Critical Issues

Timely Access to High-Quality Health Care

Recommendations:

VA and the Administration should propose budget requests similar to those laid out in the recommendations of *The Independent Budget* and Congress should favorably act on these requests.

Congress should invest significant new funds in VA capital to ensure that facilities remain up-to-date and capable of delivering safe, quality services to all veterans who need them.

VA should ensure that VA facilities understand how to deliver non-VA care through either Patient-Centered Community Care or traditional fee-basis care models and that non-VA Care Coordination teams are properly staffed to make timely outside referrals.

VA should ensure that contract non-VA care provider networks possess the tools and resources to deliver timely care to veterans upon receipt of VA referrals.

The VHA should make public its reports by VA facility, indicating the number of veterans waiting beyond the access-to-care standards.

The VHA must address the recommendations contained in Office of Inspector General audits and other reports on timely access to care.

The OIG should conduct a follow-up evaluation of the VHA outpatient scheduling systems and its procedures, compliance, employee training, monitoring, and oversight.

VA must implement a solution to the information technology limitations of the current appointment scheduling software that will also address interrelated health care delivery functions in VistA to improve efficiency of care delivery, operating, and capital resources.

The VHA should also include VA purchases from the private sector in the timeliness-of-care standards indicators for veterans who receive care.

VA should modernize the VA appointment scheduling system so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans.

VA should develop and implement wait-time standards that would trigger non-VA care referrals. These standards should be based on quality-of-care outcomes and the clinical needs of veterans. VA must ensure that these standards are enforced at every facility.

VA should strengthen accountability protocols for all VA employees—not just for senior executives—to ensure that poor-performing employees are held accountable for their actions.

VA should implement comprehensive training for all VA employees that focuses on quality customer service and positive health outcomes.

VA should streamline federal hiring protocols for VA health care professionals to ensure that VA can compete with private industry to hire and retain the best health care providers and do so in a timely manner.

VA should implement and sustain effective whistleblower protections for VA employees who expose improper practices in VA facilities.

Background and Justification:

In April 2014, the disclosure of long and secret waiting lists at the Department of Veterans Affairs Medical Center in Phoenix, Arizona, and the subsequent disclosure of thousands of veterans waiting too long for care around the country, shined the light on a problem that *The Independent Budget* has identified for years. Timely access to high high-quality health care services remains a clear objective that VA has not achieved. Access to health care, along with the cost and quality of that care, is generally considered one of the three major indicators for evaluating the performance of a health care system. Prevalent delays in delivering timely care result in patient dissatisfaction, higher costs, and increased risk for adverse clinical consequences. These facts became evident in Phoenix and other VA centers around the country.

Generally speaking, veterans who receive care from VA in a timely manner are satisfied with that care, but veterans are understandably frustrated by the roadblocks they encounter trying to receive timely appointments. VA health care access has been a subject of rigorous debate for more than a decade. As far back as 2002 more than 310,000 veterans were waiting 6 months or more without appointments for needed medical care. That same year the first *Independent Budget* wrote an article on waiting times for outpatient appointments, in which the IBVSOs urged the Veterans Health Administration (VHA) to "identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide." Unfortunately, the problems exposed around the country last year validated that our warnings had been generally ignored. Access still remains the principle problem facing the VA health care system today. Moreover, the access problem is compounded by insufficient funds, insufficient staffing, and an ineffective scheduling system.

Addressing the Funding Shortfall

We believe many of the access problems facing the VA health care system are the joint responsibility of Congress and the Administration. Although both branches of government are committed to improvements, current and past Administrations have requested wholly insufficient resources to meet the ever-growing demand for health care services and at the same time attempted to fragment the VHA health system framework. Congress bears additional burden for the problem as it continues to appropriate insufficient funding to meet the needs of veterans seeking care. The disclosure by VA late last year that it needs to add as many as 28,000 providers—physicians, nurses, therapists, etc.—to the ranks of the VHA in order to meet growing demand while also accounting for attrition of its workforce clearly reflects the fact that VA has been left wanting for resources to appropriately build its capacity.

For many years, the IBVSOs have advocated for sufficient funding for the VA health care system, and the larger VA. Our thorough analysis of health care utilization in VA evolves a set of full and sufficient budget recommendations to address known current and future utilization of the system. Moreover, our recommendations are not clouded by the politics of fiscal policy. In fact, despite the recommendations of *The Independent Budget for FY 2015* (released in February 2014), Congress enacted an appropriations act for VA that we believe was nearly $2.0 billion short for VA health care in FY 2015 (based on previous estimates) and approximately $500 million short for FY 2016. After the disclosures of seriously repressed demand across VA in 2014, we believe the funding shortfall may be significantly greater than what we projected last year.

While the IBVSOs understand that federal agencies have increasing pressure to hold down spending and that Congress has moved toward fiscal restraint in recent years, the health care of veterans outweighs those priorities. We certainly appreciate the fact that Congress provided approximately $5 billion to expand internal capacity, as well as supported other priorities, in P.L. 113-146, "Veterans Access, Choice and Accountability Act (VACAA)." However, we also recognize that these resources will be released only slowly over an extended period of time while, demand for health care services will continue to grow. To satisfy this increased demand, new and sufficient resources must be found.

Non-VA Purchased Care and Coordinated Care

VA must remain the guarantor of care, wherever that care is provided. VA facilities, therefore, must refer veterans to community providers using a system that requires full coordination and guarantees access and quality.

Under the traditional fee-basis system, VA would issue veterans in need of non-VA care authorization letters or cards. This system allowed the veteran to "shop" for a provider who accepted authorization for VA payment and who could schedule an appointment in a timely manner. Following the appointment, the veteran would be responsible for returning to VA records of the care received, in order to have them included in the veteran's VA medical record. This traditional system was entirely uncoordinated, failed to guarantee access or quality, and was highly susceptible to improper billing of the veteran and improper payments by VA. At times this system even exposed veterans to unnecessary financial hardship as a result of VA unwillingness to pay for services erroneously billed to the veteran that should have been fee-based, or because of unreasonable delays in VA payment to private providers.

The dangers of uncoordinated care are well documented. An April 2013 an Office of the Inspector General (OIG) report revealed the mismanagement of non-VA care at the Atlanta VA Medical Center in which approximately 4,000 veterans were referred to non-VA mental health providers without an adequate tracking system. The OIG found that this situation led to an average wait time of 92 days, with 21 percent of veterans receiving no care at all, and others never receiving any follow-up from VA. Even VA staff admitted to the OIG that because of the large number of referrals, many veterans had "fallen through the cracks." The lesson from Atlanta is clear: VA must not be allowed to push large numbers of veterans to outside providers without proper coordination simply to create the appearance that access is being provided.

In order to address the problems of fee-basis care, VA developed a new contract care model, Patient-Centered Community Care (PC3). Under this program, networks of specialty care providers were created to provide care at prenegotiated rates in a well-coordinated manner. VA also recently expanded the PC3 to include non-VA options for primary care. However, the PC3 networks are not yet fully operational nationwide. According to VA, veterans will be referred to PC3 providers if direct care cannot be readily provided because of lack of available specialists, long wait times, or geographic inaccessibility.

In theory, the PC3 program should help solve the access problems that have been plaguing many VA facilities. The program cannot succeed, however, if individual facilities are not open and honest about access-to-care issues and accurate appointment wait-time data, all of which continue to be unreliable. The IBVSOs believe that VA must develop and implement wait-time standards that would trigger PC3 referrals, and enforce those standards at each facility. Rather than an arbitrary number of days, these wait-time standards should be developed based on the type of care being provided and the immediacy of the individual veteran's need for that care based on a physician's or other professional provider's medical opinion.

Although the IBVSOs generally support the PC3, we will be watching its progress closely, and we ask Congress to conduct robust oversight to ensure that the PC3 is being utilized to its full potential. Specifically, we will want to know which facilities are using the PC3 appropriately to reduce actual wait times and which are not. If certain facilities are not making proper referrals because of poor training, lack of standards, or institutional resistance, VA must move swiftly to address those problems. If the PC3 is not being used effectively because of insufficient funding at the local level, we will call on VA and Congress to work together to obtain the resources they need.

The PC3 program is new, and the IBVSOs recognize that the capacity of its networks may not immediately be sufficient to provide timely access for all specialties. In addition, the PC3 is not currently set up across the board to provide primary care. Consequently, some facilities may need to enter into local contracts for specific services. Under no circumstances should veterans be expected to coordinate their own care or be held responsible for record sharing when receiving care outside of VA. We believe that all contracts and agreements should include provisions that ensure the same level of coordination, access, and quality as the PC3 contracts. Any-

thing less than full compliance to these provisions would not only fail to address the access problems many VA facilities are facing, but would also represent a huge step backward in the evolution of non-VA care.

Finally, VA recently implemented a new method through which non-VA care would be coordinated at each facility. VA facilities have now been directed to establish Non-VA Care Coordination (NVCC) teams responsible for determining whether care should be delivered through the newly commissioned Veterans Choice Card, the PC3, other contracts or sharing agreements, or traditional fee-basis models. The NVCC is also designed to ensure that the veteran will not be billed for coordinated non-VA care. The IBVSOs insist that veterans must never be held financially liable for authorized non-VA care. The IBVSOs agree that centralizing the referral, claims, and coordination process has the potential to cut down on red tape for veterans who need non-VA care, but in order to succeed, NVCC teams must be adequately staffed to competently coordinate care, and process timely referrals and payments for care. If the NVCC is poorly staffed, veterans will likely face referral backlogs and persistent billing problems, further exacerbating access issues.

