavors. It helps ensure the highest standard of care for veterans enrolled in VA health care, and elevates health-care practices and standards in all of American health care.

Improving Lives through Innovation and Discovery

For more than 60 years, the VA Research and Development program has been improving veterans' lives through innovation and discovery that has led to advances in health care for veterans and all Americans. VA researchers conducted the first large-scale clinical trial that led to effective tuberculosis therapies and played key roles in developing the cardiac pacemaker, the CT scan, radioimmunoassay, and improvements in artificial limbs. The first liver transplant in the world was performed by a VA surgeon-researcher. VA clinical trials established the effectiveness of new treatments for tuberculosis, schizophrenia, high blood pressure, and other heart diseases. The "Seattle Foot" and subsequent improvements in prosthetics developed in VA have allowed people with amputations to run and jump. VA investigators have won three Nobel prizes, six Lasker awards, and numerous other distinctions.

VA investigators are currently doing the following:

- Developing powerful new approaches to assess, manage, and treat chronic pain to help veterans with burns and other injuries.
- Working on ways to ease the physical and psychological pain of returning soldiers.
- Exploring how to deliver low-level, computer-controlled electric currents to weakened or paralyzed muscles to allow people with incomplete spinal cord injury to once again walk and perform other everyday activities.
- Gaining new knowledge of the biological and behavioral roots of post-traumatic stress disorder (PTSD) and developing and evaluating effective PTSD treatments.
- Studying new drug therapies and ways to enhance primary care models of mental health care.
- Identifying genes associated with Alzheimer's disease, diabetes, and other conditions.
- Developing new assistive devices for the visually impaired, including an artificial retina to restore vision.

- Studying ways to prevent, diagnose, and treat hearing loss.
- Pioneering new home dialysis techniques.
- Developing a system that decodes brain waves and translates them into computer commands to allow quadriplegics to perform daily tasks like using email.
- Exploring organization of care, delivery methods, patient outcomes, and treatment effectiveness to further improve access to health care for veterans.

As part of the VA integrated health-care system with a state-of-the-art electronic health record, the VA research program is able to promote prompt translation of research findings into advances in care and medical decision making. By basing its research on patient-centered evidence, VA has become an acclaimed model for conducting superior bench-to-bedside research.

VA research is veteran oriented and focused on prevention, diagnosis, and treatment of conditions prevalent in the veteran population. More than three quarters of VA researchers are clinicians who provide direct patient care to veterans. As a result, the Veterans Health Administration—the largest integrated health-care system in the world—has a unique ability to translate progress in biomedical science directly to improvements in VA clinical practices.

The VA research program is intramural; that is, only VA employees holding at least a five-eighths salaried appointment may apply for VA research awards. Unlike other federal research agencies, such as the National Institutes of Health and Department of Defense, VA does not make grants to external entities. As such, the program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA health-care system. The resulting environment of health-care excellence and ingenuity benefits every veteran receiving care in the VA health system and, ultimately, all Americans.

The Independent Budget veterans service organizations therefore recommend the funding levels shown in the table below for FY 2010–FY 2012.

Medical and Prosthetic Research (in millions)	
FY 2009	$510
***The Independent Budget* Recommendation**	
FY 2010	$575
FY 2011	$596
FY 2012	$617

Funding for VA Medical and Prosthetic Research:

Funding for VA research must be sufficient, timely, and predictable in size to meet current commitments and allow for innovative scientific growth.

The VA Medical and Prosthetic Research Program leverages the taxpayer's investment via a nationwide array of synergistic partnerships with for-profit industry partners, nonprofit organizations, and academic affiliates. Adding the ability of VA researchers to successfully compete for funding from the National Institutes of Health and other federal agencies to these partnerships, the VA research program has done an extraordinary job leveraging its relatively modest annual appropriation into a $1.8 billion research enterprise that hosts multiple Nobel Laureates and produces an increasing number of scientific papers annually, many of which are published in the most highly regarded journals. The Department of Veterans Affairs has reported that from January 1, 2001, through November 7, 2008, VA investigators and clinicians were coauthors of 65,779 articles in peer-reviewed scientific journals. This highly successful enterprise demonstrates the best in public-private cooperation, but would not be possible without the VA-funded research opportunities. As such, a commitment to steady and sustainable growth in the annual research and development appropriation is necessary for maximum productivity and continued achievement.

Predictable and Sustainable Growth

Funding for VA research has been unpredictable. For example, in FY 2005, VA research was cut by $3.3 million (0.8 percent). In FY 2006, VA research received a less than inflationary $9.7 million (2.4 percent) increase followed by essentially flat funding ($413.7 million) under the FY 2007 joint funding resolution. The FY 2007 emergency supplemental appropriations provided an additional $32.5 million for VA research, thus increasing total research funding in FY 2007 to more than $446 million. In November 2007, the second continuing resolution briefly funded VA health care at a rate equal to that proposed by the President for FY 2008. For FY 2008, the Administration proposed only $411 million for VA research, forcing VA research to temporarily reduce its annualized rate of spending by 7.9 percent. Congress responded by providing VA $480 million, causing VA to reverse course once again. For FY 2009, VA proposed $442 million, another projected and significant cut, while Congress later provided VA research $510 million.

Such a "see-saw" funding history with arbitrary peaks and valleys impedes important VA research on national priorities, including studies on post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), eye and optic nerve injuries, amputations, polytrauma, burns, and other acute and chronic health conditions long prevalent in the veteran population. VA research administrators and investigators are understandably reluctant to expand their research endeavors, since this record of inconsistent and unpredictable funding can quickly devastate plans for growth or cause interruptions and even cancellations of ongoing projects. Furthermore, should availability of research awards decline as a function of budgetary policy, VA risks losing physician-researchers and other clinical investigators who are integral to providing direct care for our nation's veterans and for sustaining high-quality programs for veterans' specialized needs.

VA research awards are typically designed for three-to-five years in duration. However, scientific advancement can demand many more years and requires steady, sustained funding to achieve its optimal potential. To maintain the current level of VA research activity over the next three years, biomedical research and development inflation is assumed at 3.5 percent for FYs 2010 through 2012. Beyond biomedical inflation, additional research funding is needed to (1) take advantage of burgeoning opportunities to improve the quality of life for our nation's veterans through "personalized medicine"; (2) address the critical needs of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and others who were deployed to combat zones in the past; (3) advance health promotion, women veterans' health and long-term care; and (4) raise the VA-imposed cap on investigator-initiated awards.

According to VA, in FY 2007 a total of 192 new projects were funded with supplemental funds provided by Congress that year. For the most part, these projects were research investigations targeting such topics as "Novel Strategies Targeting Gliosis [a process leading to scars in the central nervous system] after Traumatic Brain Injury" and "Feasibility of a Zero-Impingement Socket for Lower Limb Prostheses." In some cases, these projects involved equipment purchases, such as a "Mobile 3.0 Telsa MRI-fMRI Scanner and Mobile Clinical Assessment Center" that supports a collaborative project between Fort Hood and the Central Texas VA Health Care System on TBI and PTSD. These equipment purchases significantly expanded VA's ability to conduct research related to military trauma of OEF/OIF veterans and have leveraged VA's ability to obtain collaboration and funding from other agencies.

With the supplementary funds Congress provided in FY 2008, VA awarded 291 new research investigations, with such titles as "Growth Factor Treatment of Visual Loss in Compressive Optic Nerve Injury" and "Cholinergic Interventions [interventions related to a specific neurotransmitter] to Enhance Rehabilitation from Brain Trauma." VA would not have been able to award these projects without the additional appropriation. In addition, funding was provided to expand the scope of 652 ongoing investigations. Finally, 46 significant equipment purchases were made to improve VA's ability to conduct cutting-edge research directly relevant to veterans' health care.

The Independent Budget veterans service organizations (IBVSOs) expect VA's expansionary research portfolio to grow with the extra funding Congress provided in FY 2009—growth we recommend be sustained in FY 2010, FY 2011, and FY 2012—to support the following:

- VA is uniquely positioned to revamp modern health care and to provide progressive and cutting-edge care for veterans through genomic medicine. VA is the obvious choice to lead advances in genomic medicine. It is the largest integrated health system in the world, employs an industry-leading electronic health record, and has an enrolled treatment population for sustained research. VA combines these

attributes with high ethical standards and standardized practices and policies. Innovations in genomic medicine will allow VA to:

- reduce drug trial failure by identifying genetic disqualifiers and allowable treatment of eligible populations;
- track genetic susceptibility for disease and develop preventative measures;
- predict responses to medications; and
- modify drugs and treatments to match an individual's unique genetic structure.

- Research on strategies for overcoming the devastating injuries suffered by veterans of OEF/OIF needs to be expanded. Improvements in prosthetics and rehabilitation as well as more effective treatments for polytrauma, TBI, injuries to the eye (highly significant in this population), significant body burns, PTSD, and suicide risk are urgently needed. Funding more studies and accelerating ongoing research efforts can deliver results that will make a measurable difference in the quality of life for thousands of our newest generation of war veterans.
- Since 1999, funding limitations in VA research have forced the agency to cap many VA merit-review awards at levels lower than the average award at comparable federal research institutions. VA research awards have been modestly funded since the imposition of a $100,000 cap in 1999. Nearly a decade later, the current $150,000 cap barely keeps pace with biomedical inflation or VA's commitment to scientific innovation.

The cap is a trade-off that VA research leadership makes to continue funding the same number of awards it has historically supported. This is a problem compounded by VA's need to expand its research portfolio to include research on conditions prevalent among veterans of OEF and OIF. The IBVSOs support increasing the number of funded programs to meet these new challenges, but as a secondary objective we also support raising the cap on merit review programs in order to recognize inflation, maximize productivity, foster recruitment, and speed the translation of research from the bench to the bedside.

VA Research Infrastructure Needs

The rising concerns of the IBVSOs about the status of VA's research laboratories and associated facilities are reflected elsewhere in this *Independent Budget*. We urge Congress to begin to address these needs in FY 2010 with a major funding supplement of $142 million available exclusively to VA research infrastructure.

The Uncertain Future

As indicated in the "Critical Health Infrastructure" section of this *Independent Budget* and the *Critical Issues Report* associated with this budget, the IBVSOs are concerned about the future direction of the VA health-care system if VA shifts its focus away from inpatient services and relies primarily on affiliates or contractors to provide those services. If such a shift is being contemplated, in effect "closing" many VA hospital beds, we urge VA and Congress to consider the impact on VA's historic academic and research missions. Although VA research investigators do not necessarily need to rely on hospital inpatients as clinical subjects for their projects, inpatient services and resources are important components of VA's academic and research missions. Moving VA care to external providers raises a number of questions about the viability of both missions.

Concern about Congressionally Directed VA Research

The IBVSOs and Friends of VA Medical Care and Health Research strongly support leaving all decisions about the selection of particular research projects, and their funding, to the VA scientific peer-review process. Funding for any potential Congressionally mandated VA research, therefore, is not included in this *Independent Budget* recommendation. Any such directed research, if so desired by Congress, should be appropriated separately.

Recommendations:

To keep its research funding predictable and stable, VA requires at least $20 million per year to account for rising biomedical research costs. *The Independent Budget* veterans service organizations believe an additional $45 million in FY 2010 is needed for continued support of new research initiatives and to raise the restrictive cap on merit reviews. Thus, the President and Congress should provide an increase of $65 million for VA research in FY 2010, for a total of $575 million.

In keeping with VA's crucial need to have stable, predictable funding so that it can effectively manage critical multiyear proposals, the President and Congress should fund the VA Medical and Prosthetic Research Account at $596 million in FY 2011, and $617 million in FY 2012.

ADMINISTRATIVE ISSUES

Recruitment Challenges Facing the Veterans Health Administration:

The Department of Veterans Affairs must strengthen, energize, and expand personnel programs to recruit and retain highly qualified medical and health-care professionals within the Veterans Health Administration (VHA).

Addressing human resource issues within the Department of Veterans Affairs has never been more urgent than now, with the ongoing conflicts in Afghanistan and Iraq and the aging of both the veteran population and the "Baby Boomer" generation. Service members are returning from conflicts abroad and seeking services from VA, and, at the same time, veterans from previous wars, particularly veterans from the Vietnam era, are aging and their need for medical services and other VA benefits is steadily increasing. In this environment, sufficient staffing becomes more essential to ensuring that veterans receive adequate VA care.

The facilities of VA, like many other American health-care providers, are facing a looming and potentially dangerous shortage of available health-care personnel to meet the growing demands of sick and disabled veterans. The current documented national shortage of physicians, nurses, pharmacists, therapists of all disciplines, psychologists, and practitioners in several other professional disciplines is bound to have an impact on the effectiveness of VA's recruitment and retention programs. VA estimates that 163,308 new hires will be needed to handle attrition and maintain the VHA's workforce to 2013. VA must anticipate the effects of the national health-care workforce shortage and work to provide competitive employment packages and a more preferred workplace to ensure veterans continue to receive high quality and effective VA health care in the future.

The dwindling supply of trained and qualified health-care professionals cannot keep pace with the national growth in demand for health care. VA has recognized that the employment market is extremely competitive for some positions and is working to provide innovative professional development opportunities and programs to attract some of the new employees it will need to care for veterans. However, recruitment and retention planning can be fully successful only with sufficient, timely, and predictable funding from Congress for VA's overall health-care mission. After years of reacting to the current erratic funding process, achieving effective health-care budgetary reform can provide VA the confidence it needs to more effectively recruit, develop, and retain its health-care workforce to meet the needs of our nation's veterans.

Registered Nurses

In the area of nursing, the United States is experiencing an unprecedented shortage that is expected to continue well into the future.[153] Two national issues are directly contributing to America's national nursing shortage. First, the number of new nursing students entering nursing education programs is insufficient to meet rising demand. Second, the heightened age and lower numbers of nursing educators has forced nursing schools to restrict or deny applicants into entry-level nursing baccalaureate educational programs. The Health Resources and Services Administration in 2007 projected that the nation's nursing shortage will grow to more than 1 million nurses by the year 2020, and all 50 states will experience a shortage of nurses to varying degrees by the year 2015.

According to projections from the U.S. Bureau of Labor Statistics in the November 2005 *Monthly Labor Review,* 1,203,000 new registered nurses (RNs) will be needed by 2014 to meet job growth and replacement needs. VA must develop a recruitment strategy that attracts and encourages nursing students and new nurse graduates to commit to VA employment by using and increasing educational loan repayment programs and recruiting from local nursing schools. VA must also work to recruit and retain nurses that provide care in VA's specialized service programs, such as spinal cord injury/dysfunction (SCI/D), blind rehabilitation, mental health, and brain injury, using compensatory benefits, such as specialty pay.

According to the July 2006 Aging Workforce Survey conducted by the Nursing Management Organization, 55 percent of surveyed nurses reported the intention to retire between 2011 and 2020.[154] In addition to the

need for 30,211 RNs by 2013, the VHA turnover rate for registered nurses in 2006 was 8.5 percent (full and part-time positions, not including trainees). The American Federation of Government Employees (AFGE) reports that in 2007, 77 percent of all RN resignations within the VA occurred in the first five years of employment, and the average VA-wide cost of turnover is $47 million for nurses. VA simply cannot afford to ignore the concerns of its nurses in the areas of job satisfaction and compensation. VA must also develop and implement innovative personnel programs that allow for nurse representation and input when facility management makes personnel decisions.

The National Commission on VA Nursing report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce,* cited professional development, work environment, respect and recognition, and fair compensation as a few areas that VA must focus on to become an employer of choice for today's nurse population.[155] The commission also recommended that the VHA provide career development opportunities for nurses that enhance their ability to reach professional goals, develop and implement national staffing standards to properly allocate nursing resources and promote patient safety, and expand recognition of nurse achievements and high performance. *The Independent Budget* veterans service organizations (IBVSOs) support the commission's recommendations and believe that they serve as a sound template for improvements to VA policies and procedures that govern its health-care workforce.

With regard to nurse compensation, VA must ensure that facility managers are using locality pay and financial incentives, such as retention bonuses, to compete with private sector employers. VA must also work to consistently administer locality pay policies that are based on local labor market conditions, as well as overtime and premium pay policies for nurses that are in accordance with VA policy.

Physicians

With respect to VA physicians, the IBVSOs have serious concerns regarding VA's current and future ability to match or exceed private sector physician salaries. In 2004, Congress passed Public Law 108-445, the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004. The act is partially intended to aid VA both in recruiting and retaining VA physicians (including scarce subspecialty practitioners) by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. In the intervening years, VA has implemented the act, but we believe the act may not have provided the Department the optimum tools needed to ensure that veterans will have available the variety and number of physicians needed in their health-care system. For example, a recent review of VA physician position vacancies on usajobs.gov revealed the following: Bay Pines VA Medical Center (VAMC) was recruiting an orthopedic surgeon at a maximum salary of $175,000, while the national average income of orthopedists is $459,000. Indianapolis VAMC was seeking an emergency room physician at a maximum of $175,000, while the national average for this category is $216,000. The Greater Los Angeles VA system was offering a maximum of $270,000 for an anesthesiologist, while the average income for anesthesiologists is $311,000. The IBVSOs urge Congress to provide further oversight and to ascertain whether VA has adequately implemented its intent of P.L. 108-445, or if the Department may need additional tools to ensure full employment for qualified VA physicians as it addresses its future staffing needs.

With regard to physician recruitment, 130 VA medical centers have affiliations in which physicians represent half of approximately 100,000 VA health profession trainees. VA estimates that medical residents equate to approximately one-third of the total VA physician workforce. About 2,500 (16 percent) of VA physicians are currently eligible for voluntary retirement, and it is projected that by 2012, this number will grow to 2,909 (17 percent).[156] Notably, a 2007 survey assessed the impact of VA health profession training on VA physician recruitment. Prior to exposure to training in VA facilities, 21 percent of medical students and 27 percent of medical residents indicated they were "very" or "somewhat" likely to consider post-graduate VA employment. Following training at VA, these positive responses grew to 57 percent of medical students and 49 percent of medical residents. Although current resignation rates among VA physicians remain stable, VA projects the number of voluntary retirements will rise over time. Thus, through its training programs VA is well positioned to take advantage of a ready source of physician recruitment.

Certified Registered Nurse Anesthetists

Over the past few years, the demand for certified registered nurse anesthetists (CRNA) has steadily grown within the private and public nursing sectors. As the need for CRNAs increases, VA becomes more challenged

to recruit and retain these professionals. In a December 2007 report, the U.S. Government Accountability Office (GAO) reported that more than half of VA CRNAs are over 51 years of age, and are seven years closer to retirement eligibility than the average CRNA nationally.[157] The GAO further reported that 54 percent of VA medical facility chief anesthesiologists surveyed reported temporarily closing operating rooms, while 72 percent reported delaying some elective surgeries because no CRNAs were available for the procedures.

The GAO concluded that VA is having difficulty recruiting and retaining CRNAs because it is not providing competitive salaries in comparison to the national labor market. According to the American Association of Nurse Anesthetists, The average turnover and retirement rate for VA CRNAs is approximately 19 percent. VA must vigorously work to retain its current CRNA workforce by providing for professional development opportunities that include developing career paths and internal promotions for CRNAs and individual funding for educational advancements. The GAO reports that many VA facilities are not properly using the VA locality pay system, thus VA CRNAs' salaries have not been adjusted properly and are less competitive with other employers in the health-care industry.[158] It is essential that VA provide adequate oversight to ensure that all facilities are using locality pay correctly and consistently.

Certified registered nurse anesthetists provide the majority of anesthesia services for veterans receiving care in VA medical facilities. Therefore VA must make certain that this vital service of care for veterans is not compromised by VA's inability to succeed in a competitive market for CRNAs. The IBVSOs believe that VA must utilize recruitment bonuses and educational incentives to help offset the differences in salaries between the private sector and VA to recruit new CRNAs. The VA must also work within local nursing schools for CRNA training to recruit nurses receiving a master's degree in anesthesiology and encourage current VA RNs to consider careers as anesthetists.

Mental Health Professionals

According to the American Psychological Association, VA is the largest single employer of psychologists in the nation. The demands placed on VA's mental health service have increased dramatically because of the conflicts in Afghanistan and Iraq. Congress and VA have recognized the need to increase the number of psychologists and have added more than 800 new psychologists since 2005; however, it should be noted that these increased psychology staffing levels are a recent development.

In all, VA's report of hiring several thousand new mental health professionals includes individuals whom VA has identified as having been offered and accepted positions in mental health, but some of these individuals are not yet providing care for veterans. The length of time for a facility to receive allocated funds for staffing, advertise and recruit for a position, and interview and complete credentialing and security clearances is extremely long. VA officials in the field have reported to the IBVSOs that it is common for nine months or more to pass from the beginning to the end of this process. In some instances it has been reported that candidates that have committed to a VA position withdraw their applications because they simply could not wait the number of months to complete the hiring process. New graduates are particularly vulnerable to delay in employment offers. When a candidate withdraws after accepting employment, VA must restart the recruitment process. While we have no national statistics on VA's hiring lag time, we believe that it takes four to five months between VA's tentative offer and an applicant reporting to duty.

