

The INDEPENDENT BUDGET

A Comprehensive Budget & Policy Document Created by Veterans for Veterans
for the Department of Veterans Affairs



IBB
Fiscal Year 2013

Prologue

As the United States reflects on the fateful date—September 11, 2001—that obligated millions of service members to be deployed into combat theaters, the Department of Veterans Affairs (VA) continues to face rising pressure to meet the needs of these veterans and of veterans before them. While the future of United States military deployments remains uncertain, the lasting impact of the physical and psychological traumas that some service members experienced during that time may require a lifetime of care. The sacrifices these brave soldiers, sailors, airmen, coastguardsmen, and marines have made will leave them dealing with a lifetime of physical and psychological wounds. It is for these men and women and the millions who came before them that *The Independent Budget* veterans service organizations (IBVSOs)—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—set out each year to assess the status of the one federal department whose sole task it is to care for them and their families.

VA and the veterans it serves now face a new dynamic in which pressures resulting from the federal debt and deficit may dictate the level of services the agency can provide, whether arbitrary or not. In fact, these pressures may force VA to provide health-care services and benefits with fewer resources than might actually be necessary to meet full demand. This is a sobering proposition.

The Independent Budget is designed to alert the Administration, Members of Congress, VA, and the public to those issues concerning VA health care, benefits, and benefits delivery that we believe deserve special scrutiny and attention. This document provides a detailed funding analysis and recommendations to assist policy makers in assembling an adequate budget for FY 2013, and developing the advance appropriation for the medical care accounts for fiscal year 2014. Through these efforts, if Congress responds appropriately, the IBVSOs believe VA will be positioned to successfully meet the challenges of the future. We also hope that this report will provide direction and guidance to the Administration and Members of Congress to steer both policy and budget to the benefit of veterans served by VA.

The U.S. government confronts a number of challenges to our fiscal future. Rapid growth in federal spending, coupled with an economic recession that has had an impact on federal revenues, has set the nation on a course that appears unsustainable. Yet continued investment in VA's infrastructure and critical programs is imperative. The ongoing cost of maintaining VA's infrastructure and caring for veterans who honorably served this nation does not decline simply because financial times become challenging. With this new reality ever-present in our minds, we must take necessary steps to ensure that VA receives the

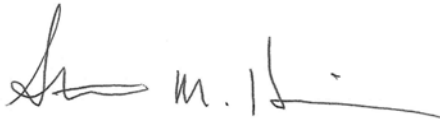
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resources it needs to meet the challenges of today and the problems of tomorrow. In order to ensure that VA obtains these resources, *The Independent Budget* veterans service organizations offer a detailed analysis of the full funding needs of VA. *The Independent Budget* is based on a systematic methodology that takes into account changes in the size and age of the veterans population, the cost of living, federal employee staffing, wages, medical care inflation, construction needs, the aging health-care capital infrastructure, trends in health-care utilization, benefits needs, efficient and effective means of benefits delivery, and estimates of the number of veterans and their dependents who will be laid to rest in our nation's cemeteries.

Our sons, daughters, brothers, sisters, husbands, wives, and grandchildren who serve on the frontier of freedom need to know that they will come home to a nation that respects and honors them for their service, provides the best medical care to restore them, orchestrates the best vocational rehabilitation to help them overcome employment barriers created by injury, and furnishes a supportive claims-processing system that delivers education, compensation, and survivors' benefits with efficiency to those who sustained harm in their service to our nation.

We are proud that this year represents the 26th edition of *The Independent Budget*. We are proud of the respect and influence that *The Independent Budget* has attained during that quarter century. We endeavor each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

We ask readers to approach this report with an open mind. War veterans should not be treated as war's refuse, but rather as proud warriors who served. Benefits and services for them are not gratuitous—they were earned, and payment is due in full.



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The four coauthoring organizations have worked in collaboration for 25 years on *The Independent Budget* to honor veterans and their service to our country. Throughout the year, each organization works independently to identify and address legislative and policy issues that affect the organizations' memberships and the broader veterans community.

AMVETS

Since 1944, AMVETS has been preserving the freedoms secured by America's armed forces, and providing support for veterans and the active military in procuring their earned entitlements, as well as community service and legislative reform that enhances the quality of life for this nation's citizens and veterans alike. AMVETS is one of the largest Congressionally chartered veterans service organizations in the United States, and includes members from each branch of the military, including the National Guard and Reserves.

DISABLED AMERICAN VETERANS

The Disabled American Veterans (DAV), founded in 1920 and chartered by Congress in 1932, is dedicated to a single purpose—building better lives for our nation's service-disabled veterans and their families and survivors. This mission is carried forward by providing outreach and free, professional assistance to veterans and their dependents and survivors in obtaining benefits and services earned through military service. DAV members also provide voluntary services in communities across the country and grassroots advocacy from educating lawmakers and the public about important issues to supporting services and legislation to help disabled veterans and their families.

PARALYZED VETERANS OF AMERICA

Paralyzed Veterans of America (Paralyzed Veterans), founded in 1946, is the only Congressionally chartered veterans service organization dedicated solely to serving the needs of veterans with spinal cord injury or dysfunction (SCI/D). Paralyzed Veterans' mission is to maximize the quality of life for its members and all people with disabilities. Paralyzed Veterans is a leading advocate for health care, SCI/D research and education, veterans' benefits, sports and recreational rehabilitation opportunities, accessibility and the removal of architectural barriers, and disability rights. Paralyzed Veterans is composed of 34 chapters that work to create an America where all veterans and people with

disabilities, and their families, can achieve their independence and thrive. Paralyzed Veterans represents more than 19,000 veterans in all 50 states, the District of Columbia, and Puerto Rico.

VETERANS OF FOREIGN WARS OF THE U.S.

The Veterans of Foreign Wars of the U.S. (VFW), founded in 1899 and chartered by Congress in 1936, is the nation's largest organization of combat veterans and its oldest major veterans service organization. Its 1.5 million members include veterans of past wars and conflicts, as well as those who currently serve in the active, Guard, and Reserve forces. Located in 7,900 VFW Posts worldwide, the VFW and the 600,000 members of its Auxiliaries are dedicated to "honoring the dead by helping the living." They accomplish this mission by advocating for veterans, service members, and their families on Capitol Hill as well as state governments; through local community and national military service programs; and by operating a nationwide network of service officers who help veterans recoup more than \$1 billion annually in earned compensation and pension.

Individually, each of the coauthoring organizations serves the veterans community in a distinct way. However, the four organizations work in partnership to present this annual budget request to Congress with policy recommendations regarding veterans' benefits and health care, as well as funding forecasts for the Department of Veterans Affairs.

Supporters

African American Post Traumatic Stress Disorder Association
Air Force Association
Air Force Sergeants Association
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Military Retirees Association
American Military Society
American Psychological Association
American Thoracic Society
American Veteran Alliance
American Veterans for Equal Rights
Armed Forces Top Enlisted Association
Association for Service Disabled Veterans
Association of American Medical Colleges
Association of the United States Navy
Blinded Veterans Association
Catholic War Veterans, USA, Inc.
Combined KORUS Veterans
Easter Seals
Fleet Reserve Association
Gold Star Wives of America, Inc.
Governor of Washington
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the USA
Korea Veterans of America, Inc.
Louisiana Veterans Coalition
Lung Cancer Alliance

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Mental Health America
Military Officers Association of America
Military Order of the Purple Heart
Minnesota Department of Veterans Affairs
National Alliance on Mental Illness
National Association for Uniformed Services
National Association of American Veterans, Inc.
National Association of Disability Representatives
National Association of State Head Injury Administrators
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Disability Rights Network
National Society of Cuban American Veterans
Navy Seabee Veterans of America, Inc.
Non Commissioned Officers Association of the USA
North Dakota Department of Veterans Affairs
Nurses Organization of Veterans Affairs
Society of Hispanic Veterans
Society of Military Spouses
Tennessee Department of Veterans Affairs
United Spinal Association
United States Coast Guard Chief Petty Officers Association
US Federation of Korea Veterans Organizations
US—Korea Allies Council
VetsFirst, A program of United Spinal Association
Veterans Affairs Physician Assistant Association, Inc.
Vietnam Veterans of America
Wyoming Veterans Commission

Guiding Principles

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

Acknowledgments

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Introduction

With America finally transitioning away from a long war in Iraq, and as we begin to plan our withdrawal from an even longer war in Afghanistan, the numbers of new veterans and disabled veterans entering the Department of Veterans Affairs (VA) health-care and benefits systems increases steadily. Tens of thousands of soldiers, sailors, airmen, marines, and coastguardsmen have experienced injury or illness associated with their service during the global war on terrorism; meanwhile, the responsibility that this country has to take care of those men and women continues to grow.

It is under this dramatic backdrop of current military events that the four coauthors of *The Independent Budget*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—offer our budget and program recommendations based upon our unique expertise and experience concerning the resources that will be necessary to meet the needs of America’s veterans in fiscal year (FY) 2013. These recommendations are designed to meet the needs of the thousands of veterans currently serving in America’s armed services who will soon have earned and will require VA health-care and financial benefits as well as the needs of the millions of veterans from previous conflicts and service who currently depend on VA.

We are proud of the fact that the FY 2013 edition of *The Independent Budget* represents the 26th consecutive year that our partnership of veterans service organizations has joined together to produce a comprehensive budget document that highlights the needs of every generation of veterans. During that time, *The Independent Budget* has improved significantly while gaining much more respect and recognition.

It is no secret that a difficult fiscal future lies ahead for this country, and we recognize that VA is not immune to this reality and will likewise face significant challenges. Following months of rancorous debate about the national debt and federal deficit during the summer of 2011, Congress agreed upon a deficit reduction measure—Public Law 112-25—that could lead to cuts in discretionary and mandatory spending for VA. While we ultimately believe that VA is exempted by law from any projected cuts in funding as a result of deficit reduction, the final decision on the impact on VA remains uncertain. *The Independent Budget* coauthors have serious concerns about the potential reductions in VA spending. While changes to benefits programs and cuts to discretionary programs have unique differences, the impact of these possibilities will be equally devastating for veterans and their families.

(Continued)

Additionally, as the Veterans Health Administration has adjusted to the implementation of advance appropriations, we must remain vigilant to ensure that VA is actually requesting and receiving the funding it requires to meet the health-care needs of millions of veterans. As has become the new norm, last year the enactment of advance appropriations shielded the VA health-care system from the political wrangling and legislative deadlock. Meanwhile, *The Independent Budget* veterans service organizations (IBVSOs) are concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on its health-care system. In fact, the FY 2012 and FY 2013 advance appropriation budget proposal released by the Administration last year included “management improvements,” a popular gimmick used by previous administrations to generate savings and offset the growing costs to deliver care. Unfortunately, these savings were often never realized, leaving VA short of necessary funding to address ever-growing demand on the health-care system. Yet we believe that continued pressure to reduce federal spending will only lead to greater reliance on gimmicks and false assumptions to generate funding.

Year after year, the IBVSOs conduct comparative analysis of VA workload information and carefully review medical and administrative cost data that form the foundation of *The Independent Budget’s* recommendations. The IBVSOs then call upon Congress and the Administration to provide sufficient funding to meet the health-care and financial benefit needs of veterans in a timely and predictable manner. This has proved to be a difficult, but welcome, challenge, particularly in light of recent economic conditions, as we seek to ensure that the needs of all veterans are properly met.

With regard to veterans’ benefits, the IBVSOs believe VA must fast-track real steps that will help ameliorate nagging claims-processing barriers. Continuing studies to find solutions must be replaced by real action plans that produce positive results. We are pleased to see that real progress is finally being achieved to bring the claims process into the 21st century. Through implementation of reforms such as the Veterans Benefits Management System, the Veterans Benefits Administration may finally be on a path to ensuring that veterans’ claims are decided in a timely fashion while also being decided correctly the first time. However, only time will tell if the myriad of reforms that the VBA is putting into place will have a significant and positive effect. Veterans and their families deserve prompt decisions regarding the benefits they have earned and deserve. These benefits are part of a covenant between our nation and the men and women who have defended it. Veterans have fulfilled their part of the covenant. Now VA must avoid further delay and move forward to meet its obligations in a timely manner.

The Independent Budget for Fiscal Year 2013 provides recommendations for consideration by our nation’s elected leadership that are based upon rigorous and rational methodology designed to support the Congressionally authorized programs that serve our nation’s veterans. The IBVSOs are proud that more than 60 veteran, military, medical service, and disability organizations have endorsed the FY 2013 edition of this document. Our primary purpose is to inform and encourage the United States government to provide the necessary resources to care for the men and women who have answered the call of our country and taken up arms to protect and defend our way of life.

Table 1. VA Accounts FY 2012 (Dollars in Thousands)				
	FY 2012 Appropriation	FY 2013 Administration**	FY 2013 IB***	FY 2014 Advance Approp.
Veterans Health Administration				
Medical Services	39,649,985	41,519,000	46,041,363	43,557,000
Medical Support and Compliance	5,535,000	5,746,000	5,596,496	6,033,000
Medical Facilities	5,426,000	5,441,000	5,572,742	4,872,000
Subtotal Medical Care, Discretionary	50,610,985	52,706,000	57,210,601	54,462,000
Medical Care Collections*	2,767,000	2,966,000		3,051,000
Total, Medical Care Budget Authority (including Collections)	53,377,985	55,672,000	57,210,601	57,513,000
Medical and Prosthetic Research	581,000	582,674	611,000	
Total, Veterans Health Administration	53,958,985	56,254,674	57,821,601	
General Operating Expenses				
Veterans Benefits Administration	2,018,764	2,164,074	2,110,140	
General Administration	416,737	416,737	430,104	
Total, General Operating Expenses	2,435,501	2,580,811	2,540,244	
Departmental Admin. and Misc. Programs				
Information Technology	3,111,376	3,327,444	3,194,592	
National Cemetery Administration	250,934	258,284	280,000	
Office of Inspector General	112,391	113,000	115,608	
Total, Dept. Admin. and Misc. Programs	3,474,701	3,698,728	3,590,200	
Construction Programs				
Construction, Major	589,604	532,470	2,693,700	
Construction, Minor	482,386	607,530	1,069,000	
Grants for State Extended Care Facilities	85,000	85,000	85,000	
Grants for Construct of State Vets cemeteries	46,000	46,000	51,000	
Total, Construction Programs	1,202,990	1,271,000	3,898,700	
Other Discretionary	156,176	159,000	159,612	
Total, Discretionary Budget Authority (including Medical Collections)	61,228,353	63,964,213	68,010,357	
*Medical care collections estimates reflect revisions made by the Administration to the original projections included in the FY 2012 Budget Request submitted in February 2011.				
**Amounts shown in FY 2013 Administration column reflect revised estimate for Medical Services. Recommendations for Medical Support and Compliance, and Medical Facilities accounts from the FY 2013 advance appropriation were unchanged in the newly released Budget Request.				
***The recommendations of The Independent Budget (IB) for FY 2013 reflect the expectation for a 0.5 percent pay raise for all VA employees just as the Administration indicated its intention to recommend a similar pay raise in January 2012.				

Benefit Programs

In addition to providing health care to millions of veterans, the Department of Veterans Affairs (VA) is the primary federal agency providing a variety of benefits to our nation's veterans. These include, but are not limited to, disability compensation, dependency and indemnity compensation, pensions, education benefits, home loans, ancillary benefits for service-connected disabled veterans, life insurance, and burial benefits.

Disability compensation payments are intended to provide relief for some of the economic and other losses veterans experience as a result of service-connected diseases and injuries. When service members die on active duty, or veterans' lives are cut short as a result of a service-connected cause or following a substantial period of total service-connected disability, eligible family members may receive dependency and indemnity compensation. Different from disability compensation, veterans' pensions provide some measure of financial support for disadvantaged veterans of wartime service who are totally disabled and unable to work as a result of nonservice-connected causes, or who have reached the age of 65; death pensions are paid to eligible survivors of these wartime veterans who have extremely low income.¹ Burial benefits assist families in meeting the costs of veterans' funerals and burials and provide for burial flags and headstones or grave markers. Other special allowances are provided for select groups of veterans and dependents (e.g., children of Vietnam veterans who suffer from spina bifida).

In recognition of the disadvantages that veterans endure from the interruption of their civilian lives to perform military service, Congress authorized certain benefits to aid veterans in their readjustment to civilian life. These readjustment benefits provide financial assistance to veterans who choose to participate in education or vocational rehabilitation programs and to seriously disabled veterans for acquiring specially adapted housing and automobiles. Educational benefits are also available for children and spouses of veterans who are permanently and totally disabled or die as a result of a service-connected disability.

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

Under several different plans, VA offers limited life insurance to eligible disabled veterans. Mortgage life insurance protects the families of veterans who have received specially adapted housing grants.

(Continued)

¹ Improved Death Pension Rate Table. <http://www.vba.va.gov/bln/21/Rates/pen02.htm>.

These programs have been adopted by Congress, as representatives of a grateful nation, to recognize the sacrifices of those who served our nation in both peace and war. The veterans service organizations comprising *The Independent Budget* have worked tirelessly to ensure that veterans and their families are not forgotten once the last soldier, sailor, airman, or marine returns home or is laid to rest in a distant land.

This is why *The Independent Budget* veterans service organizations (IBVSOs) work with Congress and the Administration to ensure that these carefully crafted benefit programs provide for the needs of our nation's veterans. We have identified areas in which adjustments are needed so that the programs better serve veterans or meet changing circumstances.

Unfortunately, the government's continued inaction to regularly adjust benefit rates or to tie them to realistic annual cost-of-living adjustments threatens the effectiveness of other veterans' benefits. Annual COLAs do not take into account the rising cost of necessities, such as food and energy, thereby increasing disabled veterans' inability to meet basic needs.

Veterans' programs must remain a national priority, being viewed in context of the service of the men and women who have sacrificed so much for this great nation. In addition to maintaining and protecting existing veterans' programs, Congress must ensure that these programs are modified and improved as necessary. In order to maintain or increase their effectiveness, the IBVSOs offer a series of recommendations in this section of *The Independent Budget*.

COMPENSATION FOR QUALITY OF LIFE AND NONECONOMIC LOSS:

In conjunction with the ongoing update and revision of the Rating Schedule, the Department of Veterans Affairs should develop and implement a system to compensate service-connected disabled veterans for loss of quality of life and noneconomic loss.

The Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation published a report, “A 21st Century System for Evaluating Veterans for Disability Benefits,” in 2007 recommending that the current VA disability compensation system be expanded to include compensation for nonwork disability (also referred to as “noneconomic loss”) and loss of quality of life.² The report touched upon several systems that could be used to measure and compensate for loss of quality of life, including the World Health Organization–devised International Classification of Functioning, Disability, and Health; the Canadian Veterans’ Affairs disability compensation program; and the Australian Department of Veterans’ Affairs disability compensation program.³

The IOM distinguished between the purpose of disability benefits and the operational basis for those benefits.⁴ The report grouped the operational measures used for compensating disabilities into seven categories and subcategories:

IA. Medical impairment: anatomical loss refers to impairment ratings that are based on anatomical loss, such as amputation of the leg.

IB. Medical impairment: functional loss refers to impairment ratings that are based on the extent of functional loss, such as loss of motion of the wrist.

II. Limitations in the activities of daily living refers to limitations on the ability to engage in the activities of daily living, such as bending, kneeling, or stooping, resulting from the impairment, and to participate in usual life activities, such as socializing and maintaining family relationships.

IIIA. Work disability: loss of earning capacity refers to the presumed loss of earning capacity resulting from the impairment and limitations in the activities of daily living.

IIIB. Work disability: actual loss of earnings refers to the actual loss of earnings resulting from the impairment and limitations in the activities of daily living.

IV. Nonwork disability refers to limitations on the ability to engage in usual life activities other than work. This includes ability to engage in activities of daily living, such as bending, kneeling, or stooping, resulting from the impairment, and to participate in usual life activities, such as reading, learning, socializing, engaging in recreation, and maintaining family relationships.

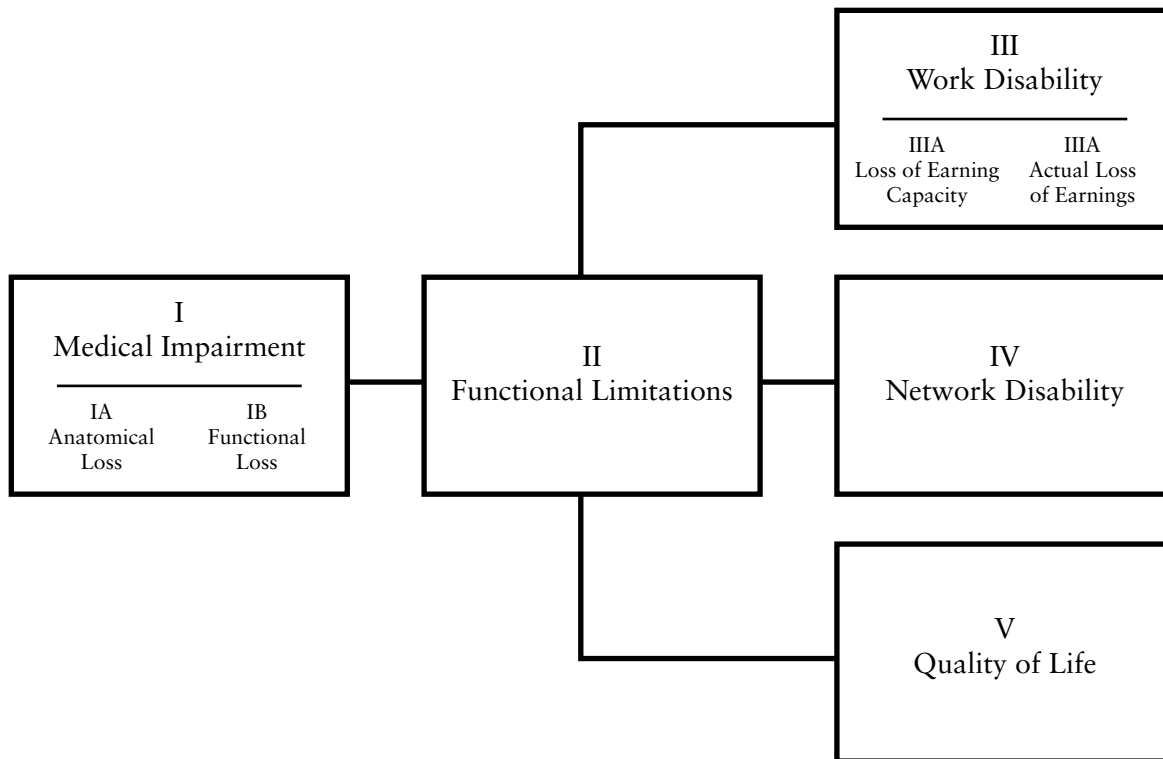
V. Loss of quality of life refers to the loss of physical, psychological, social, and economic well-being in one’s life.⁵

The report organized these categories into the relationship shown in figure 1.

Under the current VA disability compensation system, the purpose of the compensation is to make up for average loss of earning capacity (IIIA), whereas the operational basis of the compensation is usually based on medical impairment (IA and IB).⁶ Neither of these models generally incorporates noneconomic loss or quality of life into the final disability ratings, though special monthly compensation does in some limited cases. The IOM report stated:

In practice, Congress and VA have implicitly recognized consequences in addition to work disability of impairments suffered by veterans in the Rating Schedule and other ways. Modern concepts of disability include work disability, nonwork disability, and quality of life (QOL)...” [and that] “This is an unduly restrictive rationale for the program and is inconsistent with current models of disability.”⁷

Graph 1. IOM Disability Model



The Congressionally mandated Veterans Disability Benefits Commission (VDBC), established by the “National Defense Authorization Act of 2004” (P.L. 108–136), spent more than two years examining how the Rating Schedule might be modernized and updated. Reflecting the recommendations of a comprehensive study of the disability rating system by the IOM, the VDBC in its final report issued in 2007 recommended:

The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss of quality of life.⁸

The IOM report, the VDBC (and an associated Center for Naval Analysis study), and the Dole-Shalala Commission (President’s Commission on Care for America’s Returning Wounded Warriors) all agreed that the current benefits system should be reformed to include noneconomic loss and quality of life as factors in compensation.

Recommendations:

Congress should amend Title 38, United States Code, to clarify that disability compensation, in addition to providing compensation to service-connected disabled veterans for their average loss of earnings capacity, must also include compensation for their noneconomic loss and for loss of their quality of life.

Congress and VA should determine the most practical and equitable manner in which to provide compensation for noneconomic loss and loss of quality of life and move expeditiously to implement this updated disability compensation program.

² Committee on Medical Evaluation of Veterans for Disability Compensation, Institute of Medicine of the National Academies, “A 21st Century System for Evaluating Veterans for Disability Benefits (2007).”

³ *Ibid.*, 78–81.

⁴ *Ibid.*, 116.

⁵ *Ibid.*, 116–17 (emphasis in original).

⁶ *Ibid.*, 117, fig.4–1.

⁷ *Ibid.*, 117–18.

⁸ Veterans’ Disability Benefits Commission, “Honoring The Call To Duty: Veterans’ Disability Benefits in the 21st Century (2007),” 3.

UPDATING AND REVISING THE RATING SCHEDULE:

As the Veterans Benefits Administration continues working to update and revise the VA Schedule for Rating Disabilities, it should continue to seek broad input and must ensure that the proposed rules follow both the letter and spirit of the law establishing disability compensation.

The amount of disability compensation paid to a service-connected disabled veteran is determined according to the *VA Schedule for Rating Disabilities* (VASRD), which is divided into 15 body systems with more than 700 diagnostic codes found in 38 C.F.R. Part 4. In 2007, both the Congressionally mandated Veterans Disability Benefits Commission (VDBC), established by the “National Defense Authorization Act of 2004” (P.L. 108–136), as well as the IOM Committee on Medical Evaluation of Veterans for Disability Compensation in its report “A 21st Century System for Evaluating Veterans for Disability Benefits,” recommended that VA regularly update the VASRD to reflect the most up-to-date understanding of disabilities and how disabilities affect veterans’ earnings capacity.

In line with these recommendations, the Veterans Benefits Administration (VBA) is currently engaged in the process of updating all 15 of the body systems. Additionally, it has committed to review and update the entire VASRD every five years.

To help implement the recommendations of the VDBC, Congress established the Advisory Committee on Disability Compensation (ACDC) in P.L. 110–389 to advise the Secretary on “...the effectiveness of the schedule for rating disabilities...and...provide ongoing advice on the most appropriate means of responding to the needs of veterans relating to disability compensation in the future.” In its 2009 “Interim Report” and its first “Biennial Report” dated July 27, 2010, the Advisory Committee recommended that the VBA follow a coordinated and inclusive process while reviewing and updating the *Schedule for Rating Disabilities*. Specifically, the ACDC recommended that veterans service organization (VSO) stakeholders be consulted several times throughout the review and revision process, both before and after any proposed rule is published for public comment.

While the VBA has held a number of public forums and made some other good faith efforts to include greater VSO participation, the process itself does not allow input during the crucial decision-making

period. Because these public forums were conducted at the very beginning of the Rating Schedule review process, VSOs were not able to provide informed comment because the VBA had not yet undertaken review or research activities. Consequently, VSO and other stakeholder involvement ended before the actual revision process began. As a result, while the public forums may be part of the official record, it is unclear whether any of the working group members actually heard that input. As the ACDC noted, it would have been helpful to include the experience and expertise of VSOs during its deliberations on revising the VASRD.

In particular, *The Independent Budget* veterans service organizations (IBVSOs) are concerned about potential changes to the mental disorders rating table that have been discussed and may be proposed to create an entirely new methodology for rating mental health disorders, such as post-traumatic stress disorder. By statute, the rating schedule is based on “average impairments of earning capacity”, not actual earnings loss, a very different concept. While 38 CFR 4.10 addresses “functional impairment,” it does so in the context of “function under the ordinary conditions of daily life including employment,” which therefore includes non-employment functional impairment. Their proposal would only measure work impairment.

This proposal was written subsequent to the 2010 forum; no VSOs or other stakeholders participated in its development. More recently, the VBA has refused to disclose the new methodology prior to publication as a proposed regulation. These developments run counter to the Administration’s standing Executive Order on transparency in government. In part, the Executive Order provides a gateway to “ensure the public trust and establish a system of transparency, public participation, and collaboration.” We believe, especially in this sensitive area of mental health disability, that openness strengthens the process and includes a wide range of expertise that is available across different sectors of society.

Whether dramatic changes will in fact be proposed for the mental disorders or other sections of the VASRD remains to be seen, but the IBVSOs strongly believe that our collective experience assisting veterans who suffer from such disabilities in filing claims could have been useful as the VBA was seeking to develop new draft rules for changing the VASRD.

While the VBA has the regulatory authority to update and revise the VASRD, considering the limited transparency of the process, Congress should closely examine any changes being proposed. Most important, Congress must ensure that revisions adhere strictly to the law, which requires that the levels of disability compensation are based on the principle of the “average loss of earnings capacity.”

In addition, because the VBA is committed to a continuing review and revision of the Rating Schedule, it would also be beneficial to conduct reviews of the revision process so that future body system Rating

Schedule updates can benefit from lessons learned during prior updates.

Recommendations:

The Veterans Benefits Administration (VBA) should involve veterans service organizations throughout the process of reviewing and revising each body system in the Rating Schedule, not only at the beginning and end of its deliberative process.

Congress should carefully review any proposed rules that would change the *VA Schedule for Rating Disabilities*, particularly if such rules would change the basic nature of veterans disability compensation.

The VBA should conduct regular after-action reviews of the Rating Schedule update process, with veterans service organization participation so that it may apply “lessons learned” to future body system updates.



ANNUAL COST-OF-LIVING ADJUSTMENT:

Congress should provide a cost-of-living adjustment for compensation and dependency and indemnity compensation benefits in a manner which fully replaces the erosion of value due to inflation.

Congress has authorized the adjustment of compensation and dependency and indemnity compensation (DIC) by the same percent as Social Security is increased. Increases in Social Security are based on the Consumer Price Index (CPI). Due to the lack of increase in the CPI in recent years, veterans with service-connected disabilities and survivors of those who died from service-connected causes have not received an increase in compensation or DIC since December 1, 2008.

Disability compensation is paid to the men and women who returned home from military service with the residuals of disease or injury incurred coincident with their service. Compensation was designed to replace the earnings capacity lost because of service-connected disabilities.

Dependency and indemnity compensation is paid to the surviving spouse and minor or school age children of a service member who died on active duty or a veteran who died from a service-connected disability.

Inflation erodes the value of these benefits. Under current law, the government monitors inflation throughout the year and, if inflation occurred, increases compensation and DIC by the same percentage as Social Security is raised for the following year. This procedure makes beneficiaries whole for the new year but does not reimburse them for the lost value of their benefits for the year in which inflation occurred.

To fully compensate veterans and their survivors for the loss of value because of inflation, benefits would have to be adjusted retroactively.

Veterans' and Survivors' Benefits Payment Rounded Down

In 1990, Congress, in an omnibus reconciliation act, mandated that veterans' and survivors' benefit payments be rounded down to the next lower whole dollar. While this policy was initially limited to a few years, Congress eventually made it permanent.

Rounding down veterans' and survivors' benefit payments to the next lower whole dollar reduces the payments by up to \$12 per year. Each year's COLA is calculated on the rounded down amount of the previous year's payments. While not significant in the short run, the cumulative effect over time results in a significant loss to beneficiaries.

For example, a veteran totally disabled from service-connected disabilities would have received \$809 per month in 1994. Today that benefit is worth \$2,673 per month. However, had that veteran received the full COLA each year as shown in the CPI, that benefit would now be \$2,710.⁹ A reduction of \$37 per month means that the veteran receives \$444 less each year.

The cumulative effect of this provision of the law effectively levies a tax on totally disabled veterans, costing them hundreds of dollars per year.

Recommendations:

Congress should make cost-of-living adjustments retroactive to the beginning of the year in which the inflation occurred. This change would ensure that veterans and survivors receive the full value of the benefit provided them to offset the loss of earnings capacity due to service-connected disabilities for veterans or the loss of a spouse or parent due to death caused in or by military service.

Congress should repeal the current policy of rounding down veterans' and survivors' benefits payments.

⁹ This amount was calculated using the Bureau of Labor Statistics CPI calculator found at http://www.bls.gov/data/inflation_calculator.htm.



STANDARD FOR SERVICE CONNECTION:

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

Disability compensation is the basic entitlement for a veteran that exists if the veteran is disabled as the result of a personal injury or disease (including aggravation of a condition existing prior to service) while in active service if the injury or the disease was incurred or aggravated in line of duty.¹⁰

Periodically a committee, commission, government agency, or Member of Congress suggests or proposes that military service should be treated as if it were a day job: if a service member happens to get sick or injured while working a shift, he or she may be eligible, after discharge, for medical treatment and, perhaps, compensation from the Department of Veterans Affairs. Conversely, if a service member is injured before or after work, or becomes ill from a disease that isn't obviously related to military service, he or she would not be eligible for service connection at all. Further, medical care would be the responsibility of the veteran alone.

The military does not distinguish between "on duty" and "off duty." A service member on active duty is always at the disposal of military authority and is, to all intents, on call 24 hours a day, 365 days a year. A soldier, on leave, can be playing with her children in the morning and be ordered back to base, to be deployed, that same afternoon. A ship returning from a six-month tour in the Persian Gulf can be turned around in mid-ocean to undertake a new mission that will keep its crew away from home for weeks or months. The ground crews that prepared planes used to attack targets in Iraq, Afghanistan, and Libya worked not just from 9 to 5, but anytime they were needed, day or night. No one asks them if they can work overtime; they are ordered to report and work as long as required to get the job done. Unlike a day job, they cannot quit. Servicemen and -women are there when needed, every day. And far too often they are put at risk of injury, disease, or death in defense of all Americans.

Congress created the Veterans' Disability Benefits Commission to carry out a study of "the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service...." After more than 30 months of hearings, study, analysis, and debate, the commission unanimously endorsed the current standard for determining service connection.¹¹

Current law requires only that an injury or disease be incurred coincident with active military service. There is no requirement that a veteran prove a causal connection between military service and a disability for which service connection is sought.

The Independent Budget veterans service organizations believe current standards defining service connection for veterans' disabilities and deaths are practical, sound, equitable, and time-tested. We urge Congress to reject any revision to this long-standing policy.

Recommendation:

Congress should reject suggestions from any source that would change the terms of service connection for veterans' disabilities and death.

¹⁰ Title 38 C.F.R. 2.4(b)(1).

¹¹ Veterans' Disability Benefits Commission, "Honoring the Call to Duty: Veterans Benefits in the 21st Century," (October, 2007), p. 98, section 1.2.B.



STANDARD FOR DETERMINING COMBAT-VETERAN STATUS:

Evidentiary standards for establishing a disability should be relaxed if the event causing disability occurs while serving in an active combat zone.

One need only watch the evening news to recognize that a combat zone is often a uniquely hazardous place to serve. Seemingly minor injuries are often overlooked while medical treatment is focused on those more seriously injured. Further, many combat service members tend to trivialize their own injuries when in the presence of more severely injured comrades. The result is that many injuries occurring in combat zones go unreported and unrecorded.

In recent years *The Independent Budget* veterans service organizations (IBVSOs) have asked Congress to expand the provisions of 38 U.S.C. 1154 to any veteran who served in a combat zone in order to both ease the evidentiary burden on veterans and reduce time-consuming development required of the Department of Veterans Affairs so that veterans could more readily obtain service connection for certain disabilities related to service, especially post-traumatic stress disorder (PTSD).

In 2010 VA validated this recommendation when it amended 38 C.F.R. 3.304 to eliminate—

...the requirement for corroborating that the claimed in-service stressor occurred if a stressor claimed by a veteran is related to the veteran's fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of PTSD and that the veteran's symptoms are related to the claimed stressor, provided that the claimed stressor is consistent with the places, types, and circumstances of the veteran's service.¹²

This change effectively removed the single largest barrier to the proper and timely adjudication of claims involving PTSD incurred while in combat.

Unfortunately, this regulation is not without a major flaw. VA requires that the claimed stressor can only be confirmed by either a "VA psychiatrist or psychologist, or a psychologist with whom VA has contracted." While the IBVSOs recognize that VA mental health professionals have, by necessity, developed an expertise in treating veterans with PTSD, the requirement

that only they have the capability to confirm that a veteran suffers from PTSD and that the stressor is related to military service is both wrong and wasteful of scarce mental health resources.

An additional anomaly is this: the regulation states that a psychiatrist contracted to perform compensation examinations is able to diagnose PTSD and confirm the relationship of the stressor to service. However, the Veterans Benefits Administration would apparently not accept a diagnosis and confirmation if that same psychiatrist contractor diagnoses and treats a veteran in his or her private practice. This does not pass the test of common sense.

Finally, refusing to accept a diagnosis and confirmation from a private psychiatrist or psychologist is wasteful of scarce government resources. The savings to VA would be substantial if the acceptance

of information from private health-care professionals allowed VA to avoid scheduling unnecessary examinations.

Recommendations:

VA should amend 38 C.F.R. 3.304 to allow veterans to submit, and VA to accept, the diagnosis of post-traumatic stress disorder (PTSD) by a qualified private clinician along with confirmation that the stressor is directly related to PTSD and military service.

In the alternative, Congress should mandate a study by VA to determine how often VA examiners have confirmed a diagnosis of PTSD and confirmation of an in-service stressor in cases where veterans previously submitted private medical evidence that contained a diagnosis of PTSD and confirmation of an in-service stressor.

¹² *Federal Register* 75, no. 133 (July 13, 2010), 39843.



CONCURRENT RECEIPT OF COMPENSATION AND MILITARY LONGEVITY RETIRED PAY:

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

Many veterans retired from the armed forces based on longevity of service must forfeit a portion of their retired pay, earned through faithful performance of military service, before they receive VA compensation for service-connected disabilities. This is inequitable—military retired pay is earned by virtue of a veteran’s career of service on behalf of the nation, careers of usually more than 20 years.

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

same full earning potential. Their earning potential is reduced commensurate with the degree of service-connected disability.

In order to place all disabled longevity military retirees on equal footing with nondisabled military retirees, there should be no offset between full military retired pay and VA disability compensation. To the extent that military retired pay and VA disability compensation offset each other, the disabled military retiree is treated less fairly than is a nondisabled military retiree by not accounting for the loss in earning capacity. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing a service obligation can receive full VA disability compensation and full civilian retired pay—including retirement from any federal civil service position. A veteran

who honorably served and retired after 20 or more years who suffers from service-connected disabilities should not be penalized for becoming disabled in service to America.

A longevity-retired disabled veteran should not suffer a financial penalty for choosing a military career over a civilian career, especially when, in all likelihood, a civilian career would have involved fewer sacrifices and quite likely greater monetary rewards. Disability compensation to a disabled veteran should not be offset against military longevity retired pay. While Congress has made progress in recent years in correcting this injustice, current law still provides that service-connected veterans rated less than 50 percent

who retire from the armed forces on length of service may not receive disability compensation from VA in addition to full military retired pay. *The Independent Budget* veterans service organizations believe the time has come to finally remove this prohibition completely.

Recommendation:

Congress should enact legislation to repeal the inequitable requirement that veterans' military longevity retired pay be offset by an amount equal to their disability compensation if rated less than 50 percent.