Access Through Choice

To address the problems that the VA health care system experienced, Congress approved on a bipartisan basis P.L. 113-146 to expand purchased care outside of VA. The IBVSOs cannot overemphasize the fact that VA specialized services—spinal cord injury and dysfunction care, amputation care, blind care, polytrauma care, etc.—are unique VA resources that cannot be duplicated and sustained in the private sector. Moreover, establishing a scenario whereby veterans can choose to leave the VA health care system—a reality of the act of Congress—places the entire system at risk. Former VA Secretary Anthony Principi explained recently in the *Wall Street Journal* why the concept of a veterans' choice card (as provided for in the VACAA) is not a viable long-term solution to the problems facing the VA health care system:

> *"Vouchers (a concept of "choice") are not necessary to ensure high-quality health care…While this may have value in areas with long waiting lists, it raises serious questions. The VA system is valuable because it is able to provide specialized health care for the unique medical issues that veterans face, such as prosthetic care, spinal-cord injury and mental-health care. If there is too great a clamor for vouchers to be used in outside hospitals and clinics, the VA system will fail for lack of patients and funds, and the nation would lose a unique health-care asset."*

These specialized services for veterans do not operate in a vacuum. The viability of VA health care depends upon a fully integrated system where all of the services inherently support each other. Sending veterans into the private health care marketplace supports parts of this principle while undermining others. Contract care is not a viable option for veterans with the most complex and specialized health care needs. Sending those individuals outside of VA places their health at significant risk while abrogating VA of the responsibility to ensure timely delivery of high-quality health care for our nation's veterans. Leveraging coordinated, purchased care is still a part of the solution to access problems in VA. However, granting easier access to the private sector should not adversely affect the existing health care system or the catastrophically disabled veterans who rely nearly exclusively on VA for their health care.

Appointment Scheduling and Tracking

For years, VA has been tracking appointments with a scheduling system that relies on outdated software that produces unreliable wait-time data. In some cases, employees have manipulated schedules to mask the amount of time veterans waited to receive care. The IBVSOs believe that timely access is impossible unless wait times are accurately captured, recorded, and reported publically. VA must implement an updated appointment scheduling system that accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veteran. All employees must be fully trained and the policy must be adhered to at every VA facility. VA recently issued a request for proposals to acquire a new appointment scheduling system. The IBVSOs are concerned that this procurement either will be rushed and VA will award a contract that results

in a new, but still inadequate, scheduling system, or that the VA chronically troubled procurement system will bog down and procurement may take inordinate time for veterans who cannot afford to wait.

We emphasize that a new scheduling system alone will not solve VA scheduling problems. The VA current method for measuring timeliness is arbitrary and does not reflect the care needs of veterans. Arbitrary wait-time deadlines of 15, 30, or 45 days do not necessarily correlate to quality health care outcomes. A veteran's "desired date" also does not necessarily reflect the clinical needs of a patient. At worst, a desired date is a subjective timeline that has been proven to be highly susceptible to manipulation and misrepresentation. VA must determine reasonable wait times based on the different types of care needs—non-urgent and urgent, primary, and specialty—of individual veterans. If VA must track appointment wait times, they must be measured from the date a veteran contacts VA seeking care, rather than tracking from a subjective desired date.

We appreciate the fact that VA recently published regulations for tracking wait time that require care to be provided within 30 days of the date that an appointment is deemed clinically appropriate by a VA provider, or if no such clinical determination has been made, the date a veteran prefers to be seen. Under this regulation, any conflict between the clinically determined and patient's desired date must be resolved between the provider and patient. The IBVSOs believe extensive monitoring is essential to ensure that this principle is applied consistently and appropriately across the VA system and in all facilities.

Accountability

The medical community readily acknowledges that staff attitudes and proper bedside manner have an undeniable impact on quality, satisfaction, and health care outcomes. An environment in which patients are belittled or degraded does not foster recovery. Civilian hospitals know this and strive to cultivate an environment conducive to healing.

We believe that VA should be held to a higher customer-service standard than civilian hospitals. Poor customer service in VA facilities demands specific actions to address accountability, staff competencies, and staff morale. The IBVSOs have long been concerned about accountability of employees at all levels of VA from the highest executive offices at VA Central Office to the nursing assistants and part-time clerks at VA medical centers. Unfortunately, managers cannot easily sanction poor-performing employees, and VA cannot quickly hire new employees to close gaps.

During a hearing before the Senate Committee on Veterans' Affairs in May 2014, then-VA Secretary Eric Shinseki noted that VA had reprimanded, moved, demoted, retired, or terminated 3,000 VA employees for poor performance. However, when senators pressed the Secretary on exactly how many had been terminated, the Secretary acknowledged that very few were fired but instead were moved, demoted, or forced to retire.

With passage of P.L. 113-146, Congress gave the VA Secretary faster authority to immediately fire executive-level employees for poor performance effective after a brief period to appeal the decision. The IBVSOs note that the ability to take immediate action against senior executives only applies to actions initiated after the bill was signed into law. Despite the constant clamoring for individuals involved in the Phoenix scandal and other VA facilities to be terminated, VA cannot exercise its new authority against senior executives whose poor performance occurred prior to the approval of the law.

Strict firing authority is not a complete solution to accountability. The IBVSOs believe VA should instead offer robust training to employees at all levels to promote quality customer service. All employees who interact with veterans must understand that their primary function is to serve the needs of veterans in a considerate and compassionate manner. Those employees who cannot deal with veterans with compassion must only work in positions in which they do not interact with veterans or should resign from VA.

Additionally, whenever an employee leaves VA, VA acknowledges that six months to a year are required to fill vacant positions—assuming a viable pool of candidates is interested and available. When VA seeks to

replace health care professionals, VA bureaucracy cannot compete with nimble private health care systems. Private health care systems can easily fill vacancies in a matter of days or weeks. While doctors, nurses and nurse practitioners may have noble intentions of working for VA and serving veterans, many will forgo what could be a year-long waiting period and pursue timely employment opportunities elsewhere. For these reasons, the IBVSOs ask Congress to carefully review VA appointment authorities, internal credentialing processes, and common human-resources practices to identify ways to streamline the hiring process. If VA cannot quickly fill its vacancies with top talent, we cannot expect VA to deliver timely, quality care those who need it.

Several VA whistleblowers have stated that transparency was stymied within VA, meaning proper protocols could never be implemented to deal with the real challenges the agency faced in delivering timely care to veterans. When failures are identified, they must be swiftly corrected with better oversight, sufficient funding, and accountability of those responsible for retaliating against whistleblowers and mismanaging VA health care.

The IBVSOs believe that Congress and the American public should resist any suggestion that VA health care be dismantled in favor of an alternative model. The narrative that VA is a failed or flawed system could potentially be more disastrous for veterans who need care than any cover-up already exposed. Such suggestions not only serve to relieve VA of its responsibilities but fail to take into account the contributions that VA makes to veterans, their families, and the medical community as a whole. VA's goal must be to ensure that as many veterans as possible are able to receive quality VA care in a timely manner.

Fixing the VBA Claims-Processing and Appeals Systems

Recommendations:

The VBA must openly and honestly reassess whether the target goal established five years ago—that all claims would be completed within 125 days with 98 percent accuracy by the end of 2015—remains realistic and achievable. If the VBA confirms these goals are not reachable, it must work in a transparent and collaborative manner with Congress and its veterans service organization (VSO) partners to set new goals, revise current strategies, or request new resources.

The VBA must increase the amount and quality of its training programs for both new and onboard employees and managers, must allocate sufficient resources to ensure the best training methods, and must not be constrained by arbitrary travel or meeting restrictions.

The VBA must accelerate the development of the Veterans Benefits Management System (VBMS) to complete remaining core and critical components, including major modules, to allow electronic transmission of examinations and service treatment records from the Department of Defense, other government agencies, and private businesses and organizations. The VBA must be provided sufficient resources to expand VBMS with all its core components, as well as provide sufficient resources for VMBS or other compatible information technology solutions required to link the remaining VBA business lines, including the BVA.

The National Work Queue (NWQ) program must be implemented carefully in order to retain to the maximum degree practical the benefits of local processes and relationships in order to attain accurate claims decisions. The NWQ must be implemented in a manner that recognizes and responds to the different organizational structures and needs of VSOs that represent veterans in the claims process. Congress must carefully and continually oversee the NWQ program in order to ensure that the quality and accuracy of claims processing remains the most important consideration for workload management.

Congress should enact legislation to create a Fully Developed Appeals pilot program, modeled after the existing Fully Developed Claims program, one that would allow appellants to receive more timely decisions from the BVA if it agrees to a streamlined appeals process and accept responsibility for assembling new private evidence required to justify their appeals.

Congress should enact legislation requiring the VBA to provide due deference to private medical evidence that is competent, credible, probative, and otherwise adequate for rating purposes.

The VBA must strengthen the Decision Review Officer (DRO) program by refocusing DROs on the de novo review function of their responsibilities, ensuring sufficient numbers of DROs to meet appeals workload in all regional offices, and ensuring that DROs focus on appeals-related work and perform no original ratings work.