The VHA has distributed an unprecedented performance measure to field managers and human resources staffs to improve the hiring process. This measure targets 30 days as the goal to bring new employees on board after they accept employment with the VHA. This 30-day goal is one-third of the current length of time that it takes the VHA to fully hire a new employee. Even if this goal is achieved, VA's average hiring lag will still be expressed in months. This lengthy hiring process deters new applicants and potentially leads to inefficient use of personnel funds.

In 2006, the GAO issued a report critical of VA's hiring practices in mental health.[159] In the report, the GAO concluded that VA lacked proficiency in spending the funds allocated for hiring and paying mental health professionals. The IBVSOs believe that in most instances, VA is not using all of these funds because of the delays in the hiring process. The longer it takes VA to hire and encumber a new employee, the less likely it is that VA will use the full amount of funding provided for that employee's salary in the remainder of the fiscal year. It is essentially impossible for facilities to spend more than a fraction of funds associated with new positions during a new employee's first year. VA must work to speed

up the hiring process for mental health providers, particularly if it intends to refashion its mental health programs with a focus on veteran wellness and recovery. VA must also strive to retain and promote its more experienced mental health practitioners in order to meet new training and supervision requirements for new providers.

VA Human Resources Policies Are Outmoded

VA must work aggressively to eliminate outdated, outmoded VA personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment. It is reported that, on average, from the time a vacancy announcement is posted, appointment of a new employee within the VHA consumes 90 days. In some professional occupations (especially physicians and nurses), many months can pass from the date of a position vacancy until the date a newly VA-credentialed and privileged professional caregiver is on board and providing clinical care to veterans. Its lack of ability to make employment offers and confirm them in a timely manner, especially to new graduates VA has helped train, unquestionably affects VA's success in hiring highly qualified employees, and has the potential to diminish the quality of VA health care. Hiring delays depress current workforce morale and lead to overuse of mandatory overtime for nurses and others, greater workplace stress, and staff burnout. At all levels, the VHA (especially including local facility managements) must be held accountable for improving human resources policies and practices. Congress should require VA to report its efforts to improve recruiting, retention, and environmental/organizational practices to assure veterans that VA will be a preferred health-care provider in the future and will continue to provide veterans an effective health-care system to meet their specialized needs.

Employment Incentives

Existing VA loan repayment and scholarship programs were established by Congress initially to provide individuals interested in VA nursing the financial support they need to enter and stay in the field. Both a recruitment and retention tool, the centrally funded Employee Incentive Scholarship Program (EISP)[160] pays up to $32,000 for health-care-related academic degree programs, with an average of $12,000 paid per scholarship. Since its inception in 1999, through 2007 approximately 7,000 VA employees have received scholarship awards for educational programs related to title 38 and "hybrid" title 5-title 38 VA occupations. About 4,000 employees have graduated from academic programs under these auspices. Scholarship recipients include RNs (93 percent), pharmacists, physical therapists, and other allied health professionals. A five-year VA analysis of program outcomes demonstrates this program's impact on VA employee retention. For example, turnover of nurse scholarship participants is 7.5 percent compared to a nonscholarship nurse turnover rate of 8.5 percent. Also, less than 1 percent of participating nurses left VHA employment during their service-obligation period (from one to three years after completion of degree).[161]

The VA Education Debt Reduction Program (EDRP) provides tax-free reimbursement of existing education debt of recently hired title 38 and hybrid employees. Centrally funded, the EDRP is the title 38 equivalent of the Student Loan Repayment Program administered by the Office of Personnel Management for title 5 employees. More than 5,600 VA health-care professionals have participated in the EDRP. The maximum amount of an EDRP award is limited by statute to $44,000 in exchange for five years of service. As education costs have risen, the average award amount per employee has increased over the years from about $13,500 in FY 2002 to more than $27,000 in FY 2007. While employees from 33 occupations participate in the program, 77 percent are from three mission critical occupations—RN, pharmacist, and physician. The rate of losses from resignation of EDRP recipients is significantly less than that of nonrecipients as determined in a 2005 study. For physicians the study found the resignation rate for EDRP recipients was 15.9 percent compared to 34.8 percent for non-EDRP recipients.[162]

Both the EISP and EDRP initiatives need to be strengthened and expanded to new VA occupations, in particular among the 25 critical occupational categories that will be increasingly competitive as the health manpower shortage worsens. Congress must also consider reinstating the VA Health Professional Education Assistance Scholarship Program. This program would be an excellent medical care student incentive to future VA employment. These programs have proven themselves to be cost-effective recruitment tools and to provide strong incentives for individuals to remain in VA employment rather than to go elsewhere.

Summary

Given the VHA's leadership position as a health system, it is imperative that VA aggressively recruit health-

care professionals and work within established relationships with academic affiliates and community partners to recruit new employees. In order to make gains on these needs, VA must update and streamline its human resource processes and policies to adequately address the needs of new graduates in the health sciences, recruits, and current VA employees. Today's health-care professionals and other staff who work alongside them need improved benefits, such as competitive salaries and incentives, child care, flexible scheduling, and generous educational benefits. VA must actively address the factors known to affect current recruitment and retention, such as fair compensation, professional development and career mobility, benevolent supervision and work environment, respect and recognition, technology, and sound, consistent leadership, to make VA an employer of choice for individuals who are offered many attractive alternatives in other employment settings.

VA's ability to sustain a full complement of highly skilled and motivated personnel will require aggressive and competitive employment hiring strategies that will enable it to successfully compete in the national labor market. VA's employment success within the VHA will require constant attention by the very highest levels of VA leadership. Additionally, Members of Congress must understand the gravity of VA personnel issues and be ready to provide the necessary support and oversight required to ensure VA's success.

Recommendations:

VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment.

VA must implement an energized succession plan in its medical and regional offices that utilizes the experience and expertise of current employees as well as improves existing human resources policies and procedures.

VA facilities must fully utilize recruitment and retention tools, such as relocation and retention bonuses, a locality pay system for VA nurses, and education scholarship and loan payment programs as employment incentives, in both the Veterans Health Administration and the Veterans Benefits Administration.

Congress must provide further oversight to ensure adequate implementation of Public Law 108-445.

Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA's specialized services areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury.

VA must provide adequate oversight to ensure that all medical facilities correctly and consistently administer locality pay in accordance with VA policy.

VA must develop a more aggressive recruitment strategy that provides employment incentives that attract and encourage affiliated health professions students, and new graduates in all degree programs of affiliate institutions, to commit to VA employment.

Congress should improve the provisions of VA's Employee Incentive Scholarship Program and Education Debt Reduction Program and make them available more broadly to all VA employees.

VA must become more flexible with its work schedules to meet the needs of today's health-care and benefits professionals and must provide other employment benefits, such as child care, that will make VA employment more attractive.

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[153]Peter I. Buerhaus, PhD, RN; Douglas O. Staiger, PhD; David I. Auerbach, MS, "Implications of an Aging Registered Nurse Workforce," *Journal of the American Medical Association*. June 14, 2000, Vol. 283, No.22:2948–2954.
[154](www.nursingmanagement.com).
[155]National Commission on VA Nursing, 2002–2004, final report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce*, March 2004.
[156]Department of Veterans Affairs Veterans Health Administration, VHA Workforce Succession Strategic Plan, FY 2008–2012 (www1.va.gov/nursing/docs/StratPlanONS_2008–2012FIN_2.pdf); details from Office of Management and Budget (www.whitehouse.gov/omb/circulars/a11/current_year/s200.pdf).
[157]GAO-08-56.
[158]Ibid.
[159]GAO-07-66.
[160]38 U.S.C. §§ 7671–7675; established by P.L. 105-368, Title VIII, *Department of Veterans Affairs Health Care Personnel Incentive Act of 1998*, and amended by P.L. 107-135, *Department of Veterans Affairs Health Care Programs Act of 2001.*
[161]M. Palkuti M., M.Ed., director, Health Care Retention and Recruitment Office, DVA, in testimony before the Senate Committee on Veterans' Affairs, April 9, 2008 (http://veterans.senate.gov/public/index.cfm?pageid=16&release_id=11581&sub_release_id=11633&view=all).
[162]Ibid.

Attracting and Retaining a Quality VHA Nursing Workforce:

The Veterans Health Administration (VHA) must devote sufficient resources to avert the national shortage of nurses from creeping into and potentially overwhelming VA's critical health-care programs.

As indicated elsewhere in this *Independent Budget,* recruitment and retention of high-caliber health-care professionals is critical to the VHA mission and essential to providing safe, high-quality health-care services to sick and disabled veterans. Given the impact of the nationwide nursing shortage and ongoing reports of difficulty in filling nursing and other key positions within the VHA, this is a continuing challenge for the Department of Veterans Affairs. This section presents concerns specific to VHA's nursing programs.

Addressing the National Nursing Shortage—National Commission on VA Nursing

The environment of the VHA, like America's health-care enterprise in general, is ever-changing and confronted with continuing challenges. Since 2000, VA has been working to address the increasing demand for medical services while coping with the impact of a rising national nursing shortage. In 2001, VHA's Nursing Strategic Healthcare Group released "A Call to Action—VA's Response to the National Nursing Shortage." Since that time, health manpower shortages, and plans to address them, have been dominant themes of numerous conferences, reports by the Government Accountability Office (GAO), other reviewers, and Congressional hearings.

One part of the equation that has remained paramount in the discussion concerns VA's ability to compete in local labor markets, given the barriers that impede nursing recruitment and retention in general. In 2002 the National Commission on VA Nursing (commission) was established by Public Law 107-135 and charged to examine and consider VA programs, and to recommend legislative, organizational, and policy changes to enhance the recruitment and retention of nurses and other nursing personnel, and to address the future of the nursing profession within the VHA. The commission envisioned a desired "future state" for VHA nursing and made recommendations to achieve that vision. In May 2004, the commission published its final report to Congress, "Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce."

Illustrative of the commission's findings and recommendations is this synopsis in its final report:

> Recruiting and retaining nursing personnel are priority issues for every health-care system in America. VHA is no exception. With the aging of the population, including veterans, and the U.S. involvement in military activity around the world, VHA will experience increasing numbers of enrolled veterans. Consequently, as the demand for nursing care increases, the nation will grapple with a shortage of nurses that is likely to worsen as baby boomer nurses retire. VHA must attract and retain nurses who can help assure that VHA continues to deliver the highest quality care to veterans. Further, VHA must envision, develop, and test new roles for nurses and nursing as biotechnologies and innovations change the way health care is delivered.

The Office of Nursing Service in the VA Central Office developed a strategic plan to guide national efforts to advance nursing practice within the VHA, and engage nurses across the system to participate in shaping the future of VA nursing practice. VA's strategic plan embraces six patient-centered goals that encompass and address a number of the recommendations of the commission, including leadership development, technology and system design, care coordination and patient self-management, workforce development, collaboration, and evidence-based nursing practice.

The commission's legislative and organizational recommendations served as a blueprint for the future of VA nursing. The VHA's strategic plan should serve as a foundation for a delivery system that meets the needs of our nation's sick and disabled veterans while supporting those who provide their care. *The Independent Budget* veterans service organizations (IBVSOs), urge Congress to continue to provide appropriations for, and oversight of, VA health care to enable the VHA to carry out an aggressive agenda based on this blueprint, to improve VA's abilities to recruit and retain sufficient nursing manpower while proactively testing new and emerging nursing roles.

Current Workforce-Future Needs

One of VA's greatest challenges is dealing effectively with succession—especially in the health sciences and technical fields that so characterize contemporary American medicine and health-care delivery.

The VHA's Succession Strategic Plan for FY 2008–2012 reports the following:

> VHA faces significant challenges in ensuring it has the appropriate workforce to meet current and future needs, including VHA's role in national and local emergencies. These challenges include continuing to compete for talent as the national economy changes over time, as well as recruiting and retaining health care workers in the face of significant anticipated workforce supply and demand gaps in the health care sector in the near future. These challenges are further exacerbated by an aging federal workforce and an increasing percentage of VHA employees who achieve retirement eligibility each year. With health care being primarily a people-based process, it is essential to ensure the continuous presence of an effective workforce to achieve the VHA mission to provide exceptional health care to America's veterans.

In April 2007, the VHA conducted a national conference titled "VHA Succession Planning and Workforce Development." The conference report indicated the average age of all VHA employees in 2006 to have been 48 years. It estimated that by the end of 2012, approximately 91,700 VHA employees, or 44 percent of current full-time and part-time staff, would be eligible for full civil service retirement, with approximately 46,300 VHA employees projected to retire during that same period. Additionally, a significant number of health-care professionals in leadership positions would also be eligible to retire by the end of 2012. The report concluded that 97 percent of VA nurses in pay band "V" positions would be eligible to retire, and that 56 percent were expected to retire.

VHA's Succession Plan 2008–2012 estimates that 14 percent (5,640) are currently eligible for voluntary retirement, and in 2013, 20.1 percent (8,955) of nurses currently working are projected to be eligible to retire. In its assessment of current and future workforce needs, the VHA identified registered nurses (RNs) as its top occupational challenge, with licensed practical/vocational nurses and nursing assistants also among the top 10 occupations with critical recruitment needs. Currently, VA employs nearly 79,000 nursing and allied personnel, 60 percent of whom are direct care staff.

VA recognizes that in the near term the supply of qualified nurses in the nation will be inadequate to meet increasing demand for services. According to the Health Resources and Services Administration, by 2015 all 50 states will experience a shortage of nurses to varying degrees. According to projections from the U.S. Bureau of Labor Statistics in the November 2005 *Monthly Labor Review,* 1,203,000 new RNs will be needed by 2014 to meet job growth and replacement needs. Registered nurses are projected to create the second-largest number of new jobs among all occupations, growing at 27 percent or more by 2014. Contributing to this shortage is the aging of the nursing workforce. An increasing proportion of RNs are over the age of 50. According to the Health Resources and Services Administration, in 2004, 28 percent of registered nurses were over the age of 50. A recent study by Buerhaus and colleagues published in 2007 reports that the cohort of RNs over the age of 50 has expanded 11 percent annually over the past four years.

In addition, the average age of new nurse graduates has increased considerably over the past two decades. Prior to 1984, the average age of a new nurse graduate was 23.8 years; by 2000–2004, the average age was 29.6 years. Likewise, current enrollments in schools of nursing is not going to meet the projected future demand. The National League for Nursing reports that U.S. nursing schools turned away 147,000 qualified applicants from nursing programs in 2005 primarily due to insufficient number of faculty, clinical sites, and classroom space. The American Association of Colleges of Nursing has reported that three-fourths of the nation's schools of nursing acknowledge faculty shortages along with insufficient clinical practicum sites, lack of classroom space, and budget constraints as reasons for denying admission to qualified applicants. Over the past several years the VHA has been trying to attract younger nurses into VA health care and to create incentives to keep them in the VA system.

In an attempt to attain a more stable nursing corps, VA initiated a "Nursing Academy" pilot program known as "Enhancing Academic Partnerships." VA reports its Nursing Academy will be committed to nursing education and practice and will address the nursing shortages in VA while helping fill the nation's needs for

nurses as well. VA's pilot program for FY 2007–2012 initially partnered with the University of Florida, San Diego State University, the University of Utah, and Connecticut's Fairfield University, with their respective VA affiliates at Gainesville, San Diego, Salt Lake City, and West Haven.

An additional six sites were selected to begin the program in academic year 2008–2009. They included the Medical University of South Carolina, Loyola University of Chicago, Rhode Island College, the University of South Florida, and the University of Oklahoma Health Sciences Center partnering with VA facilities in Charleston, Hines, Providence, and Tampa. The sixth site selected included two institutions, the University of Detroit Mercy and Saginaw Valley State University, partnering with Michigan VA facilities in Detroit, Saginaw, Battle Creek, and Ann Arbor. Additional VA-nursing school partnerships will be selected for 2009, for a total of 14 sites altogether during the five-year pilot program. Similar to VA's long-standing relationships with schools of medicine nationwide, VA nurses with pertinent expertise will be appointed as faculty members at the affiliated schools of nursing. Academy students will be offered VA-funded scholarships in exchange for defined periods of VA employment subsequent to graduation and successful state licensure.

VHA research shows that medical students who perform clinical rotations at a VA facility are more likely to consider VA as an employer. VA is hopeful that the investment made in helping to educate a new generation of nurses, coupled with the requirement that scholarship recipients serve a period of obligated service in VA health care following graduation, will help VA cultivate and retain quality health-care staff, even during a time of nationwide shortage. Continued funding beyond the pilot program is needed to provide this benefit to all VA facilities.

VA Nursing Workplace Issues

The IBVSOs continue to hear concerns from VA nurses about a number of issues they believe have an impact on nursing recruitment and retention. There are reports that VHA staffing levels are frequently so marginal that any loss of staff—even one individual in some cases—can result in a critical staffing shortage and present significant clinical challenges at a medical facility. Some nurses report they have been forced to assume non-nursing duties due to shortages of ward secretaries and other key support personnel. Budget-related "unofficial" hiring freezes and routine delays in recruiting place additional stress on existing nursing personnel and have a negative impact on patient programs. Staffing shortages or hiring freezes can result in the cancellation or delay of elective surgeries and closure of intensive care unit beds. These staff shortages can also cause avoidable referrals of veterans to private facilities—ultimately at greater overall cost to VA. This situation is complicated by the fact that the VHA has downsized inpatient capacity in an effort to provide more services on a primary care basis. The remaining inpatient population is generally more acute, often with comorbid conditions, lengthier inpatient episodes, complicated medical histories, and needing more skilled nursing care and staff-intensive aftercare.

It has also been reported that in some locations, VA is overusing overtime, including "mandatory overtime," reducing flexibility in tours of duty for nurses, and limiting nurse locality pay. The IBVSOs believe the practice of mandatory overtime places an undue burden on nursing staff and compromises the quality of care and safety of veterans in VA health care. Additionally, these actions create a working environment that fosters staff burnout and morale problems. These reports are especially disturbing given that VA has made so much progress in establishing the current national standard of excellence in providing care to its large enrolled population. We believe many of these difficult working conditions continue to exist today for VA's nursing staff, despite the best efforts and intentions of local and central management. Therefore, we suggest Congress provide additional oversight in this area to ensure a safe environment for both patients and staff. Also, we note that many of these workplace issues are driven by short financing and extremely tight local budgets, including the now-routine Continuing Resolution that restricts overall management discretion nationwide.

In October 2007, the House Committee on Veterans' Affairs Subcommittee on Health held a hearing on recruitment and retention of VA health-care professionals. Testimony from the American Federation of Government Employees (AFGE) and the Nurses Organization of Veterans Affairs (NOVA) outlined a number of key issues believed to have an impact on VA's ability to recruit and retain qualified nursing personnel. Issues discussed included flaws in the current credentialing and boarding process for title 38 employees; increasing reliance on contract nurses and its impact on quality of care; impact of the budget on hiring practices; lack of use of authorized pay incentives

by some medical facility managers; reluctance of medical center directors to offer scheduling incentives, such as the popular compressed work schedule; the need to strengthen current overtime policies in all VHA facilities; lack of human resources support; delays in hiring caused by the lengthy process involved for security and background checks; information technology issues; and a number of pay-related issues. The IBVSOs urge Congress to review the aforementioned testimonies by these organizations made up of frontline providers for specific recommendations on how to improve recruitment and retention of VA nursing personnel.

In May 2008, the Senate Committee on Veterans' Affairs held a hearing on the Veterans Medical Personnel Recruitment and Retention Act of 2008. Testimony from AFGE and NOVA identified rationale for support of this legislation to improve retention and recruitment of health-care staff members. Specific issues targeted included waiver of offset from pay for certain reemployed retired annuitants; providing comparable pay for nurse executives and medical center directors and increasing pay limitations and pay caps; providing information and training on locality pay systems; and reestablishing the Health Professions Scholarship Program to increase recruitment of students. Both organizations testified at another hearing in May 2008 of the House Committee on Veterans' Affairs Subcommittee on Health regarding human resources challenges within the VHA. Specific human resource issues identified included retention allowances, special pay rates, streamlining the application process, funds for professional development, converting positions to excepted service, pay flexibilities, succession planning, and review of classification standards.

Like other health-care employers, the VHA must actively address those factors known to affect recruitment and retention of all health-care providers, including nursing staff, and take proactive measures to stem crises before they occur. While the IBVSOs applaud what VA is trying to do in improving its nursing programs, competitive strategies are yet to be fully developed or deployed in VA. We encourage the VHA to continue its quest to deal with shortages of health manpower in ways that keep VHA at the top of the standards of care in the nation.

Recommendations:

Congress must provide sufficient funding through regular appropriations that are provided on time and include resources to support programs to recruit and retain critical nursing staff in VA health care, in particular, to support enlargement of the Nursing Academy.