MENTAL HEALTH RATING CRITERIA:

Compensation for service-connected mental disorders should be adjusted to accurately reflect the effects those disabilities have on earnings capacity as required by law.

Federal law requires that compensation be set, as nearly as is practicable, at such a level as to offset the average impairment to earnings capacity caused by a service-connect disability.¹³

Studies published in 2007¹⁴ and 2008¹⁵ found that veterans with service-connected psychiatric conditions suffered, on average, substantially greater earnings loss at all levels than was reflected by the evaluation assigned by the Department of Veterans Affairs.

Since 2010, VA has been rewriting the section of the *Schedule for Rating Disabilities* that deals with mental disorders. VA must ensure that veterans with psychiatric problems related to service are equitably and appropriately evaluated and compensated.

To ensure that the revisions accurately reflect the intent of the law and substantially address the disparities found by the cited studies, *The Independent Budget* veterans service organizations strongly

recommend that VA conduct extensive testing of the revised criteria against cases rated under the existing criteria prior to publication of a proposed revision. The test should include both the new rating criteria and revised disability examination protocols. It is only through such testing, the results of which can be used to support the proposed revisions, that veterans can be assured that the new criteria correct past inequities.

Recommendation:

VA's revision of the Mental Disorders section of the *Schedule for Rating Disabilities* must accurately reflect the severe impact that psychiatric disabilities have on veterans' average earning capacity.

¹³ 38 U.S.C. 1155.

¹⁴ The CNA Corporation, Final Report for the Veterans Disability Benefits Commission: Compensation Survey Results and Selected Topics (2007), pp. 4, 16, 194.

¹⁵ EconSys., A Study of Compensation Payments for Service-Connected Disabilities, Vol III (2008), pp. 162-69, 180.

MORE EQUITABLE RULES FOR SERVICE CONNECTION OF HEARING LOSS AND TINNITUS:

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

Many veterans exposed to acoustic trauma during service now suffer from hearing loss and/or tinnitus. Too often, they are unable to *prove* that their hearing problems began in or were caused by military service, often because of inadequate in-service testing procedures, lax examination practices, or poor recordkeeping. The presumption requested herein would resolve this long-standing injustice.

The Institute of Medicine (IOM) issued a report in September 2005 titled “Noise and Military Service: Implications for Hearing Loss and Tinnitus.” The IOM found that patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel. Because noise exposure is endemic to military service, the total number of veterans who experience noise-induced hearing loss as a result of military service may be substantial.

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

Further, certain noncombat jobs are known to involve work around extremely loud machinery. Prolonged exposure to noise from tanks, trucks and engines, and other machinery on ships, for instance, can cause hearing loss and/or tinnitus.

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

Recommendation:

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

COMPENSABLE DISABILITY RATING FOR HEARING LOSS NECESSITATING A HEARING AID:

The VA Schedule for Rating Disabilities should provide a minimum 10 percent disability rating for hearing loss that requires use of a hearing aid.

The VA *Schedule for Rating Disabilities* contained in 38 C.F.R., Part IV does not provide a compensable rating for hearing loss at certain levels severe enough to require the use of hearing aids. The minimum disability rating for any hearing loss severe enough to require use of a hearing aid should be 10 percent, and the schedule should be amended accordingly.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment and the disadvantages of artificial hearing restoration, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device.

For example, a veteran receives full compensation for amputation of a lower extremity although he or she may be able to ambulate with a prosthetic limb. Additionally, a review of 38 C.F.R., Part 4 *Schedule for Rating Disabilities*, shows that all disabilities, whose treatment warrants an appliance, device, implant, or prosthetic, other than hearing loss with hearing aids, receives a compensable rating.

Assigning a compensable rating for medically directed hearing aids would be consistent with minimum ratings provided throughout the Rating Schedule. Such a change would be equitable and fair.

Recommendation:

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



TEMPORARY TOTAL COMPENSATION AWARDS:

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

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

The effective date of temporary total disability ratings corresponds to the beginning date of hospitalization or treatment. Title 38, United States Code, section 5111(c)(2) provides that, in cases where the hospitalization or treatment commences and terminates within the same calendar month, the increase shall commence on the first day of that month. However, in cases where the hospitalization or treatment commences in one month and terminates in a subsequent month, section 5111 delays the effective date for payment purposes until the first day of the month following the effective date of the increased rating. In many cases this delay in payment causes undue financial hardship on veterans and their families. Disabled veterans, particularly those who are unable to work as

a result of hospitalization or period of convalescence, rely heavily on this temporary total compensation to replace the income lost during the period of hospitalization or convalescence. Veterans with a period of hospitalization or convalescence beginning in one month and ending in a different month are left with their temporary total disability compensation being unnecessarily delayed by at least one month. This practice is unfair in comparison to veterans whose hospitalization or convalescence begins and ends within the same month.

Recommendation:

Congress should amend Title 38, United States Code, section 5111 to authorize increased disability compensation based on a temporary total rating for hospitalization or convalescence that commences in one calendar month and continues beyond that month to be effective, for payment purposes, on the date of admission to the hospital or on the date of treatment, surgery, or other circumstances necessitating convalescence.



AGENT ORANGE IN KOREA:

Extend the presumptive service-connection end-date for Korea veterans who served on the Korean demilitarized zone.

The delineating dates for presumptive service connection due to exposure to herbicides (Agent Orange) in Korea should be established in the same manner as they are for Vietnam veterans. If a veteran served on the Korean demilitarized zone (DMZ) north of the Imjin River at any time after Agent Orange was applied, then presumptive service connection should be granted for the conditions contained in 38 C.F.R. section 3.309(e).

Currently, the Department of Veterans Affairs recognizes that certain military personnel who were assigned to units operating in or near the DMZ in Korea from April 1968 to August 1971 are presumed to have been exposed to herbicides.¹⁶ Veterans with qualifying service in Korea may be granted service connection on a presumptive basis if they suffer from one or more of the disabilities enumerated in 38 C.F.R. 3.309(e).

The ending date of August 1971 was established by P.L. 108-183 and is found in 38 U.S.C. 1821. While *The Independent Budget* veterans service organizations applaud the action of Congress and VA to extend the ending date for this presumption of exposure from 1969 to 1971, we do not believe that it is sufficient to recognize the length of time that dioxin remains in the soil and potentially harmful to U.S. military personnel.

The Environmental Protection Agency reports that “the persistence half-life of TCDD [tetrachlorodibenzodioxin] on soil surfaces may vary from less than 1 year to 3 years, but half-lives in soil interiors may be as long as 12 years. Screening studies have shown that TCDD is generally resistant to biodegradation.”¹⁷

Research has shown that the dioxin in Agent Orange has a half-life of one to three years in surface soil, and *up to 12 years in interior soil*. “The toxicity of dioxin is such that it is capable of killing newborn mammals and fish at levels as small as 5 parts per trillion (or one ounce in 6 million tons). Its toxic properties are enhanced by the fact that it can enter the body through the skin, the lungs, or through the mouth.”¹⁸ The dioxin on the Korean DMZ did not lose its efficacy on August 1, 1969, but continued to be absorbed into the bodies of the troops who were operating north of the Imjin River, and wreaks havoc on those veterans today just as it does to Vietnam veterans.

Recommendation:

Congress should change the dates of eligibility for Korea veterans who served in the Korean demilitarized zone at any time starting from April 1968.

¹⁶ Title 38 C.F.R., section 3.307(a)(6)(iv).

¹⁷ Technical Factsheet on DIOXIN 3,7,8-TCDD (2,3,7,8-TCDD). <http://www.epa.gov/ogwdw/pdfs/factsheets/soc/tech/dioxin.pdf>, p. 2.

¹⁸ <http://www.vn-agentorange.org/newsletters.html>.

PENSION FOR NONSERVICE-CONNECTED DISABILITY:

Congress should extend basic eligibility for nonservice-connected pension benefits to veterans who served in combat environments, regardless of whether a period of war was defined.

Pension is payable to a veteran who is 65 years of age or older or who is permanently and totally disabled as a result of nonservice-connected disabilities, and who has at least one day's service during a period of war and has a low income.¹⁹

Although Congress has the sole authority to make declarations of war, the President, as Commander in Chief, may send servicemen and -women into hostile situations at any time to defend American interests. While some of these incidents occur during periods of war (e.g., Somalia, '92-'95) many other military actions take place during periods of "peace" (e.g., Granada, '83; Lebanon, '82-'87; Panama, '89). Even the Mayaguez Incident, May 12-15, 1975, falls outside the official dates of the Vietnam War, which ended May 7, 1975.

It is quite apparent that the sole service criteria for eligibility to pension, at least one day of service during a period of war, too narrowly defines military activity in the last century. Expeditionary medals, combat badges, and the like can better serve the purpose of defining combat or warlike conditions when Congress fails to declare war and when the President

neglects to proclaim a period of war for veterans' benefits purposes.

Congress should change the law to allow that the receipt of hostile fire pay, an expeditionary medal, campaign medal, combat action ribbon, or similar military decoration will qualify an individual for pension benefits. This action would ensure that veterans who served during periods of peace but who were placed in hostile situations are eligible for nonservice-connected pension.

Recommendation:

Congress should change the law to authorize eligibility to nonservice-connected pension for veterans who have been awarded the Armed Forces Expeditionary Medal, Purple Heart, Combat Infantryman's Badge, or similar medal or badge for participation in military operations that fall outside officially designated periods of war.

¹⁹ The requirements for pension, along with applicable definitions, are found throughout Title 38 United States Code (e.g., sections 101 (15, 1521, 1501)).

INCREASE OF DEPENDENCY AND INDEMNITY COMPENSATION FOR SURVIVING SPOUSES OF SERVICE MEMBERS:

The current rate of compensation paid to the survivors of deceased service members is inadequate and inequitable.

Under current law the surviving spouse of a veteran who had a total disability rating and died after at least an eight-year period following such rating is entitled to the basic rate of dependency and indemnity compensation. The same spouse will also receive additional payments based on the veteran's eight-year period of total disability prior to death. However, surviving spouses of military service members who die on active duty receive only the basic rate of dependency and indemnity compensation.

Insofar as dependency and indemnity compensation payments were intended to provide surviving spouses with the means to maintain some semblance of economic stability after losing their loved one, the rate

of payment for in-service deaths and certain service-related deaths occurring after service should not differ. Surviving spouses, regardless of the status of their sponsors at the time of death, face the same financial hardships once the deceased sponsor's income no longer exists.

Recommendation:

Congress should authorize dependency and indemnity compensation eligibility at increased rates to survivors of service members who died on active duty at the same rate paid to the eligible survivors of totally disabled service-connected veterans.



REPEAL OF OFFSET AGAINST THE SURVIVOR BENEFIT PLAN:

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

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

Career members of the armed forces earn entitlement to retired pay after 20 or more years of service. Survivors of military retirees have no entitlement to any portion of the veteran's military retirement pay

after his or her death, unlike many retirement plans in the private sector. Under the Survivor Benefit Plan (SBP), deductions are made from the veteran's military retirement pay to purchase a survivor's annuity. This is not a gratuitous benefit.

Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died from other than service-connected causes or was not totally disabled by service-connected disability for the required time preceding death, beneficiaries receive full SBP payments. However, if the veteran's death was a result of military service or after the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. When the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose all entitlement to the SBP annuity.

The Independent Budget veterans service organizations believe this offset is inequitable because no duplication of benefits is involved. Payments under the SBP and DIC programs are made for different purposes. Under the SBP, coverage is purchased by a veteran and at the time of death, paid to his or her surviving beneficiary. On the other hand, DIC is a special indemnity compensation paid to the survivor of a service member who dies while serving in the military, or a veteran who dies from service-connected disabilities. In such cases DIC should be added to the SBP, not substituted for it. Surviving spouses of federal civilian retirees who are veterans are eligible for DIC without losing any of their pur-

chased federal civilian survivor benefits. The offset penalizes survivors of military retirees whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay.

Recommendation:

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



RETENTION OF REMARRIED SURVIVORS' BENEFITS AT AGE 55:

Congress should lower the age required for remarried survivors of veterans who have died from service-connected disabilities to be eligible for restoration of dependency and indemnity compensation to conform with the requirements of other federal programs.

Current law permits the Department of Veterans Affairs to reinstate dependency and indemnity compensation (DIC) benefits to remarried survivors of veterans if the remarriage occurs at age 57 or older, or if survivors who have already remarried apply for reinstatement of DIC at age 57. Although *The Independent Budget* veterans service organizations appreciate the action Congress took to allow restoration of this rightful benefit, the current age threshold of 57 years is arbitrary. Remarried survivors of retirees of the Civil Service Retirement System, for example, obtain a similar benefit at age 55.²⁰ *The Independent Budget* veterans service organizations believe the survivors of veterans who died from

service-connected disabilities should not be further penalized for remarriage. Equity with beneficiaries of other federal programs should govern Congressional action for this deserving group.

Recommendation:

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

²⁰ <http://www.opm.gov/forms/pdfimage/RI83-5.pdf>.

SUPPLEMENTAL GRANT FOR ADAPTATION OF A NEW HOME:
Grants should be established for special adaptations to homes that veterans purchase to replace initial specially adapted homes.

Adapted housing grants for eligible service-connected disabled veterans literally open doors to independence for these men and women. Prevailing societal and structural barriers to access outside the home become easier to confront once the limitations brought on by a veteran's disability are mitigated by living circumstances that promote confidence and freedom of movement. The Department of Veterans Affairs adapted housing grants currently given to eligible veterans are provided on a once-in-a-lifetime basis. However, homeowners sell their homes for any number of reasons, both foreseeable and unforeseeable (increase or decrease in the size of families, relocation for career or health reasons, etc.). Once the housing grant is exhausted, veterans with service-incurred disabilities who own specially adapted homes must bear the full economic cost of continued

accessible living should they move and modify a new home. Those same veterans should not be forced to choose between surrendering their independence by moving into an inaccessible home or staying in a home simply because they cannot afford the cost of modifying a new home that would both mitigate their service-incurred disability and better suit their life circumstances.

Recommendation:

Congress should establish a supplementary housing grant that covers the cost of new home adaptations for eligible veterans who have used their initial, once-in-a-lifetime grant on specially adapted homes they no longer own and occupy.



STAND-ALONE GRANTS WITH COST-OF-LIVING INCREASES FOR ADAPTATION OF HOMES FOR VETERANS TEMPORARILY LIVING IN FAMILY-OWNED RESIDENCES:

A separate grant should be provided for special adaptations to homes owned by family members in which veterans temporarily reside.

In addition to entitlement to a specially adapted housing or special housing adaptation grant, veterans with certain service-connected disabilities are afforded the temporary residence allowance grant to make structural modifications in homes owned by family members. Specifically, VA provides varying rates of financial assistance for home adaptations to veterans with service-incurred mobility impairment, loss of visual acuity, and complete loss or loss of use of both hands. The grant must be used by eligible veterans within the period of eligibility.

A 2009 Government Accountability Office report revealed that only nine veterans took advantage of the grant that year. Several reasons were cited for this low usage, chief among them being the temporary residence allowance grant's effect on the overall amount of a veteran's entitlement to specially adapted housing/special housing adaptation. Consequently,

veterans who were forced to choose between achieving mobility independence at a temporary residence versus preserving more funding for modifying a future residence ultimately chose to defer independence until they had moved into their own homes.

Recommendations:

Congress should make the temporary residence allowance grant permanent with no finite eligibility period date and automatic adjustments to keep pace with inflation.

Congress should direct VA to administer the temporary residence allowance grant as a stand-alone program, separate and apart from the specially adapted housing/special housing adaptation grants.

SUPPLEMENTAL ENTITLEMENT TO AUTO GRANT FOR ELIGIBLE VETERANS:

The cost of replacing modified vehicles purchased through the VA auto grant presents a financial hardship for veterans who must bear the full replacement cost once the adapted vehicle has passed its life expectancy.

The Department of Veterans Affairs provides financial assistance, in the form of a grant, to eligible veterans toward the purchase of a new or used automobile to accommodate a service-disabled veteran or service member with certain disabilities that resulted from a disabling condition incurred during active military service. On October 1, 2011, VA increased this one-time auto grant from \$11,000 to \$18,900, thus giving service-disabled veterans who need a modified vehicle increased purchasing power. While *The Independent Budget* veterans service organizations recognize the benefit to those veterans who have not yet used the grant, those who previously exhausted the grant at much lower rates are left to replace modified vehicles at their own expense, with cost-of-living increase factored in, once those vehicles have surpassed their life expectancy.

VA acknowledged the impact that higher cost of living had on the intrinsic value of another critical ancillary entitlement. P.L. 109–233 authorized eligible veterans to utilize the specially adapted housing (SAH) grant up to three times or until the total available grant amount was exhausted. Additionally, P.L. 110–289 provided for annual increases in the maximum grant amount, to keep pace with the residential cost-of-construction index. When the maximum grant amount was increased, eligible veterans or service members were provided the opportunity to use additional allowance above the original SAH

grant entitlement that they had used. This means a veteran who previously used the grant in the amount of \$50,000 is entitled to an additional \$13,780 in SAH entitlement, the current rate of maximum entitlement, \$63,780, minus what was previously used. Insofar as the intent of this one-time grant, which allows for prorated supplementary funding as it increases, was to provide veterans with a means to overcome service-incurred disabilities in the home, the same consideration should be applied to the auto grant.

The U.S. Department of Transportation reports the average life span of a vehicle is 12 years, or about 128,500 miles. The cost to replace modified vehicles ranges from \$40,000 to \$65,000 new and \$21,000 to \$35,000 used, on average. These tremendous costs, with cost-of-living increases over the course of a decade or more, present a financial hardship for many disabled veterans who need to replace their primary mode of transportation once it passes its expected life cycle.

Recommendation:

VA should provide a supplementary auto grant to eligible veterans in an amount equaling the difference between their previously used one-time entitlement and the increased amount of the grant.

VALUE OF POLICIES EXCLUDED FROM CONSIDERATION AS INCOME OR ASSETS:

The cash value of veterans' life insurance policies should not be counted as assets, nor should dividends and proceeds be considered income, for the purpose of establishing eligibility for other government programs.

Life insurance provides the surviving spouses and dependents of veterans with a means of maintaining economic stability after the sponsor's death. In some cases, however, veterans are forced to surrender their government life insurance policies and apply the cash value of the surrendered policy toward nursing home care as a condition of Medicaid coverage. When this occurs, these policies become nothing more than a funding vehicle for one's care prior to death masquerading as a form of protection for survivors. As a result, the government is either paying for a veteran's care in life or paying proceeds to survivors in death,

versus the morally superior option of shouldering the economic burden in both instances.

Recommendation:

Congress should enact legislation that exempts the cash value of VA life insurance policies, and all dividends and proceeds therefrom, from consideration in determining veteran entitlement under other federal programs.



LOWER PREMIUM SCHEDULE FOR SERVICE-DISABLED VETERANS' INSURANCE:

Improved life expectancy and mortality rates should lower premiums for service-disabled insurance policies.

Congress created the Service-Disabled Veterans' Insurance (SDVI) program for veterans who faced difficulty obtaining commercial life insurance due to their service-connected disabilities. At the program's outset in 1951, its rates were based on contemporaneous mortality tables and remained competitive with commercial insurance.

Since that time, lowering commercial rates reflected improved life expectancy as illustrated by updated mortality tables. However, the Department of Veterans Affairs remains bound to outdated mortality tables. This results in rates and premiums that are no longer competitive with commercial insurance offerings, which deviates from the intended benefit of providing SDVI to veterans with service-incurred disabilities.

This inequity is compounded by the fact that eligible veterans must pay for supplemental coverage and may not have premiums waived for any reason. Even though Congress, thankfully, authorized an increase from \$20,000 to \$30,000 in the supplemental amount available with the passage of the "Veterans Benefits Act of 2010" (P.L. 111-275), Congress's intent will not be met under the current rate schedule because many service-disabled veterans cannot afford the premiums.

Recommendation:

Congress should enact legislation that authorizes VA to revise its premium schedule for Service-Disabled Veterans' Insurance based on current mortality tables.

General Operating Expenses

From its headquarters in Washington, DC, and through a nationwide system of field offices, the Department of Veterans Affairs (VA) administers its veterans' benefits programs. Responsibility for the various benefits programs is divided among six business lines within the Veterans Benefits Administration (VBA): Compensation, Pension and Fiduciary, Vocational Rehabilitation and Employment, Education, Loan Guaranty, and Insurance.

Under the direction and control of the Under Secretary for Benefits and various deputies, the program directors set policy and oversee their programs from the VA Central Office. The field offices administer the various programs, receiving benefit applications, determining entitlement, and authorizing or denying benefit payments and awards accordingly.

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

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

Veterans Benefits Administration

CULTURAL CHANGE NEEDED TO FIX CLAIMS-PROCESSING SYSTEM:

Success in reforming the VA claims-processing system will require the Veterans Benefits Administration to institutionalize the ongoing transformation process at all levels to develop a work culture that values, measures, reports, and rewards quality and accuracy over speed and production.

We are entering the third year of the most recent Veterans Benefits Administration (VBA) effort to transform an outdated, inefficient, and inadequate claims-processing system into a modern, automated, rules-based, and paperless system. The VBA has struggled for decades to provide timely and accurate decisions on claims for veterans' benefits, especially veterans' disability compensation; however, despite repeated attempts to reform the system, the VBA has never been able to reach the goals it has set for itself. Whether the VBA can be successful this time depends to a large extent on whether it can complete a cultural shift away from focusing on speed and production to a business culture of quality and accuracy.

There have been some encouraging steps toward such a cultural shift over the past two years; however, this early progress must be institutionalized in order to create the long-term stability needed to eliminate the current backlog of claims, and, more important, prevent such a backlog from returning in the future. The VBA must change the way it measures, reports, and rewards the work it performs so that quality and accuracy are at least as important as speed and production. Ensuring that decisions are correct the first time will, over time, increase public confidence in the Department of Veterans Affairs and decrease appeals.

Over the past decade, the number of veterans filing claims for disability compensation has more than doubled, rising from nearly 600,000 in 2000 to over 1.4 million in 2011. This workload increase is the result of a number of factors over the past decade, including the conflicts in Iraq and Afghanistan, an increase in the complexity of claims, and a downturn in the economy causing more veterans to seek VA assistance. Furthermore, new presumptive conditions related to Agent Orange exposure (ischemic heart disease, B-cell leukemia, and Parkinson's disease) and previously denied claims resulting from the *Nehmer* decision added almost 200,000 new claims this year, leading to a workload surge that will level

off in 2012. During this same decade, the VBA workforce grew by about 80 percent, rising from 13,500 full-time employee equivalents (FTEEs) in 2007 to more than 20,000 today, with the vast majority of that increase occurring during the past four years.

Yet despite the hiring of thousands of new employees, the number of pending claims for benefits, often referred to as the backlog, continues to grow. As of January 9, 2012, there were 884,427 pending claims for disability compensation and pensions awaiting rating decisions by the VBA, an increase of 114,136 from one year ago, and almost double the 487,501 that were pending two years prior. The number of claims pending longer than 125 days, the VBA's official target for completing claims, reached 576,944, which is a 65 percent increase in one year and more than twice 185,040 from two years ago. The surge of claims resulting from the Secretary's decision to add three new presumptive conditions for Agent Orange exposure partly accounts for this increase; however, almost all of those claims have now been processed.

But more important than the number of claims processed is the number of claims processed correctly. The VBA quality assurance program is known as the Systematic Technical Accuracy Review (STAR) and is now available publicly on VA's ASPIRE Dashboard. The most recent STAR measure for rating claims accuracy for the one-year period ending September 2011 is 84 percent, about the same level as one year prior, and slightly lower than several years earlier. However, the VA Office of Inspector General (VAOIG) reported in May 2011 that based on inspections of 45,000 claims at 16 of the VA's 57 regional offices (VAROs), claims for disability compensation were correctly processed only 77 percent of the time. This error rate would equate to almost 250,000 incorrect claims decisions in just the past year.

The Secretary of Veterans Affairs has focused a great deal of attention on breaking the back of the

backlog, setting an extremely ambitious long-term goal of zero claims pending over 125 days and all claims completed to a 98 percent accuracy standard. Certainly the elimination of the “backlog” will be a welcome milestone; however, eliminating the backlog is not necessarily the same goal as reforming the claims-processing system, nor does it guarantee that veterans are better served. To achieve real success, the VBA must focus on creating a veterans’ benefits claims-processing system designed to get each claim done right the first time.

Under the weight of an outdated information technology system, increasing workload, and growing backlog, the VBA faces a daunting challenge of comprehensively transforming the way it processes claims for benefits in the future, while simultaneously reducing the backlog of claims pending within its existing infrastructure. While there have been many positive and hopeful signs that the VBA is on the right path, there will be critical choices made over the next year that will determine whether this effort will ultimately succeed. It is essential that Congress provide careful and continuing oversight of this transformation to help ensure that the VBA achieves true reform and not just the arithmetic milestones, such as lowered backlogs or decreased cycle times.

One of the more positive signs has been the open and candid attitude of VBA leadership over the past several years, particularly progress toward developing a new partnership between the VBA and veterans service organizations (VSOs) that assist veterans in filing claims. VSOs have vast experience and expertise in claims processing, with local and national service officers holding power of attorney for hundreds of thousands of veterans and their families. VSOs can make the VBA’s job easier by helping veterans prepare and submit better claims, thereby requiring less time and resources to develop and adjudicate them. *The Independent Budget* veterans service organizations have been increasingly consulted on a number of the new initiatives under way at the VBA, including disability benefit questionnaires (DBQs), the Veterans Benefit Management System (VBMS), and many, but not all business process pilots, including the I-LAB at the Indianapolis VARO. Building upon these efforts, the VBA must continue to reach out to its VSO partners, not just at the central office, but also at each of the 57 regional offices.

In order to drive and sustain transformation throughout such a massive organization, the VBA must change how it measures and rewards performance in a manner designed to achieve the goal of getting it right the first time. Unfortunately, most of the measures that the VBA employs today are based primarily on measures of production, rather than quality. For example, the most common way to measure the VBA’s progress is through its Monday Morning Workload Reports,¹ which contain measures of production, but not accuracy or quality. Another major tool used to review VBA’s status is its “Dashboard,”² which provides current performance statistics for each VARO. Like the Monday Morning Reports, the Dashboard measures are primarily related to pending work inventory and production times, with just a few measures of accuracy included. Because the primary measures used to hold VBA and VAROs accountable are focused on the size of the backlog and cycle times, it is not surprising that the focus of VARO management is on production, rather than accuracy or quality.

Given leadership and management’s focus on production, it is not surprising that employees—veterans service representatives (VSRs), rating veterans service representatives (RVSRs), and decision review officers (DROs)—feel tremendous pressure to meet production goals first and foremost. While accuracy has been and remains one of the performance standards that must be met by all employees, new performance standards adopted over the past two years appear to have done little to create new incentives to drive quality above production.

There have been reports that a high percentages of VSRs and RVSRs have struggled to meet the new performance standards, and the VBA has already acknowledged that adjustments need to be made to ensure that they fairly measure current job performance. In addition, business process changes resulting from VBMS development and other initiatives being evaluated at the I-LAB will require future changes in performance standards. To be certain that performance standards provide the proper incentives for employees to perform accurate work, the VBA should develop a systematic method to measure average work output. Not only would this lead to better performance standards, it would also allow the VBA to better determine its FTEE requirements as workload rises and falls in the future.

Recommendations:

The Veterans Benefits Administration (VBA) must continue to build upon its successful efforts over the past two years to partner with veterans service organizations during the design, development, and implementation of claims process reforms.

The VBA and Congress must remain focused on and committed to reforming the claims-processing system, with the principal goal of enhancing quality and accuracy, rather than focusing on reducing the backlog.

The VBA should change the way it measures and reports progress so that there are more and better indicators of quality and accuracy, at least equal in weight to measures of speed and production.

The VBA should continue to review employee performance standards and its work credit system to ensure that it creates sufficient and proper incentives and accountability to achieve quality and accuracy.

The VBA should develop a systematic way to measure average work output for each category of its employees in order to establish more accurate performance standards, which will also allow the VBA to better project future workforce requirements.

¹ www.vba.va.gov/reports.

² Ibid.



IMPLEMENTING A NEW OPERATING MODEL FOR PROCESSING CLAIMS:

As the Veterans Benefits Administration begins to implement a new operating model for processing claims for disability compensation, it must give priority to “best practices” that have been validated to increase quality and accuracy, not just speed and production.

More than two years ago, the Veterans Benefits Administration (VBA) recognized that the claims-processing system was irretrievably broken; as a result, it began a sustained and comprehensive effort to reform and modernize it. Central to this effort, the VBA has conducted more than 40 different pilot programs and initiatives looking at new ways of establishing, developing, rating, and awarding claims for benefits. From early pilots in Little Rock, Pittsburgh, and Providence VA regional offices (VAROs), the VBA learned important lessons about mail handling, workflow, claims triage, team integration, telephone development, case management, and paperless processing. Dozens of other ideas flowed from individual employees and regional offices, leadership retreats, and an internal “innovation competition,” leading to new initiatives such as quick pay, walk-in claims, and rules-based calculators. The time has now come for the VBA to finish evaluating these experiments and put together a comprehensive new operating model for processing claims.

The Fully Developed Claims (FDC) program began as a pilot program mandated by P.L. 110-389. Under FDC, veterans can choose to submit their claims as fully developed claims if they are able to gather and submit all the private evidence required to adjudicate their claims, and certify that there is no other private evidence relevant to the claims. In return, the VBA puts its claims through a “fast-track” procedure that results in a decision within 90 days, substantially quicker than current average of 190 days to complete a regular, non-FDC claim. Although participation in the FDC program remains lower than projected or hoped for, it can relieve some of the burden on VBA employees facing an onslaught of complex new claims.

Disability benefits questionnaires (DBQs) have been developed over the past year by a joint task force with experts from both the VBA and the Veterans Health Administration (VHA). These new medical examination templates, which are replacing the Automated Medical Information Exchange worksheets, provide

a more useful and standardized method for disability evaluations. Once fully implemented, DBQs are also designed to facilitate the electronic submission of medical examinations and ultimately allow for automated, rules-based rating decisions.

The first three DBQs, completed in November 2010, were used to speed claims for the new presumptive conditions associated with Agent Orange exposure: ischemic heart disease, Parkinson's disease, and B-cell leukemia. The joint task force has since completed all 81 planned DBQs, and all 81 are now being used by VHA medical examiners and contract examiners. On December 5, 2011, the VBA released 54 DBQs for public use.³

The Independent Budget veterans service organizations (IBVSOs) have been pleased that over the past year the VBA has sought our input during the early stages of development of DBQs. Building and institutionalizing this VBA-VSO partnership is recognition of the added value of ideas and perspective, which VSOs can bring to the programs administered by the VBA.

The development of evidence is the most time-consuming stage of claims processing. To address this, the VBA in 2011 launched a pilot program testing whether the collection of private medical evidence by private contractors would be beneficial. This pilot is expected to be operated at six VAROs until sufficient information is available to determine whether this approach could reduce the time and resources required to obtain private medical records. In addition, the VBA expanded this approach by engaging a contractor to perform all development work for approximately 250,000 claims, in part to assist in reducing the backlog of claims pending due to the infusion of several hundred thousand claims resulting from the new herbicide presumptive disabilities and *Nehmer* cases. It is not clear whether the VBA intends to continue the use of contractors to perform some or all of the development function for claims processing. As with any pilots, such decisions must be made only after the outcomes are thoroughly evaluated, with proper weight to quality and accuracy, as well as the implications for the VBA's long-term capacity to process claims in the future.

In order to test how best to integrate these and other pilots and initiatives conducted over the past two years, VA established the I-LAB at the Indianapolis

Regional Office to develop a new end-to-end operating model for claims processing. A second I-LAB was later established at the Houston Regional Office to validate and expand upon the work being done in Indianapolis. The I-LAB established segmentation of claims as the cornerstone principle for designing the new operating model. The traditional triage function would be replaced at the I-LAB with an Intake Processing Center, staffed with experienced claims processors at a GS-11 level. The I-LAB operates along three separate tracks: Express, Core, and Special Ops. The Express lane is for simpler claims, such as fully developed claims, claims with one or two contentions, or other simple claims. The Special Ops lane is for more difficult claims, such as those with eight or more contentions, long-standing pending claims, complex conditions, such as traumatic brain injury and special monthly compensation, and other claims requiring extensive time and expertise. The Core lane is for the balance of claims with between three and seven contentions, claims for individual unemployment, original mental health conditions, and others.

The VBA has seen some early indications that productivity could increase through the use of the new segmentation strategy at the I-LAB; however, it may still be too soon to judge whether such results would be reproduced if applied nationally. While the VBA certainly needs to reform its claims-processing system, it must first ensure that proper metrics are in place in order to make sound decisions. The metrics must properly account for the natural increase in productivity that may have occurred due to the selection of higher performing employees, as well as the Hawthorne Effect, which refers to the tendency of some people to perform better when part of an experiment.

One of the most significant and controversial new initiatives at the VBA is the Disability Evaluation Narrative Text Tool (DENTT), which was developed at the Atlanta Regional Office. DENTT was created to automate the writing of rating decisions using standardized language and paragraphs. In its first iteration, DENTT offered very little information to explain the reasons or bases for rating decisions. The IBVSOs had concerns that DENTT decisions provided little help to veterans and their representatives toward understanding how the rating decisions were reached, whether they were accurate, or whether appeals might be warranted. To its credit,

the VBA subsequently reached out to the IBVSOs and others to review and refine the content of decision letters and award notifications that would be produced through the DENTT process.

Seeking further automation, the DENTT team also took on rating redesign and developed evaluation builders and rating calculators. While the DENTT team in Atlanta claimed significant increases in production utilizing these new tools, the IBVSOs urge the VBA to continue working with veterans service organizations to monitor and fine-tune this new process.

By the end of 2011, the VBA stood up an Implementation Team to develop a strategy and plan for implementing the new operating model for processing claims. With the Secretary's ambitious goal of processing all claims in less than 125 days with an accuracy rate of 98 percent by 2015, the VBA strategy calls for 2012 to be a year of transition; full implementation of the new operating model is planned for 2013; in 2014, the VBA anticipates stabilization and assessment of the new system; and 2015 is planned as the year of "centers of excellence," an apparent reference to a future state that will centralize some VBA activities or functions.

Critical to the success of this implementation strategy will be the choices made by the VBA this year. As has been discussed throughout this section of *The Independent Budget*, it is critical for the Implementation Team to remain focused on quality and accuracy, not just speed and productivity. Over the course of the next year, it will also be absolutely essential for Congress to provide strong oversight to ensure that the enormous pressures to show progress toward eliminating or reducing the claims backlog do not result in short-term gains at the expense of long-term reform.

There are also legislative and regulatory changes that have been discussed or proposed by Congress, the VBA, or others aimed toward streamlining and modernizing the claims process. The IBVSOs support changes in the law and regulations that allow VA to operate more efficiently, so long as that increased efficiency does not harm veterans. We encourage Congress and VA to seek out "win-win" solutions to vexing processing and quality problems.

The IBVSOs have long encouraged VA to use private medical evidence when making decisions, which

saves VA and the veteran time in development and VA the cost of unnecessary examinations. While recent court decisions have indicated that VA should accept private medical opinions that are credible and acceptable for rating purposes, we have seen no data suggesting that VA is more accepting of private medical evidence than previously.

In order to support efforts to encourage the use of private medical evidence, Congress should also consider amending Title 38, United States Code, section 5103A(d)(1) to provide that, when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request a VA medical examination. However, the additional language would not require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for rating purposes. Further, should VA determine that a private medical opinion is not adequate for rating purposes or to establish service connection, any further opinions obtained from VA health-care providers must be obtained from a provider whose qualifications are at least equal to those of the provider of the private medical opinion.

Legislation is pending in Congress that would reform VA's duty to notify and duty to assist claimants when it is highly unlikely that such notice or assistance would lead to any greater benefit to the claimant. This legislation is designed to reduce the time spent by VBA personnel, or potentially contractors, in pursuing private medical evidence that may not exist, may not be relevant, or may not result in an additional benefit to the veteran. While the IBVSOs agree that chasing nonexistent, irrelevant, or unhelpful evidence wastes time and resources, and usually delays decisions for veterans, it is important that the VBA's ability to waive notice or duty to assist be limited. As long as there is a reasonable possibility that a veteran could benefit from notice or assistance, the VBA must be required to fulfill those duties.

Legislation has also made progress in Congress to modify regional office jurisdiction regarding supplemental statements of the case in order to improve the timeliness of the appeals process. In the current process, when an appeal is not resolved, the VARO will issue a statement of the case along with a VA Form 9 (Appeal to the Board of Veterans' Appeals). Oftentimes, veterans will provide additional evidence

at this stage of the process. Evidence received at any time prior to consideration by the BVA must be considered by the regional office of jurisdiction unless the appellant specifically waives that consideration. It is not unusual for a regional office to consider new evidence at least once prior to certification of the appeal to the BVA. In addition, if new evidence is received once the case is sent to the BVA, it must be remanded to the regional office unless the appellant asks the BVA to consider it in the first instance. This process is extremely time-consuming and inefficient.

The IBVSOs support an amendment to this process that allows evidence submitted after the appeal has been certified to the BVA to be forwarded directly to the BVA and not considered by the regional office unless the appellant or his or her representative elects to have additional evidence considered by the regional office. This opt-out clause merely reverses the standard process without removing any rights from an appellant. In implementing such a change, VA must provide sufficient notice to a veteran that new evidence may be considered at the regional office level should the veteran so desire, and should allow the veteran to provide electronic notice of his or her decision, rather than adding the time and expense of mailing a response.

The IBVSOs believe this change should result in improved timeliness at the BVA, and could potentially save tens of thousands of VA work hours with no impairment of the rights of appellants. This is, in our view, a “win-win” solution.

Recommendations:

Congress must provide sufficient oversight of Veterans Benefits Administration (VBA) development of a new operating model to process claims for disability compensation and ensure that best practices are adopted and integrated on their ability to help VA get claims done right the first time.

The VBA should continue to work with veterans service organizations to expand participation in the Fully Developed Claims program, fine-tune the Disability Evaluation Narrative Text Tool process, and develop new disability benefits questionnaires (DBQs) as the *VA Schedule for Rating Disabilities* is updated and revised.

The VBA must ensure that DBQs are given the proper weight, as one piece of evidence among many, as ratings decisions are being made, and that veterans service organizations that hold power of attorney for claimants have full and immediate access to DBQs submitted electronically.

The VBA and Congress must ensure that the use of contractors to perform some or all of the development function in claims processing is carefully and comprehensively evaluated, with sufficient consideration given to VBA’s long-term workforce requirements.

Congress and the VBA must ensure that comprehensive metrics are established to assess whether proposed changes to the operating model being considered at the I-LAB will lead to more accurate and timely claims decisions.

Congress must aggressively evaluate and monitor the VBA’s implementation strategy and plan to ensure that it remains focused on getting claims right the first time, not just reducing the backlog.

Congress should consider legislation to require the Secretary to give deference to private medical opinions that are competent, credible, probative, and otherwise adequate for rating purposes as equal to that given to opinions provided by VA health-care providers.