Congress should enact legislation to effectively eliminate the "new and material evidence" standard, which generates unnecessary work for the VBA and the BVA but that provides no practical benefit to veterans.

Congress should enact legislation to require that when a claimant submits a nonstandardized form with the intention of disagreeing with a claims decision, the VBA must respond to the claimant with a standardized Notice of Disagreement (NOD) form, including instructions on how and when it must be completed and returned. The VBA must allow the claimant the remainder of the NOD time period, or 60 days, whichever is longer, to return the completed form.

Background and Justification:

In early 2010 with a growing backlog of disability compensation claims and no solution in sight, the Veterans Benefits Administration (VBA) set out to transform and modernize its systems and procedures for processing veterans' claims for benefits. Despite numerous failed attempts to modernize its claims-processing systems over the past 2 decades, the VBA made the critical decision to develop new plans to transform its paper-based systems and replace them with modern information technology systems and business processes. Former VA Secretary Shinseki announced ambitious aspirational goals for transforming the claims system, promising that by 2015, the VBA would decide all claims for disability compensation within 125 days and that they would be completed to a 98 percent accuracy standard.

Today, with less than 12 months remaining in 2015, dramatic transformation of the claims-processing system has occurred and significant progress can be measured towards reaching those goals. For example, the VBA created and implemented a new organizational model for its Regional Offices, developed and then rolled out a new fully developed claims (FDC) process to speed simpler claims, and collaborated with VSOs to create new standardized medical evidence forms, called Disability Benefits Questionnaires, to streamline the rating process. The VBA also designed, tested, and deployed critical new Information Technology (IT) systems, including the Veterans Benefits Management System (VBMS), the Stakeholder Enterprise Portal and e-Benefits, which together have revolutionized the electronic filing of claims.

In 2010, no claims were processed electronically; by the end of 2014, more than 93 percent of VBA 526,000 pending claims were fully electronic and less than 40,000 paper claims remain in the system. There have been more than one billion images scanned into the VBMS associated with veterans' new e-Folders, allowing them to be simultaneously read at all VBA offices, 148 VHA facilities, and by VSOs who represent veterans. In 2015 almost 75 percent of the rating schedule, which covers far more than 90 percent of all rating decisions, will have been coded into "calculators" and embedded in the VBMS to assist Rating Veterans Service Representatives to make rating decisions. Every day thousands of veterans file and track their claims online either through e-Benefits or with a service officer through SEP.

While all these achievements and progress are laudable, an analysis of current claims-processing data and trends raises some questions about whether the aspirational goals Secretary Shinseki first talked about in early 2010 remain achievable by year's end.

Historic Progress but Unrealistic Goals

When the VBA initiated is current transformation efforts five years ago, the volume and complexity of claims was rising and did not reach a peak until the beginning of 2013, largely driven by the VA decision to add new presumptions for Agent Orange-related conditions in Vietnam veterans. According to VBA Monday Morning Workload Analysis reports, by January of 2013 the total number of pending claims for disability compensation and pension claims had risen to over 860,000, of which more than 600,000 were older than 125 days, the VBA official metric for the backlog. However, by the end of 2013 the total pending inventory of claims had been reduced by more than 20 percent, and the number in backlog status was cut by over 33 percent. Through September 2014 the total pending inventory of claims dropped an additional 22 percent, and the backlog was reduced by almost 40 percent more. Since the peak in January 2013, the total pending inventory of claims fell from 860,000 to just over 525,000, a reduction of about 40 percent. The total number of claims in backlog status dropped even more dramatically from 600,000 to just over 240,000, a reduction of almost 60 percent.

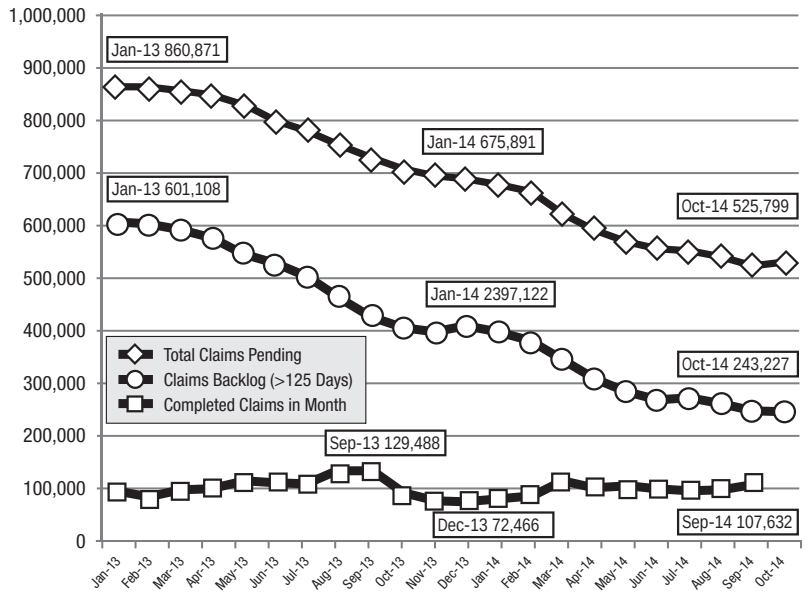
While both the total pending inventory and the total number of claims in the backlog has steadily declined for almost two years, the number of completed claims per month has remained more or less constant, hovering around 100,000 according to the VBA Aspire Dashboard. The highest work volume occurred in September 2013, when almost 130,000 claims were completed, primarily because of the VA policy of mandatory overtime that month. Overall, the trends shown in the chart above appear to indicate a slowdown in the reduction of

both the total pending inventory and the backlog.

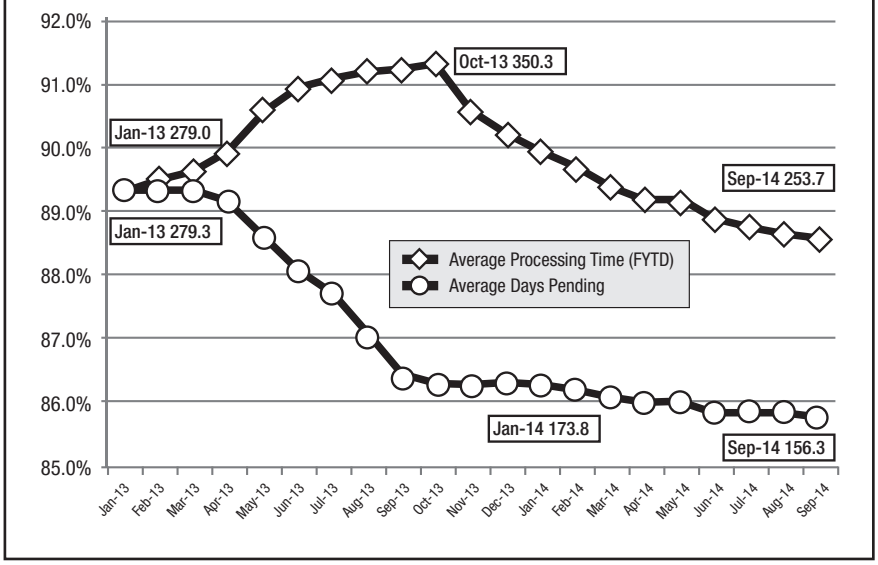
Based on data from the Aspire Dashboard, the timeliness of claims has also improved; however, it remains far from the 2015 goal for all claims to be completed in less than 125 days. In January 2013 the Average Processing Time and the Average Days Pending metrics were both approximately 280 days. Early in 2013, the VBA initiated its 2-year-old claims initiative to complete the oldest part of its inventory, followed shortly thereafter by its one-year old claims push. At that time, the VBA indicated that completing its oldest claims would increase the average processing times with a corresponding reduction in the average days pending measure, a reduction which occurred through most of 2013. Once the older claims initiatives were substantially completed, the average processing times began to rapidly fall, and the average days pending continued to fall, but at a more modest rate. By September 2014 the average days pending dropped to about 250 days and the average processing times to about 150 days.

Both of those numbers reflect "average" times, however, and the VBA's 2015 target is based on all claims being completed with 125 days requiring an average processing time of 80 to 90 days. As with pending inventory, the trends reflected on the chart above raise questions about whether the target will be met by the end of 2015.