VA should establish recruitment programs that enable the Veterans Health Administration to remain competitive with private-sector marketing strategies.

Congress should provide adequate funding to reestablish the Health Professions Scholarship Program.

Congress should provide oversight to ensure sufficient nursing staffing levels and to regulate and reduce to a minimum VA's use of mandatory overtime for VA nurses.

VOLUNTEER PROGRAMS:

The Department of Veterans Affairs needs to provide sufficient dedicated staff at each VA medical center to promote volunteerism and coordinate and oversee voluntary services programs and manage donations given to the medical center.

Since its inception in 1946, volunteers have donated in excess of 700.8 million hours of volunteer service to America's veterans in VA health-care facilities and cemeteries through the Veterans Affairs Voluntary Service (VAVS) program. As the largest volunteer program in the federal government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of more than 65 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and seven of their subordinate organizations, which report to the VA Under Secretary for Health.

The VHA volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

VAVS volunteers assist veteran patients by augmenting staff in such settings as VA hospital wards, nursing homes, end-of-life care programs, outpatient clinics, community-based volunteer programs, national cemeteries, veterans benefits offices, and veterans outreach centers. With the expansion of VA health care for patients in the community setting, additional volunteers have become involved. During FY 2008, VAVS volunteers contributed a total of 11,479,008 hours to VA health-care facilities. This represents 5,519 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $224 million if VA had to staff these volunteer positions with FTEEs.

At national cemeteries, VAVS volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on grave sites for Memorial Day and Veterans Day. Hundreds of thousands of hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The combined annual contribution made in 2008 to VA is estimated at $82 million. These significant contributions allow VA to assist direct-patient care programs, as well as support services and activities that may not be fiscal priorities from year to year. Monetary estimates aside, it is impossible to calculate the amount of caring and comfort that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers continues to increase dramatically as more demands are placed on VA health-care staff. The way in which health services are provided is changing, providing opportunities for new and less-traditional roles for volunteers. Unfortunately, many core VAVS volunteers are aging and are no longer able to volunteer. Likewise, not all VA medical centers have designated a staff person with management experience to recruit volunteers, develop volunteer assignments, and maintain a program that formally recognizes volunteers for their contributions. It is vital that the VHA keep pace with utilization of this national resource.

Recommendations:

Each Veterans Health Administration medical center should designate sufficient staff with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions. The positions must also include experience in maintaining, accepting, and properly distributing donated funds and donated items for the medical center.

Each VHA medical center should develop nontraditional volunteer assignments, including assignments that are age-appropriate and contemporary.

CONTRACT CARE COORDINATION:

The Veterans Health Administration (VHA) should develop an integrated program of contract care coordination for veterans who receive care from private health-care providers at VA expense, but should maintain vigilance in implementing a new contract care initiative that may have unintended consequences that diminish VA health care.

Current law authorizes the Department of Veterans Affairs to contract for non-VA health care (on a fee or contractual basis) and for scarce medical specialists only when VA facilities are incapable of providing necessary care to veterans, when VA facilities are geographically inaccessible to veterans, and in certain emergency situations. *The Independent Budget* veterans service organizations (IBVSOs) believe contract care should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. We have consistently opposed proposals seeking to expand contracting to non-VA providers on a broader basis than this. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serving larger veteran populations, ultimately only serve to dilute the quality and variety of VA services for new as well as existing patients.

Currently VA spends more than $2 billion annually to purchase private care for eligible veterans. Unfortunately, VA does not track this care, its related costs, outcomes, or veteran satisfaction levels. Therefore, the IBVSOs believe VA should implement a consistent process for veterans receiving contracted-care services to ensure that—

- care is delivered by fully licensed and credentialed providers;
- continuity of care is monitored and that patients are directed back to the VA health-care system for follow-up when appropriate;
- VA records of care are properly annotated with clinical information from contractors; and
- the process is part of a seamless continuum of services for enrolled veterans.

The IBVSOs believe it is critical for VA to implement a program of contract care coordination that includes integrated clinical, record, and claims information for the veterans VA directs to community-based providers. VA's current "Preferred Pricing Program" allows VA medical centers (VAMCs) to save funds when veterans use non-VA medical services by receiving network discounts through a preferred pricing program. However, VA currently has no system in place to direct veteran patients to any participating preferred provider network (PPO) so that it could—

- receive a discounted rate for the outsourced services rendered;
- use a mechanism to direct patients to credentialed and certified providers; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VAMCs, when a veteran inadvertently uses a PPO, not all facilities have taken advantage of the cost savings that are available. Thus, in many cases, VA has paid more for contract health care than is necessary. Nevertheless, the IBVSOs were pleased that VA made participation in its Preferred Pricing Program mandatory for all VAMCs in 2005. We understand that during FY 2008 the Preferred Pricing Program yielded a discount of more than $60 million, although it is not currently being utilized by all VAMCs. However, with full participation of the program, as intended by VA, there is potential to far exceed that amount with the potential of discounted savings of more than $70 million for FY 2009.

While there have been significant savings achieved through the Preferred Pricing Program (more than $172 million in gross discounts to date), through enhancements to preferring pricing, there are several ways to improve cost reduction. The implementation of electronic data interchange across all VAMCs will grow the program and savings for VA exponentially by allowing more claims to be submitted to the Preferred Pricing service-disabled veteran owned (SDVO) contractors. Other enhancements could include—

- scanning all paper claims,
- providing incentives to management and staff to participate, and
- providing additional education and training.

As efficiencies are implemented, and the transaction process is simplified, more claims will be submitted for

repricing and significantly more money will be available to support purchased care programs and the needs of veterans.

Additionally, the recent move by VA to consolidate Preferred Pricing contracts—now administered via 5 regional contracts, rather than the original 21 contracts—should facilitate greater adoption of uniform enhancements and program improvements.

Overall, the IBVSOs believe the national Preferred Pricing Program is a foundation upon which a more proactive managed care program could be established that would not only save significantly more funding when purchasing care, but, more important, could provide the VHA a mechanism to fully integrate contract care into its health-care system. By partnering with an experienced managed-care contractor(s), VA could define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value for the VA.

Currently, many veterans are disengaged from the VA health-care system when receiving health-care services from private physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to health care through coordination of community-based care. The IBVSOs believe it is important for VA to develop an effective care coordination model that achieves both its health-care and financial objectives. Doing so will improve patient care quality, more wisely use VA's increasingly limited resources, and reduce overpayments.

Components of a coordinated care program should include the following:

- Care and case management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical needs, the care coordination contractor could address both appropriateness of care and continuity of care. The result could be a truly integrated seamless health-care delivery system; and
- Provider networks that complement the capabilities and capacities of each VAMC and provide a "surge" capacity in times of increased need. Such contracted networks should address timeliness, access, and cost-effectiveness in both urban and rural environments. Additionally, the care coordination contractor could require private providers to meet specific VA requirements, such as timely communicating clinical information to VA, proper and timely submitting of electronic claims, meeting VA established access standards, and complying with other applicable performance measures.

If properly implemented, a care-coordination system also could improve veteran satisfaction with contract services and optimize workload for VA facilities and their academic affiliates.

VA is currently conducting the pilot project "Project HERO"—Healthcare Effectiveness through Resource Optimization, as directed by the Conference Report[163] on VA's fiscal year 2006 appropriation, Public Law 109-114. Project HERO, according to VA "is aimed at improving the ability of VA's patient-focused healthcare system to care for the Department's 7.7 million enrolled veterans." Under the program, VA asserts it will improve its capacity to care for its veterans at the more than 1,400 sites of care it currently operates and will take steps to ensure that community providers to whom it refers veterans meet VA's quality and service standards. The ultimate goal of Project HERO is to ensure that all care delivered by VA—whether through VA providers or through our community partners—is of the same quality and consistency for veterans, regardless of where care is delivered."[164]

In 2007 VA awarded a contract to Humana Veterans Healthcare Services, a national managed care corporation that is also a major fiscal intermediary and private network manager under the Department of Defense TRICARE program. Under this pilot program, participating Veterans Integrated Service Networks (VISNs) 8, 16, 20, and 23 are to provide primary care and, when circumstances warrant, must authorize referrals to Humana Veterans Healthcare Services for specialized services in the community. These specialty services include medical/surgical, diagnostics, mental health, and dialysis and are made available from private sources through Humana Veterans Healthcare Services. Also, as of January 14, 2008, contract services for dental care have been made available through Delta Dental.

VA asserts that Project HERO will better manage the private health-care services that VA purchases and will ensure that community providers meet the quality standards of VA care in caring for participating veterans. The IBVSOs have been informed that the quality of care provided through Project HERO would be equal

to or better than that provide directly by VA. As part of providing coordinated care, VA has indicated clinical information and patient records pertinent to the specialty care being sought will be shared among participating VA facilities and community providers to ensure quality and continuity of care.

Since this matter first emerged in the FY 2006 Congressional appropriations arena, it has remained a significant concern of the IBVSOs that Project HERO not become a basis to downsize or to privatize VA health care. Our concern remains that this initiative could become a method to contract out VA services beyond the current extent of VA contract care programs. Early in our discussions with the VA, we requested that spending under Project HERO be capped so as not to exceed total contract care costs recorded during the previous year for each network selected to participate. This limitation would have ensured that Project HERO would become an incentive to reduce contract care spending, as originally envisioned. VA chose not to accept our recommendation, and in fact expanded contract maximum spending in some cases upwards of 500 percent; thus, we remain concerned about the intent of this project.

Patient satisfaction for non-VA services provided under this program remains below VA's national average, and timeliness of completed appointments for routine care remains highly variable. In addition, the initial data are a source of concern for the IBVSOs because surveys utilized were provided only to patients that had completed a VA-referred appointment. A bias may confound the results of this survey since Project HERO contract providers are obligated to meet access-to-care standards that include patient scheduling of less than 30 days in order to exercise optional years beyond the current contract. Still, nearly a year since the contract has been awarded the existing network of non-VA providers has failed to meet its own target.

Patient satisfaction does not necessarily equate to quality of care. Of great concern to the IBVSOs is VA's lack of an incentive or measurement to assess that the quality of non-VA care to ensure that it meets or exceeds the clinical quality of VA care such as VA's revolutionary provider self-report on patient safety incidents is of great concern to the IBVSOs. Although our fear remains that under this new pilot project VA will pay significantly more for contract care without the safeguards of VA's high-quality standards—we are encouraged that VA recently contracted with Corrigo Health Care Solutions to evaluate and provide recommendations on the business processes of Project HERO.

The IBVSOs have been assured that VA will provide veterans service organizations (VSOs) with reports on a quarterly and annual basis and that reports will include metrics for cost, quality, safety, vendor performance, and other data relevant to the demonstration. This will help to ensure that Project HERO is meeting the goals and objectives outlined in the report that accompanied P.L. 109-305. While it is true that quarterly updates are being provided to the VSO community, including the organizations that produce this *Independent Budget,* we still await satisfactory reports on "cost, quality, safety, vendor performance, and other data relevant" to the Project HERO demonstration.

Recommendations:

VA should establish a contract care coordination program that incorporates the Preferred Pricing Program discussed herein, based on principles of sound medical management, and tailored to VA and veterans' specific needs. The Preferred Pricing Program should also be enhanced and leveraged to develop pilots to address the needs of rural veteran access issues as well as a formal surge capability.

Veterans who receive private care at VA expense and authorization should be required to participate in the care-coordination program, with limited exceptions.

VA and any care coordinator should jointly develop identifiable measures to assess program results and share results with Congress and stakeholders, including *The Independent Budget* veterans service organizations. Care should be taken to ensure inclusion of important VA academic affiliates in this program.

The components of a care-coordination program should include claims processing, health records management, and centralized appointment scheduling.

VA also should develop a series of tailored pilot programs to provide VA-coordinated care in a selected group of rural communities. As part of these pilots, VA should measure the relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, as compared to similar measurements of a like group of veterans in VA health care. In addition, the national Preferred Pricing Program's network of

providers should be leveraged in this effort. Each pilot also should be closely monitored by the VA's Rural Veterans Advisory Committee. These same pilots can in turn be tailored to create a more formal surge capability addressing future access needs.

VA should establish a mechanism to track contract expenditures within the Project HERO pilot network that include cost comparisons to existing contract costs.

VA should develop a set of quality standards that contract care providers must meet that are equivalent to the quality of care veterans receive within the VA system. Any Project HERO provider should be held to this standard.

VA should provide Congress, and make publicly available, the results of the first year of operations under the Project HERO initiative, including both quality and cost data.

[163]House Report 109-305, 109th Cong., 1st Sess. (2005).
[164]Michael Kussman, principal Under Secretary for Health, VHA, testimony for hearing on "Enhancing Access to Quality Care for Our Nation's Veterans Through Care Coordination Demonstrations—Project HERO" before the House Committee on Veterans' Affairs, March 29, 2006.

NON-VA PURCHASED CARE:

The extent of its decentralized structure, complex legislative authority, and the inadequate funding to local VA facilities for non-VA purchased care continue to erode the effectiveness of this necessary health-care benefit.

The Veterans Health Administration (VHA) is one of the world's largest health-care delivery organizations. As part of an integrated strategy to provide veterans with timely access to quality health-care services, VA health-care facilities are authorized to pay for health-care services acquired from non-VA health-care providers. These services may be provided to eligible veterans from non-VA health-care providers when VA medical facilities are incapable of providing necessary care to a veteran; when VA medical facilities are geographically inaccessible to a veteran for necessary care; when a medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims.

The Non-VA Care Fee Program has historically been called the Fee Program and has included the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Under the Fee Program, veterans who are determined by VHA staff to be eligible and are authorized fee-basis care are allowed to choose their own medical providers. In addition, veterans under the Fee Program are sometimes unable to secure treatment from a community provider because of VA's lower payment, less than full payment, and delayed payment for medical services. *The Independent Budget* veterans service organizations (IBVSOs) are especially concerned that service-connected disabled veterans who are authorized to use non-VA care are at times required by the only provider in their community to pay for the care up front. In these instances, health-care providers frequently charge a higher rate than VA is authorized to pay, resulting in veterans having to pay for the medical care they need and then seek reimbursement from VA. Furthermore, because VA will at times approve only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, veterans who seek reimbursement from VA are paying for part of their care.

Fundamental to a successful non-VA purchased care program (which includes CHAMPVA) is an appropriate information technology (IT) infrastructure. VA manages the authorization, claims processing, and reimbursement for services acquired from non-VA health-care providers through the Purchased Care Program. Due to the program's dated IT infrastructure and cumbersome processes of having multiple and repetitive data entry points and local modifications to suit

local needs resulting in inconsistent claims processing, VA approved funding in October 2002 to replace its IT infrastructure by FY 2009. However, the project subsequently lost its funding in December 2005, eliminating the necessary IT infrastructure to manage the program.

Much effort has been made by VA to address existing variability in processing non-VA medical care claims. By initiating improvements to its business practices, VA has begun to address the timeliness to pay a claim. The IBVSOs applaud the implementation of a national Fee training program for local fee staff as well as certification for authorization and claims processing. Field assistance teams have been deployed to work directly with the field fee offices and facilities to provide standardization in business practices and target specific improvements as requested from the field. Some temporary stand-alone IT systems have been put in place, but they lack the functionality for centralized reporting, recording, and decision support. Clearly, what leadership expects of IT today to manage this program for decision making, policy change, and the like is not being provided by the interim solution. In light of the need for significant changes to the overall infrastructure, the short-term band-aid approach may be adequate, but is not in the best interest of veteran patients or the VA to provide timely access to quality healthcare services. The IBVSOs believe VA leadership must continue to provide the support needed to achieve the goals of these initiatives. Moreover, Congress should provide the necessary resources to fulfill the need for an IT infrastructure replacement system for this program.

Recommendations:

When VA preauthorizes non-VA medical care for a veteran, it should coordinate with the chosen health-care provider for both the veteran's care and payment of medical services. Service-connected veterans should not be required to negotiate payment terms with private providers for authorized fee-basis care or pay out-of-pocket for such services.

VA should continue to pursue the regulatory changes needed for its payment methodology to provide equitable payments for the care veterans receive in the community.

VA should provide the necessary support and place a higher priority for a long-term solution to standardize business practice in the non-VA purchased care program to allow efficient and timely processing of claims.

Congress should provide the necessary funds to facilitate development and implementation of an appropriate IT infrastructure for VA's non-VA purchased care program.

CENTRALIZED INFORMATION TECHNOLOGY IMPACT ON VA HEALTH CARE

While still concerned about the impact of centralization of information technology (IT) on the Veterans Health Administration (VHA),* The Independent Budget *veterans service organizations (IBVSOs) are hopeful that a number of issues we have raised in the past will be resolved early in the new Administration.

The VA health-care system has iteratively developed and perfected a unique VA electronic health record (EHR) system over a 30-year period. The most important, impressive, and lasting value of the VHA's EHR system is that it was conceived and developed internally by thousands of VA clinicians, administrators, managers, biomedical and health services researchers, and clinical informatics experts—those same professionals who actually deliver VA health care in VA facilities.

The current version of this EHR system, based on the VHA's self-developed Veterans Health Information Systems and Technology Architecture (VistA) public domain software, sets the standard for EHR systems in the United States and has been publicly touted by the President, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other federal officials as a model to be emulated by other health-care providers nationwide.[165] In fact, a commercial form of VistA has been installed by public and private sector entities into the patient care systems of a number of U.S. and foreign health-care providers and networks, including state mental health facilities and community health centers in West Virginia; long-term care facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and health systems in a number of foreign nations (including Colombia, Finland, Germany, Mexico, and Nigeria), including one nation that is in the process of a trial implementation of VistA as its national EHR system.

VA VistA: World-Class Electronic Health Record

The VHA's unparalleled success in integrating use of its comprehensive EHR system into its day-to-day health-care delivery process has been a critical factor in the VHA's transformation in becoming recognized as a national leader in health-care quality, safety, prevention, and clinical effectiveness. Among health-care and IT industries worldwide, the VistA program is one of the most successful and remarkable Health IT and EHR systems. In recognition of this fact, in 2006 VA's VistA won the prestigious "Innovations in American Government Award." The annual award is sponsored by Harvard University's Ash Institute for Democratic Governance and Innovation at the Kennedy School of Government and administered in partnership with the Council for Excellence in Government, and honors excellence and creativity in the public sector.

The workings of this EHR system constitute one of the fundamental and critical components of the VHA's ability to deliver consistently high-quality and safe health care to 5.8 million of our nation's veterans. In fact, VHA's EHR system has hard-earned the reputation as "world class," and is acknowledged by most observers as the most successful EHR operating in the world today. It is also important to recognize that VHA's EHR is not simply an IT system, but rather is a health-care tool that is just as vital a component of the VHA's successful health-care delivery capability as its cardiac catheterization laboratories or its magnetic resonance imaging scanners. Without its EHR system, the VHA would be unable to deliver 21st century health care. Therefore, VistA should not, and cannot, be viewed as a standard IT system of network servers and operating systems but rather as a medical device. In fact, Food an Drug Administration (FDA) policies do consider the VistA system to be a medical device for regulatory purposes.

Additionally, a number of former VHA leaders who helped bring this remarkable system into being are now major participants in efforts being led by the Department of Health and Human Services (HHS) and the private sector to implement the secure, interoperable, nationwide health IT infrastructure necessary to markedly improve the quality, safety, and efficiency of health care across the United States. As part of this infrastructure to enable the desired transformational improvements, the same pervasive use of EHRs needs to be attained in routine private and other public health-care systems that the VHA has already accomplished with its VistA system, and will be advancing even more with its next-generation EHR system, HealtheVet. For example, in September the Secretary of HHS hosted a

Federal Advisory Committee of the American Health Information Community (AHIC), where, before two cabinet-level secretaries, VA was a showcase model of interoperability, a goal only achieved because the VA's VistA system already has all information available electronically.[166]

The AHIC was the initial public-private forum for setting priorities to achieve nationwide health information interoperability, including the pervasive use of interoperable EHRs in the American public and private health-care sectors-an effort that will save lives and money, improve health outcomes, and, crucially, avoid medical errors. The nation is attempting to emulate many of the lessons learned from VA's successful development of VistA as benchmarks for future development of EHR systems, specifications, and standards.

Under guidance from the AHIC and help from the public-private AHIC Successor (www.ahicsuccessor.org), private and other public health-care systems and facilities are trying to germinate the seeds and promote the incentives for mainstream American health care to achieve what the VHA already has accomplished—but many challenges lie ahead. Currently only about 12 percent of the nation's private hospitals use advanced EHRs with any clinical decision-support capability, but, as mentioned by the presenter at the September AHIC meeting, the number doubles when you include federal hospitals because of the work of VA. Additionally, only about 20 percent claim significant physician use of computerized provider order entry systems—whereas the VHA has a paperless system used universally by students, residents, and VA attending staff.