Congress should ensure that any legislation being considered to reduce VA’s duty to notify or assist claimants not endanger veterans’ ability to receive the highest rating to which they are entitled within a reasonable time frame.

Congress should approve legislation to modify the appeals procedure so that, if a veteran submits new evidence after his or her appeal had been certified to the Board of Veterans’ Appeals, that evidence would be considered by the Board by default rather than remanded to an regional office for consideration, provided the claimant is notified of his or her right to have the additional evidence reviewed by the local regional office.

³ VA Fast Letter 11-36, Disability Benefits Questionnaires Update: Groups—1, 2, and 3, December 5, 2011.

TRAINING, TESTING, AND QUALITY CONTROL:

Training, testing, and quality control are necessarily interrelated and must be given the highest priority in order to ensure that employees, managers, and leaders within the Veterans Benefits Administration are all held to the highest standards.

Veterans Benefits Administration (VBA) claims-processing transformation strategy is focused in three areas: people, process, and technology. Training, testing, and quality control are central to all three, but especially to supporting an effective and efficient workforce. Over the past year, the VBA has made some significant changes for the better in each of these areas; however, more needs to be done in order to ensure that progress made possible by new technology and business processes is fully realized.

Training is essential to the professional development of individuals and tied directly to the quality of work they produce, as well as the quantity they can accurately produce. *The Independent Budget* veterans service organizations (IBVSOs) remain concerned that due to an increasing workload and a rising backlog, VBA managers and employees have too often chosen to cut corners on training in order to focus on production at all costs. Veterans service organizations service officers have been told by many VBA employees that meeting production goals is the primary focus of management; whereas fulfilling training requirements and increasing quality is perceived as a secondary goal. It is imperative that VA regional office (VARO) efforts to increase productivity not interfere with required training of employees, particularly new employees who are still learning their job.

VBA training has traditionally been a three-stage system, which requires new veterans service representatives (VSRs) and rating veterans service representatives (RVSRs) to complete orientation training at their respective VAROs. Next, they participate in centralized Challenge Training at VA's training academy, which provides a basic introduction to job responsibilities. When they return to their respective VARO, new VSRs and RVSRs spend several more months in training, which includes completing a required curriculum by way of online learning known as the Training and Performance Support System, as well as on-the-job training and/or instructor-led classroom training. Once these individuals have successfully completed their initial training, they begin their on-the-job-training (OJT) phase, in which they

will be moved into productive roles in developing and rating cases with supervision. They will continue this OJT phase with mentoring and supervision, slowly increasing the number and complexity of cases until they are assigned a full caseload approximately two years from their dates of employment.

In 2010 the VBA modified the training program for new RVSRs by doubling the length of time for Challenge Training to eight weeks. In addition, following this significantly more intense training, they return to their local VAROs and are immediately assigned claims files to work on while the training is still fresh in their minds. Rather than spend up to six months in additional on-the-job training before receiving their initial caseload of one claims file per day, they return to their respective VARO after the Challenge Training and are immediately assigned a caseload of 1.2 claims files per day. The VBA's initial assessment of this new training approach indicates that the newest RVSRs are performing at or above quality levels of RVSRs who had four weeks of Challenge Training and six months of OJT.

Once employees achieve journeyman status, they will have the same training requirements as all other experienced VSRs and RVSRs, which requires employees to complete 80 hours of training annually through VA's online Training Management System, along with an additional five hours for cyber security and ethics. VBA training is divided between 40 hours of standardized training on topics selected by the Compensation Service and 40 hours of training on subjects selected by the VARO from the Core Technical Training Requirements and other subjects of their choosing.

A Government Accountability Office (GAO) study released in April 2010 (GAO-10-445) found experienced claims processors had concerns with the training received; specifically the hours, amount, helpfulness, methods, and timing of training. The GAO also found that the VBA did not have sufficient means to assess the adequacy and consistency of the training. More alarming, the GAO found that

the VBA did not even ensure the required training is actually completed, nor properly ascertain the total number of VSRs and RVSRs who had met the annual training requirement. The GAO found that only one VARO met the annual training requirement and nine VAROs had less than half their employees meet their annual training requirements. It is simply unacceptable to have only one VARO meeting the most basic requirement of ensuring that all employees complete 80 hours of training. The VBA must place greater emphasis on training by implementing stricter monitoring mechanisms for all VAROs and ensure that they are held accountable for failure to meet this minimal standard.

Adequate time for training must be allowed in order for employees to gain the maximum benefit of the training and improve their overall knowledge and skill. In order to accomplish this, VBA managers must ensure scheduled time for training is in place and that employees attend training. Although training time for employees is excluded from the calculation of their workload requirements and performance standards, it is clear that the pressure to produce completed claims creates disincentives for fully completing training. In the GAO survey for its report on training, 60 percent of experienced claims processors found it “difficult” to meet their annual training requirement due to their workload. The VBA must find new ways to separate out time and space for employees to assist them in meeting their training requirements.

The IBVSOs are encouraged that the VBA has recently begun to develop professional development training programs for journey-level employees and leadership training programs for senior-level employees. Given the complexities and duties of VSRs and RVSRs, more extensive training is necessary in order to gain the appropriate level of knowledge and skill to perform those duties with quality and accuracy. VSRs and RVSRs are currently required to complete 80 hours of annual training, but there is no testing to measure whether the material was understood or is being retained. Attendance is the main instrument used to verify if training is being completed, and even in that minimal measure, the VBA is failing. The VBA must examine whether it is possible for a claims processor to achieve the required proficiency level without significantly increasing the amount and intensity of training currently provided by the VBA.

After employees have been trained, it is important that they are regularly tested to ensure that they have the knowledge and competencies to perform their jobs. A GAO report published in September 2011 found that there did not exist a nationwide training curriculum for decision review officers (DROs), despite the fact that 93 percent of regional managers interviewed supported such a national training program, as did virtually every DRO interviewed. *The Independent Budget* veterans service organizations would note that following a recent DRO examination in which a high percentage failed to achieve acceptable results, the VBA required all DROs to undergo a one-week training program to enhance their knowledge and job skills. This is exactly the type of action that should regularly occur within an integrated training, testing, and quality control program.

In 2008, Congress enacted P.L. 110-389, the “Veterans’ Benefits Improvement Act of 2008,” which required the VBA to develop and implement a certification examination for all claims processors and managers. While tests have been developed and conducted for VSRs, RVSRs, and DROs, the tests for supervisory personnel and coaches have yet to be completed. For most employees, the examination is required only once, primarily for grade level increases, not for proficiency purposes. For example, if VSRs desire to elevate their grade level from a 10 to 11, they must pass a certification examination; however, they may opt out of the examination and remain at their current level. Conversely, if the same VSRs fail the certification examination, there is no penalty and they may remain in the same position. Moreover, the VBA has no remedial training programs for employees who fail certification tests, nor are they required to retake the test to show that they have mastered the skills and knowledge required to do their jobs.

Mandatory, regular, and continuing testing programs for all VBA employees, including supervisors and managers, could serve several related purposes:

- measure the proficiency and knowledge required for promotion or determining other incentives;
- identify subject matters or competencies that need additional training of the test-taker;
- evaluate the effectiveness of training programs; and
- identify weaknesses in the claims process that require systemic improvements.

The VBA cannot accurately assess its training or measure an individual's knowledge, understanding, or retention of the training material without regular testing. It is important, however, that all testing and certification be applied equally to employees and to the people who supervise and manage them. All VBA employees, coaches, and managers should undergo regular testing to measure job skills and knowledge, as well as the effectiveness of the training.

Equally important, testing must properly measure the skills and knowledge required to perform the work of processing claims. Many employees report that the testing does not accurately assess how well they perform their jobs, and there have been reports that significant numbers of otherwise qualified employees are not able to pass the tests. The VBA must ensure that certification tests are developed that accurately measure the skills and knowledge needed to perform the work of VSRs, RVSRs, DROs, coaches, and other managers.

Of greater benefit to the claims process, the VBA has recently launched a new initiative to stand up Quality Review Teams (QRTs) in every regional office. Developed from a review of the best practices used at certain high-performing regional offices, the QRT program will assign full-time, dedicated employees whose sole function is to seek out and correct errors in claims processing. The size of each QRT will be directly related to the size of the regional office, with one QRT member for every 35 VSRs and one QRT member for every 20 RVSRs. The QRTs will report to regional office leadership; however, the focus of and output from their work will be directed by the Compensation Service at the VBA in order to ensure a consistent focus on quality. QRTs will also work to develop in-process quality control measures to prevent errors before decisions are made. A critical factor in the success of this program will be the caliber and attitude of the QRT members. To increase the chances of success, the VBA must make service in a QRT unit a career path requirement for those seeking to rise to higher positions.

VA's main quality assurance program will remain the Systematic Technical Accuracy Review (STAR) program. The STAR program can identify three types of errors—benefit entitlement, decision documentation and notification, and administrative. STAR looks at such actions as whether a proper Veterans Claims Assistance Act predecision “notice” was provided

and whether the rating decision was merited based on the available evidence. Under the STAR program, VA reviews a sampling of decisions from regional offices and bases its national accuracy measures on the percentage with errors that affect entitlement, benefit amount, and effective date. The STAR program is also intended to identify major national error trends so that the Compensation Service can initiate corrective measures, such as training, improved procedural guidance, or automated system improvements.

The STAR program was last directly evaluated by the VA Office of Inspector General (VAOIG) as part of its review of compensation rating accuracy in March 2009, in the report titled “Audit of Veterans Benefits Administration Compensation Rating Accuracy and Consistency Reviews.” The VAOIG determined that the VBA's STAR program does not provide a complete assessment of rating accuracy. In addition, although STAR estimated that about 87 percent of claims in 2008 were technically accurate, the VAOIG found additional errors and projected an accuracy rate of only 78 percent. A more recent VAOIG report from May 2011 (Report 11-00510-167), reviewing systemic issues from 16 VARO audits, found that “VARO staff incorrectly processed about 23 percent of its estimated 45,000 claims,” which would correspond to a 77 percent accuracy rate, compared to the current STAR estimate of 84 percent accuracy.

To fully assess and learn from VBA quality assurance and quality control programs, the data from all such reviews should be incorporated into VBA's new Veterans Benefits Management System (VBMS) so that analysis can provide management and employees important insights into processes and decisions. This, in turn, would lead to more accurate decisions on benefits claims, and, most important, to the delivery of all earned benefits to veterans, particularly disabled veterans, in a timely manner. VBA has mountains of data about the quality and accuracy of work performed under the current system that comes from the STAR program, “coaches” reviews of employees, Inter-Rater Reliability reviews, employee certification testing, remands by Board of Veterans' Appeals and Court of Appeals for Veterans Claims, as well as the new data that will be provided by the QRTs. There needs to be a process or system to aggregate and analyze all of this data to identify error trends and breakdowns in the claims process that need improvement or additional training of personnel. The VBMS must

include this capability, and it must also be used to inform and modify employee training programs.

The only way the VBA can make and sustain long-term reductions in the backlog is by producing better quality decisions in the first instance. The only way to institutionalize such a cultural shift within the VBA is by developing and giving priority to training, testing, and quality control programs.

Recommendations:

The Veterans Benefits Administration (VBA) should review whether current training provided is appropriate for the jobs being performed and should consider significantly increasing the total annual hour requirement for continuing training of all employees.

The VBA should review the content of certification testing to ensure that it is appropriate to measure the job skills, competencies, and knowledge required to perform the work of each category of employee.

The VBA should require all employees, coaches, and managers to undergo regular testing that accurately measures job skills and knowledge as well as the effectiveness of the training itself.

The VBA must ensure that existing and new quality assurance and quality control programs, including the Systematic Technical Accuracy Review (STAR) program and Quality Review Teams (QRTs), are sufficiently funded and staffed.

The VBA should make service on a QRT unit a required step along the career path of employees seeking to reach the highest positions within the VBA.

The VBA should ensure that the Veterans Benefits Management System (VBMS) is able to systematically aggregate and analyze the information that comes from QRTs, the STAR program, “coaches” reviews, Inter-Rater Reliability reviews, employee certification testing, and data from remands from the Board of Veterans’ Appeals and the Court of Appeals for Veterans Claims to identify error trends and emerging issues that indicate a need for process improvements or additional training of employees or managers.

The VBA should develop real-time, in-process quality control mechanisms as a core component of the VBMS.



NEW VBA INFORMATION TECHNOLOGY SYSTEM:

Congress and the Veterans Benefits Administration must ensure that sufficient funding is provided to complete and deploy the Veterans Benefits Management System, the VBA’s new paperless and rules-based platform for processing veterans’ claims for benefits, as well as other important information technology initiatives, such as Veterans Relationship Management and e-Benefits.

After two years of development, the Veterans Benefits Administration (VBA) is poised to begin rolling out its Veterans Benefits Management System (VBMS) nationally over the next year. Considered by many to be the lynch pin of the VBA’s claims-process transformation strategy, the VBMS has been designed to provide a comprehensive, paperless, and rules-based method of processing and awarding claims for VA benefits, particularly disability compensation and pension. The VBMS will consist of seven subcomponents that replace an array of older programs: VBMS-E for “establishment,” VBMS-D for

“development,” VBMS-R for “rating,” VBMS-A for “award,” VBMS-C for “correspondence,” VBMS-F for “folder,” and VBMS-W for “workflow,” which will replace the old VETSNET suite of applications, such as Share, MAP-D, RBA-2000, Awards, and FAS.

In 2011 the VBA conducted live VBMS pilots at the Providence, Rhode Island, and Salt Lake City, Utah, VA regional offices (VAROs), continuing to add new functionality throughout the year. *The Independent Budget* veterans service organizations (IBVSOs) recognize and applaud VBA efforts to incorporate the

experience and perspective of veterans service organizations (VSOs) throughout the development process. Understanding the important role that VSO service officers play in the claims process, VBA proactively sought frequent and substantive consultation with VSOs, both at the national VBMS office and at the pilot locations. The IBVSOs are confident that this promising partnership will strengthen the VBMS for the VBA, VSOs, and, most important, veterans seeking VA benefits. As VBMS development continues, it will be essential to continue this successful VBA-VSO collaboration and look for new ways to institutionalize it.

As the VBA turns the corner on VBMS development leading to deployment, it is imperative that Congress and the VBA provide full funding to complete this essential information technology (IT) initiative. In today's difficult fiscal environment, there are concerns that efforts to balance the federal budget and reduce the national debt could result in reductions to VA programs, including IT programs. Over the next year Congress must ensure that the funding required and designated for the VBMS is protected from cuts or reprogramming, and spent as Congress intended. The VBA must then ensure that internal competition for IT funding does not endanger the completion of the VBMS and other vital claims-process transformation initiatives.

The VBA must also continue to provide sufficient resources to complete the Veterans Relationship Management (VRM) system and maximize the use of e-Benefits. The VRM is being designed as VA's "one front door" to all benefits and services. Whether a veteran visits, calls, texts, emails, tweets, or uses any other method of communication, the VRM system is being designed to ensure that veterans have consistent and successful interactions with VA. A key component of VA's new customer service approach is e-Benefits, VA's online portal that allows veterans to apply for, monitor, and manage their benefits over the Internet. With more than 2 million users registered, e-Benefits provides a web-based method for veterans to file claims for disability and other benefits that will directly integrate into the VBMS for adjudicating those claims. VRM is also expanding its capabilities at VA call centers through new training and IT technologies to ensure that veterans have a positive experience when calling VA. As with the VBMS, it is crucial that Congress and the VBA provide both VRM and e-Benefits full funding in order to support

the ongoing transformation of the claims-processing system.

During the early stages of VBMS development there were questions about whether rules-based decision support would be a core component of the VBMS, rather than a component to be added on after national rollout. This question has been resolved favorably, as VBMS programmers are actively working to develop algorithms to embed the VA *Schedule for Rating Disabilities* into the system. The design team in Atlanta that developed the Disability Evaluation Narrative Text Tool program to automate rating decision and award letters, has since developed a number of tools to automate the rating evaluation and decision process. Evaluation builders have been built to determine rating levels assignable for a claimed condition. Calculators have been designed to resolve both service connection and rating level questions into a rating decision.

Although significant progress has been made in creating rules-based capabilities within the VBMS, the VBA must continually test and refine these tools until they are perfected. There have been reports that early calculators sometimes produced incorrect ratings. While substantial automation of the claims process is both helpful and ultimately inevitable, final responsibility for rating decisions must remain the purview of VBA personnel. Rules-based tools and technologies must be treated like a beta version of software, constantly seeking feedback and improvement on the product. The VBMS must incorporate comprehensive quality control to provide real-time, in-process data collection, and analysis in order to support continuous process improvements.

Given the highly technical nature of modern information technology development, the IBVSOs urge Congress to fully explore these issues with the VBA and continue to suggest that it would be helpful to have an independent, outside expert review of the VBMS while it is still possible to make course corrections, should they be necessary.

The IBVSOs remain concerned about VBA plans for transitioning legacy paper claims into the new VBMS environment. While the VBA is committed to moving forward with a paperless system for new claims, it has not yet determined how to handle reopened paper claims; specifically whether, when, or how they would be converted to digital files. Because a majority

of claims processed each year are for reopened or appealed claims and because files can remain active for decades, until all legacy claims are converted to digital data files, the VBA could be forced to continue paper processing for decades. Requiring VBA employees to learn and master two different claims-processing systems—one that is paper-based and the other digital—would add unnecessary complexity and could negatively affect quality, accuracy, and consistency.

There are very difficult technical questions to be answered about the most efficient manner of transitioning to all-digital processing, particular involving legacy paper files. The VBA must consider the level of resources required to provide sufficient computer backbone and bandwidth to accomplish this massive digitization of millions of paper files. One way forward would be to leave paper files as they are in their current format unless or until there is new activity. At the time a paper file becomes active, it could be sent to a conversion center, which would scan and enter all data into the VBMS. Whether this is technically, logistically, or financially feasible in the near term must be fully explored and reviewed. However, the IBVSOs believe the VBA should do all it can to shorten the length of time this transition takes to complete, and should provide a clear roadmap for eliminating legacy paper files, one that includes clear timelines and resource requirements. While this transition may require significant up-front investment, it will pay dividends for the VBA and veterans in the future.

Recommendations:

Congress and VA must ensure that the Veterans Benefits Management System (VBMS), as well as Veterans Relationship Management and e-Benefits, are provided full funding to successfully complete transformation of the claims processing system.

The Veterans Benefits Administration (VBA) must continue to support incorporation of rules-based decision support in the VBMS, recognizing that such automation will not be perfect and must be continually evaluated and improved.

The VBMS must include real-time quality control as a core component of the system in order to build a system capable of providing accurate and timely decisions, which is the key to reducing the backlog for the long term.

The VBA should commit to incorporating all veterans' legacy paper files into the paperless environment of the VBMS within the minimum amount of time technically, practically, and financially feasible.

Congress should consider an independent, outside, expert review of the VBMS system while it is still possible to make course corrections, should they be necessary.

The VBA should continue seeking regular and ongoing input from veterans service organizations during VBMS development and deployment.

Compensation Service

SUFFICIENT STAFFING LEVELS:

Maintaining staffing in the Veterans Benefits Administration at levels that are commensurate with workload is essential to the VBA's ability to address the growing claims inventory in an accurate and timely manner.

Due to substantial support by Congress, the Veterans Benefits Administration (VBA) Compensation Service has seen a large increase in staffing during the past several years, which has allowed for an increase in the number of claims processed each year. However, an even larger increase in new and reopened claims has caused the backlog to grow. In fact, between FY 2008 and FY 2010, VBA staffing was increased by several thousand full-time employees (FTEs). This large increase in FTEs has assisted Compensation Service's ability to increase its production to adjudicate a growing disability claims workload with cases involving greater complexity than in years past. In the near term, this large increase in claims processors may actually result in an overall decline in productivity since experienced personnel are taken out of production to conduct extensive training and mentoring of new employees. Historically, approximately two years are required for new nonrating claims processors to acquire sufficient knowledge and experience to be able to work independently with both speed and accuracy. However, employees in the role of producing rating decisions require an additional period of at least two years of training before they have the skills to accurately complete most rating claims.

Congressional actions to dramatically increase staffing in recent years have provided the VBA a major resource in its efforts to reform the claims process, better manage the pending claims backlog, and begin the process of regaining control of the growing claims for benefits. It is vital, however, to recognize that the backlog of claims will not simply vanish overnight. The backlog of claims arose as a culmination of many factors, specifically the increasing complexity of claims development with an overlay of judicial review. Neither of these factors is inherently bad; in fact, the development safeguards and judicial oversight were deemed necessary to help ensure that

veterans and other claimants receive every benefit to which they are entitled under the law. Congress should recognize that it will be several years before the full impact of recent hiring initiatives is felt.

The VBA is faced with many challenges that must be addressed. For example, the number of veterans receiving benefits has significantly increased in whole numbers and as a percentage of that population. The population of newer veterans demonstrates similar disability profiles to older veterans in terms of the body systems affected. Unlike the past, newer veterans from the outset tend to claim a higher number of disabilities, which often involve greater complexity in the development of their claims. Also, the average disability rating has risen steadily since 2001, incorporating the existence of unique disabilities such as traumatic brain injury and a variety of mental disorders, as well as the general aging of the earlier service population. In fact, the number of original claims for multiple disabilities, especially claims with eight or more conditions, has increased substantially since 2005.

Due to the actions of Congress in providing the resources in order for VBA's Compensation Service to dramatically increase its staffing in recent years, *The Independent Budget* veterans service organizations are not recommending an increase in staffing for FY 2013. It should be noted that while we are not recommending an increase in Compensation Service staffing at this time, Congress must be mindful of natural attrition rates, continual growth of the backlog, and other VBA initiatives that impact the overall effectiveness in timeliness and productivity. Should there be a decline in personnel dedicated to producing rating decisions, an increase in claims or backlog, or should any of the long-awaited VBA information technology initiatives not reduce the processing times for claims, Congress must be prepared to act swiftly

and intervene with necessary resources to increase Compensation Service's staffing to facilitate its ability to adjudicate disability compensation claims under anticipated workload requirements so that veterans' claims are done right the first time.

Recommendation:

Congress should require the Veterans Benefits Administration to conduct a study to determine the actual number of full-time employees necessary to effectively manage its growing inventory of claims while ensuring that rating decisions are produced in an accurate and timely manner.



Vocational Rehabilitation and Employment

ADEQUATE STAFFING LEVELS:

Congressional funding for the VA Vocational Rehabilitation and Employment Service must keep pace with veterans' demand for vocational rehabilitation and employment services.

VA's Vocational Rehabilitation and Employment (VR&E) program, also known as chapter 31 benefits, is authorized by Congress under Title 38, United States Code. Through its VetSuccess program, VR&E provides critical counseling and other adjunct services necessary to enable service-disabled veterans to overcome employment barriers as they prepare for, find, and maintain gainful employment.

Since September 11, 2001, there have been more than 2,226,000 service members deployed. Of that group more than 941,000 have been deployed two or more times.⁴ As a result there are more than 1,442,000 individuals eligible for disability benefits, of which VR&E is one, and more than 642,000 have actually filed claims for disability.⁵ Due to the increasing number of service members returning from Iraq and Afghanistan with serious disabilities, VR&E must be provided the resources to further strengthen its program.

Approximately 48,000 active duty, Reserve, and Guard personnel are discharged annually, with more than 25,000 of those on active duty found "not fit for duty" as a result of medical conditions that may qualify for VA disability ratings and, potentially, eligibility for VR&E services.⁶

In FY 2011 there were more than 107,000 participants in one or more of the five assistance tracks of VR&E's VetSuccess program. Of those who chose the vocational rehabilitation and employment track, approximately 9,900 were deemed fully rehabilitated.

Given the protracted nature of the current conflicts, combined with an aging veterans community and the slow recovery of the economy, the demand for services may well outpace the present funding levels for VR&E programs and overtax current staffing levels as they work diligently to deliver these important benefits.

The Independent Budget veterans service organizations (IBVSOs) are concerned that service members—whether regular military, National Guard, or Reserve—who are being discharged from military service with service-connected disabilities will not receive effective vocational rehabilitation services in a timely manner because of a lack of available resources.

While VR&E Service funding has improved in recent years, the IBVSOs encourage Congress to continue to provide the necessary funding in FY 2013; otherwise, VR&E's ability to meet a rising demand for services may prove inadequate to the task.

Case Manager Workload

VR&E's VetSuccess program is a five-track employment process, which aims to advance employment opportunities for disabled veterans. This is an essential program, providing participants comprehensive rehabilitation evaluation to determine abilities, skills, and interests for employment; vocational counseling and rehabilitation planning for employment services; employment services, such as job training, job-seeking skills, résumé development, and other work readiness assistance; assistance finding and keeping a job, including the use of special employer incentives and job accommodations; on-the-job training, apprenticeships, and nonpaid work experiences; postsecondary training at a college or a vocational, technical, or business school; supportive rehabilitation services, including case management, counseling, and medical referrals; and independent living services for veterans unable to work because of the severity of their disabilities. The Compensation and Pension Service (C&P) provides compensation to veterans, and VR&E provides a bridge to future employment and a stronger sense of self-worth. While C&P staffing has increased dramatically, VR&E staffing has not kept pace with the rising VR&E participation rate.

The Government Accountability Office (GAO) conducted a 2009 study to assess VR&E's ability to meet its core mission functions. It noted that the implementation of the five-track employment process has "strengthened its focus on employment but veterans' incentives have not been updated to reflect this emphasis."⁷ A GAO survey of VA regional office staff found that "54 percent of all 57 regional offices reported they had fewer counselors than they need and 40 percent said they have fewer employment coordinators than they need"⁸ and "90 percent of the regional offices we surveyed reported that their caseloads have become more complex since veterans began returning from Afghanistan and Iraq."⁹

The current caseload target, which is one counselor for every 125 veterans, is not based on an accurate measurement study of VR&E's own processes and workloads. Feedback received by the IBVSOs from counselors in the field found a workload as high as 1:145, well above the 1:125 standard. Delays in processing initial applications due to staff shortages as well as disproportionate caseloads continue to be problematic. A 1:100 ratio would certainly provide

for a more robust counselor staff and more equitable workload distribution.

VR&E continues with its work, through collaboration with an outside contractor, to refine and refocus this important program in an effort to maximize its capabilities and deliver services within certain budgetary constraints. Given the anticipated caseload that future downsizing of the military will cause, a more concise way to determine staffing requirements must be developed.

Vocational Rehabilitation and Employment (Chapter 31)

Given its increased reliance on contract services, VR&E needs approximately 195 new staff counselors. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force¹⁰ recommended the creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

An extension for the delivery of VR&E assistance at a key transition point for veterans is through the VA VetSuccess on Campus program. This program provides support to student veterans in completing college or university degrees. VetSuccess on Campus has developed into a program that places a full-time Vocational Rehabilitation Counselor and a part-time Vet Center Outreach Coordinator at an office on campus specifically for the student veterans attending that college. These VA officers are there to help the transition from military to civilian and student life. The VetSuccess on Campus program is designed to give needed support to all student veterans, whether or not they are entitled to one of VA's education benefit programs.

The President's 2012 budget submission requested funding to support further expansion of the program beyond the eight existing sites to nine more campuses. They are University of South Florida, Cleveland State University, San Diego State University, Community College of Rhode Island, Arizona State University, Texas A&M, Central Texas, Rhode Island College, and Salt Lake Community College. The expansion uses a formula of campuses with veteran populations of 800–1,200 students.¹¹ At least nine full-time employees will be needed in FY 2013 to manage this expanding campus program.¹²

Recommendations:

Congress must provide sufficient funding and staffing to ensure that the VA Vocational Rehabilitation and Employment (VR&E) program can meet the growing demand it faces, particularly with the many seriously injured service members returning from Iraq and Afghanistan who will need this assistance.

Congress should authorize at least 195 additional full-time employees for the VR&E Service for FY 2013 to reduce current case manager workload and allow for additional one-on-one dialogue for all veterans generally and for our most severely disabled veterans particularly.

Congress should authorize at least nine new full-time employees in FY 2013 to manage VR&E's expanding campus program.

Congress must provide the resources for VR&E to establish a maximum ceiling of 1:125 as the counselor-to-client workload and a new ratio of 1:100 as the standard used for all office staffing decisions.

Congress should monitor, through its oversight function, the status and results of the ongoing work measurement and skills assessment studies and, once they are completed, provide the necessary funding to adjust staffing levels and to provide training targeted toward any core competency gaps identified in those studies.

⁴ DOD, "Contingency Tracking System," Number of Deployments for Those Ever Deployed for Operation Iraqi Freedom and Operation Enduring Freedom, as of Dec. 31, 2010.

⁵ Department of Veterans Affairs, "VA Benefits Activity: Veterans Deployed to the Global War on Terror," Through May 2011, Jul. 2011.

⁶ Congressional Research Service, "Veterans' Benefits: The Vocational Rehabilitation and Employment Program," Order Code RL34627, August 21, 2008, p. CRS-12.

⁷ Government Accountability Office, *VA Vocational Rehabilitation and Employment: Better Incentives, Workforce Planning, and Performance Reporting Could Improve Program*, GAO-09-34, January 26, 2009, p. 6. <http://www.gao.gov/new.items/d0934.pdf>.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ VA Reaching Out to Veterans on Campus Through VetSuccess New Agreements Recently Reached to Ease Transition from Active-Duty Military, VA Press Release. <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2070>, March 11, 2011.

¹² House Veterans Affairs Committee, Subcommittee on Economic Opportunity, Prepared Statement of Thomas J. Pamperin, Deputy Under Secretary for Disability Assistance, Veterans Benefits Administration, U.S. Department of Veterans Affairs, 06/02/2011.



BOARD OF VETERANS' APPEALS BUDGET GAP:

Board of Veterans' Appeals budget and staffing have failed to rise as necessary to meet its actual and projected workload.

The Board of Veterans' Appeals (Board) makes final decisions on behalf of the Secretary on appeals from decisions of local VA offices. It reviews all appeals for benefit entitlement to include claims for service connection, increased disability ratings, total disability ratings, pension, insurance benefits, educational benefits, home loan guaranties, vocational rehabilitation, dependency and indemnity compensation, and health-care delivery (medical reimbursement and fee-basis claims).¹³ The Board's mission is to conduct hearings and issue timely, understandable, and quality decisions for veterans and other appellants in compliance with the requirements of law.

While the Board has jurisdiction over a range of issues, 95 percent of appeals considered involve claims for disability compensation or survivor benefits. Other types of claims that are addressed by the Board include fee-basis medical care, waiver of recovery of overpayments, reimbursements for emergency medical treatment expenses, education assistance benefits, vocational rehabilitation training, burial benefits, and insurance benefits. While the number of claims has increased over the past several years, so too has the number of appeals to the Board.

In FY 2010, the Board conducted 13,515 hearings, 1,823 more than the prior year, and issued 49,127 decisions, slightly more than in FY 2009. The average

cycle time from receipt to decision was 99 days, one day less than the year prior, and 56 days faster than in FY 2008. The Board's accuracy rate for FY 2010 was 94 percent, the same as the prior year.¹⁴ It is important to note that productivity would have been even greater but for two unusual events in 2010: the snowstorm in February that shut down the federal government for a week and a computer virus in April that shut down the entire network, disrupting work, including telework, for about 10 days.

While productivity of the Board has risen, workload has risen even faster. The number of appeals filed rose from 51,481 in FY 2009 to 57,985 in FY 2010, and it is projected to continue rising as the number of original claims rises. The number of appeals docketed at the Board rose from 49,783 in 2009 to 52,526 in FY 2010 and will also continue to rise commensurate with the increase in claims.¹⁵ Based on historical trends, the number of new appeals to the Board averages approximately 5 percent of all claims received, so as the number of claims processed by the VBA is expected to rise significantly, so too will the Board's workload rise commensurately. It is worth noting that FY 2011 was an atypical year because a significant number of VA regional office employees were focused on processing *Nehmer* cases, instead of certifying appeals to the Board. With the *Nehmer* work winding down in FY 2012, there is expected to be a spike of new appeals sent to the Board. As a result, the backlog of cases at the Board, like at VBA regional offices, will continue to rise.

The Board is currently authorized to have 544 full-time employee equivalents (FTEEs); however, its budget in FY 2011 could only support 532 FTEEs. Expected workload projections indicate that the authorized level for FY 2013 should be closer to 585 FTEEs. *The Independent Budget* veterans service organizations are concerned that unless additional resources are provided to the Board, its ability to produce timely and accurate decisions will be constrained by an inadequate budget, and either the backlog will rise or accuracy will fall. Neither of these outcomes is acceptable.

Recommendations:

Congress must ensure that funding for the Board of Veterans' Appeals (Board) rises at a rate commensurate with its increasing workload so it remains properly staffed to decide veterans' cases in an accurate and timely manner.

To meet known and projected workload increases next year, Congress should authorize and fund an additional 40 full-time employee equivalents at the Board for FY 2012.

VA should require the Board to develop and implement an acceptable plan to increase focus on the performance of mission-critical activities, reduce the processing time for appeals, and improve the quality of its decision making.

¹³ Board of Veterans' Appeals, Fiscal Year 2010 Report of the Chairman.

¹⁴ Ibid.

¹⁵ Ibid.

Judicial Review

From its creation in 1930, decisions of the Veterans Administration, now the Department of Veterans Affairs, could not be appealed outside VA except on rare Constitutional grounds. This was thought to be in the best interests of veterans, in that their claims for benefits would be decided solely by an agency established to administer veteran-friendly laws in a paternalistic and compassionate manner. At the time, Congress also recognized that litigation could be very costly and sought to protect veterans from such expense.

For the most part, VA worked well. Over the course of the next 50 years, VA made decisions in millions of claims for benefits. This resulted in VA providing millions of sick and disabled veterans the compensation and medical care to which they were entitled.

Over time, however, complaints from veterans grew in both number and volume. The VA regulatory process and the application of laws to claims were not always accurate or even uniform. While most veterans received benefits the law provided, veterans who were denied benefits felt that because only VA employees decided their claims and appeals, they could not be assured that the decisions in their cases were correct.

In 1988, Congress enacted legislation to authorize judicial review and created the United States Court of Appeals for Veterans Claims (Court) to hear appeals from the VA Board of Veterans' Appeals (BVA). In enacting this legislation, Congress recognized that, without judicial review, the only remedy available to correct VA's misinterpretation of laws, or the misapplication of laws to veterans' claims, was through subsequent legislation.

Today VA decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This review process allows an individual not only to challenge the application of law and regulations to an individual claim, but, more important, to contest whether VA regulations accurately reflect the meaning and intent of the law. When Congress established the Court, it added another beneficial element to appellate review by creating oversight of VA decision making by an independent, impartial tribunal from a different branch of government. As a result, veterans are no longer without a remedy for erroneous BVA decisions.

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

ENFORCE THE BENEFIT-OF-THE-DOUBT RULE:

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

Title 38, United States Code, section 5107(b) grants VA claimants a statutory right to the benefit of the doubt with respect to any benefit under laws administered by the Secretary of Veterans Affairs when there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter. Yet the Court of Appeals for Veterans Claims (Court) has affirmed many Board of Veterans' Appeals (BVA) findings of fact when the record contains only minimal evidence necessary to show a plausible basis for such finding. The Court upholds VA findings of material fact unless they are clearly erroneous, and it has repeatedly held that when there is a "plausible basis" for the BVA's factual finding, it is not clearly erroneous. This makes a claimant's statutory right to the "benefit of the doubt" vacuous because claims can be denied and the denial upheld when supported by far less than a preponderance of evidence. These actions render Congressional intent under section 5107(b) meaningless.

To correct this situation, Congress amended the law with the enactment of the "Veterans Benefits Improvement Act of 2002" to expressly require the Court to consider whether a finding of fact is consistent with the benefit-of-the-doubt rule.¹ However, this intended effect of section 401 of the "Veterans Benefits Act of 2002" has not been used in subsequent Court decisions.²

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

As a result of Veterans Benefits Act section 401 amendments to section 7261(a)(4), the Court is now directed to "hold unlawful and set aside or reverse" any "finding of material fact adverse to the claimant...if the finding is clearly erroneous."³ Furthermore, Congress added entirely new language to section 7261(b)(1) that mandates the Court to

review the record of proceedings before the Secretary and the BVA pursuant to section 7252(b) of Title 38 and "take due account of the Secretary's application of section 5107(b) of this title...."⁴ The Secretary's obligation under section 5107(b), as referred to in section 7261(b)(1), is as follows:

(b) BENEFIT OF THE DOUBT—The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.⁵

Congress wanted the Court to take a more proactive and less deferential role in its BVA fact-finding review, as detailed in a joint explanatory statement of the compromise agreement contained in the legislation:

[T]he Committees expect the Court to reverse clearly erroneous findings when appropriate, rather than remand the case. The new subsection (b) [of section 7261] would maintain language from the Senate bill that would require the Court to examine the record of proceedings before the Secretary and BVA and the special emphasis during the judicial process on the benefit-of-doubt provisions of section 5107(b) as it makes findings of fact in reviewing BVA decisions...The combination of these changes is intended to provide for more searching appellate review of BVA decisions, and thus give full force to the "benefit-of-doubt" provision.⁶

With the foregoing statutory requirements, the Court should no longer uphold a factual finding by the BVA solely because it has a plausible basis, inasmuch as that would clearly contradict the requirement that the Court's decision must take due account of whether the factual finding adheres to the benefit-of-the-doubt

rule. Yet such Court decisions upholding BVA denials because of the “plausible basis” standard continue as if Congress never acted.

Congress clearly intended a less deferential standard of review of the Board’s application of the benefit-of-the-doubt rule when it amended Title 38, United States Code, section 7261 in 2002, yet there has been no substantive change in the Court’s practices. Therefore, to clarify the less deferential level of review that the Court should employ, *The Independent Budget* veterans service organizations believe Congress should amend Title 38, section 7261(a) by adding a new section, (a)(5), that states “In conducting review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision.”

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

Recommendation:

Congress should reaffirm its intentions concerning changes made to Title 38, United States Code, section 7261, by the “Veterans Benefits Act of 2002,” indicating that it was and still is its intent for the Court of Appeals for Veterans Claims to provide a more searching review of the Board of Veterans’ Appeals findings of fact, and in doing so, ensure that it enforces a VA claimant’s statutory right to the benefit of the doubt. Congress should amend 38 U.S.C. section 7261(a) by adding a new section, (a)(5), that states: “In conducting a review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision.” Congress should require the Court to consider and expressly state its determinations with respect to the application of the benefit-of-the-doubt doctrine under section 7261(b)(1), when applicable.

¹ P.L. 107-330, § 401, 116 stat. 2820, 2832.

² Section 401 of the “Veterans Benefits Act”, effective December 6, 2002; 38 U.S.C. §§ 7261(a)(4) and (b)(1).

³ 38 U.S.C. § 7261(a)(4). See also 38 U.S.C. § 7261(b)(1).

⁴ 38 U.S.C. § 7261(b)(1).

⁵ 38 U.S.C. § 5107(b).

⁶ 148 Congressional Record S11337, H9007; 148 Congressional Record S11337, H9003 (daily ed. November 18, 2002) (emphasis added). (Explanatory statement printed in Congressional Record as part of debate in each body immediately prior to final passage of compromise agreement.)