Claims Inventory | January 2013 to October 2014



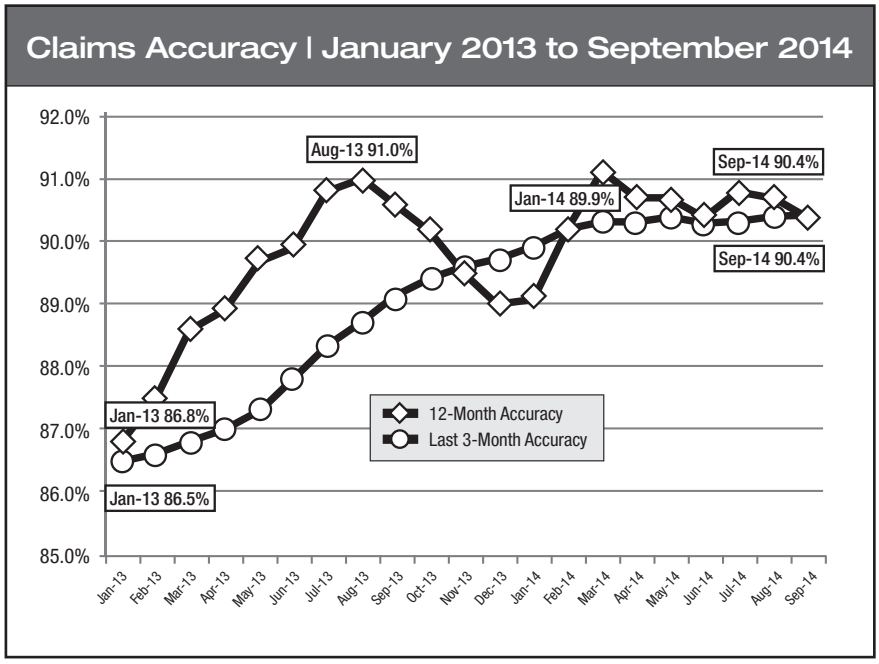
Claims Timelines | January 2013 to September 2014



Finally, perhaps the most important metric of a properly functioning claims-processing system is the accuracy of decisions. According to the VBA Aspire website, in January 2013, the VBA claims accuracy based on its Systematic Technical Accuracy Review methodology was 86.4 percent for the most recent 12-month period, and 86.8 percent for the most recent 3-month period. Throughout 2013 the 12-month accuracy rate rose steadily to almost 90 percent by year's end, while the 3-month accuracy rate climbed as high as 91 percent at one point, before declining back to 90 percent.

Among the reasons for these increases were sharpened focus on training, testing, and quality control, including the creations of Quality Review Teams, the dramatic reduction of VCAA "duty to assist" notification errors

because of the inclusion of this notice directly on application forms, and the elimination of other errors because of automation within the VBMS for certain processing steps. Based on the trend line in the chart above, the accuracy rate appears to be leveled off, raising questions about when the VBA will reach its 98 percent goal.



Overall, the VBA has made significant progress toward reaching the 2015 goals set by former Secretary Shinseki in 2010; however, with less than a year remaining to reach those "aspirational goals," now is an appropriate time for the VBA to reassess whether those goals are still appropriate and achievable. If the VBA concludes they are not, it is imperative that new, more realistic goals are set not just for this year but for the next several years. If targets need to be adjusted, strategies revised, or new resources provided, the VBA must work openly and cooperatively with both Congress and VSO stakeholders to justify these changes.

Building a Culture of Quality and Accountability

Vital lessons on the dangers of unrealistic or unachievable goals can be learned from the recent VA health care scheduling scandals. The VHA employed a metric that health care medical appointments for veterans should be scheduled within 14 days of the "desired date, a goal that was widely viewed by VHA employees, veterans, and veterans advocates as unrealistic in lieu of the VHA's capacity to provide care at that time. Constrained by an insufficient number of clinical professionals and inadequate treatment space, most VHA employees did not expect to meet this metric. Yet the metric remained the standard by which employees and their facilities would be measured and held accountable. Faced with an unachievable goal, some employees made the unfortunate decision to manipulate data and cover up true waiting lists rather than be held accountable for failure to meet this metric. Following revelations about the scheduling and waiting list violations, VA quickly removed this unrealistic metric, a decision that gained the full support of Congress, while working to develop more realistic metrics for waiting times designed to improve performance and responsibly hold employees accountable.

The critical question that VA and Congress must resolve is whether the aspirational goals established five years ago by the prior Secretary continue to positively drive the VBA performance in the right direction or whether VA should reassess and potentially revise some of the target goals now, rather than take the risk that unreachable goals again might distort reporting. VA must provide complete and accurate data and answers to these critical questions. For its part, Congress must work together with VA in an open, transparent, nonpolitical, and nonpartisan manner to ensure that VBA claims and backlog goals are driving productive change and progress to improve outcomes for veterans, not just to meet metrics.

Transparency and Partnership with VSO Stakeholders

A renewed commitment to full transparency and partnership with VSOs is another critical factor ensuring reforms in the VBA claims process. At the outset of the transformation efforts, the VBA worked very closely with VSO stakeholders in both the planning and execution phases. This cooperation, collaboration, and partnership resulted in a number of successful initiatives, including the VBMS, FDC, and Disability Benefits Questionnaires. However, VBA openness and outreach to VSOs has noticeably diminished in the past few years. Clearly, the drive to reach the 2015 goals has increased both the pressure on and the workload facing the VBA, resulting in a tendency to focus inward rather than outward.

However, the VBA would be making a mistake if does not continue to fully engage with its VSO stakeholders in the design and execution of new and existing transformation initiatives. VSOs have tremendous experience and expertise in claims processing, and through our service programs, the IBVSOs are active partners inside the VBA regional offices. Our service officers not only help veterans get quicker, more accurate decisions on their claims for benefits, they also reduce the VBA workload and serve as another layer of quality control. As the VBA works toward completing the claims transformation, it remains essential that it pro-actively engage and collaborate with VSO stakeholders and increase the level of transparency about their activities.

Information Technology Modernization and Improvement

The most critical and dramatic elements of the VBA claims-processing transformation have been the new IT systems—the VBMS, e-Benefits and SEP—built over the past five years. These three systems have led the way in moving claims processing from an outdated, paper-based system to a modern, automated digital system. Despite some early challenges, the VBMS program has proven to be an effective platform for processing claims in a digital environment. The challenge now is to fully integrate all phases of the claims-processing system, all VSOs, and the other VBA business lines into a single, unified digital-work environment.

Because of budget constraints, current planning at the VBA calls for some critical elements of the claims process, including major new modules to allow electronic transmission of examinations and service treatment records from the Department of Defense, other government agencies, and private businesses and organizations, to be slowly phased in over the next several years. Similarly, plans to expand the VBMS or other compatible IT solutions to all remaining VBA business lines and the Board of Veterans' Appeals (BVA) are being stretched into future years because of budget considerations. Congress must provide sufficient resources to the VBA to allow the critical elements of the VBMS just described to be accelerated. The VBA must also place greater emphasis on creating new and adjusted current elements of the VBMS to better integrate VSO service officers and to resolve lingering issues in the Stakeholder Enterprise Portal, both of which are essential to maximizing the benefits provided by veterans service organization service officers.

Business Process Changes

The National Work Queue

In the first quarter of 2015, the VBA is scheduled to begin operation of the National Work Queue (NWQ) program, a paperless workload-management initiative designed to improve the VBA claims-processing productive capacity. The NWQ builds on the work-flow and management capabilities provided by the VBMS allowing veteran's e-Folders containing all of their personal information, data, and records to be instantly transferred to any regional office (RO) and incorporated into the work queue of any employee. The NWQ is intended to provide the VBA with the ability to redistribute workload to ROs based on parameters such as the amount of pending workload and the number, experience, and type of employees working at each RO. The NWQ can also separate and allocate workload based on any parameters or priorities established by the VBA. In effect, the NWQ acts as the nexus between VBA business processes and IT systems, playing the role of "traffic cop" for claims processing.

During the first phase of the NWQ deployment, the primary filter for determining where a veteran's claim will be processed will be the veteran's place of residence, as is the case under the current organizational model. However, if the veteran's local RO is under-resourced or overburdened with work, the NWQ will assign that claim to another RO, brokering it in a much more efficient, timely, and accountable way than exists today. The NWQ will also have the ability to assign development of a claim to one RO but the rating work to a different RO if that referral results in a more timely decision. The NWQ could potentially divide claims by issue, assigning some of the development and rating work to multiple ROs, about which the IBVSOs would have concerns; the VBA, however, has indicated it does not have plans to divide claims in this manner.

The NWQ can provide the VBA with significant technological capabilities to reorder and redistribute workload. The VBA, however, must ensure that the NWQ remains a tool to enhance sound business processes rather than determine which business processes the VBA will use. The goal must always be to improve veterans' outcomes and protect their rights in the claims process. Furthermore, while modern information technologies are changing the nature of communication and social interaction, the VBA should retain, to the extent practical, the benefits of having VSO service officers working locally inside ROs where they help the VBA achieve quicker and more accurate decisions for veterans.

Standardized Forms for Claims and Appeals

On September 25, 2014, VA issued a Final Rule for Standard Claims and Appeals Forms, requiring that all claims and appeals for benefits must be filed on standard forms issued by the VBA, including informal claims. Under the new rule, if a claimant files a written claim or appeal using anything other than a standard form, the VBA will not recognize that filing as a claim or an appeal but will generally send the claimant the appropriate standardized form with instructions on how and when the form must be completed. This new standard form rule includes the filing of an informal claim. A claimant can only preserve an effective date for a claim by filing an informal claim on the standard form, even if the claimant makes perfectly clear in his or her written filing that he or she intends to file a formal claim in the future.

Similarly, claimants who intend to appeal a claims decision can only use the new standard Notice of Disagreement form; any other written communication will not be accepted as a Notice of Disagreement (NOD). The VBA will not be required to respond to such filings by sending claimants the standard NOD form. If a claimant files an incomplete standardized NOD form, the VBA will send the claimant a standard form with instructions on how and when he or she must complete that filing. However, the VBA will provide no extension of time to allow a claimant who submits an incomplete NOD form near the end of the NOD's one-year time period to allow him or her to complete and return the standard form.