As previously discussed, the existence of automated records enables the VHA to provide higher quality, and safer, more efficient health care to veterans. VistA empowers VA—uniquely—to avoid medical mistakes routinely being made by other providers in the private and public sectors. The Institute of Medicine in its report titled "To Err Is Human" has estimated that preventable medical mistakes result in an estimated 98,000 or more deaths in the United States annually. VistA saves veterans' lives by reducing unreadable physician orders, issuing alerts for life-threatening drug allergies, and eliminating medication errors. VA estimated that VistA improved 6,000 veterans' lives by raising rates of pneumonia vaccination among veterans with emphysema, cutting pneumonia hospitalizations in half, and reducing VA costs by $40 million per year.

Reducing Medication Errors

A report by the Institute of Medicine of the National Academy of Sciences estimates more than 1.5 million Americans are harmed by drug errors in medical settings each year, and calls for all prescriptions to be written electronically by 2010. The report said, on average, a hospitalized patient is subject to at least one medication error per day, despite recent initiatives to improve the administration of medicines.

More lives are saved through use of VistA's Bar Code Medication Administration (BCMA) to verify a patient's identity and validate that patient's proper dosage and medication—before it is administered. National implementation of this simple process, with a complex VistA applications program underpinning it, has virtually eliminated medication errors in VA inpatient services. The idea for BCMA was originated by a nurse at the Topeka VA medical center (VAMC) who worked with local IT staff to develop a working prototype. The importance of BCMA has received wide recognition, and it has become an industry standard that has sparked numerous commercial products.

In our highly mobile society, portability of health records is a major concern. In 2005, the value and power of portable electronic health records was proven during the Gulf Coast hurricanes. Many private health-care providers and organizations lost their paper medical records. The VHA's EHRs with its critical systems redundancies allowed VA to access backup records and transfer them to the veterans' new VA facility location. While VA shuttered and evacuated its New Orleans and Gulfport medical centers, as well as a number of its community-based outpatient clinics, and moved thousands of patients to higher ground, these veterans' care was uninterrupted, and not a single VA patient health record was lost.

The VHA's health-care quality improvements over more than a decade have been lauded by many independent and outside observers, including the Institute of Medicine of the National Academy of Sciences, JCAHO, the National Quality Forum, and the HHS Agency for Health Care Quality and Research. While its IT accomplishments alone certainly do not account for all of the VHA's success in improving health-care quality, the electronic integration of enrollment, computerized provider order entry, laboratory, radiology, nuclear medicine, pharmacy, surgery, scheduling, human resources, logistics, management, and multiple reporting systems en-

ables VHA to operate, coordinate, and plan health care for veterans across the continuum of care and across the largest integrated health-care system in the United States. These systems function at a level well above the capabilities of other public and private health-care organizations. In order to continue to maximize health-care quality and efficiency in a dynamic and rapidly changing environment, VHA must have the flexibility and management control to address urgent needs throughout the clinical environment of care. The VistA system is a vital health-care tool and an essential component of VA health care, no less crucial than medical devices used in diagnosis and treatment. In the judgment of the IBVSOs, VHA is the essential place where this management and governance responsibility for health IT should lie.

Despite this record of remarkable success, in late 2006 VistA (and its planned successor, HealtheVet) was swept up in a VA management decision to restructure all VA IT systems under a departmental-level chief information officer (CIO), with centralization of governance authority and IT budgets. This action was triggered in the wake of the theft of a VA laptop computer from the home of a VA management analyst. That computer, later recovered intact, contained personal information on an extensive number of living American veterans and serving members of the U.S. armed forces. This was not a VHA laptop, contained no VHA clinical information, and the employee involved was not a VHA employee (he was employed by the Secretary's Office of Policy and Planning). It should also be noted that this was primarily a breach of the employee's office security policy, not IT security policy. The medium by which the offending employee removed the sensitive information from VA was electronic, rather than paper, and this theft event was not a breach of an IT security system.

In the aftermath of the laptop theft, the Secretary of Veterans Affairs acted on VA IT systems as a whole in an effort to both satisfy Congress that VA was taking a serious action to solve a chronic and serious problem in information security, about which many critics had complained for years, and to reassure veterans that VA would use all means at its disposal to protect their personal information.

All VA IT resources have since been gathered under the new Office of Information and Technology, with a Department-wide CIO who reports to the Secretary. Both the positive and negative effects of that centralization have emerged. While the IBVSOs continue to support the idea that sensitive veteran-specific information in the hands of the government needs to be secured, the IBVSOs have expressed our concern that focusing on information security as a problem that can be solved exclusively by IT centralization may retard the creative and crucial organizational elements that might be important in sustaining a culture of organizational vigilance in information protection. VHA and the entire U.S. health-care community are subject to privacy and security regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), an act that comprehensively prescribes the vigilance required to protect health information. HIPAA is legislation that covers health information within VHA, and is used by all VHA employees to guide their privacy activities related to health information on veterans.

Nationally and internationally, private sector and governments (including the U.S. government) have turned to VHA to learn what was unique about its health-care system that would enable it to create and so extensively implement a transformational tool as powerful as VistA has become. Ironically, within VA now, the environment has been changed with the possible result of jeopardizing the unique circumstances in VHA that fostered the successful enhancement, improvement, and evolution of VistA from predecessor health and research IT activities. The future viability and sustainability of these technology advancements, now integrally intertwined with VHA's health-care delivery processes, are threatened. In doing so, VA's IT reorganization may ultimately threaten the lives of the veterans they serve.

VistA has been so successful as an electronic health record system because it was developed by clinicians and for clinicians and was responsive to the directions and priorities of the VHA leadership. Putting together IT development teams composed of clinician users, VA program managers, policy makers, and software programmers facilitated rapid development, improvement, and continued innovation. VHA clinicians are highly motivated toward investigation, research, and teaching, and the IBVSOs encourage those laudable motives because they lead to higher quality, efficiency, and improved outcomes in health care. VHA's former IT development process spurred rapid innovation and creative practical applications to solve difficult, complex problems and facilitate quality clinical care. The VA CIO Office of Enterprise Development (OED) has fallen short of this standard. Impediments to VHA's ability to determine the rate and scope of change in its health IT solutions embedded within the care delivery processes endangers VHA's abil-

ity to deliver the high-quality health care our nation's veterans deserve. As an example, when rapid development of new IT software was needed to address the needs of Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and the recommendations of the President's Commission on Care for America's Returning Wounded Warriors, the CIO Office of Enterprise Development (OED) could not meet the challenge and VHA stepped in to provide the needed clinical expertise and software development. Who will respond in the next 5, 10, or 15 years when this critical knowledge and skills are lost?

The health IT innovation exhibited by VHA cannot be sustained without maintaining the balanced systems and development principles that were responsible for its past success. All IT decisions should not be made in Washington and permission obtained for development, planning, procurement, and other key functions be granted through a centralized bureaucracy that is ignorant of the needs and input from frontline health-care providers. The dampening effects are already evident in VAMCs nationwide. VHA staff are frustrated that systems that functioned smoothly in the past no longer support their routine delivery of good health care. Such impediments delay or prevent VHA from rapidly incorporating advancements derived from its own research activities as well as from the exponentially increasing medical literature, and obstruct VHA from continuing to transform the care delivery processes themselves. Such erosion places veterans' health in jeopardy.

Governance of VA IT Systems

The IBVSOs are concerned that the current governance policy gives the VA CIO and associated offices, with no responsibility or accountability for health-care delivery to our nations veterans, decisional authority affecting VHA IT resource and mission decisions, including its EHR maintenance requirements and priorities. This is considered antithetical to both the Department of Defense health systems and the private health-care enterprise and, we believe, is against all accepted principles of existing best practices. In our opinion, no other contemporary health-care organization exists where the service provider (the CIO) is superior to, and often in a position to override, the decisions and needs of the chief health-care executive.

While the governance decision has caused a number of unintended consequences and critical challenges, some of the more significant ones are the impact on VA's medical centers, their community-based outpatient clinics, and their supervising Veterans Integrated Service Network (VISN) offices. In these locations, managers can no longer purchase needed medical IT equipment, software, or supportive services of any kind independently or even through the approval by direction of the Under Secretary for Health, without further approval by the CIO. In the current governance alignment, the VA CIO has the ability to override any Under Secretary, regional network, or local facility leadership decision to purchase IT-related equipment, software, or services—even those critical to providing direct, safe care to enrolled veterans.

The IBVSOs understand that the VHA is working on a proposal to revise governance to ensure that it regains, to a greater extent, decisional and funding authority for health-care development and ongoing operational activities of VistA. In our view, the optimal model is the VHA as mission "owner" when it comes to its own health IT system. We believe the VHA should set the strategy and agenda for the support of and future improvement to its all-important EHR system. Specifically, the VHA should have the authority commensurate with accountability to set its own priorities, define its plans, manage project resources and implement and redirect resources, if necessary. Essentially, the VHA should own and direct its IT/EHR budget and mission priorities as well. Additionally, the VHA must regain at least some responsibility for ensuring that an application and the underlying system (now VistA, and eventually migrating to HealtheVet) meets known clinical needs for safe and efficient delivery of health care to veterans. It must be understood, however, that this can only be accomplished with the right governance, organizational realignments, and appropriate accountability.

The IBVSOs further believe that the CIO structure and reporting relationships are not aligned today for optimal service delivery to the VHA. Illustrations of the kinds of problems caused by the current organizational alignment include the following:

- VHA health-care facilities are unable to obtain approval or funds to hire needed IT staff, resulting in work-arounds, including use of work-study temporary assignments, contractors, technical career field interns, clinical application coordinators, and other transient methods to meet ongoing, and even routine, workload demands.
- Facilities have limited ability to initiate IT projects to meet new and increasing patient care demands.

We urge the Under Secretary for Health to reiterate to the Secretary of Veterans Affairs our contention that the most effective field governance would be through direct alignment of the CIO field staff to the VHA networks, through permanent reassignments, with interim details until those reassignments can be effected. These staff are crucial to the daily maintenance of VistA. We are informed that the VA General Counsel has determined or opined that such reassignments of field IT staff would require a legislative authorization from Congress, a proposal that we urge be pursued if the Secretary agrees with counsel's interpretation of current law. Pending a decision to go forward with a legislative proposal to effect this change, however, we understand that the CIO has agreed to work with VHA to develop local facility governance principles to give each VISN a greater share of control and flexibility in using onsite IT staff resources. We appreciate that willingness to cooperate.

Central Office Organization Holding Up Progress

The IBVSOs observe that the current CIO OED seems unable to adequately support current and future requirements for VA's flagship EHR next-generation program, particularly the major HealtheVet programs such as pharmacy, laboratory, computerized patient record system reengineering, scheduling, health data repository, blood bank, etc. And in FY 2009, VA's ability to begin exchanging health information through the Nationwide Health Information Network may be at risk. We also have found that OED organizational and contracting issues and hiring delays are significantly exacerbating the problem, moving the previously planned implementation date for the major programs listed above from FY 2012 to FY 2015, and possibly later. We are disturbed by this delay in VA's moving to the next generation of health IT, and assuming centralization continues, we conclude that OED needs to significantly improve its programmatic capability at all levels of the OED organization, and especially at the senior level, to get this key program back on track.

Budget Inflexibility

VA is currently faced with severe restrictions imposed by Congress (and the Administration) on its budgetary management with respect to IT. Within the Medical Services account, VHA is obstructed from moving any funding into VHA IT support or development without explicit approval by Congress. Within the IT appropriation itself, VA must notify Congress and wait a specified period if it intends to move IT funds of $1 million or more from one purpose to another. At the local and network levels, VA is without any funding authority to procure local-use computing equipment, including printers, laptops, etc. These kinds of restrictions essentially paralyze VHA at all levels from being adaptive at a time of great change and great challenge in IT management.

Contracting Difficulty

Because of the IT centralization, the IBVSOs observe a VA-wide problem affecting the use of contracts and contractors in operating and maintaining VHA's EHR system to keep it up to date and running for the benefit of enrolled veterans. Corrections, "patches," and other improvements to numerous VHA critical EHR programs (scheduling, pharmacy, laboratory, radiology, etc.) are stymied due to the length of time required to navigate the unclear legal and procedural contracts-review process, one now completely centralized and under the aegis of the CIO. Given the inherent delays and bureaucratic behaviors we see occurring in procurement and legal reviews brought on by centralization, we believe because of its critical nature and tie to quality of health care, the HealtheVet next-generation development should be provided a dedicated contracting and legal review team to expedite these decisions.

Perennially inadequate, VA's contracting resources and capabilities to address the ever-growing problem in VHA IT are worsening, and a recent VA CIO decision to reduce the dollar threshold for contract legal review will only exacerbate this problem.

Recruitment of IT Workforce Lagging

As indicated elsewhere in this *Independent Budget,* the IBVSOs are concerned about VA's human resources management programs and consequently VA's ability to compete for scarce health, technical, and general professional fields. Nowhere is this more apparent than in VHA's IT field. Numerous IT hiring issues recur across the VA system, marked significantly by the inordinate length of time required to enter and successfully exit the VA hiring process. Also, VA lacks sufficient flexibility in providing attractive compensation packages to recruited IT professionals, and thereby

loses many highly valued candidates to other agencies of government and private employers. In particular, these constrictions obstruct VA from appointing military retirees with strong IT credentials—despite VA's strongly stated goal of hiring veterans. The OED section with responsibility for VA medical care IT programs, including future development of those programs, is particularly unable to timely hire sufficient personnel with critical talents, and key personnel such as major program managers, system architects, program planners, and other crucial staff.

Emerging Hope

The IBVSOs understand that the former Secretary of Veterans Affairs, who was not in VA when the centralization decision was made by his predecessor, and who is a doctor of medicine by profession and personal history, reportedly signaled a level of sympathy with and understanding of the plight of VHA IT in this hardened centralized environment. As a result, we understand that in FY 2008 the VHA was able to gain the Secretary's support for transferring significant funds from the Medical Services account to VHA IT in support of the EHR and its critical infrastructure in the field. A similar proposal for flexibility has been submitted for fiscal year 2009, but is currently pending. Partly because of this more flexible posture as exemplified by the slight shift in funding flexibility, we hold out hope that the VHA may eventually gain more control over the fate of its IT systems in the future.

Given the degree of success evident in the VHA today, not only in its clinical care results but also in its world-renowned biomedical research programs, the authors of *The Independent Budget* see no defensible justification for VA having centralized VHA IT governance and budgetary authority in a non-VHA environment that lacks any health-care expertise or accountability for health-care delivery.

The principal reason we believe VHA IT has been successful and so critically linked to the documented improvements in VA health-care quality is that VA health-care officials, who are accountable for health-care quality, have controlled and managed the VHA IT policy, planning, and budget functions for VHA for 30 years. Thousands of clinical and other VHA personnel who deliver health care to veterans have served as software developers and testers, subject matter experts on technical evaluation panels, and daily users of the IT system that supports the delivery of coordinated clinical care—care that they themselves largely manage and plan. Without this degree of health IT sophistication and integration with health-care delivery itself, we contend that the VHA could not have doubled enrollment since 1995, significantly reduced the cost of care, and improved quality and safety for America's veterans. With continued inflexible centralization, we fear these gains remain in jeopardy.

The IBVSOs believe the VHA can best manage its own IT operations, planning, and budgeting. We feel certain that this will be true with respect to the next generation of VHA software, HealtheVet, a web-enabled system that was already well into development by VHA clinicians but now under control of the OED and the CIO. We acknowledge that centralization of any governmental or business function can be made to save dollars; however, these savings in the case of VHA may come at a cost of eroded quality of care to sick and disabled veterans with an inevitable overlay of bureaucracy that is endemic to centralization. Removing field facility personnel, especially clinical caregivers, investigators, and even local IT technical personnel, from the planning and development aspects of IT, could serve to diminish VA health care.

While the IBVSOs recognize that IT centralization may make sense for many administrative functions in the Veterans Benefits Administration (VBA), various staff offices to the Secretary in the VA Central Office and functions of the National Cemetery Administration (NCA), the IBVSOs oppose absolute centralization of IT in the VHA. Those offices' functions that are candidates for centralization can be compared favorably to many other federal activities that rely on automated server systems and laptop or desktop applications such as those offered by Microsoft, Computer Associates, Oracle, and other commercial vendors of IT business platforms and database management systems.

The IBVSOs continue to believe turning on its head the VHA's 30-plus year creative authority and forcing VHA to compete with other elements of the VA for IT resources for VistA, and now for HealtheVet, while satisfying external requirements unrelated to health-care delivery, is a potential strategic mistake of major proportions. VHA's IT and its health-care delivery system are one and the same; therefore, we cannot support a policy that assumes VHA's IT needs are not materially different from any other type of administrative application.

Recommendations

The Veterans Health Administration should regain at least partial—if not total—authority over health care-related information technology used within the VA health-care systems clinical, research, and education environment. The VHA should regain its authority for planning, programming, operating, and budgeting information technology matters that directly affect delivery of health care to enrolled veterans, and those directly affecting the conduct of VA's sensitive biomedical research and development programs. In regaining some management responsibility, the VHA should establish policies and procedures that ensure coordination with the VA chief information officer to guarantee compliance with all federally mandated IT security requirements, in a manner congruent with the VHA responsibilities as a direct health-care service provider.

If Congressional action is necessary to enable the VHA to control and supervise IT staff in VA health-care facilities and network offices (more than 1,400 locations), Congress should permit this change. If Congressional action is not required (as the IBVSOs believe to be the case), the Secretary of Veterans Affairs should take administrative action to effect reassignments of field IT staffs to the respective VHA health-care facilities where they currently work.

Any strictures on VA's ability to shift funds in or out of IT financial accounts, whether by appropriations transfers or by reprogramming, should be examined by Congressional appropriations committee staffs to determine if more flexibility is needed within the VA to ensure continuity of operations of VA's IT systems—and particularly those affecting direct VA health care.

Because of its critical nature and tie to quality of health care, the HealtheVet next-generation IT development should be provided a dedicated contracting and legal review team to expedite decisions that move this key project forward.

[163]www.whitehouse.gov/news/releases/2004/04/20040427-5.html, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). (http://www.jointcommission.org/NR/rdonlyres/1C9A7079-7A29-4658-B80D-A7DF8771309B/0/Hospital_Future.pdf).

[164](www.hhs.gov/healthit/community/meetings/m20080923.html).

VHA Physician Assistant Director:

The full-time position of physician assistant advisor to the Under Secretary for Health should be located in the VA Central Office.

The Department of Veterans Affairs is the largest single federal employer of physician assistants (PAs), with approximately 1,800 full-time PA positions, and has utilized PAs since 1969 when the profession started. However, since the Veterans Benefits and Health Care Improvement Act of 2000 directed that the Under Secretary of Health appoint a PA advisor, the Veterans Health Administration (VHA) continued to assign the PA position as a part-time, field based employee until April 2008, with collateral administrative duties in addition to the PA advisor's clinical duties. Although full-time currently, the position is still field-based and often does not receive travel funding until late in the second quarter each year, resulting in missed opportunities to attend VHA meetings.

The Independent Budget veterans service organizations (IBVSOs) have requested for the past seven years that physician assistant be made a full-time position within the VHA. We testified in support of H.R. 2790, a bipartisan bill that would require a full-time PA advisor in the VA Central Office. While this bill passed the House, unfortunately, the Senate did not act.

As structured currently, PAs have been strictly field based. In addition, the PA advisor has had a limited scope of PA-specific clinical or personnel issues; has not been appointed to any of the major health care VA strategic planning committees; has not been included in many aspects of planning on seamless transition, polytrauma centers, traumatic brain injury staffing, or the Office of Rural Health Care; and has not been utilized for emergency disaster planning even though 34 percent of all VA-employed PAs are veterans or currently serve in the military reserves. This critical occupation

could bring vital experiences to new initiatives for improving veteran's health-care access, especially during a time when there is shortage of primary care physicians.

PAs in the VA health-care system are essential primary care providers for millions of veterans annually, with approximately 1,800 PAs now employed by VA. PAs currently work in ambulatory care clinics, emergency medicine, and numerous other medical and surgical subspecialties. The IBVSOs believe that PAs are a critical component of VA health-care delivery and urge that this occupation be included in any recruitment and retention legislation coming when the 111th Congress revisits S. 2969 on Enhancement of Authorities for Retention of Medical Professionals. The five-year average turnover "retention rate" for PAs has been 8.9 percent, and by 2012 it is projected that 28 percent of the PA workforce would be eligible for retirement. Similar to other critical health-care occupations, these needs must be addressed.

A new version of H.R. 2790 should be introduced early in the 111th Congress, by both the Senate and House Veterans Affairs' Committees, to ensure that the chief consultant Physician Assistant Services, within Office of Under Secretary of Health, is finally established by statute to avoid further delays.

Recommendations:

Congress should mandate a full-time chief consultant for Physician Assistant Services within the Office of the Under Secretary for Health. Implementation of this position should be required, with reports back to the chairmen of the Committees on Veterans' Affairs.