THE COURT’S BACKLOG:

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

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

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

more of the Court’s resources and defeating the purpose of the program.

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

veteran. This failure merely adds to the Court's backlog; therefore, Congress should enact legislation to help preserve the Court's resources. Such an act could be codified in a note to section 7264. For example, the new section could state,

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

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

(b) If the Department of Veterans Affairs later determines a remand is necessary, it may only seek remand by joint agreement with the appellant.

(c) No time shall be counted against the appellant where stays or extensions are necessary when the Department seeks a remand after the end of seven days after the Rule 33 conference.

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

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

Recommendation:

Congress should enact legislation as described herein to preserve the limited resources of the Court of Appeals for Veterans Claims and reduce the Court's backlog.



COURTHOUSE AND ADJUNCT OFFICES:

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

During the 21 years since the Court of Appeals for Veterans Claims (Veterans Court) was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse.

The Veterans Court should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Congress responded in fiscal year 2008 by allocating \$7 million for preliminary work on site acquisition, site evaluation, pre-planning for construction, architectural work, and associated other studies and evaluations. The issue of providing the proper court facility is now moving forward.

Recommendation:

Congress should provide all funding as necessary to construct a courthouse and justice center in a location of honor and dignity to the men and women who served and sacrificed so much to this great nation and befitting the authority and prestige of the United States Court of Appeals for Veterans Claims.

Medical Care

The Veterans Health Administration (VHA) is the largest direct provider of health-care services in the nation. The VHA provides the most extensive training environment for health professionals and is the nation's most clinically focused setting for medical and prosthetic research. Additionally the VHA is the nation's primary backup to the Department of Defense in time of war or domestic emergency.

Providing primary care and specialized health services is an integral component of the Department of Veterans Affairs (VA) core mission and responsibility to veterans. Across the nation, VA is a model health-care provider that has led the way in various areas of medical research, specialized services, and health-care technology. The Department of Veterans Affairs unique system of care is one of the nation's only health-care systems that provide developed expertise in a broad continuum of care. Currently, the VHA provides specialized health-care services that include program-specific centers for care in the areas of spinal cord injury/disease, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related polytrauma injuries. Such quality and expertise on veterans' health care cannot be adequately duplicated in the private sector. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors. Any reduction in spending on VA health-care programs would only serve to degrade these critical services.

In fiscal year (FY) 2012, VA anticipates enrolling more than 8.5 million veterans. Additionally, VA projects enrollment growing to nearly 9 million veterans by FY 2013. Of the more than 8 million veterans that VA projects for enrollment, it plans to provide health-care services to more than 6 million unique patients in FY 2012 and FY 2013. The VHA also projects more than 90 million unique outpatient visits during the course of the fiscal year.

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

(Continued)

While historically VA has faced inadequate appropriations, the enactment of advance appropriations in 2009 allowed VA to better plan and deal with the inability of Congress to complete its work. The fact that the “Military Construction and Veterans Affairs, and Related Agencies Appropriations Act,” 2012 was not completed prior to the start of the new fiscal year in October 2011 further validates the need for advance appropriations.

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

Finance Issues

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

The Department of Veterans Affairs must receive sufficient funding for veteran's health care and Congress must fully and faithfully implement the advance appropriations process to ensure sufficient, timely, and predictable VA health-care funding. Additionally, Congress must preserve critically needed VA health-care funding in the face of deficit reduction pressures.

As the country faces a difficult and uncertain fiscal future, the Department of Veterans Affairs likewise faces significant challenges ahead. Following months of rancorous debate about the national debt and federal deficit during the summer of 2011, Congress agreed upon a deficit reduction measure, P.L. 112-25, that could lead to cuts in discretionary and mandatory spending for VA. Additionally, Congress agreed to create the Joint Select Committee on Deficit Reduction with the mission to reduce the federal deficit by \$1.2 trillion over the next 10 years.

The coauthors of *The Independent Budget—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars*—have serious concerns about the potential reductions in VA spending. While changes to benefits programs and cuts to discretionary programs have unique differences, the impact of these possibilities will be equally devastating for veterans and their families.

Discretionary spending in VA accounts for approximately \$62 billion. Of that amount, nearly 90 percent of that funding is directed toward VA medical care programs. VA is the best health-care provider for veterans. Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. Across the nation, VA is a model health-care provider that has led the way in various areas of medical research, specialized services, and health-care technology. The VA's unique system of care is one of the nation's only health-care systems that provides developed expertise in a broad continuum of care. Currently, the Veterans Health Administration serves more than 8 million veterans and provides specialized health-care services that include program specific centers for care in the areas of spinal cord injury/disease, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related polytraumatic injuries. Such quality and expertise on veterans' health

care cannot be adequately duplicated in the private sector. Any reduction in spending on VA health-care programs would only serve to degrade these critical services.

Moreover, *The Independent Budget* veterans service organizations (IBVSOs) are especially concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on the VA health-care system. In fact, the FY 2012 and FY 2013 advance appropriation budget proposal released by the Administration last year included "management improvements," a popular gimmick used by previous Administrations to generate savings and offset the growing costs to deliver care. Unfortunately, these savings were often never realized leaving VA short of necessary funding to address ever-growing demand on the health-care system. We believe that continued pressure to reduce federal spending will only lead to greater reliance on gimmicks and false assumptions to generate apparent but illusory funding. In fact, the Government Accountability Office (GAO) outlined its concerns with this budget accounting technique in a report released to the House and Senate Committees on Veterans' Affairs in June 2011. In its report, the GAO states:

If the estimated savings for fiscal years 2012 and 2013 do not materialize and VA receives appropriations in the amount requested by the President, VA may have to make difficult trade-offs to manage within the resources provided.¹

This observation reflects the real possibility that exists should VA health care, as well as other programs funded through the discretionary process, be subject to spending reductions.

At the same time, Congress once again failed to fulfill its obligations to complete work on appropriations bills funding all federal departments and agencies, including VA, by the start of the new fiscal year on

October 1, 2011. Fortunately, as has become the new normal, last year the enactment of advance appropriations shielded the VA health-care system from the political wrangling and legislative deadlock. However, the larger VA system is still negatively affected by the incomplete appropriations work. VA still faces the daunting task of meeting ever-increasing health-care demand as well as demand for benefits and other services.

In February 2011, the Administration released its budget submission for VA for FY 2012, recommending an overall discretionary funding authority of \$61.9 billion, approximately \$3.6 billion less than *The Independent Budget* recommended last year. The Administration’s recommendation included a revised estimate for total Medical Care of approximately \$53.9 billion for FY 2012, including approximately \$3.1 billion in medical care collections. The budget also included \$509 million in funding for Medical and Prosthetic Research, a substantial decrease of approximately \$72 million below the FY 2011 funding level.

The IBVSOs expressed serious concerns about the downward revision of the Medical Care estimates for FY 2012. While we certainly understand that the Administration revised the estimates for Medical Care down by \$713 million due to the proposed federal pay freeze (a factor not included in the FY 2011 appropriations bill), the revised budget included ideas of greater concern. Specifically, the IBVSOs had reservations about the outline of an ill-defined contingency fund that would provide \$953 million more for Medical Services for FY 2012. Moreover, we were especially troubled that VA presumed “management improvements” of approximately \$1.1 billion to be directed toward FY 2012 and FY 2013. The use of management improvements or efficiencies is a gimmick that has been commonly used in the past to reduce the requested level of discretionary funding; yet rarely did VA realize any actual savings from those gimmicks. Finally, we were concerned about the revised estimate in Medical Care Collections from the originally projected \$3.7 billion (included in last year’s advance appropriations recommendation and supported by Congress) to now only \$3.1 billion. Given this revision in estimates, we believed then, as we do now, that the VA budget request, and ultimately the funding provided through the appropriations process, was insufficient for VA to meet the demand on the health-care system.

For FY 2012, *The Independent Budget* recommended that the Administration and Congress provide \$65.5 billion in discretionary funding to VA, an increase of \$4.9 billion above the FY 2011 operating budget level, to adequately meet veterans’ health-care and benefits needs. Our recommendations included \$55 billion for health care and \$620 million for medical and prosthetic research.

The Administration also included an initial estimate for the VA health-care accounts for FY 2013. Specifically, the budget request called for \$55.8 billion in total budget authority, with \$52.5 billion in discretionary funding and approximately \$3.3 billion for medical care collections. Given the pressures being placed on VA as a result of deficit and debt reduction, we have serious concerns whether VA will be able to meet new demand with the resources that it is being provided.

Funding for FY 2013

For FY 2013, *The Independent Budget* recommends approximately \$57.2 billion for total medical care, an increase of \$3.3 billion over the FY 2012 operating budget level provided as an advance appropriation by P.L. 112–10, the “Department of Defense and Full-Year Continuing Appropriations Act for FY 2011.” Meanwhile, the Administration recommended an advance appropriation for FY 2013 of approximately \$52.5 billion in discretionary funding for VA medical care. When combined with the \$3.3 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2013 is approximately \$55.8 billion.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2013, *The Independent Budget* recommends approximately \$46 billion for Medical Services. Our Medical Services recommendation includes the recommendations in Table 2.

Current Services Estimate	\$43,855,969,000
Increase in Patient Workload	\$1,510,394,000
Additional Medical Care Program Costs	\$675,000,000
Total FY 2013 Medical Services	\$46,041,363,000

Our growth in patient workload is based on a projected increase of approximately 110,000 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately \$1 billion. The increase in patient workload also includes a projected increase of 96,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), as well as Operation New Dawn (OND) veterans at a cost of approximately \$349 million. Our recommendations represent an increase in projected workload in this population of veterans over previous years as a result of the withdrawal of forces from Iraq, the drawdown of forces in Afghanistan, and a potential drawdown in the actual number of service members currently serving in the Armed Forces.

Finally, our increase in workload includes the projected enrollment of new priority group 8 veterans who will use the VA health-care system as a result of the Administration's continued efforts to incrementally increase the enrollment of priority group 8 veterans by 500,000 enrollments by FY 2013. We estimate that as a result of this policy decision, the number of new priority group 8 veterans who will enroll in VA should increase by 125,000 between FY 2010 and FY 2013. Based on the priority group 8 empirical utilization rate of 25 percent, we estimate that approximately 31,250 of these new enrollees will become users of the system. This translates to a cost of approximately \$134 million.

Finally, the IBVSOs believe there are additional projected funding needs for VA. Specifically, we believe there is real funding needed to restore the VA's long-term-care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of VA) and to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service). In order to restore the VA's long-term care average daily census (ADC) to the level mandated by Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act," we recommend \$375 million. In order to meet the increase in demand for prosthetics, *The Independent Budget* recommends an additional \$300 million. This increase in prosthetics funding reflects a significant increase in expenditures from FY 2011 to FY 2012 (explained in the section on Centralized Prosthetics Funding) and the expected continued

growth in expenditures for FY 2013. Additionally, it is worth noting that the VA has actively implemented the new caregiver program mandated by Public Law 111–163, the "Caregivers and Veterans Omnibus Health Services Act." However, we believe that still greater funding should be appropriated, above what the VA has currently allocated for this program, in order to more effectively and efficiently operate the program.

For Medical Support and Compliance, *The Independent Budget* recommends approximately \$5.6 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately \$5.6 billion. While our recommendation does not include an additional increase for nonrecurring maintenance (NRM), it does reflect a FY 2013 baseline of approximately \$900 million. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended two to four percent of plant replacement value. In fact, VA should actually be receiving at least \$2.1 billion annually for NRM (Refer to Construction section article "Increase Spending on Nonrecurring Maintenance).

Advance Appropriations for FY 2014

P.L. 111–81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2013 and subsequent fiscal years. With this in mind, the VA Secretary is required to update the advance appropriations projections for the upcoming fiscal year (FY 2013) and provide detailed estimates of the funds necessary for the medical care accounts for FY 2014. Moreover, the law also requires a thorough analysis and public report of the Administration's advance appropriations projections by the Government Accountability Office (GAO) to determine if that information is sound and accurately reflects expected demand and costs.

As noted previously, the GAO report that analyzed the FY 2012 budget submission of the Administration identified serious deficiencies in the budget formulation of VA. Yet these concerns were not appropriately addressed by Congress or the Administration. This analysis and the subsequent lack of action to correct these deficiencies simply affirm the ongoing need for the GAO to evaluate the budget recommendations of VA.

Recommendations:

The Administration and Congress must provide sufficient funding for VA health care to ensure that all eligible veterans are able to receive VA medical services without undue delays or restrictions.

Congress and the Administration must work together to ensure that advance appropriations estimates for

FY 2013 are sufficient to meet the projected demand for veterans' health care and authorize those amounts in the FY 2013 appropriations act.

The Administration and Congress must provide sufficient funding for VA health care to ensure that all eligible veterans are able to receive VA medical services without undue delays or restrictions.

¹ U.S. Government Accountability Office (2011, June). Veterans' Health Care Budget Estimate: Changes Were Made in Developing the President's Budget Request for Fiscal Year 2012 and 2013.



INAPPROPRIATE BILLING:

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

The Department of Veterans Affairs was granted the authority to collect payments from health insurers of veterans who receive VA care for nonservice-connected conditions, as well as other revenues, such as veterans' copayments and deductibles, and manage these collections through the Medical Care Collections Fund (MCCF).² These funds are then to be used to augment spending for VA medical care and services and for paying departmental expenses associated with the collections program. MCCF funds are transferred to a no-year Medical Care service account³ and allocated to the medical centers that collect them one month in arrears. In recent years, *The Independent Budget* veterans service organizations (IBVSOs) have expressed concern with ever-increasing budget estimates for medical care collections as well as dramatically revised estimates of collections from one fiscal year to the next. Moreover, we have serious concerns with the need of local facilities to meet collections estimates to ensure they have adequate resources leading to unnecessary and inappropriate billing.

In recent years, as there have been significant increases in both medical care collections estimates as well as the actual dollars collected, the IBVSOs have received an increasing number of reports from veterans who are being inappropriately billed by the Veterans Health Administration (VHA) for their care. Reports continue to surface within our organizations

of veterans with service-connected amputations being billed for the treatment of pain associated with amputation, and veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers, two ubiquitous problems of the spinal cord injured. Inappropriate billing for such secondary conditions forces service-connected veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden to both veterans and an already backlogged claims system.

Moreover, this is not a problem being experienced by just service-connected disabled veterans, but nonservice-connected disabled veterans as well. *The Independent Budget* has repeatedly focused attention on this issue. Unfortunately, little action has been taken to address this problem, while medical care collections continue to grow at an alarming rate. Inappropriate charges for VA medical services place unnecessary financial stress on individual veterans and their families. These inaccurate charges are not easily remedied and their occurrence places the burden for correction directly on veterans, their families, or caregivers.

Service-Connected Veterans

Service-connected veterans face the scenario of being billed for treatment of a service-connected condition (first-party billing) or having their insurance

company billed (third-party billing). The VA Office of Inspector General (OIG) issued a report in 2004 evaluating first-party billings and collections for veterans service-connected at 50 percent or higher or in receipt of a VA pension.⁴ Four recommendations were made as a consequence of the report. VA's action plan included developing information sharing initiatives targeted at improving billing practices and addressing inappropriate billing, such as the timely sharing of information across the VHA and with the Veterans Benefits Administration (VBA). Specifically, VA medical centers are to have the proper tools to ensure first-party debts are determined appropriate before bills are issued and identify inappropriate bills that have been sent to veterans for cancellation or reimbursement. In addition, the Office of Compliance and Business Integrity would monitor copayment charges issued to certain veterans⁵ and facility revenue, and the associated business office staff would take corrective action when inappropriate bills were identified.

The OIG indicated that until the VHA has demonstrated a billing error rate of less than 10 percent for two consecutive quarters, it will continue to monitor this activity. On March 4, 2010, the VHA issued a notice rescinding the First Party Co-Payment Monitoring Policy, and recommendations made by the OIG were closed. According to the December 18, 2009, memorandum to Veterans Integrated Service Networks (VISNs), effective January 1, 2010, facilities that have met the 10 percent performance target for two consecutive quarters are no longer required to continue First Party Co-Payment monitoring for priority groups 1 and 5 veterans. As per the rescission, there is no longer any collection of national performance data; however, the VHA Office of Compliance and Business Integrity will continue to provide quarterly reports identifying priority group 1 or 5 veterans who have been potentially inappropriately billed and referred to VA Debt Management Center to VISNs for action. The success of this monitoring has resulted in dramatic reductions in inappropriate referrals from 89 percent at the time of the OIG report to 16 percent in FY 2009.

However, these corrective measures do not cover all adversely affected veterans—only those veterans in priority groups 1 and 5 who have been referred to the VA Debt Management Center for collection action. Current law requires VA to collect copayments for medical care and medications provided certain veterans for nonservice-connected conditions.

While the VA OIG report focused on the appropriateness of debts, for veterans receiving compensation for service-connected disabilities rated 50 percent or higher or VA pensions, the IBVSOs do not believe VA responsibility should be limited to the OIG's focus.

While the OIG will close the recommendations contained in its report once the error rate decreases to a significantly low level (less than 10 percent) and that level is sustained for at least two consecutive quarters, we urge this office to conduct a follow-on evaluation and expand its focus to all service-connected disabled veterans who use the VA health-care system.

Prior to these most recent initiatives, inappropriate billing of veterans for VA medical care was a result of a lack of controls, such as oversight on billing and coding, or adequate reviews of whether the medical care provided was for a service-connected disability or not. In fact, the Government Accountability Office (GAO) recently outlined reasons that veterans with service-connected disabilities received inappropriate bills based on an analysis it conducted. The GAO explained in a report (GAO-11-795) released to the House and Senate Committees on Veterans' Affairs in August 2011:

VHA [Veterans Health Administration] officials said that the cause for the incorrect data related to the data transfer from VBA to VHA's HEC [Health Eligibility Center] and local medical centers...[Additionally], the disability rating recorded in HEC's and the medical centers were inconsistent, resulting in the medical center having the veteran in an incorrect priority group.⁶

Other causes of inappropriate billing include incorrect compensation and pension status information, such as the incomplete listing of service-connected disabilities that can be viewed by MCCF staff in the information system or when the system shows an incorrect effective date of claims for service connection, which may have been pending when the veteran sought treatment, making the veteran subject to copayments. Clearly, information management is crucial if inappropriate first-party billing is to be avoided. Although such simple information is readily available in the VBA information system, it may not be easily accessible by MCCF staff in a VHA facility. The VHA has certainly made progress linking these two systems to provide more accurate and up-to-date information; however, the IBVSOs continue

to receive recurring reports from our members that inappropriate billing continues.

Nonservice-Connected Veterans

The IBVSOs also continue to receive reports of nonservice-connected disabled veterans receiving inappropriate bills. The most common occurrence for nonservice-connected disabled veterans is that they are usually billed multiple times for the same treatment episode or have difficulty getting their insurance companies to pay for treatment provided by VA. In addition, nonservice-connected veterans experience inappropriate charging for copayments. These billing practices are becoming the norm rather than the exception.

Inappropriate bill coding is causing major problems for veterans subject to VA copayments. Veterans using VA specialized services, outpatient services, and VA's Home Based Primary Care programs are reporting multiple billings for a single visit. Often these multiple billing instances are the result of follow-up medical team meetings at which a veteran's condition and treatment plan are discussed. These discussions and subsequent entries into a veteran's medical record trigger additional billing. In other instances, simple phone calls from VA health-care professionals to individual veterans to discuss their treatment plan or medication usage can also result in copayment charges when no actual medical visit has even occurred.

Veterans who are astute enough to scrutinize their VA billing statements to identify erroneous charges are just beginning the cumbersome process to actually correct the problem and receive a credit for the error on a VA subsequent billing statement. It has become the veteran's responsibility to seek VA assistance wherever possible. This is not an easy task for veterans because VA billing statements are often received months after an actual medical care encounter and subsequent credit corrections only appear months after corrective intervention has taken place. It is often difficult for veterans to remember medical care treatment dates and match billing statements that arrive months after treatment to search for billing errors.

Last, while P.L. 111-163, the "Caregivers and Veterans Omnibus Health Services Act," which became law on May 5, 2010, prohibits VA from collecting copayments from catastrophically disabled

nonservice-connected veterans for medical services, this may not remove all the problems nonservice-connected veterans face. Unfortunately, the IBVSOs continue to receive reports from veterans with catastrophic disabilities who should be exempted from copayments for medical services and prescriptions but continue to receive bills from their respective VA medical centers. Apparently, implementation of the copayment exemption is not well coordinated VA-wide. While some select VA medical centers seem to have properly implemented this program, many VA medical centers have failed to address the provisions of this law. The IBVSOs believe that part of this failure rests with the VA Central Office's inability to properly roll out a national implementation plan. As such, VA medical centers around the country have chosen to follow or ignore the provisions of P.L. 111-163 as they see fit. Given the financial challenges many of these catastrophically disabled veterans are facing, it is time for VA to finally, and completely, implement this law.

Third-Party Billing

VA has implemented more effective billing practices and systems, but has been unable to meet its collection goals.⁷ Equal to the need for accurate information on the compensation and pension status of veterans, third-party insurance information is also needed to avert inappropriate third-party billing. The type of policies and the types of services covered by the insurers, patient copayments and deductibles, and preadmission certification requirements are vital to VA's MCCF program.

The Department's ability to accurately document the nonservice-connected care provided to insured veterans, and assign the appropriate codes for billing purposes, is essential to improve the accuracy of third-party collections. Failure to properly document care can lead to missed opportunities to bill for care, billing backlogs, overpayments by insurers, or denials of VA invoices. More important, although VA is authorized to bill third parties only for nonservice-connected care, the IBVSOs continue to hear reports from service-connected disabled veterans, their spouses, or caregivers that VA is billing their insurance companies for treatment of service-connected conditions. At times, notification of the billing departments of their local VA medical centers is sufficient. In other instances, however, the inappropriate third-party billing continues for the same condition or treatment.

The GAO explained in its report that VHA billing errors did not appear to be significantly high. Its tests of a probability sample led to an estimate of approximately a 4 percent error rate. However, the GAO emphasized:

[B]ecause VHA does not have established acceptable or tolerable error rates for copayment charges, the extent to which the error rates would be observed would compare to levels of performance that VHA would consider acceptable is unclear.⁸

The GAO recommended that the VHA establish a performance measure for copayment accuracy rates and to periodically assess the accuracy and completeness of its copayment charges. The GAO stated:

VHA would be able to make informed decisions concerning the rates and causes of erroneous copayment charges, including whether any actions are needed to lower its overall error rate. Such periodic assessments could be integrated into VHA's existing quality assurance monitoring efforts and provide meaningful management information on various aspects of its copayment billing systems and processes, including whether key veteran data were consistently and correctly recorded in VHA records and systems...having meaningful performance information regarding copayment accuracy to provide to stakeholders, including veterans organizations and Congress, could assist VA in responding to any questions concerning the accuracy and completeness of copayment charges.⁹

Ultimately, the IBVSOs believe all inappropriate billing is unacceptable. We look forward to continued oversight by Congress and the GAO to ensure that these occurrences do not continue. Additionally, we must emphasize that the burden to avoid and correct inappropriate billing should rest on VA—not the veteran. This undue burden is particularly egregious when placed on veterans whose disabilities are rated permanent and total, who suffer from conditions reasonably certain to continue throughout their lifetimes and render them unable to maintain substantial gainful employment.

Recommendations:

Congress should enact legislation that exempts veterans who are service-connected with permanent and total disability ratings from being subjected to first- or third-party billing for treatment of any condition.

The VA Under Secretary for Health should establish policies and monitor compliance to prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that are related to service-connected disabilities.

The VA Under Secretary for Health should establish and enforce a national policy describing the required action(s) a VA facility must take when a veteran identifies inappropriate billing as having occurred. When such actions are taken, their resolution(s) must be reported to a central database for oversight purposes.

The Veterans Benefits Administration-Veterans Health Administration eligibility data interface must be improved and simplified, to ensure the information available to the VHA is accurate, up to date, and accessible to staff responsible for VHA billing and revenue.

The VA Office of Inspector General should conduct a follow-up evaluation of its December 2004 report on Medical Care Collections Fund first-party billings and collections for all service-connected disabled veterans.

The VHA must establish a performance measure for copayment accuracy rates and to periodically assess the accuracy and completeness of its copayment charges.

² "The Consolidated Omnibus Budget Reconciliation Act of 1985," P.L. 99-272, the "Omnibus Budget Reconciliation Act of 1990," P.L. 101-508, the "Veterans' Health Care Eligibility Reform Act of 1996," P.L. No. 104-262, the Veterans Reconciliation Act of 1997," P.L. 105-33, and the "Veterans Millennium Health Care and Benefits Act," P.L. 106-117.

³ P.L. 105-65.

⁴ Office of Inspector General, Department of Veterans Affairs, Report Number 03-00940-38, *Evaluation of Selected Medical Care Collection Fund First Party Billings and Collections*. December 1, 2004. <http://www.va.gov/oig/52/reports/2005/VAOIG-03-00940-38.pdf>.

⁵ Department of Veterans Affairs, VHA Handbook 1030.03, October 16, 2006.

⁶ U.S. Government Accountability Office. (2011, August). GAO-11-795. Veterans Health Care: Monitoring is Needed to Determine the Accuracy of Veteran Copayment Charges.

⁷ Fiscal Year 2008 budget estimate of \$2.352 billion with actual collections of \$2.442 billion.

⁸ GAO-11-795.

⁹ Ibid.

HOMELAND SECURITY/FUNDING FOR THE FOURTH MISSION:

The Veterans Health Administration is playing a major role in homeland security and bioterrorism prevention. The Administration must request and Congress must appropriate sufficient funds to support the fourth mission.

The Department of Veterans Affairs has four critical health-care missions, of which the primary mission is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission is to conduct medical research, and VA's fourth mission is to serve civilians—both domestic and foreign—in times of national emergency. Whether precipitated by a natural disaster, a terrorist act, or a public health contagion, the federal preparedness plan for national emergencies, known as the National Response Framework (NRF), involves multiple agencies. VA is the second-largest department in the federal government, with medical facilities in cities and communities all across the nation. Moreover, its medical staff is second to none, and is leading the way in many areas on medicine. VA is uniquely situated to provide emergency medical assistance across the country and plays an indispensable role in our national emergency preparedness strategy.

In no area is this supporting role more important than its support of the Department of Defense. VA has statutory authority under Title 38 to serve as the principal medical care backup for military health care “[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]” On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed P.L. 107–40, “Authorization for Use of Military Force,” which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. P.L. 107–40 satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the Department of Defense.

VA's role in homeland security and responding to domestic emergencies was established by P.L. 107–188, the “Public Health Security and Bioterrorism Preparedness Response Act of 2002,” and the subsequently created National Disaster Medical System (NDMS), which combines federal and nonfederal resources into a unified response. The NDMS, an

interagency partnership between the Department of Health and Human Services (HHS), the Department of Homeland Security (DHS), DOD, and VA, was instituted in a 2005 memorandum of agreement among the agencies. VA is involved in the maintenance and evaluation of NDMS and has assigned “area emergency managers” at each Veterans Integrated Service Network to support the effort. The NDMS was most recently activated in 2010 during the Haitian earthquake, and VA was fully involved. Specifically, VA provided personnel to completely staff two federal medical stations and coordinated the receipt and distribution of patients who were evacuated to Florida and Georgia to receive life-saving care.

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

In 2002, Congress also enacted P.L. 107–287, the “Department of Veterans Affairs Emergency Preparedness Act.” This law directed VA to establish four emergency preparedness centers. These centers were to be responsible for research to develop methods of detection, diagnosis, prevention, and treatment for the use of chemical, biological or radiological threats to public health and safety. In addition, the centers were to provide education, training, and advice to health-care professionals while providing laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care

agencies and personnel involved in or responding to a disaster or emergency. Although authorized by law at a funding level of \$100 million, these centers did not receive any funding and were not established.

Calendar year 2011 was a record year for federally declared natural disasters in the United States, both in terms of overall number and cost. Public health emergencies are impossible to predict and could range from weather events to terrorism. Therefore, it is more important than ever for our nation to have a comprehensive plan in place and to responsibly leverage existing assets to maximize our potential to save lives and property.

The Independent Budget veterans service organizations believe that the Administration must request and Congress must appropriate sufficient funds in order for VA to meet these responsibilities in FY 2013. These funds should be appropriated outside the Medical Services appropriation. Without additional funding and resources, VA may encounter difficulties in becoming a resource in a time of national crisis. VA has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not received any designated funding for the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific

line item in the budget to address medical emergency preparedness or other homeland security initiatives; homeland security funding is simply taken from the Medical Services appropriation. This arrangement diverts resources needed to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, resources will continue to be diverted from direct health-care programs.

Recommendations:

Congress should provide funds necessary in the Veterans Health Administration (VHA) FY 2013 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, VA should request appropriate funding separately from the Medical Care appropriation to support its health-care-related emergency management, planning, education, and research.

The VHA should evaluate the need for the four emergency preparedness centers authorized in P.L. 107-287, the "Department of Veterans Affairs Emergency Preparedness Act," and incorporate the funding requirements for those centers in future budget requests.



Mental Health Issues

MENTAL HEALTH SERVICES:

The Department of Veterans Affairs faces significant challenges ensuring that newly returning war veterans have access to post-deployment readjustment services and specialized treatments while ensuring that all other enrolled veterans gain and keep access to effective, timely, high-quality VA mental health services.

T*he Independent Budget* veterans service organizations (IBVSOs) recognize the significant efforts made by the Department of Veterans Affairs to meet the mental health needs of our nation's veterans. However, despite the Department's obvious efforts and progress, the IBVSOs believe much still needs to be accomplished to fulfill the nation's obligations to veterans who are challenged by serious mental illness

and post-deployment mental health readjustment. We are pleased that, through its national Mental Health Strategic Plan, VA is committed to reform its mental health programs.

The development of the VA Mental Health Strategic Plan and the Uniformed Mental Health Services (UMHS) policy (detailed in *VHA Handbook*

1160.01, dated September 11, 2008)¹⁰ provide a comprehensive and ambitious roadmap for the Veterans Health Administration's transformation. However, the IBVSOs have expressed continued concern about the variable implementation across the system, the timeliness of progress, and the need for continued oversight during the implementation phase of these critical initiatives.

Historically, VA has been plagued with wide variations among VA medical centers and their community-based outpatient clinics (CBOCs) in adequacy and availability of a continuum of mental health services. To address these concerns, over the past several budget cycles VA has provided facilities with targeted mental health funds to augment specialized mental health services. This funding was intended to address widely recognized gaps in access to and availability of mental health and substance-use disorder services, to address the unique and growing needs of veterans who served in Operations Enduring and Iraqi Freedom and New Dawn (OEF/OIF/OND), and to create a comprehensive mental health and substance-use disorder system of care within the Veterans Health Administration (VHA) that is focused on recovery. Experts note that timely, early intervention services can improve veterans' quality of life, address substance-use problems, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems. According to VA, over \$5.7 billion was obligated for mental health services in FY 2011, not including services provided by Vet Centers or in primary care clinics. The amount for these mental health programs requested in the President's budget for FY 2012 totals \$6.15 billion.¹¹ Despite these significant budget increases, VA continues to struggle to meet demand and provide timely mental health services for many veterans.

The IBVSOs are concerned about VA's apparent plan to cease separately accounting for mental health expenditures beginning in FY 2013, and instead to include all these funds in VA's overall capitated allocation system. The unintended effects of this shift may diminish VA's intensity in providing for veterans' mental health and post-deployment readjustment services at a time when needs continue to rapidly escalate and program implementation is incomplete. It may also inadvertently increase the variability of veterans' access to mental health and substance use disorder services. We intend to monitor this shift to determine

its effects on veterans who need effective services, and we ask Congress to provide oversight to ensure VA continues to meet its mental health mission.

Challenges Ahead

VA has hired more than 7,500 mental health-care workers since 2005, and its mental health staff totaled almost 21,000 as of September 2011.¹² Thus, the IBVSOs are pleased that VA is developing methods to improve access; but veterans who seek VA assistance for mental health challenges too often face difficulty gaining timely appointments, despite VA policy requiring scheduling mental health specialty visits within 14 days of initial contact.

As a consequence of a July 2011 Senate Veterans' Affairs Committee oversight hearing, and pressed by the chairwoman of that committee to reconcile the disparity between VA policy and practice on waiting times, VA recently surveyed mental health providers across the system regarding timeliness. Nearly 40 percent responded they could not schedule an appointment in their own clinics for new patients within 14 days. A startling 70 percent responded that their sites lacked both adequate staff and space to meet current demands, and 46 percent reported lack of off-hour appointments to be a barrier to care. In addition, more than one in four respondents stated that demand for compensation and pension examinations diverted clinical staff away from direct care.¹³

In October 2011, the Government Accountability Office (GAO) issued a report titled "VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access," covering veterans who used VA from FY 2006 through FY 2010. Approximately 2.1 million unique veterans received mental health care from VA during this period. Although the number steadily increased due primarily to growth in OEF/OIF/OND veterans seeking care, the GAO noted that veterans of other eras still represent the vast majority of those receiving mental health services within VA. In 2010 alone, 12 percent (139,167) of veterans who received mental health care from VA served in our current conflicts, but 88 percent (1,064,363) were veterans of earlier military service eras. The GAO noted that services for the OEF/OIF/OND group had caused growth of 2 percent per year in VA's total mental health caseload since 2006. The GAO also noted that in FY 2010 the five most common diagnoses, in order of prevalence, were adjustment reaction, depressive disorder,

episodic mood disorder, neurotic disorder, and substance-use disorder.

Key barriers identified in the GAO report that hinder veterans from seeking mental health care differed from the barriers that VA found in its August 2011 query, to include stigma, lack of understanding or awareness of mental health care, logistical challenges to accessing care, and concerns that VA's care is primarily for older veterans. VA indicates it is aware of these barriers and continues to implement efforts to increase veterans' access to mental health care.

Additionally, RAND Corporation released a technical report in October 2011 titled "Veterans Health Administration Mental Health Program Evaluation," which identified 836,699 veterans in 2007 with at least one of five mental health diagnoses (schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), major depression, and substance-use disorders). While this group represents only 15 percent of the VHA patient population, these veterans accounted for one-third of all VHA medical care costs because of their high rate and intensity of use of medical services. Interestingly, the majority of health care received by veterans with these diagnoses was for non-mental health conditions, reflecting the high degree to which veterans with mental health and substance-use conditions also face difficulties maintaining their general health.

RAND's research team surveyed all VA facilities nationwide about the availability of basic and specialized services in 2007 and again in 2009 and found that by 2009, basic and specialized services were widely available. RAND also found the use of evidence-based practices (EBPs), which are linked to improved mental health outcomes, also increased substantially over that two-year period.

The RAND research team concluded that the quality of VA mental health care is generally as good as, or better than, care delivered by private health plans, but that VA does not always meet its own explicit guidelines for local performance. One notable finding was that the documented receipt of EBPs among targeted veterans was well below the reported capacity of VA facilities to deliver such care. For example, only 20 percent of veterans with PTSD and 31 percent of those with major depression were reported to have received this type of treatment. The research team also found variances in quality of care across

regions and populations; however, when most veterans were asked to express satisfaction with their care, 42 percent rated their care at 9 or 10 on a 10-point scale, while only 32 percent perceived improvement in their symptoms as an outcome of care. This level of variation causes the IBVSOs great concern, particularly given the emerging needs of our newest generation of war veterans yet to be recipients of VA mental health services.

Mental Health Services for a New Generation of War Veterans

Ten years of war have taken a toll on the mental health of American military forces. Combat stress, PTSD, and other combat- or stress-related mental health conditions are prevalent among veterans who have also deployed to war environments in Iraq and Afghanistan; some of these veterans have been severely disabled. The IBVSOs believe that all enrolled veterans, and particularly service members, National Guardsmen, and reservists returning from contingency operations overseas, should have maximal opportunity to recover and successfully readjust to civilian life. They must be able to gain "user-friendly" and timely access to VA mental health services that have been validated by research evidence to offer them their best opportunity for full recovery.

Regrettably, as was learned from our experiences in other wars, especially the Vietnam conflict, psychological reactions to combat exposure are common and could even be called expected or normal. Experts note that if not readily addressed, such problems can easily compound and become chronic. Over the long term, the costs mount due to impact on personal, family, emotional, medical, and financial damage to those who have honorably served our nation. Delays in addressing these problems can culminate in self-destructive behaviors, including substance-use disorders, incarceration, and suicide attempts. Increased access to mental health services for many of our returning war veterans is a pressing need, particularly in early intervention services for substance-use disorders and provision of evidence-based care for those diagnosed with PTSD, depression, and other consequences of combat exposure.

Unique aspects of deployments to Iraq and Afghanistan, including the frequency and intensity of exposure to combat, guerilla warfare in urban environments, and the risks of suffering or witnessing violence, are strongly associated with a risk of

chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts for early identification and treatment of behavioral health problems experienced by returning veterans. VA instituted systemwide mental health screenings, expanded mental health staffing, integrated mental health into primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. VA also has intensified its research programs in mental health. However, critical gaps remain today, and the mental health toll of this war is likely to grow over time for those who have deployed more than once, do not seek or receive needed services, or face increased stressors in their personal lives following deployment.¹⁴ The IBVSOs are concerned that while VA is winning many battles in its approaches to mental health, results for our newest veterans remain much in doubt.

Since the beginning of the conflicts in Iraq and Afghanistan, VA has faced a number of daunting challenges in providing care to a new generation of war veterans—particularly in post-deployment mental health. Initially, the needs and expectations of OEF/OIF/OND veterans and their families proved to be different from those of veterans who had typically been under VA care. These new veterans and their families wanted the Departments of Defense and Veterans Affairs to transform their approaches to post-deployment mental health services, and to stress family-centered treatment rather than focus on individual veterans—a paradigm shift for VA. Over its history, VA concentrated primarily on the single veteran-patient to the exclusion of family in most cases. But this new generation of veterans is younger, technologically savvy, and demands improved access to information via the Internet, access to state-of-the-art prosthetic items, expertise in trauma care, and advanced rehabilitation methods. They also expect support for their family caregivers and better transition and collaboration between the Department of Defense and VA in policies for caregivers. Likewise, Congress, advocacy groups, and community stakeholders, including groups in the private sector offering specialized services, have been very active in pressing for change in how VA relates to community providers and furnishes care in its mental health and rehabilitative services.

Last year the VA Office of Mental Health Services (OMHS) introduced a public health model for meeting the mental health needs of OEF/OIF/OND veterans with the knowledge that most war veterans will not develop mental illness if proper focus is concentrated on early intervention and efforts to destigmatize their seeking help and the use of effective mental health models along with increased outreach efforts to this population. The goal is to promote healthy outcomes and strengthen families, with a particular focus on resilience and recovery. This initiative requires VA to shift from its more traditional “medical model” approach to an approach that for many veterans would be less focused on obtaining a diagnosis and developing a treatment plan, and more on helping veterans and their families retain or regain an overall balance in their physical, social, and mental well-being despite the stresses of deployments. Most important, it calls for VA to reach out to veterans in their communities, adjust its message, make access easy on these veterans’ terms, and reformat programs and services to meet the needs of veterans and their families, rather than VA’s expecting veterans to fit into its traditional array of available services.¹⁵ For years the IBVSOs have called for this transition within VA, and we are pleased to see it begin in mental health.