The IBVSOs understand the need to use standard forms whenever possible in order to create a more efficient claims-processing system to benefit all claimants, but this rule allows no reasonable exceptions or extensions to accommodate the small number of claimants who would require such accommodation. Considering the fact that claimants often have physical and mental limitations from service-connected disabilities that may hinder their ability to fulfill these new requirements, the IBVSOs believe that this rule should be amended to allow limited commonsense exceptions and extensions.

For the purpose of establishing the effective date for a claim, the VBA must accept both standard and nonstandard communications that clearly indicate the intent to file a claim for benefits at the earliest possible effective date. Also, when a claimant sends any written communication to the VBA indicating his or her disagreement with a claims decision, the VBA must send that claimant the standard NOD form with instructions on how and when it must be completed. The VBA must also allow the veteran either the remainder of the one-year NOD period or 60 days, whichever is longer, to complete and return the standard NOD form.

Private Medical Evidence

The VBA must also expand the use and acceptance of private medical evidence in order to eliminate the time and resources required to administer medical examinations. Accepting private medical evidence would also increase the number of FDCs filed. Unfortunately, some ROs and employees resist giving private medical evidence the same weight as VA medical evidence. In order to further support efforts to encourage the use of private medical evidence, Congress should amend 38 U.S.C § 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 require a duplicative and redundant VA medical examination.

Appeals Reform

While the claims backlog has fallen significantly, as indicated above, the backlog of pending appeals has grown in recent years. Despite the fact that the BVA completed more than 55,000 appeals decisions in FY 2014, an increase of 10 percent over the highest previous total, the number of appeals at various stages working their way through the VBA toward the Board now tops 330,000, not counting the approximately 60,000 already pending before the Board.

Claims Decision Letters

The format and content of claims decision letter can influence the number of appeals filed. Veterans forced to wait up to a year or longer to get an initial decision are less likely to have complete confidence in that decision, particularly when the decision is a denial, than if their claim were decided within a reasonable timeframe. As *The Independent Budget* has noted in recent years, the current format of claims-decision letters, which evolved from the Simplified Notification Letter program, often contains insufficient information to allow veterans and their representatives to fully understand the rationale for the rating decisions or the evidence considered. Without sufficient confidence in rating decisions, veterans and their advocates are more likely to pursue appeals options. The VBA must continue to work with VSOs to improve claims-decision letters.

Decision Review Officer Program

An essential VBA program that can help lower the appeals workload is the Decision Review Officer (DRO) post-determination review process, which can resolve otherwise appellate-bound disputes at the local level. A DRO has "de novo" authority, meaning he or she is empowered to review a claimant's entire appeal file, with no deference given to the rating board decision. When warranted, a DRO can issue a new, independent decision that obviates further appeal. The IBVSOs strongly support the DRO program.

For years, the IBVSOs have voiced concerns that the number of DROs is insufficient for the amount of DRO work that is generated in regional offices. Further, the assignment of original claims-processing work to DROs at numerous regional offices is merely shifting the weight of the backlog from one area (claims) to another (appeals.) Over the past year the VBA leadership has made some efforts to limit the use of DROs in performing original claims-processing work; however, we continue to observe DROs at many ROs working on original claims. The IBVSOs believe it is imperative that every regional office assign an adequate number of DROs, and that DROs focus solely on appeals work; if additional personnel are needed, the VBA must request new resources, not repurpose DROs.

Fully Developed Appeals Pilot Program

In order to seek new solutions that could improve the appeals process for veterans, the IBVSOs, other VSO stakeholders, the VBA, and the BVA have informally discussed a proposal to create a "fully developed appeals" (FDA) program modeled after the FDC program. The premise of the FDA program is that the appellant would assume responsibility for gathering any new private evidence necessary to support the appeal and would agree to eliminate some steps and work currently performed by the VBA and the BVA; in return, the veteran would receive a significantly quicker appeals decision by the BVA.

At the time of the NOD election, the veteran would submit any evidence and argument he or she wants considered in appeal, and would certify that he or she has been fully informed about the FDA program and that the appeal would go directly to the BVA on a newly created FDA docket. There would be no SOC created or issued, no Form 9 to complete and file, no local RO hearings or reviews, no Board hearings, no SSOCs, and no Form 8 certification process. According to the BVA, the elimination of these steps alone could save two to three years of processing at the RO compared to a traditional appeals process.

The FDA program should be created as a statutorily authorized pilot program in order to allow Congress and stakeholders to oversee details of the program's design, implementation, and operation. While the FDA proposal is not the magic bullet that will eliminate the backlog of pending appeals, it creates another option that could save some veterans up to a thousand days waiting for their appeals to go to the Board while also reducing the workload in both the VBA and the BVA. As discussed above, the IBVSOs continue to strongly support the DRO process; the FDA program is neither a substitute nor replacement for it. Instead, it will provide another voluntary option that each individual veteran and representative, if any, could consider as they make decisions about the most effective and timely way to resolve their appeals.

New and Material Evidence Standard

Current statute (38 U.S.C. § 5108) requires that in order for a decided claim to be reopened and reconsidered, "new and material evidence" must be presented by the claimant or secured by the VBA. This standard was intended to prevent the VBA from re-opening and re-adjudicating claims based on existing evidence that was the basis for the original rating decision. However, the statute today provides no actual benefit since almost anything submitted by the claimant can arguably be considered both new and material. Further, even if the VBA does invoke the new and material standard, claimants can appeal that ruling to the Board and request a hearing, which in itself could be considered "new and material evidence."

The practical effect of the new-and-material evidence standard has been that rather than reducing the workload on the VBA by dissuading additional unnecessary submissions by claimants, the current statute has resulted in additional work by the Board without any appreciable reduction of workload for VBA. While the standard may have been intended to be a filter barring submission of irrelevant evidence, it does not effectively serve that purpose and should be repealed or reformed.

Resource, Budget and Technology Needs

Finally, in order to address BVA's pending and future workload, Congress must provide additional resources to enable the Board to hire sufficient personnel. Furthermore, BVA's need to modernize IT systems will require that additional resources be provided to the VA IT program and that those resources be allocated to BVA's IT needs. The Administration must request, Congress must provide, and VA must properly allocate sufficient resources to meet all of VBA's personnel and infrastructure needs, which includes both physical and IT infrastructure. While specific recommendations on FTEE levels, funding increases, and IT requirements are contained in the *IB's* budget report for Fiscal Year 2016, without new resources no amount of reform or reorganization will allow the BVA to meet its rising workload within a reasonable timeframe.

Over the next year VA must work collaboratively with both Congress and VSO stakeholders to openly and honestly review its budgets, goals, and plans for claims processing and appeals, and if necessary, revise these processes appropriately. The VBA must continue to refine its new business processes as well as accelerate development of new IT systems and components to support the new work. And in order to truly fix its claims processing and appeals systems, the VBA must develop a new work culture focused on quality and accountability.

Maintaining and Rebuilding VA Critical Infrastructure

The Department of Veterans Affairs opened its first National Home on November 1, 1866. World War I veterans returned from Europe with complications from shell shock and mustard gas exposure and the United States was ill-prepared to care for these unique conditions. In 1918 the need to care for veterans had grown so quickly that Congress authorized rapid expansion of veterans' hospitals. Because of this lack of planning, the Bureau of War Risk Insurance and Public Health Service had to rent space in existing hospitals and hotels to ensure care was provided to our returning veterans. By 1930, 54 veterans hospitals were built to provide direct care for the unique needs of veterans.

Today VA operates 152 hospitals, more than almost 900 community-based outpatient clinics, and 161 extended-care and domiciliary facilities. Unfortunately, many of these facilities are aging and struggling to meet the needs of today's veterans. In 2004, VA capacity was at 80 percent. Today it is 119 percent, while the conditions of the facilities hover just under 80 percent. Over the past few years, the VA budget request and the Congress's VA construction appropriation has fallen far short of the actual need. VA facilities are where enrolled veterans receive health care, and the facilities are just as important as the physicians and staff who deliver that care. A VA budget that does not adequately fund facility maintenance and construction will continue to negatively impact the quality and timeliness of veterans' health care.

In its FY 2012 budget submission, VA introduced the Strategic Capital Investment Planning (SCIP) process. SCIP provides an in-depth analysis of VA infrastructure, identifying gaps in access, utilization, and safety, and details the cost to close these gaps.

The vastness of the VA capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 6,000 buildings and almost 34,000 acres of land with a plant replacement value (PRV) of approximately $45 billion. Although VA has reduced the number of critical infrastructure gaps, more than 4,000 gaps remain that will cost between $56 and $68 billion to close, including $12 billion in activation costs.[1]

While SCIP clearly identifies the access, utilization, and safety gaps and projects the cost to close these gaps, it fails to strategically plan how VA will close these gaps. Currently, SCIP rates the gaps and places them on an integrated priority list from the most to least critical. Then each year, inexplicably, VA submits a budget request that does not consistently follow the priority list. Seismic corrections for Building 12 on the West Los Angeles VA campus were first funded in FY 2009 and were placed as number 3 on the integrated priority list as part of a larger consolidated construction project for the West Los Angeles campus. No further funding was provided for this project until FY 2015. Projects in Long Beach, California, and Canandaigua, New York, both lower on the priority list, have received substantially more funding.