Congress should include the PA occupation in any future legislation concerning health-care retention, and education, training, and debt-reduction programs.

Family and Caregiver Support Issues Affecting Severely Injured Veterans:

Given the prevalence and severity of polytrauma in the newest generation of disabled veterans, VA should establish a series of new programs to provide support and care to immediate family members who are committed to providing these veterans with lifelong personal care and attendance.

In "The Challenge of Caring for Our Newest Generation of War Veterans," *The Independent Budget* veterans service organizations (IBVSOs) describe the nature, prevalence, and degree of injuries that veterans have suffered in Operations Enduring and Iraqi Freedom (OEF/OIF). These veterans often have disabling physical conditions, such as multiple limb amputations, spinal cord injury, internal shrapnel injury, loss of sight, and residuals of severe burns. Blast injuries are common in Afghanistan and Iraq, resulting in traumatic brain injury (TBI) that compromises cognitive functions and memory and often results in an inability to inhibit certain behaviors that are self-harming, such as domestic violence and substance misuse, among other problems and risky behaviors. The violence of an improvised explosive device detonation also results in psychological stress reactions, including post-traumatic stress disorder (PTSD) in many of these severely wounded veterans.

A miraculous number of our veterans are surviving what surely would have been fatal events in earlier periods of warfare, but many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal support. Eventually, most of these veterans will be able to return to their families, at least on a part-time basis, or will be moved to an appropriate therapeutic residential care setting—but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them compensate for the dramatic loss of physical, mental, and emotional capacities as a result of their injuries.

Immediate families of severely injured veterans of OEF/OIF face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical[167] and emotional problems[168] of the severely injured veteran plus deal with the complexities

of the systems of care[169] that these veterans must rely on, while struggling with disruption of family life, interruptions of personal professional goals and employment, and dissolution of other "normal" support systems because of the changed circumstances resulting from the veteran's injuries and illness. Research suggests that caregiver support services (e.g., individual and family counseling, respite care, education, and training) can help to reduce the burden, stress, and depression arising from caregiving responsibilities and can improve overall well-being.[170, 171, 172]

Care of the Severely Wounded and Support of Caregivers

As severely injured troops are released from active duty, they are in need of full-time care. The options include institutional care provided by or paid for by VA, or full-time care in the home supported by a VA provided caregiver or by a family member. Were it not for the Caregiver Assistance Pilot Programs,[173] the VA system currently offers little recognition of the caregiver sacrifices being made daily by spouses and families in taking over the care of their wounded loved ones at home. A spouse who becomes the primary caregiver of a severely injured soldier experiences individual challenges, as well as marital stress. The injury, the result of an unexpected event, throws the family unit into a situational crisis, not something that is a part of normal family development. Events like these are likely to be perceived as more stressful than giving care to an elderly family member, simply because it is "off-time"—away from the "normative life cycle."[174]

Caregiver burden is the strain or load borne by an individual caring for an older, chronically ill, or disabled family member or other person. It is a multidimensional response to the physical, psychological, emotional, social, and financial stressors associated with caring for another person. According to a research synthesis on caregiver role strain conducted at the University of Texas, added burden and strain is experienced when the caregiver is living with the recipient; limited resources are available for tangible support; and the care recipient's self-perception of health status is poor.[175] A recent study of female partners of veterans with PTSD found that significant others also suffer from caregiver burden. The partners in this study exhibited high levels of psychological stress with their clinical stress scale scoring above the 90th percentile. In addition to psychological stress, the spouse caregivers fought depression and suicidal ideations. Clearly, mental health care, support group services, and individual counseling for family members are needed beyond VA's Polytrauma Rehabilitation Centers.

The spouse of a severely injured veteran is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. They are also more likely to be dependent on state programs and Medicaid, with great variability from state to state.[176] Complicating matters is the fact that an increasing number of the severely injured are from reserve components (primarily Army and Marine) and National Guard units. It is likely that the families of these troops have never lived on military bases and do not have access to the vibrant social support services and networks connected with active duty military life. Spouses of the injured often must give up their own employment (or withdraw from school in many cases) to care for, attend to, and advocate for their injured veterans. They often fall victim to bureaucratic mishaps in the shifting responsibility of conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation). Also, they rely on this much-needed subsistence in the absence of other personal income.

In November 2008, an account was published in the *New York Time*s documenting these very circumstances. A young staff sergeant suffered a wound to the neck, severing his spinal cord. His wife had to quit her job to take care of him. They tried to hire help provided by the government but the people they found to help were incompetent. And even a good caregiver did not allow the veteran to live the life that he wanted to live. Because of their lack of education about such a situation, the veteran and his wife were led to believe that government regulations prohibit caregivers from taking disabled veterans for whom they are caring out of the house. This sergeant did not want to live like a shut-in. So his wife had to quit her job—forcing them to get by only on his disability compensation—in order to provide him with full-time quality care.[177] This couple and many like them support legislation that would provide family caregivers compensation or a salary for keeping their loved one at home—legislation the VA has opposed.

To address the need for financial support to family caregivers of severely disabled veterans, VA testified before Congress stating, "VA currently contracts with more than 4,000 home health agencies that are approved by the Centers for Medicare and Medicaid Services (CMS) and/or are state licensed. Many of these agencies have

expertise in training and certifying home health aides, including family members. Many operate in rural communities. VA refers interested family members to these agencies and, after their training, these family caregivers become paid employees of the agencies. VA provides remuneration pursuant to agreements with the home health agencies, thus compensating family caregivers indirectly. Importantly, VA also ensures that these home health agencies meet and maintain training and certification requirements specific to caregivers of traumatic brain injured (TBI) patients."[178]

According to the Department of Labor,[179] unlike personal and home care aides, who provide mainly housekeeping and routine personal care services, home health aides help elderly, convalescent, or disabled persons live in their own homes instead of health-care facilities. Under the direction of nursing or medical staff, they provide health-related services, such as administering oral medications. Experienced home health aides, with training, also may assist with medical equipment, such as ventilators, to help patients breathe.

VA's agreements with home health agencies fall under federal guidelines for home health aides whose employers receive reimbursement from Medicare. Federal law requires home health aides to pass a competency test covering a wide range of areas; however, states may have additional licensure requirements adding to the variability, and thus complexity, of VA's program, which requires family caregivers to complete a 75-hour course of instruction and 16 hours of supervised practical training in addition to annual training. Moreover, median hourly earnings of home health aides were $9.34 in May 2006; they receive slight pay increases with experience and added responsibility. Median hourly earnings of psychiatric aides were $11.49 in May 2006.[180]

If VA were to purchase home health services, it would use a maximum payment rate that is locally calculated and specific to one of six disciplines. The Medicare low utilization payment adjustment (LUPA) rates[181] are used by VA as the maximum cap for home health aide services.[182] The LUPA rate in and of itself is used by Medicare for episodes with four or fewer visits within a 60-day period, and VA then uses it based on two hours of care per visit. In states that reimburse separately for homemaker services, VA's rate will not exceed 110 percent of the established state rate for that home care agency or geographic area. VA uses LUPA home care rates without regard to the number of visits or the length of the home care episode.[183] Unfortunately, while family members are allowed to train with the companies under contract to provide home health aides, only certain veterans are allowed to go through those companies to hire family members, and for only four hours a day. VA does not keep data on how many families use this program. Families who think the program does not go far enough object to giving a third party a cut of the money, and say that four hours is insignificant when they often spend 24 hours a day in the job. It also limits compensation to time spent on medical needs like bladder assistance and feeding, leaving out other tasks, such as chauffeuring and paperwork.[184]

For many younger, unmarried veterans, finding appropriate community-based care is even more complicated. Their primary caregivers are their parents, who have limited eligibility for military assistance, often are on limited incomes, and have no current eligibility for VA benefits or services of any kind. They, too, face the same or worse dilemmas as spouses of severely injured veterans because of their advancing age and life circumstances. The support systems they need are limited or restricted, often informal, and clearly inadequate for the long term. Under current law, the spouse of an enrolled veteran is eligible for limited VA mental health services and counseling only as a so-called "collateral" of the veteran; such services are spotty to nonexistent across the VA system. The IBVSOs have been informed by some local VA officials that they are providing a significant amount of training, instruction, counseling, and health care to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the absence of legal authority to provide these services without recognition within VA's resource allocation system and that scarce resources that are needed elsewhere are being diverted to those needs, without recognition within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are financially penalizing themselves in doing so, but they clearly have recognized the urgency of this need.

The IBVSOs have also been informed by other local providers about barriers to accessing caregiver support services that have been identified by their patients and families: education about the availability of services generally not being provided, lack of flexibility of existing services, lack of local availability of services, varied quality of services received and trust and privacy issues of VA and non-VA staff. The most commonly used example is the low utilization of VA's home respite care program. This is of great concern to the IBVSOs because

this is the only significant supportive service that addresses family caregivers of severely disabled veterans.

VA's home respite care program provides supportive care to veterans on a short-term basis to give the caregiver a planned period of relief or respite from the physical and emotional burdens associated with furnishing daily care to chronically ill and severely disabled persons. Respite care may be provided in a home or other noninstitutional setting. It also supports the veteran's desire to delay, or prevent, nursing home placement. According to VA policy,[185] a useful characteristic of respite care is the opportunity for development of a plan for respite care in advance of acute need on the caregiver's part. In this way, respite care is a key component of, rather than incidental to the provision of, routine necessary care. Although the purpose is to be a preventive scheduled benefit, herein lies the inflexibility of the program. An acute need is not a scheduled event and arises throughout the lifetime, not on a short-term basis. Moreover, VA policies indicate that respite care may be provided in a home or other noninstitutional settings or in community nursing homes, but is limited to no more than 30 days per year.

Caregivers of severely injured service members need the flexibility to access shorter respite care periods, such as in two-, four-, or even six-hour increments, as well as availability of services overnight and weekends. In addition, the lack of available beds persists for institutional respite care, and these inpatient settings are more often not an age-appropriate setting for a young generation of injured veterans. The IBVSOs believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating team or physician to approve respite care in excess of 30 days, making more flexible the number of hours/days available for use, providing overnight and weekend respite care to veterans and their caregivers, and eliminating applicable long-term-care copayments.

Another concern the IBVSOs have is on the availability of transportation. If a veteran meets VA's eligibility criteria for beneficiary travel reimbursement,[186] he or she may be eligible for special mode transportation to and from medical appointments. Caregivers may ride with the veteran if there is a designated need for an attendant, which is determined by a VA provider. Since the definition of "medically indicated" is not explicitly defined, the use of this benefit varies considerably. In general, the definition refers to veterans requiring ambulance, ambulette, air ambulance, wheelchair transportation, or transportation specially designed to transport disabled persons. Beneficiary travel regulations specifically indicate that normal modes of transport, such as bus, subway, taxi, train, or airplane, are not included.

The IBVSOs believe Congress should formally authorize, and VA should provide, a full range of psychological and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum, this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and continuous psychological burden of caring for a severely injured and permanently disabled veteran. VA should develop plans to deploy such services in every location in which VA treats OEF/OIF veterans, and at a minimum should provide such services at every Veterans Health Administration (VHA) access point, including all medical centers and substantial community-based outpatient clinics. When warranted by circumstances, these services should be made available through other means, including the use of telemental health technology and the Internet. When necessary because of scarcity or rural access challenges, VA's local adaptations should include consideration of the use of competent community providers on a fee or contract basis to address the needs of these families.

Additionally, families of severely disabled veterans need practice before they are saturated with responsibilities in caring for their extraordinary veterans. To this end, VA should establish a pilot program immediately for providing severely disabled veterans and family members residential rehabilitation services, to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans. Recognizing the tremendous disruption to their lives, the pilot program should focus on helping the veteran and other family members restarting, or "rebooting," their lives after surviving a devastating injury. An integral part of this program should include family counseling and family peer groups so they can share solutions to common problems.

Today, VA's system for providing respite care for severely injured veterans—and to provide needed rest for a family caregiver—is fragmented and unpredictable, and governed by local VA nursing home care unit (NHCU) and adult day health-care (ADHC) policies. Understandably, these programs are targeted to older veterans with chronic illnesses, whereas veterans who survived horrific injuries in Afghanistan and Iraq are still in the early parts of their lives. Thus, VA's NHCU

and ADHC programs remain unattractive to many OEF/OIF veterans. These programs need to be adapted to be more acceptable and attractive to this new generation of disabled veterans.

Policy making and planning to better serve family caregivers of severely injured veterans should depend on statistically representative data that can be used to determine validity, reliability, and statistical significance. The National Long Term Care Survey (NLTCS) is a longitudinal survey designed to study changes in the health and functional status of older Americans (aged 65 and older). It is funded through a Cooperative Agreement[187] between the National Institute on Aging and Duke University. It also tracks health expenditures, Medicare service use, and the availability of personal, family, and community resources for caregiving. The survey began in 1982, and follow-up surveys were conducted in 1984, 1989, 1994, 1999, and 2004. Ancillary surveys to include an Informal Caregiver Survey (ICS) conducted in 1982, 1989, 1999, and 2004 have been added to obtain information on the health and functional status of people who take care of the 65 years and older population in a home environment.

The NLTCS in combination with ICS can be used to examine such things as how many hours of help with activities of daily living (ADLs) and instrumental ADLs chronically disabled elders weekly, and what number and percentage of those hours are provided by informal caregivers. It can also be further broken down by primary and secondary caregivers and by relationship, (e.g., spouse, son, daughter, friend, etc.) as compared to paid workers. This enables policy researchers to measure the time burden of providing informal care on caregivers (especially primary caregivers) in relation to the severity of disability and other care recipient characteristics. The relationship between the weekly time burden of informal care and self-reported indicators of caregiver stress can then be analyzed. Further analyses could be carried out with respect to relationships among time burden of informal care, self-reported caregiver stress, use or non-use of formal services, and funding source for formal services (public/private).

Finally, the NLTCS and ICS contain numerous questions regarding the primary informal caregiver's perception of the need or lack thereof for formal services and the reason why these services are not being used if they are perceived as needed (e.g., lack of affordability, lack of local availability, etc.). This enables policy makers to estimate (using various different criteria) the potential size and characteristics of the target population for public policy interventions to assist caregivers. The IBVSOs believe VA should conduct a standardized baseline and successive national surveys of caregivers of veterans similar to the NTLCS and ICS. Considering the demographics of the VA health-care system's enrolled and user population, it should include a special emphasis on caregivers of OEF/OIF veterans.

Because health outcomes and quality of life of veterans with serious injuries and chronic disability also affect the family, a patient- and family-centered perspective is essential for quality improvement in redesigning long-term care. Policymakers must view family caregivers of severely injured service members as a resource rather than as an unrecognized cost-avoidance tool. In programs where caregivers are assessed, they can be acknowledged and valued by practitioners as part of the health-care team. Caregiver assessment can identify family members most at risk for health and mental health effects and determine if they are eligible for additional support. Effectively supporting caregivers can result in delayed placements of more costly nursing home care.[188]

Assessment is a critical step in determining appropriate support services. Caregiver assessment is a systematic process of gathering information to describe a caregiving situation. It identifies the particular problems, needs, resources, and strengths of the family caregiver and approaches issues from the caregiver's perspective and culture to help the caregiver maintain her or his health and well-being.[189]

The National Consensus Development Conference for Caregiver Assessment brought together widely recognized leaders in health and long-term care, with a variety of perspectives and expertise, to advance policy and practice on behalf of family and informal caregivers. The Family Caregiver Alliance's (FCA) National Center on Caregiving designed and convened this conference, held September 7–9, 2005, in San Francisco. The conference generated a report[190] on the fundamental principles and guidelines to advance caregiver assessment nationally and in each state, and to serve as a catalyst for change at federal, state, and local levels. The IBVSOs believe VA should conduct caregiver assessments that meet the principles outlined in the conference report. Conference participants agreed upon a set of seven basic principles to guide caregiver assessment policy and practices:

1. Because family caregivers are a core part of health care and long-term care, it is important to recognize, respect, assess, and address their needs.
2. Caregiver assessment should embrace a family-centered perspective, inclusive of the needs and preferences of both the care recipient and the family caregiver.
3. Caregiver assessment should result in a plan of care (developed collaboratively with the caregiver) that indicates the provision of services and intended measurable outcomes.
4. Caregiver assessment should be multidimensional in approach and periodically updated.
5. Caregiver assessment should reflect culturally competent practice.
6. Effective caregiver assessment requires assessors to have specialized knowledge and skills. Practitioners' and service providers' education and training should equip them with an understanding of the caregiving process and its impacts, as well as the benefits and elements of an effective caregiver assessment.
7. Government and other third-party payers should recognize and pay for caregiver assessment as a part of care for older people and adults with disabilities.

VA must realize its one-size-fits-all approach to long-term care is not patient-centric, particularly for severely injured OEF/OIF veterans, and current support services for family caregivers are deficient. VA's programs should be designed to meet the needs of younger severely injured or ill veterans who wish to reside at home with their loved ones, in addition to the generally older veteran population now served by VA programs. Where appropriate VHA services are not available because of geographic barriers, the VHA should develop contractual relations with appropriate, qualified private or other public facilities to provide respite services tailored to this population's needs.

While family caregivers may be driven by empathy and love, they're also dealing with guilt over the anger and frustration they feel. The very touchstones that define their lives—careers, love relationships, friendships, even their goals and dreams—are often being sacrificed. Simply, family caregivers who are vital for VA's patient-centric care provided in the least restrictive setting must not remain unpaid, unappreciated, undercounted, untrained, and exhausted. Given the nature of these issues, and the unique situation that confronts our newest generation of severely disabled war veterans, the IBVSOs believe Congress and the Administration need to address a number of observed deficiencies to give needed support and make a family caregiver's tasks and roles more manageable over the long term. This is in the best interests of these families, whose absence as personal caregivers and attendants for these seriously disabled veterans would mean even higher costs to the government to assume total responsibility for their care and would lower the quality of life for the very veterans for whom VA was established as a caring agency.

Recommendations:

The case management system should be seamless for veterans and family caregivers. Case manager advocates must be empowered to assist with medical benefits and family support services, including vocational services, financial services, and child care services.

Congress should formally authorize, and VA should provide, a range of transitional psychological and social support services to family caregivers of veterans with severe service-connected injuries or illnesses.

VA should provide psychological support services to the family caregivers of severely injured and ill veterans. This support must include relationship and marriage counseling, family counseling, and related assistance to the family in coping with the inevitable stress and discouragement of caring for a seriously disabled veteran. These services should be made available at every VA facility that cares for severely disabled veterans of Operations Enduring and Iraqi Freedom.

VA should establish clear policies outlining the expectation that every VA nursing home and adult day health-care program provide appropriate facilities and programs for respite care for severely injured or ill veterans. These facilities should be restructured to be age-appropriate, with strong rehabilitation goals suited to the needs of a younger population, rather than expecting younger veterans to blend with the older generation typically resident in VA nursing home care units and adult day health-care programs. VA must adapt its services to the particular needs of this new generation of disabled veterans and not simply require these veterans to accept what VA chooses to offer.

VA should develop support materials for family caregivers, including the following:

- A "Caregiver Toolkit" available in hard copy and from the Internet—to supplement the recently published "National Resource Directory," which may not be fully responsive to their needs. This should include a concise "recovery road map" to assist families in understanding, and maneuvering through, the complex systems of care and resources available to them.
- Social support and advocacy support for the family caregivers of severely injured veterans, including:
  - Peer support groups, facilitated and assisted by committed VA staff members;
  - Appointment of caregivers to local and VA network patient councils and other advisory bodies within the Veterans Health Administration and Veterans Benefits Administration; and
  - A monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled OEF/OIF veterans, through My HealtheVet or another appropriate web-based platform.

VA should enhance its respite care services to reduce the variability across a veteran's continuum of care by allowing the veteran's primary treating physician to approve respite care in excess of 30 days; making the benefit more flexible by increasing the number of hours/days, overnight respite, and weekend respite care provided to veterans and their caregivers; and by eliminating applicable copayments.

Clarification is needed regarding the application of the Family and Medical Leave Act to address the special needs of the families of severely injured veterans, including increasing the duration of family leave time that is authorized by that act and adding additional employment protections for parents who are caregivers of severely disabled veterans of OEF/OIF.

Congress should authorize a compensation system for family caregivers of severely disabled veterans, intended to make up for the loss of income resulting from full-time caregiving, and to provide supplemental financial support to maintain their homes.

Congress should require the Government Accountability Office to examine the current Civilian Health and Medical Program of Veterans Affairs to ensure the health coverage available to full-time caregivers is adequate.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys of caregivers of seriously injured veterans that will yield statistically representative data for policy and planning purposes.

VA should conduct caregiver assessments to identify the particular problems, needs, resources, and strengths of family caregivers of severely injured service members and determine appropriate support services and help the caregiver maintain her or his health and well-being.