According to the VA Office of Inspector General the percentage of OEF/OIF/OND veterans enrolled in the VA health-care system is historically higher than veterans of prior military service eras—and among these veterans, 51 percent have received a possible mental health diagnosis. Rates of post-deployment-related PTSD and depression have also risen as a result of the nature of contemporary warfare and multiple deployments for many service members.¹⁶

PACT and Mental Health

The patient-aligned care teams (PACT) is an interdisciplinary medical-home health-care delivery model that VA has embraced to organize holistic care of the veteran by primary health-care teams. In an attempt to address the growing demand for patient-centered mental health services, VA is now incorporating mental health into PACT. In doing this, VA should ensure that mental health staffing to support PACT is adequate to meet the mental health and substance use disorder needs of veterans in primary care. This strategy will require additional awareness and training of PACT team members. Recent program evaluations show that integrating mental health services into

primary care settings has increased access for large numbers of young, elderly and women veterans.¹⁷ For more complete information on PACT, see our discussion on that topic elsewhere in this *Independent Budget*.

The Invisible Wounds of War: TBI and PTSD

From October 2001 through September 2011, more than 2.2 million service members from the active and reserve components have deployed for combat service in OEF/OIF/OND. Since FY 2002, more than 1.35 million individuals, most of whom had combat deployments to these war zones, have left active duty and become eligible for VA health care and other VA benefits. These conflicts have produced a number of severe and polytrauma injuries in service members, many involving traumatic brain injury (TBI). The more visible head injuries obvious to medical personnel are properly treated; however, the IBVSOs believe gaps remain within the DOD and VA health-care systems in the recognition, diagnosis, treatment, and rehabilitation of the less-visible injuries, such as mild to moderate TBI, subsyndromal mental health conditions, and mild to moderate PTSD.¹⁸

Traumatic Brain Injury

According to the Defense and Veterans Brain Injury Center (DVBIC), a DOD center that collects and analyzes information from electronic medical records in cooperation with the Armed Forces Health Surveillance Center, an estimated 22 percent of all combat casualties from the current conflicts are brain injuries, compared to 12 percent of Vietnam-related combat casualties. Also, the DVBIC reports that 60–80 percent of soldiers and marines who have experienced blast injuries may also have traumatic brain injuries. The cumulative number of actual medical diagnoses of TBI that occurred anywhere U.S. forces are stationed or deployed from FY 2002 through the second quarter of FY 2011 is 197,637. Official TBI diagnoses rose sharply since 2007 and have steadily increased each year, with 2010 having produced the highest number at 31,353 confirmed TBIs.¹⁹

VA reported that as of August 2011 approximately 552,077 OEF/OIF/OND veterans had been screened for possible mild TBI, of whom 103,559 screened positive and consented to additional evaluation. Among that group, 77,620 have received completed evaluations and 43,004 were given a confirmed diagnosis of mild TBI. VA reported that in its polytrauma

programs, 2,160 active duty service members and veterans have been treated at its designated polytrauma rehabilitation centers. More than 66 percent of these patients were ultimately discharged to their homes, with functional improvements comparable to private sector rehabilitation rates. VA provided outpatient care to 20,052 veterans with TBI/polytrauma in FY 2010, for an accumulated 56,992 patient encounters. Additionally, VA reported a significant increase in tele-rehabilitation services for polytrauma services: a 311 percent increase over FY 2009.²⁰

Since 2003, a number of studies have been published that examined the percentages of returning veterans and service members with PTSD, depression, or the percentage reporting that they experienced TBI. For example RAND Corporation's 2008 "Invisible Wounds of War" study noted that 18.4 percent of all post-deployed service members presented conditions that met criteria for either PTSD or major depression, and that 19.5 percent reported experiencing a probable TBI during their deployments. This may be compared to a more recent RAND study, "A Needs Assessment of New York State Veterans," that found 22 percent of the sampled population (OEF/OIF/OND veterans who had separated from the military and were eligible for VA care) met criteria for probable PTSD and major depression. While the results may vary depending on the study populations as well as the methodology and timing of assessment, studies consistently show that the range of post-deployment mental health problems among returning service members is about 15–20 percent. These findings imply that about 400,000 OEF/OIF/OND veterans present conditions that meet criteria for PTSD or depression. The number who may have experienced a probable TBI during deployment could be roughly equal.²¹

Experts note that the effects of TBI are complex. Within VA many veterans have a dual diagnosis of TBI and PTSD with overlapping symptoms. Treatment protocols and best treatment plans for this population are still evolving. VA is addressing the daily needs of veterans with TBI and psychological specialists working together. VA is accruing evidence related to best practices and is adjusting its practice guidelines based on both clinical and research findings as they occur. The IBVSOs appreciate that progress but unfortunately, we continue to hear complaints from veterans about the fragmentation of

care—especially for those patients who present with TBI-related behavioral problems. Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, gaps in services are still troubling.

The IBVSOs urge continuing development of treatment protocols and guidelines and support services to better assist these veterans and their families to manage the tumultuous challenges that accompany brain injury, often attended by other severe physical injuries.

Post-Traumatic Stress Disorder

Newly returning veterans' post-deployment mental health challenges have resulted in a surge in use of VA's specialized PTSD mental health services. According to VA, among OEF/OIF/OND personnel, PTSD is estimated to affect approximately 15 percent of deployed service members. Additionally, data from a number of sources have shown rising rates of PTSD associated with multiple deployments and that service members with PTSD exhibit more problems with post-deployment readjustment, including problems with marital instability, divorce, family problems, homelessness, and higher unemployment rates.²² VA's autumn 2011 "Facility Specific Report Among OEF/OIF/OND Veterans Coded with Potential PTSD" indicates that as of September 30, 2011, more than 211,000 veterans had been treated at VHA facilities whose visits were coded for potential PTSD. Among these veterans more than 170,000 were seen at VA medical centers, nearly 15,000 were seen at Readjustment Counseling Service Vet Centers, and 27,000 were seen at both sites. The most common mental health diagnoses for OEF/OIF/OND veterans were PTSD, depressive disorders, and neurotic disorders, as contrasted with all other veterans using VA mental health services, with depressive disorders, adjustment reaction (to include PTSD), and neurotic disorders being most common for them.

Dr. Charles W. Hoge, a leading researcher on the mental health toll on veterans from the conflicts in Afghanistan and Iraq, observes that VA is not reaching large numbers of returning veterans, and high percentages drop out of treatment. In a recent analysis, Hoge wrote, "...veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD

treatment with psychotherapy or medication, a high percentage drop out....With only 50 percent of veterans seeking care and a 40 percent recovery rate, current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment."²³

The IBVSOs agree with Dr. Hoge's view that VA must develop a strategy of expanding the reach of treatment, to include greater engagement of veterans, understanding the reasons for veterans' negative perceptions of mental health care, and "meeting veterans where they are."²⁴ Until recently, little had been known about recently returned veterans' actual utilization of VA mental health care. A recent comprehensive study found that of nearly 50,000 OEF/OIF/OND veterans with new PTSD diagnoses, fewer than 10 percent appeared to have received VA evidence-based treatment for PTSD (defined by researchers as attending nine or more evidence-based psychotherapy sessions in 15 weeks); 20 percent of those veterans did not have a single mental health follow-up visit in the first year after diagnosis.²⁵

VA operates a nationwide network of specialized PTSD outpatient treatment programs, including specialized PTSD clinical teams and/or PTSD specialists at each VA medical center (VAMC). The VA's National Center for PTSD oversees a PTSD mentoring program that works with the specialty PTSD programs throughout the system. Care is available for veterans who have substance-use disorder as well as PTSD, with substance-use disorder specialists being placed in each PTSD specialty outpatient program.²⁶ VA notes that recovery from PTSD is usually complicated by co-occurring disorders, such as TBI, depression, chronic pain, and substance-use disorders and that treatment for co-occurring conditions must take place concurrently. Additionally, VA notes that although it has excellent treatment programs for PTSD alone it is still in the early stages of developing evidence-based treatment for co-occurring conditions such as PTSD and chronic pain.²⁷

Substance-Use Disorders

Misuse of alcohol and other substances, including overuse of prescription drugs, is a recognized problem in many OEF/OIF/OND service members and veterans. Ample evidence documents the severity and chronicity of substance-use disorders in earlier generations of war veterans as well. VA reports that 96 percent of

VHA patients are screened annually for at-risk drinking. An untreated substance-use disorder can result in emotional decompensation, an increase in health-care and legal costs, additional stress on families, loss of employment, homelessness, and even suicide.

A recent study that reviewed more than 456,000 OEF/OIF/OND veterans who were enrolled in VA health care between 2002 and 2009 found that 11 percent of these patients received a diagnosis of alcohol or drug-use disorders. Of that group up to three-quarters also received a diagnosis of PTSD or depression. Researchers noted that this finding indicates these veterans, diagnosed with PTSD or depression, are four times more likely to have a drug or alcohol problem. The rates found in the study were considered close to those seen in earlier studies of Vietnam veterans. Researchers in the study indicated that these findings support the need for increased availability of integrated treatment that simultaneously treats these co-occurring conditions.²⁸ Other studies indicate that comorbidity of substance-use disorder and PTSD ranges from 25–50 percent in OEF/OIF/OND personnel and that prognoses for both conditions are worse when the conditions are co-occurring rather than independent.²⁹

For these reasons, VA indicates that it should find ways to enhance access to its substance-use disorder programs with a particular emphasis on the needs of OEF/OIF/OND populations as well as women, justice-involved, and homeless veterans. VA noted that the best resolution for substance-use disorder problems comes from early intervention. There is also a need to reduce stigma associated with seeking care for a substance-use disorder—and treatments for co-occurring conditions should be coordinated and done simultaneously. VA recommended that a community of substance-use disorder–PTSD specialists should be created and that family involvement can be very helpful to the treatment of both conditions in veterans. Additionally, VA indicated the attractiveness of VHA substance-use disorder services should be enhanced and that more computerized aids should be used for substance-use disorder services. Most important, there needs to be an integration of services to address complex problems presented in patients with combinations of substance-use disorder and TBI, chronic pain, homelessness, nicotine dependence, and community/family readjustment deficits. VA reported

that about two-thirds of patients with a substance-use disorder diagnosis are treated in a VA primary care or mental health clinic rather than in substance-use disorder specialty services.³⁰

The Congressional Research Service reported, given the comparatively low rates of drug abuse and dependence relative to PTSD or alcohol dependence, VA policy does not require routine drug use screening; however, it does require an annual alcohol screening which is waived for veterans who drank no alcohol in the prior year. VA offers medication and psychosocial interventions for substance-use disorders as well as acute detoxification if necessary. The prevalence of drug dependence and abuse among OEF/OIF/OND veterans using VA health care during the period FY 2002 through 2010 is 3 percent for dependence, 4 percent for abuse and 7 percent for alcohol dependence. The prevalence of alcohol abuse was not provided; however, many studies show alcohol abuse is a concern worth addressing.³¹ In August 2011, *The Journal of Rural Health* published a study with support of VA's Office of Research and Development comparing alcohol consumption among urban, suburban, and rural veterans. It concluded that alcohol use does not vary by rurality, but found that among the 33,883 VHA outpatients who responded to a mailed survey, 14,967 (44 percent) reported alcohol abstinence; and among 18,916 drinkers, 8,524 (45 percent) screened positive for unhealthy alcohol use.³²

The GAO noted in a March 2010 report, *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans*, that the three main challenges VA faces are (1) accessing substance-use disorder services; (2) meeting the specific treatment needs of veterans with substance-use disorder; and (3) assessing the effectiveness of substance-use disorder treatments. VA has recently begun a number of national efforts to address these challenges, including increasing veterans' access to its substance-use disorder services; promoting the use of evidence-based substance-use disorder treatments; and assessing substance-use disorder services and monitoring treatment effectiveness.³³

Recently, VA has indicated that early substance use disorder screening and treatment will be the responsibility of the PACT primary care providers. While this is likely to increase access for veterans enrolled

in primary care, VA should provide training, evaluate the provider skills and monitor the treatment outcomes of veterans who receive treatment for substance use disorder from PACT teams.

Suicide Prevention Program

Over the past 10 years of war, the suicide rate of members of our armed forces has steadily increased, and hit a high in 2009. While suicide prevention is still a key priority within the DOD and VA, data for 2010 show only a small yet measurable improvement in most of the branches of service.

VA reports that 18 veterans take their own lives each day, a number that translates to 6,750 veterans' suicides per year, or more than 65,000 in the 10 years since the onset of the conflicts in Afghanistan and Iraq. VA estimates that on an annual basis less than one-fourth are enrollees receiving health care from VA.³⁴ In 2008, the last year when official data were used to identify veterans' suicide by matching suicides from the National Death Index with the roster of veterans in VA administrative data, the rate of suicide was 38 per 100,000 for OEF/OIF/OND male and female veterans enrolled in VA health care. These data do not include unsuccessful suicides attempted.

It is clear to the IBVSOs that ready access to robust VA primary mental health and substance-use disorder treatment programs, emphasizing early interventions and routine screenings for all post-deployed personnel and veterans, are critical building blocks of any effective suicide prevention effort.

According to VA, for each veteran identified as at high risk for suicide, a suicide prevention safety plan is developed and the veteran's medical record is flagged. Additionally, every VA Medical Center is staffed with a suicide prevention coordinator and VA has recently rebranded its suicide hotline into a campaign promoting a Crisis Hotline as well as an online chat service, and an online suicide prevention resource center maintained jointly with the DOD.³⁵ To date there have been more than 400,000 calls to VA's Veterans Crisis Hotline; 5,000 of those calls were from active duty service members. There have been almost 15,000 "rescues" of suicidal veterans and service members.³⁶

For the past 10 months, the DOD and VA have been implementing a DOD/VA Integrated Mental Health Strategy (IMHS) consisting of 28 strategic actions within specific milestones and outputs. One of these strategic actions specifically addresses suicide risk and prevention, but all are designed to improve mental health care and outreach to service members and veterans. VA and the DOD have also partnered in hosting an annual suicide prevention conference where the goals are information sharing and strengthening the provider network between the two health-care systems.³⁷ The IBVSOs applaud these developments and urge their continuation and expansion.

In addition, the DOD asked RAND Corporation to evaluate information and data on military service member suicides, identify the agreed upon elements that should be part of a state-of-the-art suicide prevention strategy, and recommend ways to make sure the programs and policies provided by each military service branch reflect best practices. This request culminated in a February 2011 report from Rand, "The War Within: Preventing Suicide in the U.S. Military." Evidence suggests the focus should remain on the delivery of high-quality care for those with behavioral health problems and those who are determined to be at imminent risk of suicide.³⁸

According to the RAND analysis, needed changes include making service members aware of the advantages of using behavioral health care, ensuring that providers are delivering high-quality care, and ensuring that service members can receive confidential help for their problems. Despite these efforts and progress made, this issue still remains a significant concern to the IBVSOs, and we urge Congress to provide clear oversight to ensure adequate focus and attention remain on this issue.³⁹

The Center for a New American Security issued a new report in October 2011, *Losing the Battle: The Challenge of Military Suicide*. This report draws stark conclusions about the potential for suicide risk in the active duty post-deployed military service member population, especially given the cessation of our two current wars.⁴⁰ This policy brief makes a series of recommendations for military commanders and indirectly for VA leadership to better address suicide risk, self-destructive behaviors, and suicide attempts. The IBVSOs strongly endorse these recommendations.

Veterans Justice Program

VA also reports it is increasing its justice outreach efforts. It is working in collaboration with a number of state-based veterans' courts to assist in determining the appropriateness of diversion for treatment rather than incarceration as a consequence of veterans' behaviors. Likewise, VA reports it is participating in crisis intervention training with local police departments to help train and provide guidance to police officers on approaches to deal effectively with individuals who exhibit mental health problems (including veterans) in crisis situations. VA is working with veterans nearing release from prison and jail to ensure that needed health-care and social support services are in place at the time of release. Finally, each VA medical center has been asked to designate a facility-based Veterans' Justice Outreach Specialist, responsible for direct outreach, assessment, and case management for justice-involved veterans in local courts and jails, and liaison with local justice system partners.

The IBVSOs salute VA mental health leaders for taking these proactive steps that not only can prevent recurrence of involvement with the justice system but are cost-saving to local and state governments and VA itself and benefit society at large. Although this program is only in its beginning stages, it appears to have been beneficial for many veterans who have had the opportunity to get needed treatment for PTSD, TBI, depression and substance-use disorders rather than having been subjected to punishment by incarceration after committing a wrong against family, community, or society. Thus, while we do not approve of excusing felonious behavior by veterans, the IBVSOs strongly support expansion of the elements of this particular program because it offers a more humane way to deal with postcombat veterans' challenges, more so than any justice program could accomplish, and at a much lower cost all around.

Women Veterans: Unique Needs in VA's Post-Deployment Mental Health Services

The numbers of women now serving in our military forces are unprecedented in U.S. history, and today women are playing extraordinary roles in the conflicts in Afghanistan and Iraq. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, military police officers, civil affairs specialists, and in many other military occupational specialties that expose them to the risk of combat,

serious injury, and death. To date, more than 140 women have been killed in action in these two wars, and women service members have suffered grievous injuries, with almost 850 who have been wounded in action, including those with multiple amputations.⁴¹ The current rate of enrollment of women veterans in VA health care constitutes the second most dramatic growth of any subset of veterans. In fact, VA projects the number of women veterans coming to VA for health-care services is expected to double in the next two to four years. According to VA, between FY 2002 and FY 2010 approximately 50 percent of women who deployed for service in OEF/OIF/OND and have since been discharged from military service have utilized VA health care.⁴²

As the population of women veterans undergoes exponential growth over the next decade, VA must act to prepare to meet their specialized mental health needs, especially for those who served in combat theaters. Women service members' involvement in Lioness teams, and now in Female Engagement Teams, requires that VA mental health professionals educate themselves on what the contemporary deployment experience is like for women as well as the novel and unique readjustment challenges they face in the military and upon returning to civilian life. VA researchers have been studying the impact of war on the physical and mental health of women to determine how to best address their unique needs. The National Center for PTSD has established a number of specialized groups and evidenced-based treatments for women with combat-related PTSD, those who have experienced military sexual trauma, or have a dual diagnosis of combat-related PTSD and PTSD related to military sexual trauma. This research will help VA providers develop better programs to meet their needs.

According to VA, 37 percent of women veterans using VA outpatient services also used mental health services in 2009; and 12 percent of these women had more than six mental health visits compared with 7 percent of men. Researchers have found that OEF/OIF/OND women veteran users are more likely than their male counterparts to have mild depression, major depression, and adjustment disorders.⁴³ Studies have shown that women present exhibiting PTSD are more likely to have psychological reactivity to trauma cues, a startle response, restricted affect, depression, and an avoidance of trauma cues.

Women may also be more likely to present with the specific comorbidities of depression, panic attacks, eating disorders, and somatic complaints. When it comes to treating women with PTSD, studies have shown that women may develop chronic PTSD and may have slower recoveries but may be more likely to seek treatment. The treatments noted for being most successful include cognitive behavioral therapy with a combination of psychotherapy and pharmacotherapy, prolonged exposure, cognitive processing therapy, and family therapy.⁴⁴ VA notes that women who use VA mental health services tend to make many visits, suggesting that mental health care for women often requires more high-intensity services.⁴⁵

With more women serving in combat theaters of operation in OEF/OIF/OND than at any other time in U.S. history, it is critical that VA health professionals gain a clear understanding of the personal experiences and sacrifices of women in today's armed forces and that specialized programs and services be developed to meet their unique needs post-deployment.

Researchers have found that many women veterans need help reintegrating back into their prior lives after repatriating from war. Some women have reported feeling isolated, experiencing difficulties in communicating with family members and friends, and not getting enough time to readjust. Post-deployed women often complain of difficulties reestablishing bonds with their spouses and children, and resuming their role as primary parent, caretaker of children and disciplinarian. Women reported they routinely felt out of sync with their families and felt that they had missed much during their absences. Employment concerns were also expressed by women and included financial issues either due to making less money as a civilian than while in the military or about finding employment in the civilian sector where they could apply their military skills and training.⁴⁶

Likewise, researchers found that women experience difficulty finding effective support systems upon reintegration and that they need additional support from the DOD and VA to assist them with their post-deployment lives.⁴⁷ While progress has been made, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans successfully readjust. P.L. 111-163 included provisions that required

VA to conduct a pilot program of group counseling for women veterans newly separated from the armed forces in retreat settings. VA reports that it is now conducting these pilot retreats through its Readjustment Counseling Service Vet Center program. Three retreats have been completed to date, with three more planned. The VA Vet Center program worked with the Women's Wilderness Institute to develop the locations and agendas for the retreats. Feedback from women veterans who participated in the retreats thus far has been very positive, and the IBVSOs are hopeful the remaining retreats will be very successful.⁴⁸ We urge VA to continue supporting these retreats for women.

Another challenge some women veterans are facing in their post-deployment lives is sustained housing. The October 2011 *Supplemental Report to the 2010 Annual Homelessness Assessment Report* noted that women veterans are at a particularly high risk of experiencing homelessness compared to nonveterans: shockingly, in fact, they are reported to be twice as likely to become homeless. The risk increases significantly for women veterans living in poverty. The IBVSOs find the increasing trend of homelessness among women veterans particularly disturbing, but we congratulate the Secretary of Veterans Affairs on his initiative to end homelessness in the veteran population by 2015, and its successes to date. This comprehensive initiative has led to numerous "stand-downs" in varied locations over the past several years and appears to be beneficial for many veterans who are facing or experiencing homelessness. However, we urge VA to direct special focus to the unique needs of homeless women veterans and to develop specialized services, particularly for homeless women with children. Although VA cannot provide direct services to children, it can partner with community homeless assistance providers to ensure homeless women veterans are able to find housing that accommodates both them and their children.

In addition to increasing rates of homelessness among post-deployed women, it appears that women are at higher risk for suicide as well. A National Institute of Mental Health five-year research study with the goal of identifying Army soldiers most at risk of suicide released findings in 2011 noting that women soldiers' suicide rate triples when we are at war from five per 100,000 to 15 per 100,000.⁴⁹

The “signature injuries” for the current wars are traumatic brain injury (TBI) and polytrauma injuries involving multiple extremities and/or the brain. According to VA, approximately 8 percent of all polytrauma patients from OIF/OEF/OND are women.⁵⁰ For this reason, the IBVSOs also urge VA to concentrate on improving services for women with serious physical disabilities such as spinal cord injury, burns, traumatic brain injury, amputation, and blindness. The physical space and size of examination rooms, the need for specialized equipment, the overall setting, and safety issues should also be evaluated against women’s needs throughout the VA health-care system. The IBVSOs are pleased with the work of the Women’s Prosthetic Workgroup, which is evaluating all items in VA’s Prosthetic and Sensory Aids Service to ensure all routine and specialized items and gender-specific items are available to women veterans who are amputees or need other custom prosthetic or orthotic appliances.

Given the unique post-deployment challenges women veterans face, all of VA’s specialized services and programs—including those for polytrauma rehabilitation and transitional services, substance-use disorders, homelessness, domestic violence, and post-deployment readjustment counseling—and other VA programs and services should be evaluated to ensure women have equal access. Likewise, VA researchers should continue to study the impact of war and gender differences on post-deployment medical and mental health care to determine the best models of care, rehabilitation, and treatment to address the unique needs of women veterans.

Stigma: A Barrier to Accessing Mental Health Care

The IBVSOs urge VA and DOD to continue research into stigma and to improve outreach efforts, advance each department’s existing anti-stigma campaigns, and identify and deploy the best evidence-based treatment strategies for these populations. For soldiers and marines who deploy, there has been a measurable decrease in perceived stigma in asking for and receiving mental health care, although importantly, one of the challenges is that stigma is still strongest among those who screen positive for psychological problems.⁵¹ Easy access to mental health services in primary care is essential to addressing and overcoming stigma frequently associated with seeking mental health within the DOD and VA health-care systems.

Mandatory Mental Health Screening

In October 2009, the President signed P.L. 111–84, the “National Defense Authorization Act for Fiscal Year 2010” (NDAA). The act included a critical provision requiring mandatory, person-to-person, confidential mental health screenings for every service member returning from a contingency operation (such as a deployment to Iraq) at specified intervals up to 18 months after deployment. Put simply, every service member returning from a combat deployment should be screened routinely three times on return, either by a mental health professional or other personnel trained and certified to provide such assessments. Since that important provision was signed into law, the service branches of the military and VA have begun to implement this mandate. Work remains, however, to ensure that all service members and veterans receive the three mandated screenings, that screeners are qualified to do these assessments, and that follow-up care occurs and is contiguous across agencies.

The significant rates of PTSD, depression, and traumatic brain injury among new veterans and stigma associated with seeking care make these mandatory screenings critical. Almost half of the Army soldiers and one-third of Marine Corps personnel studied in Afghanistan who screened positive for a mental health condition were concerned that they would be seen as weak by their fellow service members, and more than one in four of these personnel expressed worry about the effect of a mental health diagnosis on their military careers.⁵²

We understand the services have implemented these one-on-one mental health screenings to varying degrees. The Air Force has been in full compliance with the law since January 1, 2011, and as of September 1, 2011, 73,007 airmen received assessments. The Army has added an in-theater risk assessment and immediate return post-deployment assessment during deployment cycles as well as annual assessments for all Army service members beyond the requirements imposed by the law. Approximately 412,819 soldiers have completed the enhanced behavioral health process as of September 1, 2011. The Army reports less success implementing the same standards in the Army reserve component. The Navy and Marine Corps are behind schedule but indicate they plan to implement the mental health assessments by the end of November 2011. So far, Navy-wide only 924

mental health assessments were carried out during a pilot effort in May 2011. The Coast Guard, which is dependent on the Navy for necessary forms and technology, has completed 230 of 233 pre-deployment health assessments and 353 of 359 post-deployment health assessments.⁵³

In addition to the differences of response among service branches, there are other challenges in implementation of the screenings. As of October 14, 2011, 3,431 providers had been trained by the different branches of the military to administer these required screenings.⁵⁴ VA says that it has increased its overall mental health staff from approximately 14,000 in FY 2006 to 21,000 in FY 2011, although these staff increases include occupational therapists, pharmacists, and others, in addition to psychiatrists, psychologists, and social workers.⁵⁵ The IBVSOs are concerned that the number of screeners and the level of training provided to them is still woefully inadequate and not in keeping with the intent of the NDAA provision, although VA data, in particular, are moving in the right direction.

Another concern is lack of follow-up care. Data show that less than 50 percent of reservists who complete Post-Deployment Health Reassessment (PDHRA) questionnaires in the year-out reassessment are then following through on mental health referrals.⁵⁶ Although these data do not specifically discuss the experience of reservists receiving one-on-one screenings, the numbers indicate a future challenge. As the services and VA implement the one-on-one screenings, they must also ensure that service members and veterans obtain their referrals and receive the care they need. Ensuring that this happens will require coordination between DOD and VA and establishment of a continuum of care. Our goal remains for veterans to have a more seamless transition experience between the Departments as they reenter civilian life. This program is a good example of where transition improvements are still needed.

Readjustment Counseling Service: Vet Centers

VA also offers mental health services to eligible veterans in community-based outpatient clinics and psychological readjustment services in VA's Readjustment Counseling Centers, known as Vet Centers. VA has more than 300 community-based Vet Center sites of care and more than 50 mobile centers. The staff at Vet Centers are composed of combat veterans from

multiple service eras as well as family members of combat veterans. One-third of current Vet Center staff served in Iraq, Afghanistan, or both. Additionally, more than 42 percent of Vet Center staff are women veterans, many of them with combat deployments.

Vet Centers are reporting rapidly growing enrollments in their programs. In FY 2010 the Centers provided services to 191,508 veterans and family members in more than 1.2 million visits. Thirty-five percent (74,666) of all veterans receiving Vet Center services were not seen at a VHA facility. Within the total services listed above, 16,134 veteran families were provided 72,717 visits. Cumulatively through June 30, 2011, Vet Centers have touched more than 40 percent (546,701) of separated OEF/OIF/OND veterans. Although VA has steadily increased the number of Vet Centers to meet workload growth, the IBVSOs believe that Vet Centers should also be provided additional funding to further bolster their staffing to ensure that all the centers can meet their expanding caseloads. In addition to traditional counseling, they also provide outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma. Additional funds would also allow them to expand the current fleet of 50 mobile Vet Centers (if found cost-effective) to support readjustment counseling for combat veterans and their families throughout the United States in rural communities and areas where VA facilities may not be accessible. There is also an around-the-clock confidential call center where combat veterans and their families can call to talk about their military experiences or other issues they are facing in their readjustment to civilian life.⁵⁷

Section 401 of P.L. 111-163 authorizes active duty service personnel and serving members of the National Guard and reserve components who have deployed to combat zones to receive psychological and readjustment counseling in VA Vet Centers. Section 402 also permits Vet Centers to help individuals with problematic military discharges by referring them to counseling services outside VA or for assistance with character of discharge correction when appropriate. The IBVSOs are very encouraged by these new approaches; however, we understand these provisions are going through the lengthy joint concurrence process. We ask that VA expedite the implementation of section 401 of the act so that these services may

be provided. Given the existence of stigma within the military ranks, we urge VA to make strong outreach efforts to active duty, National Guard, and reserve components to make them aware of the availability of the benefit and to welcome them into Vet Centers. Also, we hope this outreach emphasizes that such counseling would be confidential and unreportable to their military line commanders or armories, or even to VA medical authorities. As workloads related to this new authority grow, we urge VA to ensure that Vet Centers maintain proper staffing to carry out the intent of Congress in providing this important service to our newest generation of wartime veterans.

VA attempts to meet the needs of wartime veterans with post-deployment mental health challenges through two parallel mental health systems: a nationwide network of medical centers and clinics, and community-based Vet Centers across the nation that provide readjustment counseling and related services to combat veterans of all eras and their immediate family members. In some areas, the two systems work closely together; in others, there is only limited coordination. The differences in approach allow veterans increased access, choice, and flexibility in receiving readjustment services and outreach.

New veterans generally report having had positive experiences with Vet Centers and their staffs, a high percentage of whom are themselves combat veterans and who convey an understanding and acceptance of combat veterans' problems. While these centers do not provide comprehensive mental health services, their strengths tend to highlight perceived limitations with experiences young veterans report regarding mental health care at VA medical centers and clinics.

Dr. Hoge echoes several of these points in urging what amounts to a call for a more veteran-centric approach to treating PTSD and other war-related conditions:

Improving evidence-based treatments...must be paired with education in military cultural competency to help clinicians foster rapport and continued engagement with professional warriors... (m)atching evidence-based components of therapy to patient preferences and reinforcing narrative processes and social connections through peer-to-peer programs are encouraged. Family members, who have their own unique perspectives,

are essential participants in the veteran's healing process and also need their own support.⁵⁸

The Way Forward: Gaps Must Be Closed

The IBVSOs agree that VA must do a great deal more to meet veterans where they are, and must also improve access and timeliness of mental health care within VA facilities, reducing and hopefully eliminating gaps between national policies and variations in practice. To illustrate, in 2007, VA developed an important policy directive that identifies the wide range of mental health services that VA facilities should make available to all enrolled veterans who need them, no matter where they receive care.⁵⁹ But almost five years later VA has acknowledged in public testimony from external reviews, that directive is still not fully implemented.⁶⁰ Access remains a problem and geographic barriers are often the most prominent obstacle. Research suggests that veterans with mental health needs are generally less willing to travel long distances for needed treatment than veterans with other types of health problems. The timeliness of treatment and the intensity of the services a veteran ultimately receives are affected by the geographic accessibility of that care.⁶¹

VA faces a particular challenge in providing rural veterans access to mental health care. Almost half of VA's rural facilities are small community-based outpatient clinics (CBOCs) that offer limited mental health services.⁶² VA policy directs that facilities contract for mental health services when they cannot provide the care directly.⁶³ But some facilities have apparently made only very limited use of that authority. VA also must do more to adapt to the circumstances facing returning veterans who are often struggling to re-establish community, family, and occupational connections and associated challenges. These challenges may compound the difficulties of pursuing and sustaining mental health care.⁶⁴ VA has proven that PTSD and other war-related mental health problems can be successfully treated. But, if returning veterans are to overcome combat-related mental health issues and begin to thrive, critical gaps in the VA mental health-care system must be closed.

A query of VA mental health professionals was conducted at the request of Senate Committee on Veterans' Affairs following a July 2011 hearing that examined the gaps in VA mental health care. The resulting August 2011 report, a very small sample

due to the quick turnaround time requested, queried 319 general outpatient mental health providers for each facility within five Veterans Integrated Service Networks (VISNs), and 272 responded. Alarming, although not surprising based on the feedback Disabled American Veterans has been receiving, more than 70 percent of the respondents reported that their facilities had insufficient mental health staff resources to meet veterans' demands for care, and almost 70 percent indicated that their sites had shortages in physical space to accommodate mental health services. Nearly 40 percent reported they cannot schedule an appointment in their own clinics for a new patient within 14 days, and 46 percent reported that lack of off-hour appointment times was a barrier to care. More than 50 percent reported that growth in patient workloads contributed to mental health staffing shortages, and more than 26 percent noted that the demand for Compensation and Pension examinations diverted clinicians from providing direct care.

Based on the results of this VA internal survey and continuing reports from veterans themselves, it appears that despite the significant progress—specifically an increase in mental health programs and resources, and the number of mental health staff hired by VA in recent years—significant gaps still plague VA efforts in mental health care. The impact of these gaps may fall greatest on our newest war veterans, many of whom are in urgent need of services. Oversight is needed to ensure that these issues are effectively addressed.

Summary

The IBVSOs applaud efforts made by VA and DOD to improve the safety, consistency, and effectiveness of mental health-care programs for post-deployed service personnel and veterans. We also appreciate that Congress is continuing to provide increased funding in pursuit of a comprehensive package of services to meet the mental health needs of veterans, in particular veterans with wartime service. The IBVSOs are pleased with VA's progress in implementing its Mental Health Strategic Plan, yet we have concerns that these laudable goals may be frustrated unless proper oversight is provided and VA enforces mechanisms to ensure its policies at the top are reflected as results on the ground in VA facilities. In that regard we are deeply concerned that substance-use disorder programs in VA are focused primarily on chronic and severe addictions rather than on prevention and

early intervention in the cases of new veterans home from combat. Given the significant indications of rising substance-use disorder problems in the OEF/OIF/OND population, the IBVSOs urge VA to aggressively initiate these early intervention programs to prevent chronic long-term substance-use disorder in this population. We are convinced that efforts expended early in this population can prevent and offset much larger costs to VA and American society in the future.

The development of the Mental Health Strategic Plan and the new Uniform Mental Health Services policy provide an excellent roadmap for VHA's transformation of its mental health services. However, gaps remain to be closed, especially in the oversight of mental health programs and in the available treatments for co-occurring conditions and case management programs for OEF/OIF/OND combat veterans with dual diagnoses of TBI and PTSD. As the latest scientific research has indicated, VA must increase its efforts to close real gaps in its mental health system to reach and effectively treat these new veterans.

One important area for revised focus should be greater outreach to post-deployed veterans who are reluctant to seek needed help. VA certainly works to provide returning veterans information about its benefits and services. But, with the exception of Vet Center efforts, the Department does little direct one-on-one outreach, even to those at greatest risk of combat-related mental health problems. Moreover, outside the Vet Center environment, VA has failed to date to implement provisions of a 2010 law directing the Secretary to employ returning veterans at VA medical care facilities to conduct outreach to their peers.⁶⁵ This important lapse needs to be addressed with urgency.

The IBVSOs also urge closer cooperation and coordination between VA and DOD and between VAMCs and Vet Centers within their areas of operations. We recognize that the Readjustment Counseling Service is independent from the VHA by Congressional intent and in fact by statute and conducts its readjustment counseling programs outside the traditional medical model. We respect that division of activity, and it has proven itself to be highly effective for over 30 years. However, in addition to having concerns about VA's ability to coordinate with community providers in caring for veterans at VA expense, we believe veterans will be best served if better ties and

at least some mutual goals govern the relationship of Vet Center counseling and VA medical center mental health programs.

One overarching concern of the IBVSOs is the lack of clear and unambiguous data to document the rate of change occurring in VA's mental health programs, as noted in the May 2010 GAO report "VA Health Care: Reporting Spending and Workload for Mental Health Services Could Be Improved." We have indicated in a number of interactions, as well as in Congressional testimony, that VA needs more effective measures to record and validate progress. Congress and the Administration have invested enormous resources in VA mental health. Transparent, validated data and information sharing would go a long way toward reinforcing our confidence that VA is moving forcefully to adopt recovery for older veterans suffering from the challenges of chronic mental illnesses, and assertively embracing the transition and readjustment mental health needs of our newest war veteran generation.⁶⁶

The IBVSOs urge continued oversight by the Committees on Veterans' Affairs, Committees on Appropriations, as well as the Secretary of Veterans Affairs, to ensure that VA's mental health programs and the reforms outlined in this discussion of *The Independent Budget* meet their promise—not only for those returning home from war now, but for those already here.

Recommendations:

Congress should require VA to develop performance measures and provide an assessment of resource requirements, expenditures, and outcomes in its mental health programs, as well as a firm completion date for implementation of the components as well as the full Uniformed Mental Health Services (UMHS) package.

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

VA should focus intensive efforts to improve and increase early intervention and the prevention of substance-use disorder in the veteran population.

VA should provide training, evaluate the provider skills, and monitor the treatment outcomes of veterans who receive treatment for substance use disorder from patient-aligned care teams.

VA should conduct health services research on effective stigma reduction, readjustment, prevention, and treatment of acute post-traumatic stress disorder in combat veterans and increase funding and accountability for evidence-based PTSD treatment programs.

VA should conduct an assessment of the current availability of evidence-based care, including services for PTSD, identify shortfalls by sites of care, and allocate the resources necessary to provide universal access to evidence-based care.

VA should ensure that all professional staff are provided specialized training and orientation to the current roles and experiences of women returning from combat theaters and their unique post-deployment mental health challenges.

VA should implement the Congressional requirement to employ veterans of Operations Enduring and Iraqi Freedom and Operation New Dawn at VA medical centers to provide both direct one-on-one peer outreach to other new veterans of Iraq and Afghanistan who might not otherwise seek treatment and peer-to-peer support to help sustain veterans in treatment.

VA should increase staffing at Vet Centers and expand the number of Vet Center sites, with emphasis on locating new Vet Centers near military facilities, and substantially improve patient-care coordination among Vet Centers, medical centers, and community-based outpatient clinics.

VA should develop and carry out education and training programs for clinical staff on military culture and combat exposure to help forge a more effective connection with young veterans returning from combat theaters.

VA should increase its efforts to provide needed mental health and counseling services to immediate family members whose own mental health issues may

diminish their capacity to provide emotional support for returning veterans.

VA should establish pilot programs to improve continuity of care and retention of veterans in evidence-based PTSD treatment programs.

VA should provide periodic reports that include facility-level accounting of the use of mental health enhancement funds, with an accounting of overall mental health staffing, the filling of vacancies in core positions, and total mental health expenditures, to Congressional staff, veterans service organizations, and to the VA Advisory Committee on the Care of Veterans with Serious Mental Illness and its Consumer Liaison Council.