The IBVSOs understand that some projects move through the planning and contracting stages quicker than others, but to allow safety gaps to sit for seven years, such as the one in West Los Angeles, with no clear strategy to correct them, not only impedes access for veterans but potentially puts them in harm's way. Another key element that appears to be missing from the gap analysis criteria is a comprehensive assessment of the existing contracts and sharing agreements resources that exist outside of VA.

Without a comprehensive understanding of the health care resources that exist within and outside of VA, the Department would encounter difficulty making sound decisions on capital investments and to right-size its inventory of facilities for the near, mid, and long term vista.

These issues were among the findings in a report that the Government Accountability Office issued on January 31, 2011, titled *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities is Needed*. Funding to close infrastructure gaps continues to be insufficient and arbitrary. VA must begin requesting fund-

[1]Department of Veterans Affairs, FY 2015 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2014, p. 1-4, 9.2-7.

ing that will close all safety, condition, access, and utilization gaps, and at the same time present a five- and ten-year plan that will systematically describe when and how VA plans to close each gap. In developing these five- and ten-year plans, VA must work from a budget proposal that is designed to maintain VA facilities for the buildings expected life-cycle as well as to eliminate existing gaps in safety, access, and utilization.

VA must submit a plant replacement value (PRV) for all VA-owned property and calculate its baseline and each facility's nonrecurring maintenance (NRM) funding request from that value. Adding the PRV to SCIP will allow VA to more accurately determine the appropriate amount to request for NRM and objectively decide when a facility becomes more costly to maintain than to replace. Using PRV as a tool, VA can more accurately determine the annual funding levels needed for NRM by facility, allowing for the reduction in the NRM backlog and fully funding future needs in a way that would be the most cost-effective. The industry goal for NRM is around 2 percent of the PRV. At that rate, facilities can operate for 50 years or more without outspending the cost to replace the facility. Knowing what percentage of the PRV is being spent will allow Congress and VA to assess, taking a long-term view of capital planning, when a facility will need to be replaced.

Even though NRM is funded through the VA Medical Facilities appropriation and not through a construction account, the account is critical to VA capital infrastructure and provides for more than 40 percent of the current infrastructure backlog. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors, among other routine maintenance needs. Completing NRM is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

VA is increasingly lagging in closing current NRM safety, condition, utilization, and access gaps, and continues to fall behind on preventing future gaps from occurring. Just to maintain what VA has in its infrastructure portfolio, the VA NRM account must be funded at $1.35 billion per year, based on IBVSOs' estimate of PRV. NRM is currently being funded at $462 million per year. Along with the PRV-calculated funding baseline, additional funding needs to be invested to prevent the $22 billion NRM backlog[2] from growing even larger.

Because NRM accounts are organized under the Medical Facilities appropriation, it has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This formula was intended to allocate health care dollars to those areas with the greatest demand for health care. In our opinion, VERA is not an ideal method to allocate NRM funds. When dealing with maintenance needs, this formula may prove counterproductive by moving funds away from older medical centers and reallocating the funds to newer facilities where patient demand is greater, even if the maintenance needs are not as great. The IBVSOs are encouraged by actions the House and Senate Committees on Veterans' Affairs have taken in recent years requiring NRM funding to be allocated outside the VERA formula, and we hope this practice will be sustained.

To close all major and minor construction safety, condition, access and utilization gaps, VA will need to invest approximately $23 billion. Nearly $5 billion is needed to close seismic deficiencies alone. Studies have identified 12 major construction seismic correction projects and 9 of those projects are partially funded. These projects cannot wait any longer. As VA develops its five- and ten-year plans, it must make closing these gaps a priority with the goal to have seismic deficiencies closed within five years.

The remaining gaps are building specialty care spinal cord injury, mental health, and women's health clinics; additions to existing structures; cemetery expansions; and new, freestanding medical facilities. Based on access and financial analysis, VA looks at four alternatives to determine the most effective way to close each gap. New construction would be the most cost effective, and in many cases the only method, to close the remaining $18 billion of major and minor construction need. VA must begin requesting adequate funding and develop a long-term plan to close all major and minor construction gaps.

[2]Department of Veterans Affairs, FY 2015 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2014, p. 9.3-14

While VA works to close all identified gaps, VA must also develop a more comprehensive system of identifying and addressing future needs. Included in this plan must be a system-wide program for architectural master planning.

Over the life cycle of a medical facility, utilization and services often change because of a shifting demographic of patients and new technologies that alter the way health care is delivered. VA must invest in medical center-based, architectural master planning so these changes can be better anticipated and funding can be made available as the need arises, not years later. Congress must appropriate an additional $15 million to allow VA to fund 10-year comprehensive facility master plans.

VA must do a better job of engaging local community partners to increase access and better utilize resources. Each facility master plan should include an analysis of services provided and services needed. When it makes sense, VA must leverage those partnerships to improve care and better allocate resources.

The IBVSOs fully support the GAO recommendation in the January 2011 report to enhance transparency by requiring VA to submit an annual report to Congress on the results of the SCIP process, subsequent capital planning efforts, and details on the costs of future projects. The IBVSOs also support the inclusion of new gap analysis criteria that considers resources that are available to the VHA through existing contracts and sharing agreements. We urge a more rigorous gap analysis that informs the priority list of projects in SCIP. The IBVSOs, in turn, will be monitoring the level of funding for each of the infrastructure accounts to ensure that all current gaps are closed within 10 years and that emerging and future gaps will receive sufficient funding.

Quality, accessible health care continues to be the focus for the IBVSOs, and to achieve and sustain that goal, large capital investments must be made. Presenting a well-articulated, completely transparent capital asset plan is important, and VA has done so, but funding that plan at nearly half of the prior year's appropriated level and at a level that is only 25 percent of what is needed to close the access, utilization, and safety gaps will not fulfill VA requirements; nor will it serve veterans' best interests.

Improvements Needed in the Program of Comprehensive Assistance for Family Caregivers of Severely Injured Veterans

Recommendations:

Congress should pass legislation to correct the inequity in access to the VA program of comprehensive assistance for family caregivers.

Congress should conduct oversight of VA in-home and community-based services for supporting caregivers.

Congress should pass legislation to allow primary caregivers to earn income credits for caregiving a disabled veteran to safeguard their own income security.

Congress must provide and VA must request sufficient funding of the caregiver program.

VA must fill key leadership vacancies within the VA Caregiver Support Program Office and provide necessary new staff to improve the program's delivery and quality of support to caregivers.

VA must provide a more integrated, robust, and flexible IT system to properly manage, evaluate and improve all aspects of the Caregiver Support Program.

VA must establish a complementary Caregiver Support Program operations office to monitor and ensure integrity, quality, and value of caregiver supports.

To improve the program, VA should conduct periodic surveys to assess the caregiver population being served, their challenges and needs, and whether existing programs are meeting those needs. The study should be designed to yield statistically representative data, the results from which should be provided to Congress.

Background and Justification:

Family caregivers supporting severely wounded, injured, and ill veterans require considerable strength to tend to the needs of family and home, assist their veterans with everyday activities, take their veterans to appointments, or just be there in their veterans' times of need. Caregiving takes endurance, commitment, love, and patience. With proper support, many severely injured or ill veterans can benefit from residing at home instead of being institutionalized. Support from family caregivers plays a crucial role helping to reduce health care utilization and health care costs and in improving veterans' psychosocial well-being. Being a caregiver, however, carries a significant cost.

Studies show improving family caregivers' well-being and sustaining them as caregivers requires a multifaceted approach—including training, health care coverage, and support services—to reduce the burden caregiving may create and to bolster their ability to serve as caregivers more effectively.

The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law No. 111-163, requires VA to create caregiver support programs to serve three types of family caregivers:

1. Primary caregivers who are the main source of support for veterans severely injured on or after September 11, 2001;
2. Secondary caregivers who generally serve as a back-up to the primary caregiver, and;
3. General caregivers who are the main source of support for all other severely ill and injured veterans enrolled in the VA healthcare system.

The law's multifaceted approach of support from VA includes:

- General caregiver support includes caregiver education and training, use of telehealth technologies, restricted counseling and mental health services, and respite care.

- Secondary family caregiver support includes all general caregiver supports, monitoring veterans' quality of life, instruction and training specific to a veteran's needs, paid travel expenses while accompanying veterans to appointments, information and assistance to address the routine, emergency, and specialized caregiving needs and individual and group therapy, counseling and peer support groups.

- Primary family caregivers support includes all general caregivers and secondary family caregivers supports, a monthly caregiver stipend, at least 30 days a year of respite care, and CHAMPVA healthcare coverage if the veterans have no other coverage.

Almost 12,000 primary caregivers were receiving needed supports and services from this VA program at the end of 2013. Also in 2013, VA launched an evidence-based six-week online workshop designed to reduce caregiver stress and increase family caregiver well-being. The VA family caregiver website (www.caregiver.va.gov) received over 1,300 hits a day on average, and the caregiver support line (1-855-260-3274) received over 92,000 calls during the year.

The Law's Inequity for Caregivers and Veterans

Family caregivers of veterans suffering from severe illnesses (such as amyotrophic lateral sclerosis, multiple sclerosis, or Alzheimer's disease) provide enormous amounts of care and support to them. However, they are excluded from primary caregiver supports, even if the veteran served in combat in Iraq, Afghanistan, or in World War II or Vietnam.