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[167]Stacy A. Brethauer, Alex Chao, et al., "U.S. Navy/Marine Corps Forward Surgical Care During Operation Iraqi Freedom," *Archives of Surgery* 143(6) (2008): 564–69.
[168]T. Tanielian and L. Jaycox, ed., Executive Summary, in *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corp., Center for Military Health Policy Research, 2008).
[169]Atul Gawande, "Casualties of War: Military Care for the Wounded from Iraq and Afghanistan," *New England Journal of Medicine* 351(24) (2004): 2471–75.
[170]B. G. Knight, S. M. Lutzky, and F. Macofsky-Urban, "A Meta-analytic Review of Interventions for Caregiver Distress: Recommendations for Future Research." *Gerontologist* 33(2): 240–48.
[171]S. K. Ostwald, K. W. Hepburn, et al., "Reducing Caregiver Burden: A Randomized Psychoeducational Intervention for Caregivers of Persons with Dementia, *Gerontologist* 39(3): 299–309.
[172]S. H. Zarit, M. A. Stephens, et al., "Stress Reduction for Family Caregivers: Effects of Adult Day Care Use, *Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 53(5) S267–77.
[173]P.L. 109-461, Title II § 214, Pilot Program on Improvement of Caregiver Assistance Services.
[174]Tracey A. Revenson, "Scenes from a Marriage: Examining Support, Coping, and Gender within the Context of Chronic Illness," in J. Suls and K. Wallston, ed., *Social Psychological Foundations of Health and Illness* (pp. 530–559) (Oxford, England: Blackwell Publishing, 2003).
[175]Rebecca G. Judd, *Caregiver Role Strain: A Research Synthesis* (Arlington, Texas: University of Texas, 2006).
[176]United States Agency for Healthcare Research and Quality, 2007 National Healthcare Quality & Disparities Reports, Rockville, MD, 2008. Also, Jim Garamone, U.S. Military Recruiting Demographics," American Forces Press Service, November 23, 2005; David S. Riggs, "Difficulties in Family Reintegration Following Military Deployments," *Healing the Scars of War* (New York: Institute for Disaster Mental Health. 11 Apr. 2008); U.S. Department of Defense, Population Representation in the Military Services. (Washington: Office of the Under Secretary of Defense, Personnel and Readiness, 2006) (www.defenselink.mil/prhome/PopRep_FY06).
[177]Leslie Kauffman, "Veterans' Families Seek Aid for Caregiver Role," *New York Times,* November 11, 2008.
[178]Gerald M. Cross, principal deputy under secretary for health, DVA, statement before the Subcommittee on Health, House Committee on Veterans' Affairs, September 9, 2008.
[179](www.bls.gov/oco/ocos165.htm).
[180]Ibid.
[181]"Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2009," Notice. *Federal Register* 73 (3 November 2008): 65351–65384.
[182]Home health aide, $53.78; skilled nursing, $118.75; medical social services $190.36; occupational therapy $130.71; physical therapy, $129.84; speech-language pathology, $141.09.
[183]DVA, Veterans Health Administration Handbook 1140.3, August 16, 2004.
[184]Leslie Kauffman, "Veterans' Families Seek Aid for Caregiver Role," *New York Times,* November 11, 2008.
[185]DVA, VHA Directive 2002-016, March 19, 2002.
[186]DVA, Beneficiary Travel Handbook1601B.05, July 29, 2008.
[187]Cooperative Agreement Grant 2 U01 AG0007198.
[188]M. S. Mittelman, S.H. Ferris, et al., "A Family Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease: A Randomized Controlled Trial," *JAMA* 276(21): 1725–31.
[189]Lynn Feinberg, "Caregiver Assessment," *Journal of Social Work Education* 44(3) (2008): supplement.
[190]Family Caregiver Alliance, Caregiver Assessment: Principles, Guidelines and Strategies for Change: Report from a National Consensus Development Conference, vol. 1 (San Francisco: Family Caregiver Alliance, 2006) (www.caregiver.org/caregiver/jsp/content/pdfs/v1_consensus.pdf).

Construction Programs

On May 5, 2008, the Department of Veterans Affairs released the final results of its Capital Asset Realignment for Enhanced Services (CARES) business plan study for Boston. The decision to keep the four Boston-area medical campuses open was the culmination of many years of work and tens of millions of dollars as it marked the final step of the CARES planning process.

CARES—VA's data-driven assessment of its current and future construction needs—gave the Department a long-term road map and has helped guide its capital planning process over the past few fiscal years. CARES showed a large number of significant construction priorities that would be necessary for VA to fulfill its obligation to this nation's veterans, and over the past several fiscal years the Administration and Congress have made significant inroads in funding these priorities. Since FY 2004, $4.9 billion has been allocated for these projects. Of these CARES-identified projects, VA has completed 5, and another 27 are currently under construction. It has been a significant, but necessary, undertaking and VA has made slow, but steady, progress on these critical projects.

The challenge for VA in the post-CARES era is that there are still numerous projects that need to be carried out, and the current backlog of partially funded projects that CARES has identified is large, too. This means VA is going to continue to require significant appropriations for the major and minor construction accounts to live up to the promise of CARES.

VA's most recent Asset Management Plan[191] provides an update of the state of CARES projects—including those only in the planning or acquisition process. Appendix E of the plan shows a need for future appropriations of $2.195 billion to complete these projects.

Approved Construction Projects	
Project	**Funding ($ in Thousands)**
Pittsburgh	$62,400
Orlando	$462,700
San Juan	$91,620
Denver	$580,900
Bay Pines	$156,800
Los Angeles	$103,864
Palo Alto	$412,010
St. Louis	$122,500
Tampa	$202,600
TOTAL	**$2,195,394**

The $2.195 billion represents only the backlog of current approved construction projects. It also does not reflect the additional $401 million Congress gave VA as part of the FY 2009 appropriation, which did not earmark specific construction projects.

Meanwhile, VA continues to identify and reprioritize potential major construction projects. These priorities, which are assessed using the rigorous methodology that guided the CARES decisions, are released in the VA's annual "5-Year Capital Plan," which is included in the Department's budget submission. The most recent one was included in Volume IV and is available on the VA website.[192] Pages 7–12 of that document show the priority scoring of projects. Last year's budget request sought funding for only three of the top-scored projects. No funding was requested for any other new project, including those in Seattle, Dallas, Louisville, or Roseburg, Oregon. In addition to the already-identified needs from that table, pages 7–86 show long list of potential major construction projects the Department plans to evaluate from now through FY 2013. These 122 potential projects demonstrate the continued need for VA to upgrade and repair its aging infrastructure and that continuous funding is necessary for not only the backlog of projects, but also to keep VA viable for today's and future veterans.

In a November 17, 2008, letter to the Senate Veterans' Affairs Committee, Secretary Peake said "the Department estimates that the total funding requirement for major medical facility projects over the next five years would be in excess of $6.5 billion."

It is clear that VA needs a significant funding for its construction priorities; its own words and studies show this.

Major Construction Account Recommendations	
Category	**Recommendation ($ in Thousands)**
Major Medical Facility Construction	$900,000
NCA Construction	$80,000
Advance Planning	$45,000
Master Planning	$20,000
Historic Preservation	$20,000
Miscellaneous Accounts	$58,000
TOTAL	**$1,123,000**

Major Construction Account recommendations shown in the table are as follows:

- Veterans Health Administration (VHA) Facility Construction—this amount would allow VA to continue addressing the $2 billion backlog of partially funded construction projects. Depending on the stages and ability to complete portions of the projects, any additional money could be used to fund new projects identified by VA as part of its prioritization methodology in its 5-Year Capital Plan.
- National Cemetery Administration (NCA) Construction—pages 7–143 of the 5-Year Capital Plan detail numerous potential major construction projects for the National Cemetery Administration throughout the country. This level of funding would allow VA to begin construction on at least three of its scored priority projects.
- Advance Planning—this amount helps develop the scope of the major medical facility construction projects as well as identify proper requirements for their construction. It allows VA to conduct necessary studies and research similar to planning processes in the private sector.
- Master Planning—a description of *The Independent Budget* (*IB)* request follows later in the text.
- Historic Preservation—a description of the *IB* request follows later in the text.
- Medical Research Infrastructure—a description of the *IB* request follows later in the text.
- Miscellaneous Accounts—these include the individual line items for such accounts as asbestos abatement, the judgment fund, and hazardous waste disposal. The *IB* recommendation is based upon the historic level for each of these accounts.

Minor Construction Account Recommendations	
Category	**Funding ($ in Thousands)**
Veterans Health Administration	$550,000
Medical Research Infrastructure	$142,000
National Cemetery Administration	$100,000
Veterans Benefits Administration	$20,000
Staff Offices	$15,000
TOTAL	**$827,000**

Minor Construction Account recommendations are:

- VHA—pages 7–95 of VA's capital plan reveal hundreds of already-identified minor construction projects that update and modernize VA's aging physical plant, ensuring the health and safety of veterans and VA employees. Additionally, a great number of minor construction projects address maintenance deficiencies identified in the facility condition assessment, the backlog of which was nearly $5 billion at the start of FY 2008 (page 7–64).
- Medical Research Infrastructure—a description of the *IB* request follows later in the text.
- NCA—pages 7–145 of the capital plan identify numerous minor construction projects throughout the country, including the construction of several columbaria, installation of crypts, and landscaping and maintenance improvements. Some of these projects could be combined with VA's new NCA nonrecurring maintenance efforts.
- Veterans Benefits Administration—pages 7–126 of the capital plan lists several minor construction projects in addition to the leasing requirements VBA needs. This funding also includes $2 million transferred yearly for the security requirements of its Manila office.
- Staff Offices—Pages 7–166 list numerous potential minor construction projects related to staff offices, including increased space and numerous renovations for the VA Office of Inspector General.

[191]www.va.gov/oaem/docs/FY08AssetManagementPlan.pdf.
[192]www.va.gov/budget/summary/2009/index.htm.

CONSTRUCTION ISSUES

Inadequate Funding and Declining Capital Asset Value

The Department of Veterans Affairs must protect against deterioration of its infrastructure and a declining capital asset value

The past decade of delayed and underfunded construction budgets has meant that VA has not adequately recapitalized its facilities. Recapitalization is necessary to protect the value of VA's capital assets through the renewal of the physical infrastructure. This ensures safe and fully functional facilities long into the future. VA's facilities have an average age of more than 55 years, and it is essential that funding be increased to renovate, repair, and replace these aging structures and physical systems.

As in past years, *The Independent Budget* veterans service organizations (IBVSOs) cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). It found that from 1996–2001, VA's recapitalization rate was just 0.64 percent. At this rate, VA's structures would have an assumed life of 155 years.

The PTF cited a PricewaterhouseCoopers' study[193] of VA's facilities management programs that found that to keep up with industry standards in the private sector and to maintain patient and employee safety and optimal heath-care delivery, VA should annually spend a minimum of 5 percent to 8 percent of plant replacement value (PRV) on its total capital budget.

The FY 2008 VA Asset Management Plan[194] provides the most recent estimate of VA's PRV. Using the guidance of the federal government's Federal Real Property Council, VA's PRV is just over $85 billion.

Accordingly, using that 5 percent to 8 percent standard, VA's capital budget should be between $4.25 and $6.8 billion per year in order to maintain its infrastructure. VA's capital budget request for FY 2009—which includes major and minor construction, maintenance, leases, and equipment—was just $3.6 billion. The IBVSOs greatly appreciate that Congress increased funding above that level with an increase over the Administration request of $750 million in Major and Minor Construction alone. That increased amount brought the total capital budget in line with industry standards, and we strongly urge that these targets continue to be met and we would hope that future VA requests use these guidelines as a starting point without requiring Congress to push them past the target.

Recommendation:

Congress and the Administration must ensure that there are adequate funds for VA's capital budget so that VA can properly invest in its physical assets to protect their value and to ensure that it can continue to provide health care in safe and functional facilities long into the future.

[193]Final Report, Independent Review of Office of Facility Management, PriceWaterhouse, June 17, 1998.
[194]www.va.gov/oaem/docs/FY08AssetManagementPlan.pdf., p. 26.

Increased Spending on Nonrecurring Maintenance:

The deterioration of many VA properties requires increased spending on nonrecurring maintenance.

For years, *The Independent Budget* veterans service organizations (IBVSOs) have highlighted the need for increased funding for the nonrecurring maintenance (NRM) account. NRM consists of small projects that are essential to the proper maintenance and preservation of the lifespan of VA's facilities. NRM projects are one-time repairs, such as maintenance to roofs, repair and replacement of windows and flooring, or minor upgrades to the mechanical or electrical systems. They are a necessary component of the care and stewardship of a facility.

These projects are vitally important. If left unrepaired, they can exact a significant toll on a facility, leading to more costly repairs in the future and the potential of a need for a minor construction project. Beyond the fiscal aspects, facilities that fall into disrepair can create access difficulties and impair patient and staff health and safety. If the needs develop into a larger construction project because early repairs were not done, it creates an even larger inconvenience for veterans and staff.

The industry standard for medical facilities is for managers to spend from 2 percent to 4 percent of plant replacement value (PRV) on upkeep and maintenance. The 1998 PricewaterhouseCoopers[195] study of VA's facilities management practices argued for this level of funding, and previous versions of VA's own Asset Management Plan have agreed that this level of funding would be adequate.

The most recent estimate of VA's PRV is from the FY 2008 Asset Management Plan.[196] Using the standards of the federal government's Federal Real Property Council (FRPC), VA's PRV is just over $85 billion. Accordingly, to fully maintain its facilities, VA needs an NRM budget of at least $1.7 billion. This number would represent a doubling of VA's budget request from FY 2009, but it is in line with the total NRM budget when factoring in the increases Congress gave in the appropriations bill and the targeted funding included in the supplemental appropriations bills.

Increased funding is required not just to fill current maintenance needs and levels, but also to reduce the extensive backlog of maintenance requirements VA has identified. VA monitors the condition of its structures and systems through the Facility Condition Assessment (FCA) reports. VA surveys each medical center periodically, giving each building a thorough assessment of all essential systems. Systems are assigned a letter grade based upon the age and condition of various systems, and VA gives each component a cost for repair or replacement.

Most of these repairs and replacements are managed through the NRM program, although the large increases

in minor construction over the last few years have helped VA to address some of these deficiencies. VA's 2009 5-Year Capital Plan discusses FCAs and acknowledges the significant backlog, noting that in FY 2007, the number of high-priority deficiencies—those with ratings of D or F—had replacement and repair costs greater than $5 billion. Even with the increased funding of the past few years, VA estimates that the cost for repairing or replacing the high-priority deficiencies is more than $4 billion. VA uses the FCA reports as part of its FRPC metrics. It calculates a facility condition index, which is the ratio of the cost of FCA repairs to the cost of replacement. According to the FY 2008 Asset Management Plan, this metric has gone backward from 82 percent in 2006 to just 68 percent in 2008. VA's strategic goal is 87 percent, and for it to meet that, it would require a sizable investment in NRM and minor construction.

Given the low level of funding the NRM account has historically received, the IBVSOs are not surprised at the metrics or the dollar cost of the FCA deficiencies. The 2007 "National Roll-Up of Environment of Care Report,"[197] which was conducted in light of the shameful maintenance deficiencies found at the Department of Defense's Walter Reed Army Medical Center, further proves the need for increased spending on this account. Maintenance has been neglected for far too long, and for VA to provide safe, high-quality health care in its aging facilities, it is essential that more funding be allocated for this account.

The IBVSOs also have concerns with how NRM funding is actually apportioned. Because it falls under the Medical Care account, NRM funding has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This model works when distributing health-care dollars, targeting funding to those areas with the greatest demand for health care. When dealing with maintenance needs, however, this same formula may actually intensify the problem, moving money away from older hospitals, such as in the Northeast, to newer facilities where patient demand is greater, even if the maintenance needs are not as high. We were happy to see that the conference reports to the VA appropriations bills required NRM funding to be apportioned outside the VERA formula, and we would hope that this continues into the future.

Another issue related to apportionment of funding came to light in a May 2007 Government Accountability Office (GAO) report that found that the bulk of NRM funding is not actually apportioned until September, the final month of the fiscal year.[198] In September 2006, the GAO found that VA allocated 60 percent of that year's NRM funding. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and because NRM funding is year-to-year, this practice could lead to wasteful or unnecessary spending as managers attempt to hastily spend their apportionment before forfeiting it. We cannot expect VA to perform a year's worth of maintenance in a month. It is clearly poor policy and not in the best interest of veterans. The IBVSOs believe that Congress should consider allowing some NRM money to be carried over from one fiscal year to another. Whereas we would hope that this would not resort to medical centers hoarding funding, it could result in more efficient spending and better planning than the current situation in which hospital managers sometimes have to spend a large portion of maintenance funding before losing it at the end of the fiscal year.

Recommendations:

VA must dramatically increase funding for nonrecurring maintenance in line with the 2 percent to 4 percent total that is the industry standard so as to maintain clean, safe, and efficient facilities. VA also requires additional maintenance funding to allow the department to begin addressing the substantial maintenance backlog of facility condition assessment–identified projects.

Portions of the nonrecurring maintenance account should be continued to be funded outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that actually have the greatest maintenance needs.

Congress should consider the strengths of allowing VA to carry over some maintenance funding from one fiscal year to another so as to reduce the temptation some VA hospital managers have of inefficiently spending their NRM money at the end of a fiscal year for fear of losing it.

[195]Final Report, Independent Review of Office of Facility Management, PriceWaterhouse, June 17, 1998.
[196]www.va.gov/oaem/docs/FY08AssetManagementPlan.pdf., p. 26.
[197]www1.va.gov/opa/pressrel/docs/Environment_of_Care_Roll-up.pdf.
[198]www.gao.gov/new.items/d07410r.pdf.

Maintain VA's Critical Health Infrastructure:

The Independent Budget ***veterans service organizations (IBVSOs) are concerned with VA's recent attempts to back away from the capital infrastructure blueprint laid out by the Capital Asset Realignment for Enhanced Services (CARES) plan, and we are worried that its emerging plan to begin widespread leasing and contracting for inpatient services might not meet the needs of veterans.***

The Department of Veterans Affairs acknowledges three main challenges with its capital infrastructure projects: First, they are costly. According to a March 2008 briefing given to veterans service organizations, over the next five years VA would need $2 billion per year for its capital budget. Second, there is a large backlog of partially funded construction projects. That same briefing claimed the difference in major construction requests given to the Office of Management and Budget was $8.6 billion from FY 2003 through FY 2009 and that it has received slightly less than half that total. Additionally, there is a $2 billion funding backlog for projects that are partially but not completely funded. Third, VA is concerned about the timeliness of construction projects, noting that it can take the better part of a decade from the time VA initially proposes a project until the doors actually open for veterans.

Given these challenges, VA has broached the idea of a new model for health-care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF, VA would begin leasing large outpatient clinics in lieu of major construction. These large clinics would provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

On the face of it, this sounds like a good initiative. Leasing has the advantage of being able to be completed quickly, as well as being adaptable, especially when compared to existing major medical facilities. Leasing has been particularly valuable for VA as evidenced by the success of the community-based outpatient clinics and Vet Centers.

The IBVSOs are concerned, however, with VA's plan for inpatient services. VA aims to contract for these essential services with affiliates or community hospitals. This program would privatize many services we believe VA should continue to provide. We lay out our objections to privatization and widespread contracting for care in the "Contract Care Coordination" section of this *Independent Budget.*

Beyond those objections, though, is the example of Grand Island, Nebraska. In 1997 the Grand Island VA Medical Center closed its inpatient facilities, contracting out with a local hospital for those services. Recently the contract between the local facility and VA was canceled, meaning veterans in that area can no longer receive inpatient services locally. They must travel great distances to other VA facilities, such as the Omaha VA Medical Center. In some cases, when Omaha is unable to provide specialized care, VA is flying patients at its expense to faraway VA medical centers, including those in St. Louis and Minneapolis.

Further, with the canceling of that contract, the local hospital no longer provides the same level of emergency services that a full VA medical center would provide. With VA's restrictions on paying for emergency services in non-VA facilities, especially for those who may have some form of private insurance, this amounts to a cut in essential services to veterans. Given the expenses of air travel and medevac services, the current arrangement in Grand Island has likely not resulted in any cost savings for VA. Ferrying sick and disabled veterans great distances for inpatient care also raises patient safety and quality of care concerns.

The HCCF program raises many concerns the IBVSOs believe VA must address. Among these questions, we wonder how VA will handle governance, especially with respect to the large numbers of non-VA employees who would be treating veterans? How will the non-VA facility deal with VA directives and rule changes that govern health-care delivery and that ensure safety and uniformity of the quality of care? Will VA apply its space planning criteria and design guides to non-VA facilities? How will VA's critical research activities, most of which improve the lives of all Americans and not only veterans, be affected if they are being conducted in shared facilities, and not a traditional part of VA's first-class research programs? What will this change mean for VA's electronic health record, which many have rightly lauded as the standard that other health-care systems should aim to achieve? Without the electronic health record, how will

VA maintain its high quality of care standards and continuity for a veteran who moves to another area?