Congress should ensure that the new mandatory, person-to-person mental health screening process for post-deployed combat service members (including guardsmen and reservists) required by the “National Defense Authorization Act for FY 2010” is fully implemented for all service branches, and conducted by DOD and VA personnel who are effectively trained to identify these veterans’ problems. This responsibility should be jointly embraced by both Departments.

Consistent with strong Congressional oversight and in consideration of the findings of the recent survey of mental health practitioners, the Under Secretary for Health should appoint a mental health management work group to study the funding of VA mental health programs and make appropriate recommendations to the Under Secretary to ensure that the Veterans Health Administration’s resource allocation system sustains adequate funding for the full continuum of services mandated by the Mental Health Enhancement Initiative and UMHS handbook, and retains VA’s stated commitment to recovery as the driving force of VA mental health programs.

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

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

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OEF/OIF Issues

THE CONTINUING CHALLENGE OF CARING FOR WAR VETERANS AND AIDING THEM IN THEIR TRANSITION TO CIVILIAN LIFE:

Lack of coordination between the Departments of Defense and Veterans Affairs creates unnecessary bureaucracy and confusion for injured and ill service members trying to access needed health care and benefits.

As service members return from overseas engagements and separate from military service, the Departments of Defense and Veterans Affairs must provide them with a seamless transition of benefits and services to ensure their successful reintegration into civilian life. The transition from a military to veterans' health-care system continues to be a challenge for many newly discharged veterans, and *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to experience bureaucratic delays to obtain the benefits and health care that they have earned and deserve. We are particularly concerned that the injured and ill veterans of the conflicts in Afghanistan and Iraq and veterans returning from other fronts of the war on terror have prompt quality care. The increase in deployments to Afghanistan and the increased lethality of the weapons being used pose a high risk of more seriously injured veterans returning in the next few years. Veterans' families must be treated with sensitivity and understanding, and their benefits must be awarded efficiently and accurately.

The DOD and VA must work together to meet the needs of a new generation of war veterans and their families while effectively caring for all military beneficiaries and veterans, and must ensure that injured and ill service members transition seamlessly from military to civilian life.

Polytrauma—Traumatic Brain Injury

From October 2001 through September 2011, more than 2.2 million service members from the active and reserve components have deployed for wartime service in Operations Enduring and Iraqi Freedom (OEF/OIF). With multiple deployments, there are increased risks of exposure to improvised explosive devices (IEDs) that result in both physical and mental health injuries. Advancements in military medicine have resulted in an approximately 90 percent survival rate among those physically wounded; however,

many service members sustain severe or polytrauma injuries involving one or more limb amputations and/or brain injury.

According to VA, between March 2003 and September 2011, 2,160 total patients with severe injuries have been treated at VA Polytrauma Rehabilitation Centers.⁶⁷ VA's Polytrauma System of Care consists of five regional TBI/Polytrauma Rehabilitation Centers located in Richmond, Virginia; Tampa, Florida; Palo Alto, California; Minneapolis, Minnesota; and San Antonio, Texas.

VA reported that as of August 2011 approximately 552,077 OEF/OIF and Operation New Dawn (OND) veterans had been screened for possible mild traumatic brain injury (TBI), of whom 103,559 screened positive and consented to additional evaluation. Among that group, 77,620 have received completed evaluations and 43,004 were given a confirmed diagnosis of mild TBI. VA also reported that in its polytrauma programs, 2,160 active duty service members and veterans have been treated at its designated Polytrauma Rehabilitation Centers. More than 66 percent of these patients were able to be discharged to home, with functional improvements comparable to private sector rehabilitation discharge rates. VA also reports seeing 20,052 in veterans FY 2010 with TBI/polytrauma in an outpatient setting—for an accumulated 56,992 patient encounters—and experienced a significant increase in tele-rehabilitation services: a 311 percent increase in polytrauma encounters.⁶⁸

Experts note that the effects of TBI are still poorly understood. VA is now providing continuing education credit through its Veterans' Health Initiative TBI web-based course launched in February of 2011 and conducting "mini-residencies" to expand access to the number of TBI-trained clinical providers. Additionally, VA has developed a TBI Veterans Health Registry of OEF/OIF veterans experiencing

TBI-related symptoms. Clinicians are able to access information to make comparisons of screenings, diagnostic methods, and treatment options.

We are pleased to note VA has established a number of key TBI-related initiatives, including a five-year assisted living pilot program; a TBI training program for VBA Compensation and Pension examiners; and a polytrauma and Blast-Related Injuries Quality Enhancement Research Initiative. VA and DOD are also collaborating on a number of TBI, post-traumatic stress disorder (PTSD), and polytrauma studies and are part of a steering committee for Federal Interagency TBI research and a joint task force steering committee for blast-induced brain injury studies.⁶⁹

Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, gaps in services are still troubling. The IBVSOs urge development of programs and support services to better assist these veterans and their families to manage the tumultuous challenges that accompany brain injury, often attended by other severe physical injuries.

Clearly 10 years of war have also taken a toll on the mental health of American fighting forces. Combat stress and combat-related mental health conditions are highly prevalent among veterans who deployed to Iraq and Afghanistan and are often severely disabling. Unique aspects of deployments to Iraq and Afghanistan—including the frequency and intensity of exposure to combat, guerilla warfare in urban environments, and the risks of suffering or witnessing violence—are strongly associated with a risk of chronic PTSD.⁷⁰ Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts at early identification and treatment of behavioral health problems experienced by returning veterans. It instituted systemwide mental health screening, expanded mental health staffing, integrated mental health and primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. Yet there remain critical gaps, and the mental health toll of this war is likely to increase over time for those who deploy more than once, do not get needed services, or face increased stressors following deployment.⁷¹

The IBVSOs have commented extensively on mental health issues affecting our newest generation of

war veterans in the Mental Health section of this *Independent Budget*. We urge readers to review that section for a more comprehensive discussion on PTSD, substance-use disorders, suicide, stigma, post-deployment mental health screening, and Vet Centers.

Eye Injuries to New War Veterans: A Rising Concern

Vision is a critical sense for optimal military performance in combat and support positions, and is vulnerable to acute and chronic injury in those environments. Traumatic eye injury and other visual disorders from penetrating wounds and TBI rank second only to hearing loss as the most common injury among active duty military service members, and account for 16 percent of all injuries in those wounded in Operations Iraqi Freedom, Enduring Freedom and New Dawn (OIF/OEF/OND), an increase from 13 percent in 2009.^{72, 73} The Veterans Health Administration (VHA) reports 46,000 enrolled OEF/OIF/OND veterans have been diagnosed with eye conditions and the DOD Vision Center of Excellence estimates 58,000 eye injuries within its data.⁷⁴ VA also notes that of the OEF/OIF/OND veterans diagnosed with eye conditions, including visual problems as a result of a TBI, that upwards of 75 percent of all TBI patients experience short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems.

The DOD has identified the diagnosis, treatment, and mitigation of visual dysfunction associated with TBI as one of eight gaps in defense-related vision research, along with inadequate treatments for traumatic injuries, vision restoration, epidemiological studies on sight-injured patients, ocular diagnostics, vision rehabilitation strategies, computational models of combat ocular injuries, and vision care education and training.⁷⁵ The November 2008 DOD Medical Surveillance Defense report from the Armed Forces Health Center reported 4,970 moderate-to-severe penetrating eye injuries, with 8,441 retinal and choroidal (the vascular layer of the eye containing connective tissue) hemorrhage injuries, 686 optic nerve injuries, along with 4,294 chemical and thermal eye burn injuries occurring in active duty service members between 1998 and 2007. This 10-year study of active duty service members with eye injuries demonstrated a sharp increase in eye injuries that occurred starting in 2003 in Iraq and Afghanistan.⁷⁶

Low-vision clinics at VA Polytrauma Rehabilitation Centers in Palo Alto, California; and Hines, Illinois, found that veterans screened positive for TBI-related visual system dysfunction an average of 66 percent of the time. Vision research published by the Palo Alto Polytrauma Rehabilitation Center found that 75 percent of the veterans with polytrauma injuries have subjective visual complaints, with objective visual diagnostic disorders found, including 32 percent with loss of field of vision; 39 percent with accommodation insufficiency; 42 percent with convergence disorder; and 13 percent with ocular-motor dysfunction. Nearly 60 percent of these patients reported an inability to interpret print, and 4 percent were determined to be legally blind.⁷⁷

RAND Corporation's 2008 "Invisible Wounds of War" study found that 19.5 percent of veterans reported experiencing a probable TBI during deployment. Since 2003, a number of studies have examined the percentages of returning service members with PTSD, depression, or reporting that they had experienced a TBI, and while the results may vary depending on the study population as well as the methodology and timing of assessment, studies of populations and methodologies similar to the RAND report consistently show that the rate of post-deployment mental health problems among returning service members is about 15–20 percent at any given time. This implies that as many as 400,000 OEF/OIF/OND veterans have experienced a probable TBI during deployment.⁷⁸ Based on the TBI vision dysfunction noted in a *New England Journal of Medicine* study performed by doctors practicing at the Palo Alto VA Polytrauma Center who studied polytrauma patients diagnosed with TBI who had no knowledge of an eye injury or a previously reported eye injury (eyes with open injury were excluded from analysis), upon comprehensive eye exams 43 percent had a closed eye injury in at least one location. These data combined with the 16 percent of those with known, or open, vision injuries imply that approximately 200,000 veterans may be experiencing mild, moderate, or severe neurological vision dysfunction.⁷⁹

Research to effectively treat eye damage can have long-term implications for an individual's vision health, productivity, and quality of life. *The Independent Budget* veterans service organizations (IBVSOs) believe that proper screening, diagnosis, treatment, and rehabilitation research options are

vital to address these growing TBI neuro-vision complications and penetrating eye injuries.

The IBVSOs are encouraged by the Defense Veterans Eye Injury Vision Registry Pilot, which began development in October 2010. The registry will be the first to combine DOD and VA clinical information into a single data repository for tracking patients and assessing longitudinal outcomes. The registry records in the pilot will include current and historical eye ocular data and will be a baseline for other Centers of Excellence registries as well as provide additional electronic data sharing opportunities with other federal and nonfederal registries and databases. The actual Vision Registry Pilot was kicked off in September 2011 and is hosted on a platform at the Joint Information Technology Center in Maui and is now entering a second phase of testing.⁸⁰ This registry should remain a DOD/VA information technology (IT) priority in order to track research, outcomes, develop best practices, and coordinate traumatic injury care between military treatment facilities and VA medical centers.

The establishment of a Vision Center of Excellence (VCE) for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries was authorized by the FY 2008 "National Defense Authorization Act" (NDAA) (P.L. 110–181, section 1623), and the Hearing Center of Excellence (HCE) and Limb Extremity Center of Excellence were established in the FY 2009 NDAA (P.L. 110–417). Congress established these three defense centers as joint DOD/VA programs to improve the care of American military personnel and veterans affected by eye, hearing, and limb extremity trauma and to improve clinical coordination between the DOD and VA. These centers are also tasked with developing fully operable DOD/VA registries containing up-to-date information on the diagnostic, treatment, and surgical reports to facilitate clinical follow-up for the injuries received by our nation's military personnel.

VA reports hearing injuries as most common service-connected injury from the current wars, with more than 90 percent occurring as a result of IED blasts. It reports 94,141 service-connected veterans for tinnitus, and 78,076 with documented levels of hearing loss.⁸¹ While the Departments have appointed a director and deputy director for VCE, HCE, and Limb Extremity Center of Excellence, the VCE now

has 11 other joint staff for support, but the other two centers lack dedicated joint personnel, which has greatly hampered their full establishment. Congress must continue to request briefings and hearings with VA and the DOD on the implementation, funding, and governance of the Defense-VA VCE, Hearing-Audiology, and the Limb Extremity Centers of Excellence (COEs) as well as direct greater oversight of the joint Senior Oversight Committee (SOC) and the Health Executive Council (HEC) joint role in the establishment and operations of the three NDAA Centers of Excellence.

The IBVSOs find the delays in implementation of these COEs troubling in light of the congressional mandate to create these three Defense COEs.⁸² Year-long delays in memoranda of understanding, difficulties over governance, and funding inadequacies have created major challenges in these Defense Centers of Excellence meeting their mandated objectives. The Assistant Secretary of Defense for Health Affairs and the VA Under Secretary for Health must be held accountable for the delays in joint staffing and meeting NDAA requirements. The IBVSOs are deeply concerned that these Centers of Excellence could suffer serious setbacks, given the status of the federal deficit. As we enter into this critical period of funding for FY 2013, the status of the VCE needs more oversight by both the joint DOD-VA Health Executive Council and by Congress.

Better Case Management and Caregiver Support Are Essential

Many critically wounded veterans require a variety of medical, prosthetic, psychosocial, and personal supports, and while many will be able to return home at least part-time or be moved to a therapeutic residential setting, there is every expectation that family members will serve as lifelong caregivers to these injured veterans. This is a challenge for many family members as they cope with the physical and emotional problems their loved ones face while managing the complex systems of care, added to the disruption of their family lives, personal goals, and employment, and often the dissolution of other “normal” support systems.

The IBVSOs believe that robust case management is necessary to ensure uninterrupted support for severely injured veterans and their family caregivers as these

veterans transfer from the DOD to VA care. A veteran’s spouse is likely to be young, have dependent children, and reside in a rural area where access to support services is limited. Spouses often fall victim to bureaucratic mishaps as a result of the conflicting pay and compensation systems on which they rely. For many younger, unmarried veterans, their caregivers are their parents, who have limited eligibility for military assistance and historically have had virtually no eligibility for VA benefits or services.

The IBVSOs were pleased that the President signed P.L. 111–163, the “Caregivers and Veterans Omnibus Health Services Act,” on May 5, 2010. This law allows VA to create an array of new or enhanced supportive services for family caregivers of disabled veterans from all eras of military service, and will provide a monthly stipend, Civilian Health and Medical Program of the Department of Veterans Affairs health care, and other benefits to financially burdened family members of the most severely wounded and disabled OEF/OIF veterans. The law will also improve certain access and health-care issues for our women veterans of all eras. While VA provides limited services to some family members, we hope the new law will spur VA to create a more thorough program in caregiver support, education, training and other assistance.

While this new law responds to some of *The Independent Budget’s* most significant legislative goals in recent years, and the IBVSOs are pleased that Congress acted, we remain concerned about the unmet needs of caregivers of disabled veterans of earlier eras of military service, and believe that the services provided to caregivers of veterans serving should be authorized to all VA-enrolled veterans on the basis of medical, social, or financial need.

On May 3, 2011, VA published the interim final rule for implementing the Family Caregiver Program under P.L. 111–163, and began taking applications from eligible veterans effective May 9, 2011. The program is managed by VA’s Office of Care Management and Social Work, which is under the Office of Patient Care Services. The IBVSOs applaud VA’s efforts to establish its Caregiver Support Program; however, our concerns remain. Additional information can be found under “Support for Family and Caregivers of Severely Injured Veterans” in this *Independent Budget*.

DOD-VA Information Interoperability

The IBVSOs urge increased collaboration between the DOD and VA for the transfer of military service records and health-care information. We acknowledge that progress has been made; however, the military service branches and VA are still not sharing electronic health information on a broad scale. Paper records are still being used at many DOD facilities and are incompatible with VA's information technology systems in the Veterans Benefits Administration and the VHA. In health care, VA continues to rely on its aging Veterans Health Information Systems and Technology Architecture (VistA) platform for computerized patient care records, while the development of VA's next-generation health IT system is being redirected from HealthVet to an "open source" software approach for VistA. The DOD recently announced an intention to award a contract for the development of a new electronic health record system to replace its aging system, the Armed Forces Health Longitudinal Technology Application (AHLTA). The absence of a joint system—or separate systems that are designed to communicate with each other—is a major deterrent to the DOD and VA achieving seamless transition for injured and ill military service personnel.

The DOD must be positioned to accurately collect medical and environmental exposure data electronically while personnel are still in theater, and equally important, this information must be provided to VA. Electronic health information should also include an easily transferable electronic DD-214 to allow VA to expedite claims and give service members faster access to their benefits.

To expedite the exchange of electronic health information between the two departments, Section 716 of P.L. 111–84, the "National Defense Authorization Act for Fiscal Year 2010," required the DOD to report on improvements to the governance and execution of health information management and IT programs within the military health system. Part of the law's requirement includes an assessment of both the DOD's capability to meet the requirements for joint interoperability with VA as otherwise mandated by law and the progress made by VA and the DOD on the establishment of a joint virtual lifetime electronic record for members of the armed forces.

In conjunction with interoperability capabilities previously achieved through the Federal Health Information Exchange, Bidirectional Health Information

Exchange, and the Clinical Data Repository/Health Data Repository, the DOD and VA believed the achievement of six objectives would be sufficient to satisfy full interoperability by September 2009 as required by law: (1) to refine social history data currently captured in the DOD electronic health record; (2) to share physical exam data captured in the DOD electronic health record; (3) to demonstrate initial network gateway operation; (4) to expand questionnaires and self-assessment tools; (5) to expand Essentris in the DOD to at least one additional site in each military medical department; and (6) to demonstrate initial capability for document scanning into the DOD electronic health record and forwarding those documents electronically to VA.

These six objectives were recommended based on defining full interoperability as the ability to share the necessary information to support the continuum of care between VA and the DOD. Furthermore, the Departments' officials, including the cochairs of the group responsible for representing the clinician user community, believe they have satisfied the September 30, 2009, requirement for developing and implementing systems or capabilities that allow for full interoperability. The IBVSOs respectfully disagree.

The IBVSOs are concerned that the Departments' definition falls short of a fully interoperable exchange of health information, which means achieving computable electronic data sharing (i.e., electronically entered data that can be computed by other systems). In September 2009, VA and the DOD demonstrated an initial capability for scanning medical documents into the DOD electronic health record and sharing these documents electronically with VA utilizing a test environment. Going forward, when fully implemented, this capability could enable DOD users to scan/import documents and artifacts, associate those documents/artifacts with a patient's record, and make them globally accessible to authorized VA and DOD users. Not all scanned or imported documents are in computable form; at this level, the data are in a standardized format that a computer application can act on (for example, to provide alerts to clinicians of drug allergies or help researchers identify and collect data for studies). In other cases data can be viewed only—a lower level of interoperability that still provides clinicians with important information.

In 2009, the DOD expanded its Essentris system to four Army medical facilities, one Navy, and one

Air Force site. In total, Essentris is operational at 27 DOD sites, but still is only sharing with VA inpatient discharge summaries in 24 DOD sites (59 percent of total DOD inpatient beds). Regarding the scanning of medical records, VA and the DOD met the objective to demonstrate an initial capability for scanning medical documents and sharing these documents electronically with VA utilizing a test environment. There is need for additional work to expand the capability from limited-user test sites to full implementation. As such, in the opinion of the IBVSOs, both agencies failed to meet the Congressional requirement for full interoperability by September 30, 2009.

Another IBVSO concern regarding health information sharing is with the DOD's Pre- and Post-Deployment Health Assessment (PPDHA), the Post-Deployment Health Assessment and Reassessment (PDHRA), and other self-assessment tools, such as ones for TBI and mental health.

The PPDHA and PDHRA health protection programs are designed to enhance and extend the post-deployment continuum of care. It is a mandatory process for pre- and post-deployment of all active duty and reserve component service members and voluntary for those separated from military service. The PDHRA is administered by active duty health-care providers and/or DOD contract providers through two modes of delivery: a face-to-face interview with a DOD contract health-care provider at active duty locations and via telephone and/or a web-based module and coordinated follow-up referrals with VA. At reserve and National Guard locations, DOD contract health-care providers are responsible for administering the PDHRA.

These assessment tools offer education, screening, and a global health assessment to identify and facilitate access to care for deployment-related physical health, mental health, and readjustment concerns for all service members, including reserve component personnel deployed for more than 30 days in a contingency operation. During the 90 to 180 days post-deployment period, PDHRA provides outreach, education, and screening for deployment-related health conditions and readjustment issues, outreach, and referrals to military treatment facilities, VA health-care facilities, Vet Centers, TRICARE providers, and others for additional evaluation and/or treatment.

The TBI assessment tools are used during active service and prior to separation to measure deterioration, improvement, or stability in people whose brain function has been compromised, either through illness, disease, or injury. The DOD Mental Health Self-Assessment Program, now known as Military Pathways, provides free, anonymous mental health and alcohol self-assessments for family members and service personnel in all branches, including the National Guard and reserve. The self-assessments are a series of questions that, when linked together, help create a picture of how an individual is feeling and whether he or she could benefit from talking to a health professional. The assessments address depression, PTSD, generalized anxiety disorder, alcohol use, and bipolar disorder and are available online, over the phone, and at special events held at installations worldwide. After an individual completes a self-assessment, he or she is provided with referral information, including services provided through the DOD and VA.

While these questionnaires and other self-assessment tools are shared with VA, these data are only viewable. Lacking is the ability for VA to leverage this information in a computable format to analyze data that would assist the Department in directing programs, services, and resources and adjusting policy to meet the needs of the newest generation of veterans.

Of greater concern is that of VA mental health providers in the field and active duty service members over the transferability of private and VA mental health treatment records to the DOD. These service members seek care at VA and the private sector because they perceive the barrier, however diminishing, of information sharing as a safeguard against adverse impact on their security clearances and advancement in military service. The consternation over seeking treatment or not is of great concern to both patients and providers.

The IBVSOs are pleased that two virtual lifetime electronic record (VLER) pilot programs are operational in San Diego, California, and Hampton Roads, Virginia. The VLER pilot is an Internet-based network enabling web-based, secure exchange of health information for sharing among VA, the DOD, other government entities, and private providers. Other pilots are in development in three more communities: Indianapolis; Spokane, Washington; and the Moab region in Utah. The benefit of these pilot programs

is not solely for our veterans but the nation as well. Implementation and operation of VLER tests the complex Nationwide Health Information Network (NHIN), a set of standards, services, and policies that enable secure health information exchange over the Internet. The NHIN will provide a foundation for the exchange of health information across diverse entities, within communities, and across the country.

The IBVSOs remain firm that the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and that allows for two-way, real-time electronic exchange of health information and occupational and environmental exposure data for transitioning veterans. Effective record exchange could increase health-care sharing between agencies and providers, laboratories, pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase our understanding of the clinical, safety, quality, financial, and organizational value of health IT. We therefore urge Congress to provide oversight to ensure these purposes are achieved, in making VA and DOD records more interoperable and thus more available to those who need them.

Notwithstanding progress made in the virtual lifetime electronic record and our concern over the DOD's progress in meeting six of its interoperability objectives, the DOD has a new strategy to refine and increase sharing of electronic health records with VA that includes initiatives to modernize current electronic health record capabilities and stabilize legacy systems serving as its platform for interoperability. The DOD identified the Electronic Health Record Way Ahead as its effort to improve the accuracy and completeness of its electronic health data, improve the exchange of electronic health information with VA, and support electronic medical data capture and exchange between private health-care providers, and state, local, and other federal agencies.

Because the AHLTA has consistently experienced performance problems and has not delivered the full operational capabilities intended, the DOD has initiated plans to develop a new electronic health record system. As with AHLTA, department officials stated that the new electronic health record system is expected to be a comprehensive, real-time health record for active and retired service members, their families, and other eligible beneficiaries. They added

that the new system is being planned to address the capability gaps and performance problems of previous iterations and to improve existing information sharing between the DOD and VA and expand information sharing to include private sector providers.

The IBVSOs are concerned over DOD resources allocated to the completion of the Electronic Health Record Way Ahead. The DOD has said it would provide these additional details after the completion of its analysis of alternatives and approval of the FY 2012 Program Objectives Memorandum submission. We applaud Congress for its continued oversight to determine the reasons for continuing delays toward full interoperability. The IBVSOs urge Congress ensure these additional details are provided by the DOD in order to have a more complete picture of risks and resource needs for achieving the timelines and goals of the Department's health information and information technology programs. Moreover, we urge Congress to ensure the DOD-VA Interagency Program Office reaches the remaining benchmarks and that full electronic sharing of computable health information is achieved. Additional information on our concerns about VA information technology, and a broader discussion about VA's current and planned use of technology, may be found in "Information Technology" in this *Independent Budget*.

Federal Recovery Coordinator Program

In 2008, VA and the DOD partnered to create the Federal Recovery Coordinator Program (FRCP) to coordinate clinical and nonclinical care for severely injured and ill service members and to also make VA easier to access. According to Government Accountability Office (GAO) testimony, from January 2008, when FRCP enrollment began, through May 2011, the FRCP provided services to a total of 1,665 service members and veterans; of these, 734 are currently active enrollees in this program. They include OEF/OIF service members and veterans who suffered traumatic brain injuries, amputations, burns, spinal cord injuries, visual impairments, and post-traumatic stress disorder. Currently 556 clients are enrolled, another 31 are being evaluated for enrollment, and an additional 497 have received assistance through the FRCP.

The IBVSOs remain concerned about the gaps that exist in the FRCP and the accompanying social work case management essential to coordinating complex components of VA and DOD care, particularly for

polytrauma patients and their families. A key challenge in providing continuity of patient and family-centered care is due to the large number of services needed by wounded service members and veterans that is caused by a disparate array of DOD and VA programs. Difficulty in care coordination produces gaps in services and loss of continuity of care. These gaps were highlighted by disabled veterans and their caregivers in Congressional hearings in 2009, 2010, and 2011, and warrant continued oversight and evaluation by Congress, VA, and the DOD.

Prior to the establishment of the FRCP, veterans and their families were confronted with a complex and frustrating bureaucracy when trying to get the appropriate care for themselves or their loved ones within the DOD and VA systems “on their own.” Some poignant descriptions recent witnesses have used to describe the difficulty in navigating these systems include “...a journey of blind exploration; lost paperwork, confusing processes and lack of information,” “13 social work representatives within VA and the DOD—but none that communicated regularly with each other,” and, summing it up, “the responsibility is daunting, the stress is never ending, and we need a lifeline.”

One spouse of a severely disabled veteran reported a similar experience prior to the establishment of the FRCP, but stated that once the program was up and running things began to go more smoothly—until a new FRCP was assigned to their case after only four months, an event that required them to start over again.

These hearings brought forward detailed complaints showing a lack of continuity, coordination of care, and communication between the DOD and VA during a service member’s transition from active duty, the return home, veteran status, and VA health and benefits systems. Likewise, families complained they felt they alone were carrying the burden of a service member’s recovery and reintegration back into civilian life and had little guidance or support from VA or the DOD.

Although these hearing witnesses all agreed that the FRC program was needed and had the potential to be beneficial, a number of issues must be addressed, including better communication, education, promotion of the program, and streamlining the referral process. Some family members are not aware of their

option to request an FRCP and are sometimes confused about the roles of the multitude of advocates, program managers, and DOD/VA social workers and case managers assigned to their wounded loved ones. The FRCP’s level of knowledge about catastrophic injuries and their impact on patients and families—as well as being knowledgeable about the myriad benefits and services available from the DOD and VA—are vitally important to family members and caregivers alike. They also want the FRC to be able to address the need of lifelong care and caregiving for their injured loved ones should these veterans outlive their parents, spouses, or other caregivers, or in cases where caregivers become unable to continuously care for these veterans.

The collaborating agencies involved in the FRC acknowledge these ongoing challenges but add that many lessons have been learned and adjustments are under way to improve overall effectiveness. For these reasons, the IBVSOs again urge continued Congressional oversight of this extremely important program and recommend the FRC program be closely monitored, and that families and veterans be surveyed periodically to make needed adjustments and improvements.

For newly injured or ill service members who use outpatient services but do not need the services of the FRCP, VA reports it has 33 VA military liaisons for health care stationed at 18 military medical treatment facilities to transition ill and injured service members from the DOD to VA specialized services closer to home. VA military liaisons are social workers or nurses who are co-located with DOD case managers at military treatment facilities. In FY 2010, through June, VA military liaisons coordinated 5,000 referrals for health care and more than 20,000 professional consultations. Each VA facility has an OEF/OIF care management team in place, which consists of a program manager, a clinical case manager, VBA service representatives, and a transition patient advocate. Severely injured OEF/OIF veterans are provided a case manager, and other OEF/OIF veterans may be assigned one based on initial assessment or upon request. A “lead” case manager now serves as a central point of contact for patients and their families.

Under VA’s clinical and nonclinical case management strategy, veterans transitioning from the DOD to VA who are not assisted by the FRC program may be forced to interact with as many as five VA

representatives, their primary and specialty care provider or team, and a DOD case manager. The IBVSOs are concerned that so many points of contact impede assistance to veterans and their families at a critical juncture in their lives. Moreover, veterans suffering from cognitive impairment may be overwhelmed by this fragmented and confusing arrangement, and it may hamper their ability to effectively participate in their care and rehabilitation. This is of particular concern as the DOD has expanded its efforts to identify those who may have mild TBI. As greater numbers of these veterans are identified, the need for treatment services will also increase, further challenging the system. We are hopeful VA's move to patient-aligned care teams or a medical home model of care will provide a more cohesive and empathetic environment for these veterans.

Occupational Exposures

Service members have been placed at risk for exposure to both natural and man-made toxins throughout the history of warfare. In the conflicts in Afghanistan and Iraq, veterans, physicians, and scientists have raised a number of concerns about the possible adverse health effects from exposures to the so-called "burn pits," open-air incineration facilities used to dispose of everything from normal trash to chemicals, body parts, and batteries. Many service members have complained of severe headaches, breathing difficulties, and other health concerns as a result of living and/or working near or in the paths of the plumes of smoke that have been ever present in these wars.

As a result of the efforts of the IBVSOs, the "National Defense Appropriations Act of 2010" was amended to include the "Military Personnel War Zone Toxic Exposure Prevention Act." The following provisions relate to burn pits:

- Prohibit the use of burn pits for hazardous and medical waste except if the Secretary of Defense sees no alternative;
- Require the DOD to report to the Congressional oversight committees whenever burn pits are used and justify their use, and every six months to report on their status;
- Require the DOD to develop a plan for alternatives, in order to eliminate the use of burn pits; further, the DOD must report to Congress how and why it uses burn pits and what is burned in them;
- Require the DOD to assess existing medical surveillance programs of burn pits exposure and make recommendations to improve them;
- Require the DOD to do a study of the effects of burning plastics in open pits and evaluate the feasibility of prohibiting the burning of plastics.⁸³

A consensus study, the first step in this process, was undertaken by the Institute of Medicine (IOM) and published on October 31, 2011. The study, titled "Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan," is described as follows:

An IOM committee will determine the long term health effects of exposure to burn pits in Iraq and Afghanistan. Using the Balad burn pit in Iraq as an example, the committee will examine existing literature that has detailed the types of substances burned in the pits and their by-products, and examine the feasibility and design issues for an epidemiologic study of veterans exposed to the Balad burn pit. The committee will explore the background on the use of burn pits in the military. Areas of interest to the committee might include but are not limited to investigating: Where burn pits are located, what is typically burned, and what are the by-products of burning; The frequency of use of burn pits and average burn times; and Whether the materials being burned at Balad are unique or similar to burn pits located elsewhere in Iraq and Afghanistan.⁸⁴

The study particularly focused on the burn pit used to dispose of solid waste at Joint Base Balad (JBB) in Iraq, which burned up to 200 tons of waste per day in 2007.⁸⁵ JBB was one of the largest U.S. military bases in Iraq and a central logistics hub.

In 2005, the burn pit operations at JBB were initially sampled by a preventive medicine team from the U.S. Army Center for Health Promotion and Preventative Medicine (USACHPPM) who were deployed down-range to carry out this initial analysis.⁸⁶ The team used the U.S. Environmental Protection Agency standard health risk assessment methodology. Based on their analysis, they concluded that "...no environmental monitoring data collected at Joint Base Balad to date have identified an increased risk for long-term health conditions. It is possible, however, that combinations of some exposures, such as smoke from burn pits, the high levels of airborne dust, and/or tobacco smoke in

smokers, may increase the risk of chronic health conditions in a small number of people, although there is no direct evidence of this at the present time.”⁸⁷

Despite anecdotal concerns around the burning of plastics and the potential for release of dioxins into the atmosphere, the results of health risk assessment screenings released in 2008 and 2009 found an acceptable health risk from burn pits to personnel. To provide further analysis of this issue, between 2007 and 2009 USACHPPM carried out air sampling in an effort to assess the potential risk of exposure to dioxins and other chemicals for deployed personnel. The IOM study concluded, “Unfortunately, the environmental monitoring conducted at JBB was done on an insufficient number of days (that is, sampling was only done on 53 days in 2007 and 2009 combined) to provide reliable estimates of long-term average exposures to burn pit emissions.”⁸⁸

Insufficient data on service members’ exposures to emissions from open-air burn pits for trash on military bases in Iraq and Afghanistan led the IOM to conclude that it was not possible to determine if these emissions could cause long-term health effects. “High background levels of ambient pollution from other sources and lack of information on the quantities and composition of wastes burned in the pits also complicate interpretation of the data.”⁸⁹

Some of the shortcomings of previous analysis included “... lack of information on the specific quantities and types of wastes burned and on other sources of background pollution when air samples were being collected meant it was difficult to correlate pit emissions, including smoke events, with potential health outcomes. Different types of wastes produce different combinations of chemical emissions with the possibility of different health outcomes in those exposed. Moreover, it is hard to determine whether surrogate populations such as firefighters experience exposures to pollutants and durations of exposures similar to those of service members stationed at JBB.”⁹⁰

Overall, the IOM recommended a study be conducted to evaluate the health status of service members post-deployment to JBB over many years to assess incidences of chronic diseases, including cancers, that may develop over decades.⁹¹ The specific study recommendations are as follows:

- A cohort study of veterans and active duty military should be considered to assess potential long-term health effects related to burn pit emissions in the context of the other ambient exposures at the JBB. This type of study, while complex, is not unique in a military setting (for example, standard methods exist for the U.S. Air Force Ranch Hand Study that examined health effects of Agent Orange).
- An independent oversight committee composed of military and external experts in air pollution, analytical chemistry, exposure assessment, epidemiology, toxicology, biostatistics, and occupational and environmental medicine should be established to provide guidance and to review specific objectives, study designs, protocols, and results from the burn pit emissions research programs that are developed. Such a committee could provide an essential peer-review function to lend greater scientific credibility to the investigations. An example is the advisory committee that was established to oversee the conduct of the Ranch Hand Study (IOM 2006).
- A pilot study should be conducted to ensure adequate statistical power, ability to adjust for potential confounders, to identify data availability and limitations, and develop testable research questions and specific objectives. The objectives should be used to motivate essential study design features. Examples of these features include subject eligibility criteria, size and demographic characteristics of the cohort, length of follow-up required, health outcomes to be studied, critical time periods of exposure, and potential confounding and modifying factors that would need to be measured. Careful consideration should be given to defining sensitive and useful exposure measures.
- Assessment of health outcomes is best done collaboratively using the clinical informatics systems of the DOD and VA, in addition to the nonmilitary methods of follow-up (for example, National Death Index, state cancer registries) that can be used to identify the incidence and prevalence of health effects over time. Integration of current programs would increase feasibility and ease of study initiation. Multiple health assessments in the form of questionnaires and specific medical assessments could be administered periodically to better address intermediate and nonfatal health outcomes.

- An exposure assessment for better source attribution and identification of chemicals associated with waste burning and other pollution sources at JBB should be conducted prior to beginning a new epidemiologic study to help VA determine those health outcomes most likely to be associated with burn pit exposures. The committee's analysis of available data from the environmental monitoring conducted at JBB suggests that exposure to particulate matter emitted from sources such as diesel and jet engines, upwind Iraqi urban areas, and soil, may be of greater concern than exposure to burn pit emissions.
- Exposure assessment should include detailed deployment information including distance and direction individuals lived and worked from the JBB burn pit, duration of deployment, and job duties. Multiple methods of estimating exposure have been discussed; however, the most applicable method should be defined by the study questions, data availability and limitations, and study design. Study of troops currently deployed at bases with operating burn pits, in addition to JBB, would allow for prospective exposure assessment of those troops and provide information useful to interpretation of results from JBB.⁹²

The IBVSOs believe that such a program needs to be instituted immediately. While a consensus study is a first step, an epidemiological study with its survey questions, and other research tools should also be used to improve understanding of veterans' illnesses and treatments needed, and to compensate those who become disabled as a result of exposure. Having an ongoing monitoring and tracking program of current service members and veterans would provide the data needed.

As an option, the IBVSOs recommend that VA consider basing this program on an existing national, Congressionally mandated program that targets former Department of Energy workers who were likely exposed to toxic fumes and substances during the manufacture of chemical weapons and other hazards. This program has enabled these former workers to receive diagnoses for illnesses that are often not common to the general population as a basis for treatment and potential compensation for their associated illnesses. Starting such a monitoring, tracking, and referral program targeting OEF/OIF veterans would

be a proactive way for VA to establish a program that can, and should, be used to test any veterans who may have or believe they may have suffered adverse health effects from hazardous environmental exposures during their military service.

The IBVSOs strongly urge VA to immediately start identifying, tracking, offering systematic medical monitoring, and, if needed, treating veterans exposed to all known hazards, such as the burn pits now instead of waiting years or decades to determine what diseases may be linked to these exposures.

DOD and VA Integrated Disability Evaluation System

The President's Commission on Care for America's Returning Wounded Warriors recommended that the "DOD and VA create a single, comprehensive, standardized medical examination that the DOD administers. The IBVSOs support the recommendation the Commission's recommendation. Such an exam would serve DOD's purpose of determining fitness and VA's of determining initial disability level."⁹³ We believe this should be a mandatory examination completed as a prerequisite of completing the military separation process. If a single separation physical becomes the standard practice, VA should be responsible for handling this duty as VA has the expertise to conduct a more thorough and comprehensive examination, given its focus on evaluating veterans for compensation and pension benefits.

The Disability Evaluation System (DES) is the mechanism used to evaluate a service member for fitness for duty by the DOD and to compensate for injury or disease incurred in the line of duty that inhibits service members' ability to perform the duties of their office, grade, rank, or rating. DES includes a medical evaluation board (MEB) (an informal process of the medical treatment facility), physical evaluation board (PEB) (informal and formal fitness-for-duty and disability determinations), appellate review process, and final disposition. A PEB Liaison Officer is assigned to assist the Service member through the process. The PEB recommends that the service member either returns to duty, be placed on temporary disabled/retired list, separate from active duty, or be medically retired. While the DOD Legacy DES process only rates those disabilities that directly impact continued military service, the VA evaluation takes into account

all disabilities incurred or aggravated during military service warranting a disability rating of 10 percent or higher.

A DES pilot project premised on the President's Commission on Care for America's Returning Wounded Warriors recommendation was launched by the DOD and VA in 2007 and is managed by the VA-DOD Joint Executive Council. Using lessons from the pilot, the program expanded to 27 facilities in 2009, with more than 5,400 service members participating. Based on service members' high satisfaction rates with the revised program, the DOD and VA have designed an integrated disability evaluation system (IDES), with the goal of expediting the delivery of VA benefits to all out-processing service members. The current 27 locations participating in the pilot program examine about 47 percent of service members (12,735 in 2010) who enter the DOD disability evaluation system annually.