While Title I of P. L. 111-163 created a program to address the adverse impact of caregiving, the law also turned a blind eye to family caregivers of severely ill veterans, and did so without regard to how heavy a burden they shoulder.

Program Leadership and Operations

Despite some service enhancements to the Caregiver Support Program, the GAO and the VA Office of Inspector General reports in 2014 describe specific weaknesses. Because the VHA Caregiver Support Program Office does not have the tools, resources or support to properly manage, evaluate, and improve the program, caregivers of ill and injured veterans are being adversely affected.

Currently, only one person is acting as both the director and deputy director of the Caregiver Support Program. The program and the caregivers of severely injured veterans, therefore, are not being effectively represented in higher organizational policy discussions. Moreover, unlike other clinical programs under the VHA's current organizational structure, its Caregiver Support Program Office has no corresponding Clinical Operations office with which to work collaboratively to support field operations.

Ostensibly, having a program director, deputy director, and Caregiver Support clinical operations office would make developing and deploying a more robust and integrated IT system for the caregiver program a high priority. Filling these positions also would capture comprehensive workload data to support effective oversight and management.

Without reasonable support and reliable data, the IBVSOs are concerned about the VA's ability to properly analyze and project the amount of resources needed to address the backlog of pending applications and continue supporting the growing caregiver population and their veterans. While the Administration's FY 2015 budget request appeared reasonable when it was submitted last year, a flat-line FY 2016 advance appropriations request for the Caregiver Support Program is not adequate.

Enhancements Needed in Other Caregiver Supports

The IBVSOs have heard consistent criticism from primary caregivers on certain aspects of the Caregiver Support Program. Many primary caregivers comment on differences between this program and the Department of Defense's Special Compensation for Assistance with Activities of Daily Living in terms of eligibility and caregiver training.

The IBVSOs hear most from primary caregivers about the training and education component of the program as being more of an orientation than about the training itself. While the education and training component is required by law, the content is wholly within VA's discretion, and VA should amend such education and training to account for the primary caregivers' experience and accordingly better meet specific caregiving needs.

In addition, family caregivers applying for comprehensive supports under this program have voiced frustration over the lack of transparency of the application process and details about the program. Notably, there is no publicly available directive, handbook, or manual to educate caregivers about what to expect.

Creating and implementing a policy to better serve caregivers of severely injured veterans should depend on representative data that can be used to determine validity, reliability, and statistical significance. The IBVSOs note that in an earlier version of the caregiver bill, Congress would have authorized VA and the Department of Defense to contract for a national survey of family caregivers of seriously disabled veterans and service members and to submit a report to Congress. The final bill failed to include this language. VA estimates the survey would cost approximately $2 million over a four-year period.

VA's In-Home and Community-Based Services for Supporting Caregivers

The Caregiver Support Program does not consider primary caregivers to be working more than 40 hours a week, assumes 40 days of in-home respite care, and makes assumptions about other in-home and community-based services that VA will provide. The reality is many primary caregivers occupy a formal caregiving role for more than 40 hours per week, and access to in-home and community-based support services is variable, limited, at the discretion of local VA facilities.

VA, OIG, and GAO reports from early 2000 to as recently as late 2013 repeatedly have documented that some VA medical facilities employed local restrictions to limit access to these services. In September 2013, the OIG reported some VA medical facilities depress waiting time data and used various methods and strategies to restrict access to homemaker/home health aide, respite, and skilled care services—in-home services often employed to support family caregivers.

Future Income Security for Primary Caregivers

Caregivers of severely injured and ill veterans often withdraw from school and/or give up time from work and forgo income opportunities in order to spend many hours per week supporting, attending, and advocating for their injured veterans.

Under the VA comprehensive caregiver support program, primary caregivers—predominantly spouses, and some parents, relatives, and friends—receive a tax-free stipend based on the amount of hourly assistance these veterans receive. About 6,000 of these caregivers were assigned to "Tier 3" (the highest level, providing a maximum of 40 hours of caregiving per week) for their stipend payments.

This "living stipend," a term used by Congress, has been interpreted by VA to be "exempt from taxation under 38 U.S.C. 5301(a)(1)" based on the language contained in the law that states, "[N]othing in this section shall be construed to create… an employment relationship between the Secretary and an individual in receipt of assistance or support under this section."

Because of the relative youth of many of these seriously injured veterans, their primary caregivers are facing a long-time horizon of supporting their veterans. Because of its tax-free nature, primary caregivers cannot claim stipend payments as income, and stipends are not considered wages or earnings creditable for the purposes of Social Security, placing their future income security at risk. Congress needs to address this inequity to obviate future poverty in these caregivers as they approach their elder years, or in the event they, too, become disabled.

Ensuring That Women Veterans Gain Timely Access to High-Quality Care and Benefits

Federal agencies need culture change and should reevaluate programs and services for women veterans to ensure they are meeting the unique needs of women service members and transitioning women veterans.

Recommendations:

VA and the DOD should aggressively pursue culture and organizational change to ensure that women are respected and valued.

The DOD, VA, and other federal partners should collaborate to develop and maintain an up-to-date central directory and mobile applications for federal programs and services that are available to women service members and veterans who are transitioning from military to nonmilitary life.

The federal government should collect, analyze, and publish data by gender and minority status for every program that serves veterans to improve understanding, monitoring, and oversight of programs that serve women veterans.

The DOD, VA, and local communities should work together to establish peer support networks for women. VA should establish child-care services as a permanent program to support health care, vocational rehabilitation, education, and supported employment services.

VA should build upon the local community partnerships and outreach established for other programs, such as those for homeless veterans, to establish support networks for women veterans in accessing health care, employment, financial counseling, and housing.

The DOD and VA should increase engagement and treatment of family members in post-deployment health care and the transition programs for service members and veterans.

VA needs to improve access to gender-specific health care for women veterans by requiring every VA Medical Center to hire a part-time or full-time gynecologist.

VA and the DOD should remove existing barriers and improve access to mental health programs for women. They should explore innovative programs for providing gender-sensitive mental health programs for women. An interagency work group should be tasked to review options, develop a plan, fund pilots, and track outcomes. VA and the DOD should consider collaborations on joint group therapy, peer-support networks, and inpatient programs for women who served after 9/11.

The DOD should eliminate rape, sexual assault, and sexual harassment in every part of its organization and take action to establish a culture that does not tolerate sexual assault and sexual harassment.

The DOD should allocate the resources needed to fully implement its Sexual Assault Prevention and Response Office's Strategic Plan. The DOD should conduct program evaluations and prospective scientific studies to monitor the success of its plan to prevent military sexual trauma, change the military culture, assess program progress and outcomes, and adjust actions as needed.

The DOD should improve policies and programs that provide family support to the spouses and children of women veterans.

VA and DOD should develop a pilot program for structured women's transition support groups to address issues with marriage, deployment, changing roles, child care, and life as a dual military family. VA should evaluate the effectiveness of transition support groups and determine whether these efforts help achieve more successful outcomes for women.

Congress should make permanent and expand the authority for the VA Readjustment Counseling Service's women veterans retreat program. VA researchers should study the program to determine its key success factors and whether it can be replicated in other settings.

VA should address the needs of women veterans in education by piloting programs such as education and career counseling, virtual peer support for women students, and child-care services. VA should establish comprehensive guidelines that schools can use to assess and improve their services and programs for student veterans. Special attention should be given to the needs of women veterans on campus. Schools who adopt these guidelines should be rated on the GI Bill Comparison Tool. VA should market its Education Counseling services on the Veterans Benefits Administration website and emphasize them during the Transition Assistance Program (TAP) process. Alternative options such as live chat and email should also be made available and marketed.

VA should enhance its monitoring and reporting on educational institutions to include consistent standards for granting credit for military-training and education-credit transfer; support for veteran students with identified disabilities, educational outcomes, and barriers; and availability of career counseling and job-placement success.

TAP partners should conduct an assessment to determine needs of women veterans and incorporate specific breakout sessions during the employment workshops or add a specific track for women in the three-day sessions to address those needs.

The DOD should transfer contact information and data on all TAP participants to VA and the Department of Labor, who should be responsible to provide gender-sensitive follow up with all service members 6 to 12 months after separation to offer additional support and services.

Data on participation, satisfaction, effectiveness, and outcomes for TAP should be collected and analyzed by gender, ethnicity, and race and returned in real time to commanders for assessments and corrective actions. To judge the success of TAP, employment outcomes and educational attainment should be tracked and reported on a rolling basis, analyzed by gender, ethnicity, and race, for all separated service members.

To assist women veterans with job placement and retention, the DOL and VA should develop structured pilot programs that target unemployed women veterans modeled on the promising practices from DOL Career One Stop service centers.

The DOL should work more closely with state certification organizations to translate military training and certification to private-sector equivalency. VA and the DOD should establish a grant program to accelerate these efforts.

Congress should reauthorize and fully fund the Supportive Services for Veteran Families program to promote positive transitions for women veterans during the anticipated downsizing of the armed forces.

VA and the Department of Housing and Urban Development should invest in additional safe transitional and supportive beds designated for women veterans.

VA should work with community partners to provide housing programs to accommodate women veterans with dependent family members.

The VBA should continue to track, analyze, and report all its rating decisions separated by gender to ensure accurate, timely, and equitable decisions on claims filed by women.