But, most important, CARES required years to complete and consumed thousands of hours of effort and millions of dollars of study. The IBVSOs believe it to be a comprehensive and fully justified road map for VA's infrastructure as well as a model VA can apply periodically to assess and adjust those priorities. Given the strengths of the CARES process and the lessons VA learned and has applied from it, why is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one? We have yet to see evidence that it is and until we see more convincing evidence that it will truly serve the best interests of veterans, the IBVSOs will have a difficult time supporting it.

Recommendation:

VA must not implement the Health Care Center Facility model without fully addressing the many questions raised in *The Independent Budget*, and VA must explain how the program would meet the needs of veterans, particularly as compared to the road map the Capital Asset Realignment for Enhanced Services laid out.

Research Infrastructure Funding:

The Department of Veterans Affairs must have increased funding for its research infrastructure to provide a state-of-the-art research and laboratory environment for its excellent programs, but also to ensure that VA hires and retains the top scientists and researchers.

VA Research Is a National Asset

Research conducted in the Department of Veterans Affairs has led to such innovations and advances as the cardiac pacemaker, nuclear scanning technologies, radioisotope diagnostic techniques, liver and other organ transplantation, the nicotine patch, and vast improvements in a variety of prosthetic and sensory aids. A state-of-the-art physical environment for conducting VA research promotes excellence in health professions education and VA patient care as well as the advancement of biomedical science. Adequate and up-to-date research facilities also help VA recruit and retain the best and brightest clinician scientists to care for enrolled veterans.

VA Research Infrastructure Funding Shortfalls

In recent years, funding for the VA Medical and Prosthetics Research Program has failed to provide the resources needed to maintain, upgrade, and replace VA's aging research facilities. Many VA facilities have exhausted their available research space. Along with space reconfiguration, ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades in VA's academic health centers. In the 2003 Draft National Capital Asset Realignment for Enhanced Services (CARES) plan, VA included $142 million designated for renovation of existing research space and build-out costs for leased researched facilities. However, these capital improvement costs were omitted from the Secretary's final report. Over the past decade, only $50 million has been spent on VA research construction or renovation nationwide, and only 24 of the 97 major VA research sites across the nation have benefited.

In House Report 109-95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." In FY 2008, the VA Office of Research and Development initiated a multiyear examination of all VA research infrastructure for physical condition and capacity for current research, as well as program growth and sustainability of the space needed to conduct research.

Lack of a Mechanism to Ensure VA's Research Facilities Remain Competitive

In House Report 109-95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." A significant cause of research infrastructure's neglect is that there is no direct funding line for research facilities.

The VA Medical and Prosthetic Research appropriation does not include funding for construction, renovation, or maintenance of research facilities. VA researchers must rely on their local facility managements to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with other medical facilities' direct patient care needs—such as medical services infrastructure, capital equipment upgrades and replacements, and other maintenance needs—for funds provided under either the VA Medical Facilities appropriation account or the VA Major or Minor Medical Construction appropriations accounts.

Recommendations:

The Independent Budget veterans service organizations anticipate VA's analysis will find a need for funding significantly greater than VA had identified in the 2004 Capital Asset Realignment for Enhanced Services report. As VA moves forward with its research facilities assessment, the IBVSOs urge Congress to require the VA to submit the resulting report to the House and Senate Committees on Veterans' Affairs no later than October 1, 2009. This report will ensure that the Administration and Congress are well informed of VA's funding needs for research infrastructure so they may be fully considered at each stage of the FY 2011 budget process.

To address the current shortfalls, the IBVSOs recommend an appropriation in FY 2010 of $142 million, dedicated to renovating existing VA research facilities in line with the 2004 CARES findings.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs encourage the Administration and Congress to support a new appropriations account in FY 2010 and thereafter to independently define and separate VA research infrastructure funding needs from those related to direct VA medical care. This division of appropriations accounts will empower VA to address research facility needs without interfering with the renovation and construction of VA direct health-care infrastructure.

Program for Architectural Master Plans:

Each VA medical facility must develop a detailed master plan.

The delivery models for quality health care are in a constant state of change. This is the result of many factors, including advances in research, changing patient demographics, and new technology.

The Department of Veterans Affairs must design health care facilities with a high level of flexibility in order to accommodate these new methods of patient care. VA must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs and provide for growth in already existing programs.

A facility master plan is a comprehensive tool to look at potential new patient care programs and how they might affect the existing health-care facility. It also provides insight with respect to possible growth, current space deficiencies, and other facility needs for existing programs and how VA might accommodate these in the future.

In some cases in the past, VA has planned construction in a reactive manner. After funding, VA would place projects in the facility in the most expedient manner—often not considering other projects and facility needs.

This would result in shortsighted construction that restricts rather than expands options for the future.

The Independent Budget veterans service organizations believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility. Short- and long-term Capital Asset Realignment for Enhanced Services (CARES) objectives should be the basis of the master plan.

Four critical programs were not included in the CARES initiative. They are long-term care, severe mental illness, domiciliary care, and polytrauma. VA must develop a comprehensive plan addressing these needs and its facility master plans must account for these services. VA has undertaken master planning for several VA facilities, most recently in the Tampa medical center. This is a good start, but VA must ensure that all facilities develop a master plan strategy to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care. Other projects for consideration in developing master plans should include Jackson, Mississippi; San Diego; Long Beach, California; and Memphis.

Recommendations:

Congress must appropriate $20 million to provide funding for each medical facility to develop an architectural master plan.

Each facility master plan should include the areas omitted from the Capital Asset Realignment for Enhanced Services: long-term care, severe mental illness, domiciliary care, and polytrauma programs as they relate to a particular facility.

The VA Central Office must develop a standard format for these master plans to ensure consistency throughout the VA health-care system.

Completed architectural master plans should be considered as VA develops future major medical construction budget requests.

Empty or Underutilized Space:

The Department of Veterans Affairs must not use empty space inappropriately and must continue disposing of unnecessary property where appropriate.

Studies have suggested that the VA medical system has extensive amounts of empty space that the Department can reuse for medical services. Others have suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function and the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. For example, VA cannot use unoccupied rooms on the eighth floor to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a function expands or moves, these demands create a domino effect of everything around it. These secondary impacts greatly increase construction expense, and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, interstitial space, column spacing, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration.

Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expense and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, a renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but they are rarely economical.

Many older VA medical centers that were rapidly built during and after World War II to treat a wounded veteran population are simply unable to be renovated for contemporary needs. Most of these Bradley-style buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it is impossible to retrofit them for modern mechanical systems. Many also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another critical problem with this unused space is its location. Much of it is not located in a prime location; otherwise, VA would have previously renovated or demolished this space for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

Public Law 108-422 incentivized VA's efforts to dispose of excess space by allowing VA to retain the proceeds from the sale, transfer, or exchange of certain properties in the Capital Asset Fund. Further, that law required VA to develop short- and long-term plans for the disposal of excess facilities, which it reports to Congress annually. VA must continue to develop these plans, working in concert with their architectural master plans and the long-range vision for VA medical centers. VA has developed metrics to track its use of underutilized space and actively monitor this as part of the Federal Real Property Council reporting requirements.

Recommendation:

VA must continue to monitor and develop short- and long-term plans with respect to the disposal of unnecessary space in nonhistoric properties that otherwise are not suitable for medical or support functions because of the structure's permanent characteristics or its location.

VA Space Planning Criteria/Design Guides:

The Department of Veterans Affairs must continue to maintain and update its Space Planning Criteria and Design Guides to reflect state-of-the-art methods of health-care delivery.

VA has developed space-planning criteria it uses to allocate space for all VA health-care construction projects. These criteria are organized into 60 chapters: one for each health-care service provided by VA and its associated support services. VA updates these criteria to reflect current methods of health-care delivery.

In addition to updating these criteria, VA has utilized a computer program called VA SEPS (Space and Equipment Planning System) as a tool to develop space and equipment allocation for all VA health-care projects. This tool is operational and VA currently uses it on all projects.

The third component used in the design of VA health-care projects is design guides. Many of the 60 space-planning criteria chapters has an associated design guide. These design guides go beyond the allocation of physical space and outline how this space is organized within each individual function, as well as how the function relates to the entire medical facility.

VA has updated several of the design guides to reflect current patient delivery models. These include guides that cover spinal cord injury/disorders center, imaging, and polytrauma centers, as well as several other services.

Recommendation:

VA must continue to maintain and update the space-planning criteria and the VA Space and Equipment Planning System tool. It also must continue the process of updating the design guides to reflect current delivery models for patient care. VA must regularly review and update all of these space-planning tools as needed, to reflect the highest level of patient care delivery.

Design-Build Construction Delivery System:

The Department of Veterans Affairs must evaluate use of the design-build construction delivery system.

For the past 10 years, VA has embraced the design-build construction delivery system as a method of project delivery for many health-care projects. Design-build attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to the owner and reduce the project delivery schedule. Design-build, as used by VA, places the contractor as the design builder.

Under the contractor-led design-build process, VA gives the contractor a great deal of control over how he or she designs and completes the project. In this method, the contractor hires the architect and design professionals. With the architect as a subordinate, a contractor may sacrifice the quality of material and systems in order to gain profits at the expense of the owner.

Use of design-build has several inherent problems. A shortcut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents may not provide adequate scope for the project, leaving out important details regarding the workmanship or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, which often compromises VA's design standards.

Design-build forces the owner to rely on the contractor to properly design a facility that meets the owner's needs. In the event that the finished project is not satisfactory to the owner, the owner may have no means to insist on correction of work done improperly unless the contractor agrees with the owner's assessment. This may force the owner to go to some form of formal dispute resolution, such as litigation or arbitration.

Recommendations:

VA must evaluate the use of design-build as a method of construction delivery to determine if design-build is an appropriate method of project delivery for VA health-care projects.

VA must institute a program of "lessons learned." This would involve revisiting past projects and determining what worked, what could be improved, and what did not work. VA should compile and use this information as a guide to future projects. VA must regularly update this document to include projects as they are completed.

Preservation of VA's Historic Structures:

The Department of Veterans Affairs must further develop a comprehensive program to preserve and protect its inventory of historic properties.

VA has an extensive inventory of historic structures that highlight and memorialize America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great nation. Of the approximately 2,000 historic structures in VA's inventory, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected, and preserved because they are an integral part our nation's history.

Most of these historic facilities are not suitable for modern patient care. As a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services process. For the past six years, *The Independent Budget* veterans service organizations (IBVSOs) have recommended that VA conduct a formal inventory of these properties, classifying their physical condition and their potential for adaptive reuse. VA has been moving in that direction and historic properties are identified on its website. VA has placed many of these buildings in an "Oldest and Most Historic" list, and these buildings require immediate attention.

At least one project has received funding. VA has invested more than $100,000 in the past year to address structural issues at a unique round structure in Hampton, VA. Built in 1860, it was originally a latrine and the funding is allowing VA to convert it into office space.

The cost for saving some of these buildings is not very high considering that they represent a part of history that enriches the texture of our landscape that once gone cannot be recaptured. For example, VA can restore the Greek revival mansion in Perry Point, Maryland, which was built in the 1750s, to use as a training space for about $1.2 million. VA could restore the 1881 Milwaukee Ward Memorial Theater for use as a multipurpose facility at a cost of $6 million. This is much less than the cost of a new facility.

As part of its adaptive reuse program, VA must ensure that the facilities that it leases or sells are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

The IBVSOs encourage the use of P.L. 108-422, the Veterans Health Programs Improvement Act, which authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property.

Recommendation:

VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

Career and Occupational Assistance

Employment policy is vital to veterans and veterans with disabilities in today's environment, in which work is critical to independence and self-sufficiency. People with disabilities, including veterans, often encounter barriers to entry or reentry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties, in turn, contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, entitlement programs cannot keep pace with the current and future demand for benefits.

The Department of Defense indicates that each year approximately 25,000 active duty service members are found "not fit for duty" due to medical conditions that may qualify for VA disability ratings and eligibility to Vocational Rehabilitation and Employment (VR&E) services. In response to criticism of the VR&E Service, a VR&E task force was formed to conduct an "unvarnished top-to-bottom independent examination, evaluation, and analysis" of the program and recommend "effective, efficient, up-to-date methods, materials, and metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment (Congressional Research Service Report for Congress RL34627). In March 2004, the task force released its report with 110 recommendations for VR&E improvements. By the end of fiscal year 2007, only 89 had been implemented.

Citing several studies of VR&E within the past decade, the Veterans' Disability Benefits Commission (VDBC) in 2007 identified a host of ongoing problems with the program, including:

- the need for more aggressive and proactive approaches to serving veterans with serious employment barriers;
- a limited number of VR&E counselors and case managers to handle a growing caseload;
- inadequate and ineffective tracking and reporting on participants;
- employment outcomes that are measured no further than 60 days after hiring; and
- the possibility that the current 12-year limit for veterans to take advantage of VR&E may be unrealistic.

The Independent Budget continues to support the recommendations of the VR&E task force and the VDBC:

- expanding access to all medically separated service members;
- making all disabled veterans eligible for vocational rehabilitation counseling services;
- screening through VR&E counselors all applicants for individual unemployability ratings;
- increasing VR&E staffing and resources, tracking employment success beyond 60 days, and implementing satisfaction surveys of participants and employers; and
- creating incentives to encourage disabled veterans to complete their rehabilitation plan.

The Independent Budget veterans service organizations look forward to monitoring the continued implementation of these recommendations and future program changes.

Career and Occupational Assistance Programs

VOCATIONAL REHABILITATION AND EMPLOYMENT

VOCATIONAL REHABILITATION AND EMPLOYMENT FUNDING:

Congressional funding for the VA Vocational Rehabilitation and Employment (VR&E) Service must keep pace with veteran demand for VR&E services.

The VR&E program is authorized by Congress under title 38, United States Code and is better known as chapter 31 benefits. The program provides services and counseling necessary to enable service disabled veterans to overcome employment barriers and allow them to prepare for, find, and maintain gainful employment in their communities. The program also provides independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their reentry back to private life. The program further offers educational and vocational counseling to service-disabled veterans recently separated from active duty and helps to expedite their reentry into the labor force. These services are also available to dependents of veterans who meet certain eligibility requirements.

The Office of Management and Budget (OMB) estimates the average cost of placing a service-disabled veteran in employment at $8,385 as calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, OMB calculations do not include a provision for inflation, increased student tuition costs, and the numbers of veterans who drop out of the VR&E program or enter interrupt status of their rehabilitation plan. Comparisons to other vocational programs are not appropriate since nonfederal dollars are excluded when calculating their cost to place an individual in employment status.

Many veterans are facing significant challenges as they return home from the global war on terrorism. These large numbers of regular military, National Guard, and Reserves are creating tens of thousands of new veterans, many of whom are eligible for VR&E programs. As indicated earlier, present funding levels for VR&E programs cannot keep pace with the current and future demands for VR&E benefits.

The Independent Budget veterans service organizations are concerned that service members, National Guard, and Reservists involved in the global war on terrorism who are being discharged from military service with service-connected disabilities will not receive effective vocational rehabilitation services in a timely manner due to a lack of available resources.

Recommendation:

Congress must provide the funding level to meet the increasing veteran demand for VA Vocational Rehabilitation and Employment program services.

VOCATIONAL REHABILITATION AND EMPLOYMENT PRODUCTIVITY:

Staffing levels of the VA Vocational Rehabilitation & Employment (VR&E) Service are not sufficient to meet the needs of our nation's veterans in a timely manner.

The VR&E Service is charged with the responsibility to prepare service-disabled veterans for suitable employment and provide independent living services to those veterans with severe disabilities and who are unlikely to secure suitable employment at the time of their entry into the program. VR&E must begin to strengthen its program due to the increasing number of service members returning from Afghanistan and Iraq with serious disabilities. These veterans require both vocational rehabilitation and employment services. There is no VA mission more important during or after a time of war than to enable injured military personnel to have a seamless transition from military service to a productive life after serving their country.

Success in the transition of disabled veterans to meaningful employment relies heavily upon VA's ability to provide vocational rehabilitation and employment services in a timely and effective manner. Unfortunately, the demands and expectations being placed on the VR&E Service are exceeding the organization's current capacity to effectively deliver a full continuum of comprehensive programs. The service had been experiencing a shortage of staff nationwide because of insufficient funding, which, as a result, has caused delays in providing VR&E services to disabled veterans, thus reducing the veteran's opportunity to achieve successful rehabilitation.

To increase emphasis on employment, the service has begun an initiative titled "Coming Home to Work" as an early outreach effort to provide VR&E services to eligible service members pending medical separation from active duty at military treatment facilities. This and other new programs will require additional staff to maintain efforts nationwide. We must stress the point again, that VA must increase VR&E staffing levels to meet the increasing demand our nation's veterans have for services.

The number of veterans in the various phases of VR&E programs is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Even though the focus of the VR&E program has drastically changed to career development and employment, it is not clear, despite VR&E's addition of 83 employment coordinators, whether VA is able to meet the current and future demand for employment services. It is just not good enough to say the program's focus is on employment when the data demonstrate that only 9,000 veterans were placed in employment out of 90,000 active cases.

In addition, there is no specific data to demonstrate how long beyond 60 days that a newly employed veteran remains in the workforce. Once the veteran is placed, there is minimal follow-up by VR&E with the employer.

For many years, *The Independent Budget* veterans service organizations have criticized VR&E Service programs and complained that veterans were not receiving suitable vocational rehabilitation and employment services in a timely manner. Many of these criticisms remain a concern, including the following:

- inconsistent case management with lack of accountability for poor decision making;
- delays in processing initial applications due to staff shortages and large caseloads;
- declaring veterans rehabilitated before suitable employment is retained for at least six months;
- inconsistent tracking of electronic case management information system; and
- failure to follow up with veterans, employers, and referral agencies beyond 60 days to ensure employment placement is appropriate for the veteran.

Recommendations:

VA needs to strengthen its Vocational Rehabilitation and Employment program to meet the demands of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce and providing placement follow-up with employers for at least six months.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

The VR&E Service must place higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

VOCATIONAL REHABILITATION AND EMPLOYMENT NATIONAL SURVEY AND PERFORMANCE DATA:

The Department of Veterans Affairs should report accurate performance data that include all veterans who participate in the Vocational Rehabilitation & Employment (VR&E) program and initiate a national survey to determine why veterans drop out prior to rehabilitation.

Performance reporting for the VR&E, chapter 31 benefits program, which is used by VA and Congress to authorize funding and staffing needs, must be improved. For example, in FY 2006, VA reported a rehabilitation rate of 73 percent in its Performance and Accountability Report and Budget Submission. However, VA excluded veterans who discontinued participating in the program without implementing a written rehabilitation plan, even though these veterans represent a majority of veterans served by the program. When calculating the rehabilitation rate including all participants, the VR&E success rate would be 18 percent. As a result, decision makers and Congress are not totally aware of the overall performance rate when making decisions on needed resources.

Recommendations:

The Independent Budget veterans service organizations recommend that the Vocational Rehabilitation & Employment Service initiate a nationwide study to reveal the reasons why veterans discontinue participation in the VR&E program and use the information to design interventions to reduce the probability of veterans dropping out of the program.

The VR&E Service needs to report the true number of veterans participating in the program and accurate performance data for budgetary and other resource decisions.

VOCATIONAL REHABILITATION AND EMPLOYMENT ELIGIBILITY:

Congress needs to change the eligibility requirements for the VA Vocational Rehabilitation and Employment (VR&E) program.

The period of eligibility for VR&E benefits is 12 years from the date of separation from the military or the date the veteran was first notified by VA of a service-connected disability rating. Unfortunately, many veterans are not informed of their eligibility to VR&E services or do not understand the benefits of the program. In addition, veterans who later in life may become so disabled that their disabilities create an employment barrier would benefit from VR&E services well beyond the 12-year delimiting date.

Many veterans who served this country honorably and returned from service uninjured acquire nonservice-connected disabilities post-discharge and, if these disabilities are severe enough, they will be eligible for Social Security Disability Insurance. Under current law, they will not be eligible for the VR&E program but must rely on vocational and employment help from state vocational rehabilitation programs, Social Security work incentives, Department of Labor veterans programs, and other private sector options available to most people with disabilities. In addition to forcing veterans with nonservice-connected disabilities to seek vocational services outside the VA, this adds to increasing demands placed on non-VA vocational rehabilitation programs, which are also underfunded.

Recommendations:

Congress needs to change the eligibility delimiting date for VA Vocational Rehabilitation and Employment services by eliminating the 12-year eligibility period for chapter 31 benefits and allow all veterans with employment impediments or problems with independent living to qualify for VR&E services.

The VR&E Service must develop an aggressive outreach program to inform veterans of the benefit of participating in the VR&E program.