Active Component Service members completed the DES pilot in an average of 289 days, and Reserve Component Service members completed in an average of 270 days, compared to a Legacy DES average of 540 days. Surveys revealed significantly higher satisfaction among DES pilot participants. On July 30, 2010, the SOC cochairs directed that IDES expand worldwide beginning October 2010.⁹⁴

The expansion of each stage of the IDES expansion and cumulative DES population that will be served is as follows:⁹⁵

- Stage I—West Coast and Southeast (October–December 2010)—28 sites, 58 percent
- Stage II—Mountain Region (January–March 2011)—24 sites, 74 percent
- Stage III—Midwest and Northeast (April–June 2011)—33 Sites, 90 percent
- Stage IV—Outside Continental United States (July–September 2011)—28 sites, 100 percent
- Total IDES locations when complete: 140

While the IBVSOs have been pleased at the progress of the IDES to date, we are concerned that service members who are participating in the new approach to discharge evaluation are not systematically being encouraged to seek representation from a veterans service organization. Most are relying instead on the

advisory services of military counsel, yet each service provides access to military legal counsel in different manners and circumstances.

The Recovering Warrior Task Force (RWTF), chartered for five years, from 2010 through 2014, is conducting an assessment of the effectiveness of DOD programs and policies for recovering warriors. One of those areas of study was the issue of legal representation of disabled military personnel as they were processed through the DOD's IDES. The RWTF noted that depending on the availability of resources, all service members have access to routine legal support, including advice and advocacy related to the IDES process. The Army has 24 MEB Outreach Counsel attorney/paraprofessional teams for approximately 8,000 recovering warriors enrolled in the DES. The Marine Corps, Navy, and Air Force have fewer assets devoted to MEB support. During on-site briefings, legal personnel indicated to the RWTF that they are greatly understaffed. The Army, Navy, and Marine Corps provide legal counsel for both MEB and PEB. The Air Force provides specific legal counsel only for the PEB. Air Force installation-level legal counsel can address IDES issues prior to PEB. However, the Air Force is the service with the lowest satisfaction with legal counsel and the only service whose IDES participants were not more satisfied than their legacy DES participants. These survey results reinforce the importance of providing legal counsel for the MEB as well as the PEB.⁹⁶

Despite survey results demonstrating the value of having legal counsel available throughout the disability evaluation process, the majority of RWTF focus group participants lacked personal experience with, or knowledge of, these specialized legal resources. Additionally, the services are not systematically capturing the metrics necessary to justify resource requirements or shape possible improvements.⁹⁷ Without a systematic approach, no process changes or programmatic enhancements should be anticipated.

Based on the observations of the RWTF of the lower satisfaction of some military personnel with their access to legal counsel at all phases of the IDES process that are provided by the services, the IBVSOs offer that most service members undergoing the discharge evaluation process are unaware of the complexities

of the disability adjudication and retirement systems. A lack of informed opinion by service members may result in their accepting PEB decisions that are not in their best interest and/or the benefits they receive may be less than what they would have received had they been fully cognizant of the long-term impact of their decision to accept a particular PEB decision. As a result, we believe their interests in the IDES process would best be served by their being represented by an informed national service officer of a chartered veterans service organization. The IBVSOs believe that all veterans transitioning from military service to civilian life as a result of disability should be afforded the benefit of representation by an advocate before the fact, and we urge the DOD and VA to address this observed gap in IDES. Unfortunately, not all of the IBVSOs are allowed access to military installations in order to be available to provide this representation.

Military Separation Physical Examinations

A mandatory separation physical examination is not required by the DOD for demobilizing National Guard and reserve members. In some cases we believe these personnel are not made aware the option is available to them as they return from deployments. Although the physical examinations of demobilizing personnel have greatly improved in recent years, a number of service members opt out of these examinations even when encouraged by DOD medical personnel to complete them.

While the expense and manpower needed to facilitate these physical examinations might be significant, the separation physical is critical to the future care of demobilizing service members. The mistakes of the first Gulf War should not be repeated for future generations of war veterans, particularly among members of our National Guard and reserve forces. Mandatory separation physical examinations would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by each to recognize, treat, and compensate for illnesses and injuries resulting from military service and, in particular, combat deployments.

Recommendations:

VA and the DOD should coordinate efforts to better address mild and moderate TBI and concussive injuries and establish a comprehensive rehabilitation program, including establishment of therapeutic residential facilities, and deployment of standardized protocols utilizing appropriately formed clinical assessment techniques to recognize and treat neurological and behavioral consequences of all levels of TBI and all generations of veterans who suffer the lingering effects from earlier injuries.

Any TBI studies or research undertaken by VA and the DOD for the current generation of TBI-injured veterans should include older veterans of past military conflicts who may have suffered similar injuries that went undetected, undiagnosed, and untreated.

VA should establish an immediate program of monitoring, research, and treatment of conditions that may be associated with veterans' exposure to hazardous toxins from burn pits in Afghanistan and Iraq.

Congress should authorize and VA should provide a full range of medical, psychological, financial, and social support services to family caregivers of veterans, especially for those with brain and severe physical and polytrauma injuries. In that connection, Congress should closely oversee VA's full implementation of caregiver benefits authorized by P.L. 111-163. Congress should expand the benefits afforded by this act to family caregivers of enrolled veterans, on the basis of need, rather than the period during which they served.

Congress should provide oversight to ensure that the DOD and VA improve the Federal Recovery Coordinator Program in military treatment and VA facilities caring for severely injured service members and veterans. VA should periodically survey the family members of veterans assigned to federal recovery coordinators to determine where improvements might be necessary to the services they provide these veterans and their families.

The DOD and VA should provide all military personnel going through IDES the option to choose between the legal counsel offered by the military and that available at no cost through national service officer of chartered veterans service organizations.

The DOD should allow access to military installations for chartered veterans service organizations to provide services to active duty personnel.

The DOD mandatory separation physical examination should be required not just for active duty personnel but for all demobilizing National Guard and reserve members.

⁶⁷ David X. Cifu, MD, National Program Director, VA Physical Medicine & Rehabilitative Services, FY 11 Update: VA Polytrauma System of Care, Federal Advisory Committee, PowerPoint Presentation (November 1, 2011).

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ National Center for PTSD. "National Center for PTSD Fact Sheet," Brett T. Litz, "The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq," January 2007. http://www.nami.org/Content/Microsites191/NAMI_Oklahoma/Home178/Veterans3/Veterans_Articles/5uniqecircumstancesIraq-Afghanistanwar.pdf (accessed 10 June 2011).

⁷¹ Ibid.

⁷² National Alliance for Eye and Vision Research, Educational Briefing at the U.S. House of Representatives, Rayburn B-340, "Vision Research Meeting Battlefield Needs: Diagnosing Vision Problems Resulting from TBI" (February 22, 2011).

⁷³ Glenn C. Cockerham, MD, et al., Department of Veterans Affairs, "Eye and Visual Function in Traumatic Brain Injury," *Journal of Rehabilitation Research & Development*, Vol. 46, No. 6 (2009) pp. 811-818.

⁷⁴ VHA Office of Public Health and Environmental Hazards, "Analysis of VA Health Care Utilization Among OIF, OEF, Fourth Quarter Report FY 2010." PowerPoint.

⁷⁵ National Alliance for Eye and Vision Research, Educational Briefing at the U.S. House of Representatives, Rayburn B-340, "Vision Research Meeting Battlefield Needs: Diagnosing Vision Problems Resulting from TBI" (February 22, 2011).

⁷⁶ Armed Forces Health Surveillance Center, Eye Injuries among Members of Active Components, U.S. Armed Forces, 1998-2007, MSMR Volume 15, no. 9 (November 2008).

⁷⁷ Goodrich, Greg, L. Brahm, Karen, D. Palo Alto VAMC, "Visual Impairment and Dysfunction in Combat Injured Service Members with Traumatic Brain Injury" *Optometry and Vision Science*, Vol. 86, No. 7 (July 2009).

⁷⁸ James Hosek, Senior Economist, RAND Corporation, Testimony before the United States Senate Committee on Veterans' Affairs, Hearing, "Examining the Lifetime Costs of Supporting the Newest Generation of Veterans" (July 27, 2011).

⁷⁹ Cockerham G. C., et al., "Closed-eye ocular injuries in the wars in Iraq and Afghanistan." *N Engl J Med* 364 (June 2, 2011): 2172-2173.

⁸⁰ Department of Defense, Vision Center of Excellence (November 2011). <http://vce.health.mil/index.aspx>.

⁸¹ VA Office of Public Health and Environmental Hazards 4th Quarter OIF and OEF Utilization Report December 2010.

⁸² Department of Defense, Office of the Secretary of Defense, *Quadrennial Defense Review* (February 1, 2010).

⁸³ FY 2010 "National Defense Authorization Act," P.L. 111-84, Section 317, October 28, 2009.

⁸⁴ Institute of Medicine, Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan. <http://www.iom.edu/Activities/Veterans/BurnPitsLongTermHealth.aspx>.

⁸⁵ TheNationalAcademyPress. http://www.nap.edu/catalog.php?record_id=13209#description.

⁸⁶ Statement by Mr. John Resta, Scientific Advisor, U.S. Army Center for Health Promotion and Preventative Medicine, Senate Veterans Affairs Committee Hearing, "Occupational and Environmental Health Exposures in Military Operations," October 8, 2009, p. 9.

⁸⁷ Ibid., 10.

⁸⁸ Institute of Medicine, Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan. <http://www.iom.edu/Activities/Veterans/BurnPitsLongTermHealth.aspx>, p. 121.

⁸⁹ Ibid., 4.

⁹⁰ Ibid.

⁹¹ Evidence Inconclusive About Long-Term Health Effects of Exposure to Military Burn Pits, National Academy of Sciences Press Release, Oct. 31, 2011. <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=13209>.

⁹² Ibid., 127.

⁹³ The President's Commission on Care for America's Returning Wounded Warriors (July 2007), 7.

⁹⁴ Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces, Disability Evaluation System, p. D-34.

⁹⁵ Statement of John R. Campbell, Deputy Under Secretary of Defense (Wounded Warrior Care and Transition Policy), Department of Defense, before Senate Committee on Veterans' Affairs, Hearing, "Review of the VA and DOD Integrated Disability Evaluation System" (November 18, 2010).

⁹⁶ Ibid., 22.

⁹⁷ Ibid.

Access Issues

TIMELY ACCESS TO VA HEALTH CARE:

The Veterans Health Administration needs to improve data systems that record and manage waiting lists for primary care, and improve the availability of some clinical programs to minimize unnecessary delays in scheduling specialty health care.

In 1996, Congress passed P.L. 104-262, the "Veterans' Health Care Eligibility Reform Act," which changed eligibility requirements and the way health care was provided to veterans. As a result of this landmark legislation, along with a number of other factors, greater numbers of veterans chose to access the VA health-care system. VA health was well on its way to becoming a remarkable success story, and millions of veterans were enrolling in VA health care for the first time in their lives.

The act required VA establish a system for enrolling veterans for health care and to use this system for managing delivery of services. Since implementing its enrollment system at the beginning of FY 1999, VA had enrolled about 4 million veterans. However, demand for care has increased and this increase affected the delivery of timely care to veterans in some Veterans Integrated Service Networks (VISNs).⁹⁸ Funding shortfalls that included such schemes such as "management efficiencies" did not keep pace with

demand, and at its peak in the summer of 2002, VA reported that 310,000 veterans were waiting at least six months for their first appointment for primary care. In addition to primary care, then-General Accounting Office (now Government Accountability Office or GAO) found increased waiting times for specialty care as reported by VISN directors.⁹⁹

On January 17, 2003, the VA Secretary announced a “temporary” exclusion from enrollment of veterans whose income exceeded geographically determined thresholds and who were not enrolled before that date. This decision denied health-care access to 164,000 priority group 8 veterans in the first year alone. Since 2003, VA notes, more than 565,000 priority group 8 veterans have sought access to VA health care but have been denied.¹⁰⁰ Although Congress provided \$543 million¹⁰¹ in FY 2009¹⁰² to allow a projected 260,000 priority group 8 veterans to enroll, during the first half of 2011, nearly 47,000 veterans applied but were denied enrollment due to the means test threshold.¹⁰³

To meet its then self-prescribed 30-30-20 timeliness goals for outpatient care,¹⁰⁴ VA proposed in its fiscal year 2001 budget submission to Congress to spend \$400 million on an initiative to improve the timeliness of service, patient access to telephone care, and timely access to clinical information. Specifically, VA planned to redesign or replace its outpatient appointment-scheduling package because it did not allow flexibility in appointment length or scheduling across different facilities. The information technology plan would also allow VA to develop reliable national waiting time data.

Subsequently, to develop more reliable data on waiting times VA made several modifications to its outpatient scheduling system—the Veterans Health Information Systems and Technology Architecture (VistA), one of VA’s main computer systems for clinical, management, and administrative functions. In March 2001, VA began using these waiting times data to identify clinics that failed to meet its 30-day standard.

To reduce waiting times, the initiative included plans to use additional contract specialist physicians to reduce the backlog of patients waiting for specialty care and, as a result, reduce the amount of time patients must wait to receive such care. In June of 1999, VA contracted with the Institute for

Healthcare Improvement (IHI) to develop and implement techniques to reduce waiting times in specific clinics selected by VA facilities nationwide.¹⁰⁵

With IHI, the process of re-engineering its clinic patient flowed through what came to be called VA’s Advanced Clinic Access (ACA) Initiative. This initiative emphasizes managing a panel of patients by balancing the patient “demand” for appointments with the provider “supply” of appointments in order to provide access to care with minimal waiting times. The core principle of Advanced Clinic Access is for patients to see their own provider (or have phone or email access to that provider) on the same day as they request care.

Notably, maintaining a balance of demand and supply requires practices to have eliminated any backlogged appointments, which requires practices to increase capacity temporarily (work harder) so the waiting times are eliminated and then to continue with minimal or no waiting times by maintaining a balance of demand and supply. This has proven challenging for practices, since any provider absence (including illness, training, or vacation) or provider turnover can dramatically affect supply. Further, long waiting times were often the result of high percentages of patients not showing up for appointments, poor scheduling procedures, and inefficient use of staff.¹⁰⁶ Nonetheless, because of the dramatic success of ACA in reducing waiting times in primary care, the VHA began to expand the improvement efforts to address specialty care, mental health, and inpatient access problems.

Early efforts to address timely access to care (improve cancer care delays, hiring delays, and telephone responsiveness, among others) and reliability of waiting time data were largely fragmented. Local initiatives were successful at implementing a primary care model, referral guidelines to specialty care, centralized appointment scheduling, and a system for triaging walk-ins, but such successes were not disseminated and guidance from VA headquarters was lacking. However, as improvement communities began to form and in recognition of the broadening effort, the initiative was renamed Systems Redesign in 2005.

A small program office was created initially within VHA Operations, and System Redesign led multiple national collaboratives, which were formed to be a national focus for improvement communities doing

this work. In addition, as suggested by the Institute of Medicine in the ground-breaking monograph “Building Better Delivery Systems,” this office also led the creation of the nation’s first investment in health-care engineering, or Veterans Engineering Resource Centers (VERCs), which consist of system and industrial engineers engaged in efforts to improve the VA’s health-care delivery system.

In 2011, the effort underwent another evolution as the Central Office reorganization split the National Systems Redesign Program office into partners Systems Redesign with VERCs, Utilization Management, and the Office of Clinical Consultation and Compliance. This partnership involves front-line work on health-care delivery processes, redesigning these processes to eliminate delay and waste in order to create more reliable systems. In this instance, systems that can achieve and sustain access levels that meet and exceed the VHA performance standards for waiting times.

As the VHA embraced the new models of primary care delivery in 2009 (see “Transformation of the Department of Veterans Affairs Health-Care Delivery Model—Patient-Centered Medical Home or Patient-Aligned Care Teams (PACT)” in this *Independent Budget*), access principles and strategy implementation was again re-invigorated and redesigned as a central theme of PACT.

One of the principles in PACT involves enhanced access such as open access scheduling, expanded hours, and new options for communication. ACA implemented open access scheduling to meet patient’s desired appointment date. The VHA is developing an initiative to systematically extend clinic hours to include more early morning, night, and weekend hours. PACT is building on open access scheduling and adding new avenues for patient-provider communication (phone, email, group visits, and telehealth). These new ways of communicating with a VA provider increase “access,” but measuring this type of “access” to care requires some consideration.

In partnership with research, the VHA is learning more about the best approaches to measurement of timeliness for appointments. In order to sustain the teaching of this increasing complex knowledge base, the VHA has developed an access “academy” that will provide specialized training to measure and improve access.

The VHA is also in the process of developing coordinated efforts to improve specialty care and access. National Specialty Care Collaboratives are being piloted to engage facilities in identifying and implementing strong practices to improve care in select specialties. The VHA is working with engineers to provide better specialty measures and development of better consult data timeliness.

Improving access to inpatient care is another area of VA focus. Further work to systematize and spread this through implementation of Access and Flow Coordination Centers, or the “control tower” for inpatient services, will soon provide national information regarding availability of beds and services. This information is possible because of investments in technology, including a Bed Management Solution and Emergency Department and Surgery software.

What to Measure

There is a lot of truth to the adage “you can’t improve what you can’t measure.” In order to improve access, the VHA began to measure and report access data across the entire system.

In 1995, VA established a goal that all non-urgent primary and specialty care appointments be scheduled within 30 days of the request and been seen within 20 minutes of their selected appointments, and that its clinics would meet this goal by 1998. The GAO reports and Congressional hearings strongly suggested the Department was not meeting these timeliness standards.

In its first attempt to collect outpatient waiting time information, VA designed a software program to extract data from VistA’s appointment scheduling component once a month at every VA outpatient clinic nationwide. For primary care appointments, the third available appointment (time between “today” and when the third open slot appears on the schedule) was used because, according to VA, the first and second appointments are often held open for urgent care and would not be given to veterans calling for routine care.

However, clinics varied in how they used the appointment-scheduling component, and data generated for the third available appointment could not be aggregated to obtain an overall picture of waiting times. Several other problems with this first data collection

effort resulted in VA not being able to determine whether waiting times in a given clinic were understated or overstated.

Subsequently, from 2000 to 2004 VHA used the first next available appointment measure. Again, because of limitations with VHA's scheduling software, among other things, this approach of measuring schedule capacity evolved to measuring actual patient waiting times from one point in time to another point in time. The September 2007 Office of Inspector General report, *Audit of the Veterans Health Administration's Outpatient Waiting Times*,¹⁰⁷ challenges the validity of the VA data.

A time stamp measure using a combination of “create date” (the date an appointment was created or made), and “desired date” (the date a patient or provider ideally wants the appointment to occur) measured timeliness of access. Then in 2009, in response to a growing chorus of concerns about the create date, the VHA began to rely exclusively on the desired date time stamp to measure access to the millions of appointments created every year. To track and assesses the utilization and resource needs for specialty care, the desired date is established through the use of electronic consult requests in the Computerized Patient Record System.

VA until recently had four reports to track and manage waiting times, which include the “Missed Opportunities Report” (patients who did not show for their appointments or whose appointments were canceled), “Completed Appointments Report,” “Electronic Waiting List Report” (patients treated without prior appointments), and the “Access Waiting List Report” (patients who have not completed their appointments).

These reports are used in VA's Performance and Accountability Reports (PARs), which contain key performance measures to track its progress in accomplishing its overall mission. Under VA's third strategic goal for fiscal year 2009,¹⁰⁸ VA has listed performance measures to track all patients based on a 30-day benchmark: the percentage of primary care appointments scheduled within 30 days of a patient's desired date, the percentage of new patient appointments completed within 30 days of the “create” dates, and the percentage of unique patients waiting more than 30 days beyond the desired appointment

date. In subsequent *Accountability Reports*, the VHA claimed even better results for fiscal years 2007, 2008, and 2009: 97.2, 98.7, and 99 percent of primary care, and 95, 97.5 and 98 percent of specialty care patients, respectively, falling within the 30-day time frame.

It appears VA has finally resolved the reliability issue with regard to the “desired date”—the first point in time for the purposes of measuring access to care. In 2010, VA began measuring wait time for all patients based on a 14-day benchmark: percentage of new and established patients completed within 14 days of a patient's desired date for both primary and specialty care appointments including mental health. As reported in the PARs, VA has met or exceeded targets in these measures with 93.65 percent of new primary care appointments and 94.51 percent of new specialty care appointments completed within 14 days of desired date in FY 2011. In addition, since FY 2009, more than 95 percent of eligible new mental health patients have had a documented follow-up evaluation within 14 days.

However, these are not the only available reports on access to VA health care. Based on internal reports, the number of patients waiting longer than 14 days from the desired appointment date for FY 2011 ranged from a low of more than 109,000 to a high of more than 175,000.

As of September 2011, there were more than 138,000 veterans for whom the Department did not meet its own mandate. This number includes more than 10,500 Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and more than 40,500 priority group 1 veterans (service connected 50 percent or greater). Moreover, *The Independent Budget* veterans service organizations (IBVSOs) have also learned that some facilities may have reverted back to resorting to paper wait lists despite national policy prohibiting such practices.¹⁰⁹

The IBVSOs urge the VHA to make public these other access list reports. Without the ability to compare these waiting time reports to external benchmarks, we cannot accurately evaluate VA's performance. Greater transparency would allow for clearer accountability, for consistency and performance comparison, across the VA health-care system.

Tools to Measure

To assess its success in reducing waiting times, the VHA uses scheduling software developed in the 1970s, supplemented by electronic waiting lists. Initially, the VHA measured waiting times for primary and specialty care separately and produced data for six monitored clinic stops nationwide (primary care, urology, cardiology, audiology, orthopedics, and ophthalmology). These clinics demonstrated steady reductions in patient waiting times.

Over time, new functionality and enhancements were made to VA's scheduling software to address findings by VA's Office of Inspector General (OIG)¹¹⁰ and Booz Allen Hamilton¹¹¹ on weaknesses in the Department's outpatient scheduling process.¹¹² However, after spending an estimated \$127 million over nine years (from fiscal years 2001 through 2009) on its outpatient scheduling system project to develop a core computer application to schedule patient appointments, VA today is still in need of replacing its archaic scheduling software.^{113, 114}

Had the new system been implemented, it would also have been a core piece of VA's HealtheVet electronic health record that includes patient enrollment and scheduling, a pharmacy system, a data repository, a workload management system, and a gateway for patients to manage their own health records and personal information.

The IBVSOs urge VA to finalize an overall comprehensive development plan for a new scheduling model update. The plan should incorporate critical areas of system development and consider all dependencies and subtasks, including use as a means of determining progress for critical components, such as patient waiting times. Such software can address the validity of data that remain suspect, optimize VHA health-care capacity, and improve access and health outcomes.

Timely access is crucial to the VHA health-care system's capacity to provide health care quickly after a need is recognized and is crucial to the quality of care delivered. Significant and recurring delays for appointments result in patient dissatisfaction, avoidable waste of finite resources, and possible adverse clinical consequences.¹¹⁵ Since *The Independent Budget* first addressed the waiting time issue in its 2002 edition, the IBVSOs have consistently recommended that the

VHA "identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide." In 2002, at the zenith, more than 310,000 veterans were waiting six months or more for care.¹¹⁶ In January 2008, 109,970 veterans were waiting more than 30 days to be seen. However, the VHA measurement system for outpatient waiting times continues to lack credibility.

Because the Institute of Medicine identified timeliness as one of the six key "aims for improvement" in its major report on the quality of health care,¹¹⁷ the IBVSOs believe the VHA must take a more aggressive stance to provide greater transparency toward efforts to ensure that veterans are receiving timely access to care. Also, we believe waiting times for all primary and specialty care appointments, regardless of whether these services are directly provided or purchased by VA, should be measured. The unprecedented growth of non-VA purchased care, highlighted in the "Coordination of VA Purchased Care" section of this *Independent Budget*, cannot be ignored in performance measurement. So, too, must the VHA track and manage veterans' access to care in this arena. This advance will bring the Department closer to a more comprehensive measurement of performance in delivering health care to our nation's disabled veterans. The perception of the VHA's quality is important to its success.

Recommendations:

The Veterans Health Administration (VHA) should make every effort to establish external comparisons, such as the Institute for Healthcare Improvement's outcome measures to gauge its performance in providing timely access to care.

The VHA should make public its Missed Opportunities Report, Completed Appointments Report, Electronic Waiting List Report, and the Access Waiting List Report used to track and manage waiting times.

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

VA must ensure that schedulers receive adequate annual training on scheduling policies and practices

in accordance with the recommendations of its Office of Inspector General (OIG).

The OIG should conduct a follow-up evaluation of VA's outpatient scheduling processes and procedures, compliance, training, monitoring, and oversight.

VA should complete development of the replacement system for HealthVet scheduling.

The VHA should also include the timeliness of care standards for veterans who receive non-VA purchased care.

⁹⁸ GAO/T-HEHS-99-158.

⁹⁹ Ibid.

¹⁰⁰ Personal communication with director, Business Office, VHA.

¹⁰¹ Includes \$375 million for medical services, \$100 million for medical support and compliance, and \$68 million for medical facilities.

¹⁰² P.L. 110-329.

¹⁰³ September 16, 2011, letter to VA Secretary Shinseki from Senators Blumenthal and Tester.

¹⁰⁴ (1) receive an initial, non-urgent appointments with their primary care or other appropriate provider within 30 days of requesting one; (2) receive specialty appointments within 30 days when referred by a primary care provider; and (3) be seen within 20 minutes of their scheduled appointments. VA's timeliness standard for urgent care requires access to such care 24 hours a day. (See

also: Testimony of VA Under Secretary for Health, Thomas L. Garthwaite, MD, before the House Committee on Veterans' Affairs Subcommittee on Health, April 3, 2001.

¹⁰⁵ GAO/HEHS-00-90.

¹⁰⁶ GAO-01-953.

¹⁰⁷ www4.va.gov/oig/52/reports/2007/vaig-07-00616-199.pdf.

¹⁰⁸ P.L. 103-62, "Government Performance and Results Act of 1993"; P.L. 106-531, "Reports Consolidation Act of 2000."

¹⁰⁹ VHA DIRECTIVE 2010-027, VHA Outpatient Scheduling Processes and Procedures, June 9, 2010.

¹¹⁰ VA Office of Inspector General, *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures*, Report No. 04-02887 (Washington, DC: July 8, 2005); *Audit of the Veterans Health Administration's Outpatient Waiting Times*, Report No. 07-00616-199, (Washington, DC: September 10, 2007); *Review of Alleged Manipulation of Waiting Times, North Florida/South Georgia Veterans Health System*, Report No. 08-03327-35 (Washington, DC: December 4, 2008).

¹¹¹ Executive Summary, Final Report on the *Patient Scheduling and Waiting Times Measurement Improvement Study* (Washington, DC: Booz Allen Hamilton, July 22, 2008).

¹¹² VHA *Outpatient Scheduling Processes and Procedures*, VHA Directive 2010-027 (June 9, 2010).

¹¹³ Department of Veterans Affairs press release, "Initial 45 Projects Targeted for New Department-wide Management System" (July 17, 2009). <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1734>. 55; M. Murray and C. Tantau, "Must Patients Wait?" *Journal on Quality Service Improvement* 24, no. 8 (1998): 423-25.

¹¹⁴ U.S. Government Accountability Office, *Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System*, GAO Report 10-579 (May 27, 2010).

¹¹⁵ Institute of Medicine, NIH, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press, 2001).

¹¹⁶ VHA survey conducted in July 2002. Senate Report 107-222, 107th Cong., 2nd Sess. (2002).

¹¹⁷ Institute of Medicine, NIH, *Crossing the Quality Chasm*, note 97.



TRANSFORMATION OF THE DEPARTMENT OF VETERANS AFFAIRS HEALTH-CARE DELIVERY MODEL—PATIENT-CENTERED MEDICAL HOME OR PATIENT-ALIGNED CARE TEAMS:

The Veterans Health Administration is undergoing change in the way it delivers health care. As the VHA implements a patient-centered medical home model, Department of Veterans Affairs' leadership must ensure that the unique health-care needs of the veteran population are met while sustaining quality and satisfaction.

Over the past 15 years, the Department of Veterans Affairs has been transformed into a nationally recognized, first-rate, and comprehensive health-care system. To maintain its high standards of quality care, VA recently announced its intention to transition into a patient-centered medical home (PCMH) model using the patient-aligned care team (PACT) approach. *The Independent Budget* veterans service organizations (IBVSOs) believe that such a change has the potential to enhance the delivery of health services for veterans; however, to ensure that the expected positive outcomes are achieved, VA must include three critical factors as fundamental components of the medical home model: (1) the PACT approach must meet the unique needs of

disabled veterans; (2) PACTs must be accessible and provide timely care to and communication with veterans and their advocates; and (3) the VHA's infrastructure needs must be aligned with the new model of care.

In January 2011, VA announced that the newly created Office of Patient Centered Care and Cultural Transformation would be primarily responsible for managing the implementation of all PACTs throughout the VHA. PACTs are interdisciplinary teams with primary care providers, registered nurse case managers, clinical and administrative staffs, and medical professionals who are requested based on the health-care needs of individual veterans. As of July 2011,

VA reported 80 percent of VA medical facilities have elements of PACTs in operation, and VA leadership projects that all VA health-care sites will function as PACTs by 2015. VA has identified the principles of the patient-centered medical home model as:

- Team-based care that emphasizes continuity of care over the lifespan of the veteran patient;
- A larger role for nurses, nurse practitioners, and physician assistants in coordinating care;
- Use of email, secure messaging, and other alternative forms of communication and telemetry with patients to monitor care;
- Greater attention to behavioral and mental health issues; and
- Increased focus on what patients want while increasing patient and practitioner satisfaction.

The five elements of PACT implementation include (1) assessment and readiness; (2) building staffing infrastructure; (3) training and education; (4) innovation and evaluation; and (5) measurement. Each of these elements constitutes a tool used by VA to define, assess, and develop the overall mission and responsibilities of PACTs. Most important, these elements must incorporate the principals of quality care that VA has successfully delivered to America's veterans.

Because the PCMH model requires each PACT to be responsible for coordinating, managing, and developing health-care plans for a panel of veteran patients, there is great potential to improve the delivery of health-care services as it relates to continuity of care, communication with veterans, and comprehensive services. However, over the years VA has established specialized systems of care and primary care teams with specialty-trained practitioners for veterans who have experienced spinal cord injury or disease, blindness, amputations, polytrauma injuries, and chronic mental illness challenges, and these specialized systems of care serve as excellent models for patient-centered care delivery and cannot be replaced or diluted by the advent of PACTs that focus on the basic outpatient model of care. While the IBVSOs understand the importance of the transition to a new model of care, PACTs may not be trained to adequately meet the specialized health-care needs of these populations.

VA leadership must make certain that PACT staffing is sufficient to provide quality care and addresses the individual medical needs of veterans. Such an outcome would severely jeopardize the quality of

VA health care. Therefore, to guarantee the success of this health-care delivery model and improve VA health-care services, Congress and VA must ensure that VA medical centers have adequate funding, as well as clearly prescribed patient-to-staff ratios for PACTs. Specifically, staffing levels at each medical center must be in direct alignment with the number of veterans seeking services. Funding must be made available to hire additional full-time medical staff, as well as make facility enhancements to support implementation of the PCMH model.

An important counterpart to the PACT approach is a supportive adjustment to the Veterans Equitable Resource Allocation model and to existing individual and organizational performance plans and measures, both of which incentivize a primary care system, not necessarily PACTs. The VHA should redesign management tools that modify behaviors of the health-care system so it can make a successful transition to PACTs.

As PACT implementation moves forward, the changes inherent in this cultural shift in health-care delivery must be taken into account in VA's infrastructure and capital investment policies. With the advent of PACTs, VA would no longer simply be replacing worn-out medical centers and clinics with like, but modernized, facilities; VA's evolution to the PACT approach in all likelihood will result in the need for VA to redesign its thinking for how a 21st century VA health-care system, based on the new PACT model of care, should be configured. Therefore, the IBVSOs strongly encourage VA to incorporate a sixth element of PACT implementation, *building facility infrastructure and technology*. As PACT implementation progresses, VA must assess the physical infrastructure and technology needs of its medical centers in order to fully support the transition to a PCMH model of care and utilize integral components of this new health-care system, such as the use of telemedicine and telemetry to help manage and coordinate veterans health care, as well as reach and treat certain patient populations.

VA must help veterans, family members, and caregivers understand the purpose and goals of VA's new culture to help them become true collaborators in the health-care decisions and care plans formulated to maintain veterans' health. In addition to the goal of better health outcomes and management of chronic diseases, the value of long-term, one-to-one relationships that are established and nurtured between patient and practitioner and the emphasis on enhanced access

to care, quality, safety, and coordination of care are also important and beneficial. As PACTs are established in VA medical centers, the IBVSOs recommend that VA schedule frequent meetings to reach out to veterans and their advocates for input and feedback, as well as identify tools to monitor quality performance using measurable indicators to ensure that the intended health-care outcomes are achieved.

The PACT model is only the initial step in making the veterans' health system more patient centered. VA should continue these laudatory efforts with enactment of patient-centered communication by VA providers, implementation of shared decision-making tools for preference-sensitive medical decisions, greater use of technology and home telehealth to increase continuity of care, and establishment of veterans and family councils at every VA medical facility.

Recommendations:

VA must ensure that the specialized systems of care are not replaced or diluted by standard patient-aligned care teams (PACTs) that may not be trained to adequately meet unique health-care needs of the populations needing specialized care.

VA must implement policies to provide continuity of care throughout the Veterans Health Administration (VHA) to ensure safe delivery of quality health care.

VA must use the data collected from its research efforts to bring all of the facets of the PACT plan into a cohesive and integrated whole.

VA must create and implement a comprehensive educational component for veterans and their advocates during the early stages of PACT implementation to increase the likelihood VA users understand how the new model serves them and represents an improvement.

VA must include *The Independent Budget* veterans service organizations as an integral part of the transformational process and keep them informed and involved in changes to come so as to help serve and educate their memberships and the veterans VA serves.

VA capital investment planning, and VA's academic missions, must be accommodated as VA shifts its culture to that of PACTs.

VA must develop a sixth element of PACT implementation—*building infrastructure and technology*—to assess the current physical infrastructure and technology needs of medical centers and ensure efficient management of care.

VA must test and create clearly prescribed patient-to-staff ratios for PACTs to ensure timely health-care services at all medical centers.

VA should enhance its efforts by adding training of VA providers and patient-centered communication, implementing shared decision-making tools, increasing infrastructure support and use of technology, and home telehealth to increase continuity of care.

VA should mandate establishment of veterans and family councils at every VA medical facility to ensure that veterans, families, and veterans service organizations are integrated into these efforts. Should the Office of General Counsel determine that VA is restricted by the "Federal Advisory Committee Act" from taking this action, then legislation should be enacted to exempt these councils from such restrictions.

The VHA should redesign the Veterans Equitable Resource Allocation model and make changes to existing performance measures that modify behaviors of the health-care system so that it can make a successful transition to the PACT approach.

COMMUNITY-BASED OUTPATIENT CLINICS:

The Department of Veteran Affairs should improve specialty care provided by community-based outpatient clinics and improve oversight regarding contracted CBOC facilities and staff while consolidating contracts at either the medical center or network level.

More than 20 years ago, Congress addressed the critical need to increase access to health care for veterans not in close proximity to a full-fledged medical center by establishing a network of community-based outpatient clinics (CBOCs) across the nation. Since 1994, when VA opened the doors of the first community-based clinic, 804 clinics have become operational, and approximately 45 others are currently scheduled to open by the end of FY 2013. These clinics, whether staffed by VA employees or through contracted staffing, are intended to reduce risk of readmission into a VA inpatient setting by properly utilizing outpatient care options, which have been proven to be sufficient to treat many of the nonacute conditions that would have previously resulted in VA hospital admissions.

The quality of care at CBOCs is required to be at the same standard as care received at other VA health-care facilities, and all relevant VA policies and procedures for quality, patient safety, and performance are required to be fully enforced in CBOCs as well. However, this has proven difficult to achieve for a number of reasons, including different performance measures and pricing models within an individual catchment area and the aggressive pace at which VA has rolled out CBOCs. The result is a more complex, less efficient contract administration structure that generates superfluous work for already overburdened contracting officials, and the provision of a sometimes uneven benefit for veterans who access CBOCs for their primary care.

Ongoing work in the VA Office of Inspector General continues to provide evidence of these and other long-standing deficiencies. The most recent annual evaluation data highlight specific areas of inadequacy over the entire CBOC network, while also drawing a stark contrast on the disparity that often exists between VA-staffed CBOCs and their contracted counterparts. In the case of addiction counselors, 52.4 percent of VA-staffed CBOCs had addiction counselors on-site—a statistic that the IBVSOs believe leaves much room for improvement—while a paltry 2.4 percent of contracted CBOCs had an addiction counselor on staff.

This is a disappointing statistic that clearly shows the need for robust guidance and greater oversight.

The Veterans Health Administration (VHA) lacks an effective management control system to ensure CBOCs provide consistent care and are in compliance with current VA policies and procedures. The lack of oversight starts with the delegation of management and oversight to VA medical facilities or centers in the area. These parent facilities are divided into 21 networks, known as the Veterans Integrated Service Networks (VISNs). Because the VISNs conduct no regular, consistent oversight over the CBOCs, compliance to policies and procedures varies, often due to a lack of enforcement or awareness.

CBOCs also do not currently have a single standard by which they compensate mental health providers at contracted clinics. Multiple pricing models without proper oversight can lead to inefficiency and questionable rates and payments, and that lack of clarity in regulatory authority can generate additional work that strains the budget and time of administrative personnel. The need for veterans to have access to mental health services is more important than ever before, and the IBVSOs urge the VHA to review the various payment structures being used to ensure available funds are being used in the most effective manner possible.

That lack of enforcement is also evidenced by separate data that show CBOCs providing a range of services comparable to traditional VA facilities when evaluated in the aggregate, but also shows more variable performance when CBOCs are compared to their affiliated parent VA medical center. The IBVSOs believe that more analysis of these data may lead to opportunities for improvement across the system.

In cases where major problems arise, such as the case of Williamson and Logan, West Virginia, in 2011, VA often states that it can terminate a third-party contract and build a VA-managed CBOC in the same area. However, this is made difficult because of the backlog of projects, limited resources, and the bureaucratic hurdles that slow down the process. Moreover, the lack of

clear, consistent metrics to evaluate performance and conduct oversight complicates even identifying where problems exist. VA is often left depending on randomized, no-warning spot surveys of contracted facilities to uncover problems with such facilities. Complicating matters is the fact that in cases where such problems are discovered, VA often terminates the existing contracts, leaving facilities closed for days or weeks while a new contractor is sought and secured.

Perhaps the most meaningful action the VHA could take to improve the care CBOCs provide would be to incorporate telemedicine enhancements or specialized care services in targeted areas such as post-traumatic stress disorder, and to ensure thorough treatment in other targeted areas, such as military sexual trauma and traumatic brain injury. In such cases, veterans cannot be treated at the local CBOC. Instead, they must travel elsewhere—often to a VA medical center—for treatment, so many opt not to be treated at all. Such behavior complicates VA's efforts by reducing opportunities to engage in options that reduce inpatient care episodes and decrease cost to treat veterans. While the IBVSOs understand that fee-basis care must be a component of care that CBOCs provide, we also believe that areas of care that veterans are particularly susceptible to should be integrated into the portfolio of care that CBOCs provide on-site.