Background and Justification:

Women are a rapidly growing and important component of the U.S. military services, yet their contributions have been under-recognized, even by the women themselves. Today women constitute approximately 20 percent of new recruits, 14.5 percent of the 1.4 million active-duty component, and 18 percent of the 850,000 members of the reserve components. Over 300,000 women have served in Afghanistan and Iraq. While the number of male veterans is expected to decline by 2020, the number of women veterans is expected to grow to 11 percent of the total veteran population.

Over the past decade of war, women have served in forward, exposed positions in unprecedented numbers. They are assigned to female engagement and reconstruction teams, military police units, transportation teams, as helicopter and jet fighter pilots, and in a variety of other positions that put them in combat, resulting in exposure to trauma, injury, and myriad environmental threats associated with modern warfare.

Despite a government that provides an array of benefits to assist veterans with transition and readjustment following military service, serious gaps are evident for women in every aspect of existing federal programs. These gaps impede their successful transitions to civilian life. Today, women lack consistent access to a full range of gender-sensitive benefits and services, and the federal government has not ensured that the staffs of each agency are exemplifying and promoting culture that supports women veterans. The vast majority of these deficiencies result from a disregard for the differing needs of women veterans and a focus on developing programs for men who are prominent in both numbers and public consciousness. Resources for implementation and evaluation of programs that address culture and climate for women are long overdue, but the IBVSOs believe they are achievable.

Because of their role in the military and society, women veterans confront unique transition challenges. The challenges of readjustment to post-military life affect women differently than men and should receive attention from their local communities and the federal government at a level that is at least comparable to that received by men. One of the most persistent problems is a military and veterans' culture that is not perceived by women as welcoming and does not afford them equal consideration. The VA Women Veterans' Task Force noted the "need for culture change across VA to reverse the enduring perception that a woman who comes to VA for services is not a veteran herself, but a male veteran's wife, mother, or daughter."

Similar to their male counterparts, wartime deployments expose women to harsh living conditions. This environment impacts overall health and wellness, and women's health concerns must be considered and addressed in order for them to be effective and fully functioning members of military units. To accomplish this goal, in December 2011 the Army Surgeon General directed the establishment of a Women's Health Task Force team to assess the health care needs of Army women. The task force reported a lack of education and information on birth control, menstrual cycles, and feminine hygiene. The physical effect of poor-fitting uniforms and protective gear, barriers to seeking gender-specific care during deployment, the psychosocial impact of deployment on new mothers, reintegration with spouses and children, and sexual harassment and assault were also highlighted by the task force as key issues. The Armed Services Committees of the House and Senate should review these recommendations and should assume a strong oversight responsibility and agenda to see that all service branches make progress in resolving these important challenges, which IBVSOs believe are universal across the services, National Guard, and reserve components.

Many women who return from deployments are made stronger by their experiences, but some have difficulty in their transitions and are not fully supported by existing federal programs. Research demonstrates that women veterans returning from deployments in Iraq and Afghanistan experience higher rates of under-employment and unemployment than male peers, experience disturbingly high rates of homelessness—at least twice as high as women nonveterans, have high rates of sexual assault during military service, and reveal a lack of safe housing, especially for women with minor children.

Women continue to report access to child-care services as a barrier to needed health care services based on the success of the VA's child-care pilot program. The IBVSOs believe VA should establish child-care services as a permanent program to support health care, vocational rehabilitation, education, and supported employment services.

Women experience deployment and reintegration differently than do men. According to a special report issued by DAV in 2014, women are believed to focus more on disruption of interpersonal relationships, they report experiencing less social support once they return home, and they do not find services or commanders prepared to support women and their families after deployment. Compared to men, women are less likely overall to be married, and if married more likely to be married to a fellow service member, more likely to be a single parent, more likely to be divorced, and more likely to be unemployed after military service.

Women veterans have been underserved for far too long by the federal, state, and local programs. While VA deserves praise for its efforts to improve women's health programs, for its outreach to women, and for establishing comprehensive primary care programs for women veterans at all VA facilities, very serious gaps still occur in some VA clinics and specialty services. For example one third of VA medical centers do not employ a gynecologist. Holistic, evidence-based programs for women's health, mental health, and rehabilitation programs must be expanded to address the full continuum of care needed by all veterans, including women veterans.

Where Do Gaps Exist?

Health Care Services

Numerous reports have indicated that women veterans suffer from a high burden of post-traumatic stress disorder (PTSD), depression, and other comorbid conditions; yet, VA has experienced difficulty in establishing gender-specific group counseling, residential treatment, and specialty inpatient programs to serve women. The IBVSOs recognize the difficulty in building a critical volume of women to maintain these specialized programs in every location; therefore, we recommend that VA and DOD work collaboratively on pilot programs to address these issues, such as "tele-group" therapy, VA-DOD joint programs, and expanding regional centers of excellence. These agencies should jointly explore "warm handoffs" and other new approaches to transitioning care from the DOD to VA.

Sexual assault and rape are crimes. The recent dramatic increase in reported military sexual trauma is an illustration of problems and solutions that require radical change in the culture of our armed forces. In order to successfully eliminate rape, other forms of sexual assault, and sexual harassment in the forces, the DOD must address organizational, culture, and preventive solutions. Although VA has excellent evidence-based treatments for military sexual trauma (MST) survivors, VA still lags in providing the number of qualified providers with specific training and expertise in treating the consequences of MST and helping veterans recover.

The DOD has neither adequately supported nor adjusted its programs to meet the needs of deployed women and their families. For example, husbands of deployed women service members do not receive the same level of family support services available to women spouses because programs are not designed to meet men's concerns, needs, and schedules, or are not viewed as welcoming to men's participation. Current transition programs and treatments for relationship building, family reintegration, prevention of intimate partner violence, and support for family functioning are based on civilian programs and lack evidence of effectiveness in military and veteran populations. Improved transition support programs designed for prevention, treatment, and support for women and their families are needed.

While the VA women veterans' mental health retreat program has been a resounding success in reducing stress, improving coping skills, and improving women's sense of psychological well-being, it is only a small pilot effort and has served a limited number of women. However, in its report to Congress, VA noted that 85 percent

of participants showed improvements in psychological well-being, 81 percent showed significant reduction in stress symptoms, and 82 percent showed an improvement in positive coping skills. These kinds of outcomes warrant permanent reauthorization of the program by Congress, and justify a study of long-term outcomes in women who participate in these retreats.

In order to understand the experience of women in the military and veterans, data needs to be routinely collected, analyzed and reported by gender and minority status. The IBVSOs recommend improved data collection on women and minorities for health care, disability compensation, justice involvement, education, transition assistance, sexual trauma, employment, and housing programs. Congress, policy makers, program directors, and researchers need this information in order to monitor and enhance services for women veterans.

Education

The Post-9/11 GI Bill represents the largest expansion of educational support to military and veterans in our post-World War II experience, and this Congressional authority provides excellent educational benefits. However, there is a paucity of information available on the education subsidies and support received by women veterans or on the outcomes of the use of the Post-9/11 GI Bill benefits and services by women. More information is needed for program planning, policy-makers, and researchers to ensure this program is meeting women's needs after service.

Transition Assistance Program

There are no comprehensive studies that evaluate the effectiveness of the Transition Assistance Program (TAP) program. The hallmark of adult learning is that adults seek out and absorb information when they perceive that they need it, not necessarily when it is available. Some transitioning service members may not be primed to absorb TAP training during their preseparation periods but would be more receptive once they are actively seeking help and assistance following their discharges several months later.

Employment

The need for assistance will become even more pressing as the DOD executes its downsizing plan. Those who expected full military careers will be suddenly thrust, with little warning, into ill-prepared civilian communities and job markets as new veterans. The Department of Labor (DOL) has provided women veterans with many customized programs, communications, and supports. Despite these efforts the unemployment and under-employment rates for women veterans are higher than those for men. The planned military downsizing is likely to exacerbate this problem. Additional efforts are needed to reverse these trends.

Housing

VA's efforts to eliminate veterans' homelessness have been impressive and are showing significant success. However, women veterans still have higher rates of homelessness than their nonveteran counterparts, and housing support for women veterans needs to be enhanced, particularly for women with dependent children.

Disability Compensation

The burden of illness and injury in post-9/11 veterans is high and nearly half have applied to VA for disability compensation. VA confirmed that disability evaluation ratings for MST-related PTSD claims were lower for women veterans and took action to educate and retrain staff on proper adjudication of these claims. VA needs to do more to assure that women are receiving fair and equitable adjudication of all their disability compensation claims.

Summary

Women veterans deserve an integrated approach to address their transition needs, and the IBVSOs expect to observe and support an overhaul of the culture, values, and services of the federal systems that should be supporting them in a successful transition home.

The following recommendations cover the broad range of transition needs of women veterans in culture change, health care, disability compensation, family and community support, education, transition assistance, employment, housing, and in efforts to treat the devastating effects of MST and prevent sexual assault. The IBVSOs urge Congress, federal, and state agencies and community partners to re-evaluate existing programs and services and make necessary changes to ensure they are tailored to meet the needs of all veterans, including women. Congress should provide the necessary resources to meet this goal and should furnish continuing oversight of programs and services to ensure the unique transition needs of women veterans are being fully met.