VA needs to streamline eligibility and entitlement to VR&E programs to provide earlier intervention and assistance to disabled veterans.

VOCATIONAL REHABILITATION AND EMPLOYMENT INDEPENDENT LIVING PROGRAM ANNUAL CAP:

Congress needs to eliminate the Vocational Rehabilitation & Employment (VR&E) Independent Living annual participation cap.

The VR&E Independent Living (IL) program was established by Congress in 1980 to serve severely disabled veterans who were determined by VA to be unable to obtain and retain suitable employment due to their disabilities. The IL program provides these disabled veterans services to enable them to achieve maximum independence in daily living. However, Chapter 31, title 38, United States Code, limits the maximum length VA can provide services to 30 months and restricts the number of disabled veterans who can be placed in the program to 2,500 annually. Therefore, because of this cap, the VR&E Service has instructed VA regional offices to discontinue placing veterans into IL status as they approach the 2,500 participant cap. It is this anticipation of exceeding the cap that has delayed access of eligible veterans into the IL program.

In May of 2007, the VA Secretary stated that "VR&E anticipates a steady increase in demand for IL services over the next 10 years based on historical data and the increased need for IL services by OEF and OIF veterans."[199] VA estimates a program growth of 10 percent in FY 2009 and future years.

The Independent Budget veterans service organizations believe that the ever-growing number of seriously disabled veterans returning from the conflicts in Iraq and Afghanistan could result in significant demand for IL services and low-cost transitional housing. VA should not be constrained from providing these services by an arbitrary cap on new cases or limit the amount of time they may provide services. Many of the newly injured veterans have multiple complex disabilities that will require long-term management and programs to include IL services.

Recommendation:

Congress should eliminate the 30-month maximum requirement for providing Independent Living services and the statutory cap of 2,500 new Vocational Rehabilitation and Employment Independent Living program participants because the effect of the cap and the increasing veteran demand for services delays providing needed IL programs to severely disabled veterans.

[199] DVA OIG Report 06-00493, December 17, 2007.

FOLLOW-UP ON REFERRALS TO OTHER AGENCIES FOR ENTREPRENEUR OPPORTUNITIES:

VA Vocational Rehabilitation and Employment (VR&E) Service staff should follow up with veterans who are referred to other agencies to ensure the veterans' entrepreneur opportunities have been achieved.

VR&E has expanded its effort toward fostering awareness and opportunities for self-employment by signing memorandums of understanding with the Department of Labor, the Small Business Administration, the Veterans Corporation, and SCORE. They have also implemented the Five Track Employment Process, which places emphasis on self-employment as a potential for gainful employment. VR&E has further included self-employment in standardized operation materials, online employment sources, and information guides. However, VR&E must follow up with veterans who were referred to other agencies for entrepreneur opportunities and reassess their employment needs if they were not successful.

Recommendation:

Vocational Rehabilitation & Employment Service staff must follow up with veterans after being referred to other agencies for self-employment to ensure that veterans' entrepreneur opportunities have been successfully achieved.

VOCATIONAL REHABILITATION AND EMPLOYMENT COUNSELING PARTNERS:

VA needs to improve its coordination with non-VA counselors to ensure that veterans are receiving the full array of Vocational Rehabilitation and Employment (VR&E) programs and services in a timely and compassionate manner.

VA's Strategic Plan for FY 2006–2011 reveals that VA plans to continue the utilization of non-VA providers to supplement and complement services provided by VR&E staff. Numerous nonprofit vocational rehabilitation providers have served veterans with disabilities for many years in partnership with the VA. Unlike state vocational rehabilitation processes, through which qualified providers partner with state agencies to provide vocational rehabilitation services, the VA's national acquisition strategy is viewed as overly cumbersome. As a result, non-VA providers that could address some of the demand by veterans with disabilities for employment assistance are shut out by complicated contracting rules.

At the same time, VR&E must maintain its responsibility to the veterans it serves by monitoring the quality and impact of vocational rehabilitation services delivered by these non-VA agencies.

Recommendations:

The VA Vocational Rehabilitation and Employment Service should improve its national acquisition strategy to make it easier for qualified vocational rehabilitation providers to offer services to veterans with disabilities.

VR&E Service staff must improve the oversight of non-VA counselors to ensure veterans are receiving the full array of services and programs in a timely and effective manner.

The VR&E Service should improve case management techniques and use state-of-the-art information technology to track the progress of veterans served outside VR&E.

The VR&E Service should follow up with rehabilitated veterans for at least six months to ensure that the rehabilitation and employment placement plan has been successful.

BUILDING VOCATIONAL REHABILITATION COUNSELING PARTNERSHIPS:

There are 10 times as many state vocational rehabilitation counselors as there are VA Vocational Rehabilitation and Employment (VR&E) counselors across the nation.

Given these statistics, it is evident that state vocational rehabilitation agencies could amplify the assistance available to veterans with disabilities if appropriate outreach and partnerships are established. Many state vocational rehabilitation agencies have memorandums of understanding with their state departments of veterans services to coordinate services to veterans with disabilities, and some state agencies have identified counselors with military backgrounds to serve as liaisons with the VA and veterans groups. State vocational rehabilitation and VA VR&E programs should offer joint training to their staffs on traumatic brain injury, post traumatic stress disorder, and other veteran specific disability issues to improve cross-agency coordination. VA should also work with the Rehabilitation Services Administration to establish national criteria for state agencies' acceptance of veterans with service-connected disability ratings to avoid inconsistent admission policies and the potential for veterans to be bounced between state vocational rehabilitation and VA VR&E.

Recommendation:

VA needs to utilize more effectively those resources within the nation's workforce development system that focus on obtaining and maintaining gainful employment for veterans. Until such time as the Vocational Rehabilitation & Employment Service's resources can accommodate the full range of services needed by veterans with disabilities, better coordination with state vocational rehabilitation programs, One-Stop Career Centers, and private sector vocational rehabilitation programs can help prepare veterans for interviews, offer assistance creating résumés, and develop proven ways of conducting job searches.

VETERAN ENTREPRENEURSHIP:

Promotion of self-employment continues to be a challenge for the Department of Veterans Affairs.

Increasing attention has been called to the entrepreneurial needs of American veterans, particularly those who have service-connected disabilities. Not since the Vietnam War have American veterans experienced such high rates of disabilities. For many of these veterans, self-employment will be the only alternative to employment and successful reintegration back into society.

More than one-third of both new veteran entrepreneurs and current veteran business owners have gained skills from their military service that are relevant to business ownership. Several government reports indicate that approximately 22 percent of America's war fighters returning from the war on terrorism are purchasing, starting, or considering starting a small business. Unfortunately, there are many obstacles for them to overcome. There are major issues that veterans face, including financing, bonding, and access to federal contracts. These necessary business elements have become so restrictive that it has become impossible for many veterans to establish or maintain their own small business enterprises.

As an effort to resolve these problems, a new VA program entitled the Center for Veterans Enterprise (CVE) was established by the passage of the Veterans Entrepreneurship and Small Business Development Act of 1999.

The CVE is a subdivision of the Office of Small and Disadvantaged Business Utilization that extends entrepreneur services to veterans who own or who want to start a veteran-owned small business. It also helps federal contracting offices to identify veteran-owned small businesses in response to Executive Order 133600 calling for federal contracting and subcontracting oppor-

tunities for Service-Disabled Veteran-Owned Small Businesses. In addition, the CVE works with the Small Business Administration's Veterans Business Outreach Centers nationwide regarding veteran business financing, management, bonding, and providing technical support for veteran entrepreneurs with the goal of increasing the number of veteran- and service-disabled veteran-owned small businesses. Unfortunately, the funding for this program is insufficient to meet the ever-increasing needs of our nation's veterans.

Recommendations:

Congress should provide VA with additional funding for the Center for Veterans Enterprise so it can meet the increasing veteran demand for entrepreneurial services.

VA must help eliminate the barriers that veterans face when trying to establish and/or maintain a veteran- or service-disabled veteran-owned small business.

VA FAILURE TO IMPLEMENT P.L. 109-461 CONTRACTING:

VA has yet to approve any policy or procedures to guide VA contracting officers on how to set aside and/or award sole source contracts for service-disabled veteran-owned small businesses.

Public Law 109-461, the Veterans Benefits, Health Care and Information Technology Act of 2006, was signed into law by President Bush on December, 22, 2006, and required the law to take effect by June 20, 2007. The law allows VA special authority to provide set-aside and sole source contracts to small businesses owned and operated by veterans and service-disabled veterans. This legislation is codified in 38 United States Code sections 8127 and 8128.

Nearly two years have passed, and Acquisition and Material management staff, in conjunction with VA attorneys, have yet to approve any policy or procedures to guide VA contracting officers on how to set aside and/or award sole source contracts for service-disabled veteran-owned small businesses. Without specific guidance and changes to the Federal Acquisition Regulations, existing acquisition policy will continue to apply. VA personnel involved in the acquisition process need to become familiar with the new authorization and their responsibilities under P.L. 109-461. Our service-disabled veterans who own small businesses cannot afford to wait any longer for VA to become compliant with the law.

Recommendation:

VA must expedite the overdue implementation of P.L. 109-461 so veteran entrepreneurs can receive set-aside and sole source contracts. Further delays in approving policy and regulation endanger the success and longevity of recently established service-disabled veteran-owned small businesses.

VETERAN SURETY BONDING:

Surety bonding levels provided by the Small Business Administration (SBA) are inadequate for veteran entrepreneurs to compete in today's construction field.

Surety bonding continues to be a major problem for service-disabled veteran-owned small businesses in the construction field. Surety bonding levels currently guaranteed by SBA at $2 million are grossly inadequate for today's federal construction process. Service-disabled veterans who are small business owners find it difficult to obtain surety bonding required by federal contracting officers to compete for government contracts. Service-disabled veteran small business owners also have difficulties preparing their businesses to withstand the scrutiny of the surety bonding process, especially when working on other construction projects.

Recommendation:

VA needs to establish a shared bonding process in conjunction with the Small Business Administration and provide a process to increase bonding limits upward to $15 million, which is necessary for service-disabled veterans to compete in today's construction market. VA should also develop a program for service-disabled veterans to teach them how to prepare their companies to overcome the obstacles that preclude them from obtaining surety bonding in a timely and efficient manner.

VA VENDOR INFORMATION PAGE DATABASE:

Government agencies need a one-stop access to identify veteran-owned and service-disabled veteran-owned small businesses and verify their veteran status.

At the present time, vendors desiring to do business with the federal government must register in the Central Contractor Registration (CCR) database, and those who indicate they are veterans or service-disabled veterans, self-certify their status without verification. P.L. 109-461 required VA to establish a Vendor Information Page (VIP) database designed to identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. Congress should take appropriate steps to require all agencies to use VIP to certify veteran status and ownership before awarding contracts to companies claiming to be a veteran-owned or service-disabled veteran-owned small business.

Recommendation:

All federal agencies should be required to certify veteran status and ownership through the VA's Vendor Information Page program before awarding contracts to companies claiming to be veteran-owned or service-disabled veteran-owned small businesses.

TRAINING INSTITUTE INADEQUATELY FUNDED:

The National Veterans Training Institute (NVTI) lacks adequate funding to fulfill its mission.

The NVTI was established to train federal and state veterans' employment and training service providers. Primarily, these service providers are Disabled Veterans' Outreach Program (DVOP), Local Veterans' Employment Representative (LVER), and employment coordinators under the VA Vocational Rehabilitation and Employment (VR&E) Service. DVOP/LVER specialists are located throughout the country at various locations, such as state workforce centers. VA employment coordinators are found at VA VR&E Service offices and VA medical centers.

These employment specialists help veterans make the difficult and uncertain transition from military to civilian life. They help provide jobs and job training opportunities for disabled veterans by serving as intermediaries between employers and veterans. They maintain contacts with employers and provide outreach to veterans. They also develop linkages with other agencies to promote maximum employment opportunities for veterans.

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. It is administered by the Department of Labor Veterans Employment and Training Service through a contract with the University of Colorado at Denver. The NVTI curriculum covers an array of topics that are essential to DVOP/LVER and VA employment coordinators and provides them with the knowledge and ability to assist veterans in their quest to obtain and maintain meaningful employment. *The Independent Budget* veterans service organizations are concerned because, after several years of level funding, appropriations for the NVTI have decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

Recommendation:

Congress must fund the National Veterans Training Institute at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

National Cemetery Administration

The Department of Veterans Affairs National Cemetery Administration (NCA) currently maintains more than 2.9 million gravesites at 125 national cemeteries in 39 states and Puerto Rico. Of these cemeteries, 65 will be open to all interments; 20 will accept only cremated remains and family members of those already interred; and 40 will only perform interments of family members in the same gravesite as a previously deceased family member. The NCA also maintains 33 soldiers' lots and monument sites. All told, the NCA manages 17,000 acres, half of which are developed.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the global war on terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 100,000 in 2007 to 111,000 in 2009. Historically, 12 percent of veterans opt for burial in a state or national cemetery.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and cherished.

The Independent Budget veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families. We call on the Administration and Congress to provide the resources needed to meet the changing and critical nature of NCA's mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

National Cemetery Administration Accounts

In FY 2008, $195 was million appropriated for the operations and maintenance of the National Cemetery Administration (NCA), $28.2 million more than the Administration's request, with only $220,000 in carryover. The NCA awarded 39 of the 42 minor construction projects that were in the operating plan. The State Cemetery Grants Service awarded $37.3 million of the $39.5 million that was appropriated. This carryover was caused by the cancellation of a contract that the NCA had estimated to be $2 million but the contractor's estimation was considerably higher. Additionally, $25 million was invested in the National Shrine Commitment.

The NCA has done an exceptional job of providing burial options for 88 percent of the 170,000 veterans who fall within a 75-mile radius-threshold model. However, under this model, no new geographical area will become eligible for a national cemetery until 2015. St. Louis, Missouri, will, at that time, meet the threshold due to the closing of Jefferson Barracks National Cemetery in 2017. Analysis shows that the five areas with the highest veteran population will not become eligible for a national cemetery because they will not reach the 170,000 threshold.

The NCA has spent years developing and maintaining a cemetery system based on a growing veteran population. In 2010 our veteran population will begin to decline. Because of this downward trend, a new threshold model must be developed to ensure more of our veterans will have reasonable access to their burial benefits. Reducing the mile radius to 65 miles would reduce the veteran population that is served from 90 percent to 82.4 percent, and reducing the radius to 55 miles would reduce the served population to 74.1 percent. Reducing the radius alone to 55 miles would bring only two geographical areas in to the 170,000 population threshold in 2010, and only a few areas into this revised model by 2030.

Several geographical areas will remain unserved if the population threshold is not reduced. Lowering the population threshold to 100,000 veterans would immediately make several areas eligible for a National Cemetery regardless of any change to the mile radius threshold. A new threshold model must be implemented so more of our veterans will have access to this earned benefit.

The Independent Budget recommends an operations budget of $241.5 million for the NCA for fiscal year 2010 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

The NCA is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; (3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; (4) to award a presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turfs, and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

Therefore, in accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a five-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY 2008 operations budget.

Volume 2 of the Independent Study provides a systemwide, comprehensive review of the conditions at 119 national cemeteries. It identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. These projects include cleaning, realigning, and setting headstones and markers; cleaning, caulking, and grouting the stone surfaces of columbaria; and maintaining the surrounding walkways. Grass, shrubbery, and trees in burial areas and other land must receive regular care as well. Additionally, cemetery infrastructure, i.e., buildings, grounds, walks, and drives must be repaired as needed. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options, and maintenance programs.

The Independent Budget veterans service organizations (IBVSOs) are encouraged that $25 million was set aside for the National Shrine Commitment for FY 2007 and FY 2008. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. By enacting a five-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

In addition to the management of national cemeteries, the NCA is responsible for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries. Public Law 110-157 gives VA authority to provide a medallion to be attached to the headstone or marker of veterans who are buried in a private cemetery. This benefit is available to veterans in lieu of a government furnished headstone or marker.

FY 2010 National Cemetery Administration	
Category	**($ in Thousands)**
FY 2009 Administration Request	$181,000
FY 2009 *IB* Recommendation	$251,975
FY 2009 Enacted	$230,000
FY 2010 *IB* Recommendations:	
Operations and Maintenance	$241,500
Shrine Initiative	$50,000
Total FY 2010 *IB* Recommendation	**$291,500**

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully. We believe Congress should provide NCA with $241.5 million for fiscal year 2010 to offset the costs related to increased workload, additional staff needs, general inflation and wage increases and include as part of the NCA appropriation $50 million for the first stage of a $250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

The State Cemetery Grants Program:

Adequate funding is needed to ensure that the SCGP can meet the challenge of growing interest from states to provide burial services in areas that are currently underserved.

The SCGP complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials through this program.

The SGGP faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. The intent of the program is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery. Currently there are 55 state and tribal government cemetery construction grant preapplications, 34 of which have the required state matching funds necessary, totaling $120.7 million.

The Independent Budget recommends that Congress appropriate $52 million for the State Cemetery Grants Program for FY 2010. This funding level would allow SCGP to establish six new state cemeteries that will provide burial options for 179,000 veterans who live in region that currently have no reasonably accessible state or national cemetery.

Recommendation:

Congress should fund the State Cemetery Grants Program at a level of $52 million.

Veterans' Burial Benefits:

Veterans' families do not receive adequate funeral benefits.

In 1973 NCA established a burial allowance that provided partial reimbursements for eligible funeral and burial costs. The current payment is $2,000 for burial expenses for service-connected (SC) death, $300 for nonservice-connected (NSC) deaths, and $300 for plot allowance. At its inception, the payout covered 72 percent of the funeral cost for a service-connected death, 22 percent for a nonservice-connected death, and 54 percent of the burial plot cost. In 2007 these benefits eroded to 23 percent, 4 percent, and 14 percent, respectively. It is time to bring these benefits back to their original value.

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potters' fields. In 1923 the allowance was modified. The benefit was determined by a means test, and then in 1936 the allowance was changed again, removing the means test. In its early history, the burial allowance was paid to all veterans, regardless of the service-connectivity of their death. In 1973 the allowance was modified to reflect the relationship of their death as service connected or not.

The plot allowance was introduced in 1973 as an attempt to provide a plot benefit for veterans who did not have reasonable access to a national cemetery. Although neither the plot allowance nor the burial allowances were intended to cover the full cost of a civilian burial in a private cemetery, the increase in the benefit's value indicates the intent to provide a meaningful benefit by adjusting for inflation.

The national average cost for a funeral and burial in a private cemetery has reached $8,555, and the cost for a burial plot is $2,133. At the inception of the benefit the average costs were $1,116 and $278, respectively. While the cost of a funeral has increased by nearly seven times the burial benefit has increased only by 2.5 times. To bring both burial allowances and the plot allowance back to their 1973 values, the SC benefit payment will be $6,160, the NSC benefit payment will be $1,918, and the plot allowance will increase to $1,150. Readjusting the value of these benefits, under the current system, will increase the obligations from $70.1 million to $335.1 million per year.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that VA separate burial benefits into two categories: veterans who live inside the VA accessibility threshold model and those who live outside the threshold. For those veterans who live outside the threshold, the service-connected burial benefit should be increased to $6,160; nonservice-connected veteran's burial benefit should be increased to $1,918; and the plot allowance should be increased to $1,150 to match the original value of the benefit. When a veteran lives within reasonable accessibility to a state or national cemetery that is able to accommodate burial needs but the veteran prefers to be buried in a private cemetery, the burial benefit should be adjusted. These veterans' burial benefits will be based on the average cost for VA to conduct a funeral: the benefit for a service-connected burial will be $2,793; the amount provided for a nonservice-connected burial will be $854; and the plot allowance will be $1,150. This will provide a burial benefit at equal percentages, but based on the average cost for a VA funeral and not on the private funeral cost that will be provided for those veterans who do not have access to a state or national cemetery.

The recommendations of past legislation provided an increased benefit for all eligible veterans but it currently fails to reach the intent of the original benefit. *The Independent Budget's* benefit distribution model will cost $211.1 million annually as opposed to the $221.1 million it would cost to implement past legislation. The new model will provide a meaningful benefit to those veterans whose access to a state or national cemetery is restricted as well as provide an improved benefit for eligible veterans who opt for private burial.

Recommendations:

Congress should establish two categories of veterans for the purpose of burial benefits: veterans within the accessibility model and veterans outside the accessibility model.

Congress should increase the plot allowance from $300 to $1,150 for all eligible veterans and expand the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected burial benefit from $2,000 to $6,160 for veterans outside the radius threshold and to $2,793 for veterans inside the radius threshold.

Congress should increase the nonservice-connected burial benefit from $300 to $1,918 for veterans outside the radius threshold and to $854 for veterans inside the radius threshold.

Congress should enact legislation to adjust these burial benefits for inflation annually.

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