These are only some of the areas and opportunities for VA to improve the delivery of health care at CBOCs, which would greatly benefit from a system that is streamlined and supported by leadership that aggressively supports a single standard of care across the VHA system. Without dedicated leadership the initiatives that are needed, and very well may be undertaken, will be limited in their success. Leadership and dedication to succeed are the essential components of these and other needed changes.

Recommendations:

VA should improve specialty care offered at community-based outpatient clinics (CBOCs) and should aggressively enhance mental health services at all CBOCs, both VA-staffed and contracted.

VA must improve oversight for CBOCs to eliminate discrepancies in care, thereby ensuring consistently high-quality care at all CBOCs.

VA should concentrate on improving the oversight of contract CBOCs and should consider consolidating contract CBOCs at VA medical center or network levels. More aggressive oversight is necessary to ensure consistent requirements and performance measurements while also simplifying contract administration. Such a move could also ensure more aggressive pricing, but should be based on regional costs and rates within contract CBOCs.

The Veterans Health Administration (VHA) must develop and use clinically specific protocols to guide patient management in cases where a patient's condition calls for expertise or equipment not available at a given facility.

VA should enhance telemedicine infrastructure and use of technology to deliver specialty services at CBOCs.

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

VETERANS' RURAL HEALTH CARE:

The Department of Veterans Affairs is continuing to improve access to health-care services by veterans living in rural areas, with demonstration projects, experiments and innovation, but should not diminish existing internal VA capacities to provide specialized health-care services.

The *Independent Budget* veterans service organizations (IBVSOs) believe that, after serving their nation, veterans should not experience neglect of their health-care needs by the Department of Veterans Affairs because they live in rural and remote areas far from major VA health-care facilities. In *The Independent Budget for Fiscal Year 2012*, we detailed pertinent findings dealing with rural health care, disparities in health, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom, and New Dawn (OEF/OIF/OND). These conditions remain relatively unchanged:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and risks of stress, depression, suicide, and anxiety disorders as major unmet rural health concerns.¹¹⁸
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.¹¹⁹ The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services.¹²⁰
- Nearly 22 percent of the elderly live in rural areas, where they represent a larger proportion of the population than they do in urban areas. As the elderly population grows, so do the demands on acute care and long-term care systems. In rural areas, some 7.3 million people need long-term care services, accounting for one in five of those who need long-term care.¹²¹

Given these general conditions of scarcity of resources, the following facts should not seem surprising or unusual with respect to those serving in the U.S. military for National Guard and reserve component members, and to veterans of prior service.

- There are disparities and differences in health status between rural and urban veterans. According to the VA Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans “have worse physical and mental health related to quality of life scores. Rural/urban differences within some Veterans Integrated Service Networks (VISNs) and U.S. Census regions are substantial.”¹²²
- More than 44 percent of military recruits and service members deployed to Iraq and Afghanistan come from rural areas.
- More than 60,000 service members have been evacuated from Iraq and Afghanistan as a result of wounds, injuries, or illness, and tens of thousands have reported readjustment or mental health challenges following deployment.¹²³
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health-care users, 40.1 percent (nearly 2 million) reside in rural areas, including 79,500 from “highly rural” areas, as defined by VA.
- Thirty-five percent of OEF/OIF/OND veterans enrolled in VA are from rural and highly rural areas.¹²⁴
- Older enrolled veterans were more likely to reside in rural or highly rural areas, with 77 percent of rural and highly rural veterans being older than the age of 55. Among these rural veterans, 44 percent are over the age of 65.¹²⁵
- More than 70 percent of highly rural veterans must drive more than four hours to receive tertiary care from VA.¹²⁶

Currently, VA operates 153 VA medical centers and systems of care, including over 800 community-based outpatient clinics (CBOCs). VA staffs more than 550 CBOCs total; contractors manage the remainder of these clinics. At least 333 CBOCs are located in rural or highly rural areas as defined by VA. In addition, VA is expanding its capability to serve rural veterans

by establishing rural outreach clinics. Currently, 41 VA outreach clinics are operational, along with 51 CBOCs that primarily serve rural veterans. These facilities provide care to nearly 58,000 rural veterans.¹²⁷

Rural Veterans

In rural America, veterans and the community entities that work with them are often unaware of VA benefits and how to obtain them. A study commissioned by the Office of Rural Health (ORH) surveyed non-VA providers to identify issues on which health professionals lacked information concerning rural veterans, and among the top areas cited were “general issues in negotiating and managing the VA care system to meet needs of rural veterans.”¹²⁸

An analysis completed by the ORH in 2008 using FY 2007 VA utilization data¹²⁹ revealed that one in three veterans enrolled in VA health care was defined as rural or highly rural. It also found that, for most health characteristics examined, enrolled rural and highly rural veterans were similar to the general population of enrolled veterans, but this analysis confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately one-quarter of all enrolled veterans fell into this age group. In 2007 (most recent data available), rural veterans had a median household income of \$19,632, 4 percent lower than the household income of urban veterans (\$20,400). The median income of highly rural veterans showed a larger gap at \$18,528.

Ninety-five percent of rural and highly rural enrolled veterans are men, and approximately 5 percent are women. This proportion corresponds to the overall population of enrolled veterans. Nevertheless, elsewhere in this *Independent Budget* the IBVSOs discuss the greater role women play in today’s military services. Once out of service, these women are flocking to enroll in VA health care in unprecedented numbers. Also, approximately 4 percent of enrolled rural and highly rural veterans are veterans of OEF/OIF/OND deployments,¹³⁰ but given the Administration’s stated intention to wind them down and withdraw our service personnel, we expect a greater proportion of rural veterans will be demanding services from VA.

Veterans Rural Health Resource Centers Are Key Components of Improvements

VA operates three Veterans Rural Health Resource Centers for the purpose of improving its understanding of rural veterans’ health challenges; identifying their disparities in health care; formulating practices or programs to enhance the delivery of care; and developing special practices and products for implementation VA systemwide. According to VA, these centers serve as satellite offices for the ORH. They are located in VA medical centers in White River Junction, Vermont; Iowa City, Iowa; and Salt Lake City, Utah. The concept underpinning the establishment of these centers was to support a strong ORH presence across the VA health-care system with field-based offices. These offices are charged with engaging in local and regional rural health issues in order to develop potential solutions that could be applied nationally across the Veterans Health Administration (VHA), including building partnerships and collaborations—steps that are imperative in rural America. These offices have made appreciable progress in reaching out to state offices of rural health and their existing or potential collaboration with local rural health providers. The IBVSOs commend that progress and encourage its expansion and continuance, including developing a national-level collaboration, executed via the Rural Health Resource Centers, with Department of Health and Human Services grantee community health centers.

These satellite offices of the ORH and their efforts, along with those of VISN rural health consultants (now 20 in number), are validating the importance of the work and extending the reach of the ORH in the VHA, to reinforce the idea that it is moving VA forward using the direct input of the needs and capabilities of rural America, rather than VA trying to move forward alone from a Washington, DC, central office. Nevertheless, the IBVSOs understand that some local VA health-care officials tend to resist these rural resource centers’ and the consultants’ efforts to bring their collaborations and findings on rural matters into basic operations. We believe Congress and the Administration should examine these difficulties and take corrective actions to create incentives to promote better VA coordination with community health centers and other potential resources for the care of rural veterans.

Although some of the work these centers engage in is similar to that of the Mental Illness Research, Education, and Clinical Centers and the similar VA specialized centers in geriatrics, Parkinson's, and multiple sclerosis, the Veterans Rural Health Resource Centers are unique in that, as satellite offices, they have been delegated the appropriate obligation to more directly support the operations of the ORH, in addition to executing demonstration projects and conducting the analytical and scholarly studies required under their charters. The centers should continue to be leveraged to assist and execute the agenda of the ORH. For example, with the significant and recurring funding now flowing to VA from Congress to support improvements in rural health care for veterans, the IBVSOs believe that local, hands-on engagement and technical assistance from the Veterans Rural Health Resource Centers and the VISN Rural Health Consultants, with oversight by the ORH, is an appropriate direction for VA in rural health.

Despite our recommendation in *The Independent Budget for Fiscal Year 2012*, these resource centers still remain under temporary charters within the VHA, and are the recipients of centralized funding not to exceed five years' duration. The nature of that arrangement has had unintended consequences for the centers, including the problematic recruitment and retention of professional staff. The IBVSOs have been informed that most staff appointments to the Veterans Rural Health Resource Centers remain as temporary or term appointments, rather than career VA positions, primarily because there is reluctance on the part of the host VA medical centers to be put in the position of absorbing these personnel costs if their centralized funding from Washington suddenly ends. If the concept of field-based satellite offices for this key function is to be successful and sustained, the centers need to be established permanently, with full-time career staff elements.

Grassroots Rural Health Coordination

As indicated above, the VHA has established VA rural care designees—VISN rural consultants—in 20 of its VISNs to serve as points of contact and liaison with the ORH. While the IBVSOs appreciate that the VHA designated the liaison positions, we remain concerned that many of these liaisons serve these purposes only on a part-time basis, along with other

duties. We continue to believe rural veterans' needs, particularly those of the newest war generation, are sufficiently challenging to deserve full-time attention and tailored VA programs. Therefore, in consideration of other recommendations dealing with rural veterans' needs put forward in this *Independent Budget*, we continue to urge VA to confirm at least one full-time rural liaison position in each network, and more if warranted.

Beneficiary Travel Should Be Addressed in a Larger Context of Rural Strategy

Over the past three years Congress has provided VA additional funding to supplement the beneficiary travel mileage reimbursement allowance authorized under Title 38, United States Code, section 111, a benefit intended for certain service-connected and poor veterans as an access aid to VA health care. Today VA reimburses eligible veterans at a higher rate, 41.5 cents per mile traveled. While we appreciate this development and applaud both Congress and VA for raising the reimbursement rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by privately owned conveyance, and provides only limited relief to those who have no alternative but to drive or be driven long distances by automobile for VA health care.

According to an analysis completed by one of the ORH rural resource centers in 2009, VA's transportation reimbursement policy represents only one strategy in the need to improve rural veterans' access to VA health care. However, this existing reimbursement policy would be best viewed as an interlocked component of a larger strategy to improve access. According to the analysis, the policy should also consider a greater use of technology (i.e., telehealth, telemental health, and other forms of telemetry to avoid the need to travel) to provide selected services, partnering with local community health resources when rural veterans' personal transportation to VA facilities would be impractical or painful for them, and bringing health resources from VA to rural and highly rural communities (primarily via mobile clinics) when justified by workload volume. In a more recent study commissioned jointly by the ORH and the VA Office of Research and Development, investigators found that distance and the need to travel continue to serve as major access barriers to rural veterans.¹³¹

The IBVSOs agree with this analysis. Transportation policy would be most effectively planned and evaluated as one component of an overall strategy to improve access to care, since these strategies are not mutually exclusive. For instance, many veterans travel substantial distances to participate in real-time telehealth and telemental health sessions at CBOCs. A successful transportation policy for rural veterans should be comprehensive and include consideration of using alternative means to aid rural veterans in gaining access to services.

To our knowledge, little evaluation of these current policies, including recent significant changes in reimbursement, has been accomplished within VA. We believe evaluating these policies is important to improving rural veterans' access to care. Accordingly, we urge VA to conduct these analyses and report their results.

Veterans Transportation Network

The Office of Rural Health has commissioned a demonstration project to provide greater access through a Veterans Transportation Network. VA's stated goal is to explore the establishment of a network of community transportation service providers that could include veterans service organizations, community and commercial transportation providers, and federal, state, and local government transportation services as well as nonprofits, operating within each network of VA facilities or even within a local facility.

The Salt Lake City VA Medical Center is one of the original four VA locations chosen to pilot this new transportation program. By the end of this year, according to VA, the Salt Lake City facility hopes to transport 1,000 veterans per month to and from their appointments. VA's other phase one pilot sites are VA facilities in Temple, Texas; Muskogee, Okla.; and Ann Arbor, Mich. VA indicates the next phases of its plan are in the process of being implemented by 2012 at 43 additional VA sites. VA anticipates that similar transportation services will be available at an additional 110 VA locations by 2014.¹³²

The IBVSOs greatly appreciate this progress VA is making to enhance access to care for rural as well as seriously disabled veterans without the means to readily provide their own travel for health care.

Telehealth—A Major Opportunity, But Still Linger

The IBVSOs believe that the use of technology, including the Internet, telecommunications, and telemetry, offers VA a great but still unfulfilled opportunity to improve rural veterans' access to VA care and services. The IBVSOs understand that VA's intended strategic direction in rural care is a necessity to enhance non-institutional care solutions. VA provides home-based primary care as well as other home-based programs and is using telemedicine and telemental health—but on a rudimentary basis in our judgment—to reach into veterans' homes and community clinics, including Indian Health Service (IHS) facilities and Native American tribal clinics, as well as VA's own CBOCs. It would be a much greater benefit to veterans in highly rural areas if VA installed general telehealth capability directly into a veteran's home or into a local non-VA medical facility that a rural veteran might easily access, versus the need for rural veterans to drive to distant locations for telehealth services that could be delivered in their homes or local communities. This enhanced cyber-access could be made available in the veteran's home via a secure website and inexpensive computer-based video cameras, and private or other public clinics closer to veterans' residences could use general telehealth equipment with a secure Internet line or secure bridge to VA facilities.

Expansion of telehealth would allow VA to directly evaluate and follow veterans without their having to travel great distances to VA medical centers. VA has reported it has begun to use Internet resources to provide limited information to veterans in their homes, including up-to-date research information, access to their personal electronic health records, and the online ability to refill prescription medication. The IBVSOs agree these are positive steps, but we urge VA management to coordinate rural technology efforts among its offices responsible for telehealth, rural health, and information technology at the Department level, in order to continue and promote these advances, but also to overcome privacy, policy, and security barriers that prevent telehealth from being more available in veterans' homes in highly rural areas or in already-established private rural clinics serving as VA's partners in rural areas. We believe advancing telehealth in this manner would be fully consistent with VA's stated intention to move the VA delivery system from its primary care base to that of the patient-aligned care team, also known as the medical home, discussed elsewhere in this *Independent Budget*.

Rural Outreach Needs More Assertiveness

Without question, section 213 of P.L. 109–461 offers a significant mandate to meet the health-care and other needs of veterans living in rural areas, especially those who have served recently in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, the law requires VA to collaborate with employers, state agencies, community health providers, rural health clinics, Critical Access Hospitals (as designated by Medicare), social service agencies, and local units of the National Guard and reserve components to ensure that, after completing their military service, all veterans can have ready access to VA health-care and other benefits they have earned by that service. Given that this mandate is more than four years old now, the IBVSOs urge VA to finally move forward on this mandatory outreach effort to include outreach to all rural veterans—and that outreach under this authorization be closely coordinated with the ORH, or even be managed by the ORH if determined appropriate, to avoid duplication and to maintain consonance with VA's overall mandate on rural health care. To be fully responsive to this legislation, VA should report regularly to Congress the degree of its success in conducting effective outreach and the result of its efforts in public-private and intergovernmental coordination to help rural veterans. One potential method of improving outreach to rural and highly rural veterans might be to create and train a volunteer network of VA-informed individuals to work in local rural communities as a VA “clearinghouse” function—individuals armed with information on all VA services and benefits and how veterans can obtain them. In this connection, veterans service organizations national service officers could be harnessed under a national memorandum of understanding with VA, or VA could contract with, or make grants to, rural organizations or rural state departments of veterans' affairs (or equivalent agencies) to accomplish this goal.

VA should be required to report to Congress its degree of success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans, also in consultation with, or led by, the ORH.

Execution of Congressionally Directed Rural Health Funds

The IBVSOs understand that in allocating these Congressionally directed rural funds (\$250 million in each of fiscal years 2009, 2010, and 2011), some VA offices may have diverted rural funding to underwrite new community-based outpatient clinics, or put those funds to other uses outside the mandate. While we generally support the establishment of new CBOCs, this mandate from the Appropriations Committees in providing these funds specified that they be used for innovative new models of care, given the scarcity of populations involved and the paucity of providers in rural areas. VA's CBOC business plans are governed by criteria focused on population densities. We do not agree with these decisions, if they occurred, and ask Congress and the Administration to investigate to determine if these rural health funds were in fact diverted to uses other than those intended in this rural health initiative.

While Popular, Privatization Is Not a Preferred Option

P.L. 110–387, the “Veterans' Mental Health and Other Care Improvements Act of 2008,” directs the Secretary of Veterans Affairs to conduct a three-year pilot program under which a highly rural veteran who is enrolled in the system of patient enrollment of VA and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health-care provider at VA expense. More recently, in section 307 of P.L. 111–163, the “Caregivers and Veterans Omnibus Health Services Act of 2010,” Congress clarified eligibility for these services by redefining a “highly rural veteran” as one who resides more than 60 minutes' driving time from the nearest VA facility providing primary care services, more than 120 minutes' driving time from a VA facility providing acute hospital care, or more than 240 minutes' driving time from a VA facility providing tertiary care (depending on which services a veteran needs). The original act allows participation also by a rural veteran who, not meeting these specific mileage criteria, otherwise experiences such hardships or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of that veteran. During the three-year demonstration period the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

While we applaud the sponsors' intentions, unless carefully administered, such measures could result in unintended consequences for VA. Chief among these is the diminution of established quality, safety, and continuity of VA care for rural and highly rural veterans. It is important to note that VA's specialized health-care programs, which are authorized by Congress and designed expressly to meet the specialized needs of combat-wounded and ill veterans—such as the blind rehabilitation centers, prosthetic and sensory aids programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the National Center for Posttraumatic Stress Disorder, as well as several others—could be irreparably affected by the loss of veterans from those programs. Also, VA's medical and prosthetic research program, designed to study and, it is hoped, cure the ills of injury and disease consequent to military service, could lose focus and purpose if service-connected and other enrolled veterans were no longer physically present in VA health care.

Additionally, Title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when P.L. 104–262, the “Veterans’ Health Care Eligibility Reform Act,” was enacted in 1996. Unfortunately, some of that capacity has dwindled. The IBVSOs believe VA must maintain a “critical mass” of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with sophisticated health problems, such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health-care programs, such as this rural demonstration program, may only exacerbate the problems currently encountered.

In light of the escalating costs of health care in the private sector, to its credit, VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected veterans might seek care in the private sector as a matter of personal convenience as a result of the enactment of vouchering and privatization bills, they would lose the many safeguards built into the VA system through its patient safety and prevention program, evidence-based medicine, clinical guidelines, electronic health

record, and bar code medication administration. These unique VA features culminate in the highest quality of care available, public or private. Loss of these safeguards—ones that are generally not universally available in private sector systems—would equate to diminished oversight and coordination of care, and ultimately could result in a lower quality of care for those who deserve it most.

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

The IBVSOs urge Congress and the Administration to closely monitor and oversee the development of the new rural pilot demonstration project from the “Veterans Mental Health and Other Care Improvements Act of 2008,” especially to protect against any erosion or diminution of VA's specialized medical programs and to ensure participating rural and highly rural veterans receive health-care quality that is comparable to that available within the VA health-care system. We especially ask VA, in implementing this demonstration project, to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state, or other federal agencies) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements, outcomes, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. These pilot programs should not become simply another form of unmanaged “fee-basis” care, but should be managed and coordinated carefully by VA, and led by the ORH.

To the greatest extent practicable, VA should coordinate these demonstrations and pilot projects with interested health professions' academic affiliates of VA. The principles of the recommendations from the "Contract Care Coordination" section should guide VA's approaches in this demonstration, and we recommend these projects be closely monitored by VA's Rural Veterans Advisory Committee. Further, the IBVSOs believe the ORH should be designated the overall coordinator of this demonstration project, in collaboration with other pertinent VHA offices and local rural liaison staff in the VHA's rural VISNs that are selected for this demonstration.

VA has recently announced an intention to contract with qualified private providers to furnish Patient-Centered Community Care nationwide, to include all medical and surgical services, but excluding primary care, dialysis, and mental health. VA has indicated it hopes this effort will enhance opportunities for collaboration with non-VA providers when VA facilities are not able to provide needed specialty care. The contracts will be available for all VA medical centers throughout the Veterans Health Administration and will be centrally supported by the VHA Chief Business Office in the VA Central Office.

The IBVSOs are concerned about this new development that may portend drastic changes in the way VA health care is provided to rural veterans, and we intend to monitor it closely to ensure it does not violate our principles on maintenance of VA's specialized medical programs as well.

VA's Readjustment Counseling Service Vet Centers: Key Partners in Rural Care

Given that 44 percent of newly returning veterans from OEF/OIF/OND service live in rural areas, the IBVSOs believe that these veterans, too, should have access to specialized services offered at VA's Vet Centers. The mission of Vet Centers is to provide non-medical readjustment services to veterans through psychological and peer-counseling programs (including trained peer counselors who are combat veterans). Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers represent the primary access points to VA programs and benefits for nearly 25 percent of veterans who use them. This core group of veteran users primarily receives

readjustment and psychological counseling related to their military experiences and recovery from them.

Congress recently passed P.L. 111-163, the "Caregivers and Veterans Omnibus Health Services Act of 2010." Section 401 of that act authorizes active duty military personnel and members of the National Guard and reserve components who have completed deployment in Iraq and Afghanistan to be counseled at VA's Vet Centers, hopefully without notification to, or reimbursement by, the Department of Defense for such counseling. The IBVSOs are grateful to Congress for including that helpful and humane provision in this omnibus bill, and urge VA and the DOD to implement this provision as soon as practicable. This novel authority will aid National Guard members and reservists home from deployments in rural, suburban, and urban environments alike to confront any readjustment challenges they and their families may be experiencing, without exposing them to the potential stigma that might well ensue if they identified themselves to their military commanders as challenged by their psychological traumas from combat. The IBVSOs are advised that VA's new policy to implement this provision is nearing completion and urge VA to move forcefully in putting it into practice in the Vet Centers.

The IBVSOs were pleased that VA took steps to further address rural access concerns by implementing a mobile Vet Centers program. We believe that now is the time to evaluate the effectiveness of these mobile Vet Centers and to determine if and how mobile services contribute to enhanced delivery of care to veterans in rural areas, as well as the relative costs of other approaches to reach rural and remote veterans with psychological counseling. The same logic used in the ORH analysis discussed previously on evaluation of transportation strategies would apply to VA's decisions in expanding further outreach with mobile Vet Centers.

VA Should Stimulate Rural Health Professions

Health workforce shortages and recruitment and retention of health-care personnel (including clinicians) are a key challenge to rural veterans' access to VA care and to the quality of that care. The Future of Rural Health report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health-care professionals working in rural areas. To this end, VA's deeper involvement in education in the health

professions for future rural clinical providers seems appropriate in improving these situations in rural VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health sciences students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners—receive training in VA facilities.

The IBVSOs believe these relationships with health profession schools should be put to work in assisting rural VA facilities with their health personnel staffing needs. Also, evidence shows that providers who train in rural areas are more likely to remain practicing in rural areas. The VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations. The VHA Office of Workforce Recruitment and Retention should execute initiatives targeted at rural areas, in consultation with, and using available funds as appropriate from, the ORH. Different paths to these goals could be pursued, such as the leveraging of an existing model used by the Health Resources and Services Administration to distribute new generations of health-care providers in rural areas. Alternatively, the VHA could target entry-level workers in rural health and facilitate their credentialing, allowing them to work for VA in their rural communities. Also, VA could offer a “virtual university” so future VA employees would not need to relocate from their current environments to more urban sources of education. While VA has made some progress with telehealth in rural areas as a means to provide alternative VA care to veterans in rural America, it has not focused on training future clinicians on best practices in delivering care via telehealth. This initiative could be accomplished by use of the virtual university concept or through collaborations with established collegiate programs with rural health curricula. If properly staffed, the Veterans Rural Health Resource Centers could serve as key “connectors” for VA in such efforts.

Consistent with our Health Resources and Services Administration suggestion, VA should examine and establish creative ways to collaborate with ongoing

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

Update on the Rural Veterans Advisory Committee

The Veterans Rural Advisory Committee, established by the Secretary of Veterans Affairs as an advisory committee under the “Federal Advisory Committee Act,” is fully operational and issued its first annual report in 2010. The IBVSOs appreciate the work of that important committee and commend its most recent recommendations to VA.

The ORH: A Critical Mission for Rural Veterans Who Need Care

As described by VA, the mission of the Office of Rural Health is to develop policies and identify and disseminate best practices and innovations to improve health-care services to veterans who reside in rural areas. VA maintains that the ORH is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VA also attests that the ORH will conduct, coordinate, promote, and disseminate research on issues important to improving health care for rural veterans. With confirmation of these stated commitments and goals, the IBVSOs believe the VHA would start to incorporate the unique needs of rural veterans as new VA health-care programs are conceived and implemented; however, the ORH is a relatively new function within the VA Central Office, and it is only at the threshold of tangible effectiveness, with many challenges remaining.

Given the lofty goals VA has articulated in rural health, the IBVSOs remain concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning, rather than within the operational arm of the VA health-care system, closer to decision makers in VHA executive management. Having to traverse the multiple layers of the VHA's

bureaucratic structure frustrates, delays, and even cancels worthy initiatives established by the ORH. We continue to believe that rural veterans' interests would be best served if the ORH were elevated to a more appropriate level in the VA Central Office, perhaps at the deputy Under Secretary level.

Summary

The IBVSOs believe VA is working in good faith to address its shortcomings in rural areas but still faces major challenges as denoted in this discussion. In the long term, its methods and plans offer rural and highly rural veterans potentially the best opportunities to obtain quality care to meet their specialized health-care and readjustment needs. The IBVSOs commend the ORH Director and staff for the significant progress we have observed over the past year. However, we vigorously disagree with broadly privatizing, vouchering, and contracting out by fee-basis arrangements VA health care for rural veterans: such a development would be destructive to the integrity of the VA system—a system of immense value to sick and disabled veterans (including rural veterans) and to the IBVSOs. Thus, we remain concerned about VA's demonstration mandate and its latest announcement to privatize health-care services without strong coordination of care and will continue to closely monitor these developments.

Recommendations:

VA must ensure that the distance veterans travel, as well as other hardships they face, be considered in VA policies in determining the appropriate location and setting for providing direct VA health-care services and the benefits they have earned by their service to the nation.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans. In each of the past four fiscal years, Congress has provided VA \$250 million to fund rural health initiatives; this dedicated funding stream should be maintained for FY 2013.

The Veterans Health Administration and at the VA departmental level, collaborating with the Office of Rural Health (ORH), should seek and coordinate the implementation of novel methods and means of communication, including use of the Internet and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health-care services, providers, technologies, and therapies, including greater access to their electronic health records, prescription medications, and primary and specialty appointments.

Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary automobile travel and should continue to work to develop a transportation strategy in rural and highly rural cases that takes into account alternatives, including greater use of telehealth coordination with available providers and VA mobile services when cost-justified.

The ORH should be organizationally elevated in VA's Central Office to be closer to VA resource allocators and executive decision makers.

The ORH should establish at least one full-time rural staff position as a Rural Health Coordinator in 20 Veterans Integrated Service Networks, and more if appropriate.

The Veterans Rural Health Resource Centers should be established permanently with full-time career staff elements, to properly execute the important function of field-based satellite offices providing operational field support and pertinent rural health analysis.

VA should ensure that mandated outreach efforts in rural areas required by P.L. 109-461 are closely coordinated with the ORH, or sponsored by ORH directly.

Congress and the Administration should investigate to determine if Congressionally directed rural health funds for new innovations in rural and highly rural areas were diverted to underwrite new VA community-based outpatient clinics in nonrural areas, and if confirmed, should take appropriate action to address those deviations from Congressional intent.

VA should establish additional mobile Vet Centers where needed to provide outreach and readjustment counseling for veterans in rural and highly rural areas, based on analysis and cost-effectiveness of current mobile services deployed by the Readjustment Counseling Service. VA should report the findings of its analysis to the Veterans Rural Advisory Committee and to Congress.

Given VA's affiliations with schools of health professions, the VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative or initiatives, aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations and to supply additional health manpower to rural America in general. Section 306 of P.L. 111-163 is illustrative of a model for such a policy initiative.

VA should rapidly implement section 401 of P.L. 111-163, which authorizes active duty service members and National Guard and reserve component veterans of Operations Enduring/Iraqi Freedom to be counseled in VA Vet Centers for their readjustment problems.

Recognizing that in some areas of particularly sparse veteran population and absence of VA facilities travel to them impractical, the ORH and its satellite Veterans Rural Health Resource Centers should sponsor and establish demonstration projects with available providers of mental health and other health-care services for enrolled veterans, taking care to observe and protect VA's role as the coordinator of care. The projects should be reviewed and guided by the Rural Veterans Advisory Committee. Funding should be made available by the ORH to conduct these demonstration and pilot projects, and VA should report the results of these projects to *The Independent Budget* veterans service organizations and the Congressional Committees on Veterans' Affairs.

At rural VA community-based outpatient clinics (CBOCs), VA should establish a staff function of "rural outreach worker" serving to coordinate potentially fragmented care, collaborating with rural and highly rural non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available, or to VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs.

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

¹¹⁸ L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010*, Vol. 2, College Station, Texas: Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003). www.mentalhealthcommission.gov/reports/FinalReport/downloads/downloads.html.

¹¹⁹ President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (July 2003).

¹²⁰ Institute of Medicine, NIH, Committee on the Future of Rural Health Care, *Quality through Collaboration: The Future of Rural Health* (The National Academies Press, 2005).

¹²¹ Gamm, Hutchison, et al., *Rural Healthy People 2010*.

¹²² Weeks, et al. *American Journal of Public Health* (2004) 94:1762-1767).

¹²³ Jack Smith, MD, acting deputy assistant secretary for clinical and program policy, U.S. Department of Defense, *Caring for Severely Injured OEF/OIF Veterans and Service Members*, Testimony before the U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Health (July 22, 2010)

¹²⁴ Department of Veterans Affairs, Office of Rural Health, *Demographic Characteristics of Rural Veterans* Issue Brief (Summer 2009).

¹²⁵ VA Office of Rural Health, Fact Sheet, Vol. 1, Issue 12, November 2011. http://www.ruralhealth.va.gov/docs/ORH_FactSheet_Issue12_110111.pdf.

¹²⁶ Department of Veterans Affairs, Office of Rural Health, *Rural Veterans' Geographic Access to VA Health Services* (2008).

¹²⁷ VA Office of Rural Health, Fact Sheet, Sep. 2011. http://www.ruralhealth.va.gov/docs/ORH_FactSheet_Issue_10_September2011.pdf.

¹²⁸ A study by Booz Allen Hamilton commissioned by the ORH in February 2008 (*Veterans Rural Health: Perspectives and Opportunities*) surveyed non-VA providers to identify health-care issues on which health professionals required training to serve the health-care needs of rural veterans. The top four among them were: (1) general issues in negotiating and managing the VA care system; (2) cultural sensitivity to the needs of rural veterans; 3-4) training on understanding, identifying, and treating post-traumatic stress disorder and traumatic brain injury.

¹²⁹ Booz Allen Hamilton, Inc., for the Department of Veterans Affairs Office of Rural Health, *Analysis for the Department of Veterans Affairs Fee Basis Program for the Office of Rural Health*, Contract #W74V8F-04-D-0078 (September 28, 2008).

¹³⁰ Department of Veterans Affairs, Office of Rural Health, *Demographic Characteristics of Rural Veterans*, note 108.

¹³¹ Buzza, et al., "Distance is Relative: Unpacking a Principal Barrier in Rural Healthcare," *Journal of General Internal Medicine*, 2011, Nov. 26 Suppl. 2: 648-54.

¹³² <http://www.va.gov/health/NewsFeatures/20111006a.asp>.

IMPLEMENTATION OF WAIVER OF HEALTH-CARE COPAYMENTS FOR CATASTROPHICALLY DISABLED VETERANS:

In light of passage of Public Law 111-163, Congress must provide proper oversight to ensure that the Department of Veterans Affairs does not continue to bill veterans with catastrophic disabilities.

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

The addition of nonservice-connected catastrophically disabled veterans to priority group 4 was in recognition of the distinct needs of these veterans and the VA's vital role in providing their care. However, access to VA services is only part of the answer to providing quality health care to catastrophically disabled veterans. Exempting these veterans from all health-care copayments and fees completes this quality health-care equation.

Fortunately, in 2010, Congress recognized this important distinction when it enacted P.L. 111-163, the "Caregiver and Veterans Omnibus Health Services Act of 2010." This legislation exempted all veterans determined to have a catastrophic disability from payment of copayments. This included veterans in priority group 4 as well as those enrolled in priority group 2 and priority group 3 who might also have a nonservice-connected catastrophic disability. The legislation addressed copayments for medical services provided in an inpatient and outpatient setting.

Additionally, in July 2010, the VA General Counsel released an opinion addressing questions about the scope of P.L. 111-163. Specifically, the General Counsel was asked to determine if the legislation exempted collections for prescription drug copayments. In its opinion, the General Counsel determined that the legislation does prohibit VA from collecting copayments for prescription drugs for veterans enrolled in priority group 4. Additionally, the opinion emphasizes that the language of the bill essentially prevents VA from collecting any copayments or fees for any type of medical service catastrophically disabled veterans.

Catastrophically disabled veterans are not casual users of VA health-care services; they require a great deal of care and a lifetime of services because of the nature of their disabilities. Private insurers do not offer the kind of sustaining care for spinal cord injuries found in the VA system even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. The catastrophically disabled most often fall within lower income brackets among veterans, while incurring the highest annual health-care costs. In many instances, fees for medical services, equipment, and supplies can climb to thousands of dollars per year.

Unfortunately, we continue to receive reports from veterans with catastrophic disabilities who should be exempted from copayments for medical services and prescriptions but continue to receive bills from their respective VA medical centers. Apparently, implementation of the copayment exemption is not well-coordinated VA-wide. While some select VA medical centers seem to have properly implemented this program, many VA medical centers have failed to address the provisions of this law. We believe that part of this failure rests with VA Central Offices inability to properly roll out a national implementation plan. As such, VA medical centers around the country have chosen to follow or ignore the provisions of P.L. 111-163 as they see fit. Given the financial challenges many of these catastrophically disabled veterans are facing, it is time for VA to finally, and completely, implement this law.

Recommendations:

VA must continue to monitor implementation of the provisions of P.L. 111-163 to ensure that catastrophically disabled veterans are not still being billed for the medical care or prescriptions.

Congress must provide real oversight to ensure that the full intent of Congress to exempt catastrophically disabled veterans from paying medical care and prescription copayments is accomplished.

NON-VA EMERGENCY SERVICES:

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

Many veterans have filed claims for reimbursement for emergency treatment and post-stabilization care that is often necessary in the wake of medical emergencies. However, the strict conditions of eligibility for reimbursement have prohibited VA from paying many veterans who file claims. Moreover, *The Independent Budget* veterans service organizations (IBVSOs) understand that there have also been significant delays in VA reimbursement of approved claims. Delayed reimbursements can damage veterans' credit—by definition of the eligibility criteria,¹³³ the veteran is liable for these costs—with no means of redress.

The “Veterans’ Eligibility Reform Act of 1996,” P.L. No. 104–262 (Eligibility Reform Act) specifically provides that the Secretary shall furnish hospital care and medical services to certain veterans without their needing to enroll. The IBVSOs believe all enrolled veterans should qualify for reimbursement for non-VA emergency care when necessary, without the caveat of having been seen at VA facilities within the past 24 months.

Section 402 of P.L. 110–387, the “Veterans’ Mental Health and Other Care Improvements Act of 2008,” amended sections 1725 and 1728 of Title 38, United States Code, which now requires VA to reimburse for the emergency treatment of VA patients outside VA facilities when these veterans believe a delay in seeking care will seriously jeopardize their lives or health. In addition, VA’s definition of “emergency treatment” under both statutes now conforms to a term commonly known as the “prudent layperson” standard, which has been widely used in the health-care industry.

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

Intending to complete a VA health-care benefits package comparable to that of many managed-care plans, Congress initially directed this benefit at “regular users” of VA facilities: veterans who were enrolled, had used some kind of VA care within the past two years, and had no other claim to coverage for such care. Once these veterans were stabilized in private facilities, Congress intended VA to transfer them to the nearest VA medical facility.

Recommendations:

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

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

¹³³ 62 38 U.S.C. § 1725(b).

Specialized Services

Prosthetics and Sensory Aids

CONTINUATION OF CENTRALIZED PROSTHETICS FUNDING:

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

The protection of Prosthetic and Sensory Aids Service (PSAS) funding by a centralized budget for the PSAS continues to have a major positive impact on meeting the specialized needs of disabled veterans. However, *The Independent Budget* veterans service organizations (IBVSOs) are concerned about ongoing discussions within the Veterans Health Administration (VHA) regarding the decentralized funding process for the PSAS. Such a policy change would significantly hinder the timely delivery of quality prosthetic services, as well as create an arbitrary decision-making process that made centralized funding necessary in the recent past.

Before the VHA utilized centralized funding, as a result of budget shortfalls, many VA medical centers held down costs by cutting spending for prosthetics. This delayed provision of wheelchairs, artificial limbs, and other prosthetic devices, which was unacceptable. For this reason, the IBVSOs strongly encourage the continuation of the centralized funding process and recommend that Congress ensure sufficient appropriations to meet the prosthetic needs of disabled veterans.

Centralized funding has assured better accounting for the national prosthetics budget and medical equipment funding related to specialized services, such as

Prosthetic Item	Total Cost Spent in FY 2011	Projected Expenditure in FY 2012
WHEELCHAIRS & ACCESSORIES	\$180,361,193	\$233,116,559
ARTIFICIAL LEGS	\$58,313,287	\$75,369,832
ARTIFICIAL ARMS	\$4,766,570	\$6,160,784
ORTHOSIS/ORTHOTICS	\$56,274,046	\$72,734,116
SHOES/ORTHOTICS	\$49,447,051	\$63,910,236
*SENSORI-NEURO AIDS	\$313,563,825	\$405,280,752
RESTORATIONS	\$5,042,562	\$6,517,503
OXYGEN & RESPIRATORY	\$115,490,739	\$149,271,598
MEDICAL EQUIP & SUPPLIES	\$252,495,646	\$326,350,226
MEDICAL SUPPLIES	\$34,984,278	\$45,217,124
HOME DIALYSIS	\$2,400,309	\$3,102,396
HISA	\$18,150,184	\$23,459,084
*SURGICAL IMPLANTS	\$481,238,239	\$621,999,669
BIOLOGICAL IMPLANTS	\$73,503,548	\$95,003,220
OTHER ITEMS	\$5,282,479	\$6,827,596
	\$1,651,313,956	\$2,134,320,695
Services and Repairs	\$343,252,046	\$443,652,730
Total Cost	1,994,566,002	2,577,973,425

*As reported by Department of Veterans Affairs PSAS

spinal cord injury, traumatic brain injury, and amputee systems of care. In FY 2011, expenditures were approximately \$1.8 billion, and the 2012 proposed budget allocation for prosthetics is estimated at \$2.3 billion. Funding allocations for FY 2012 are based primarily on FY 2010 National Prosthetics Patient Database (NPPD) expenditure data, which also included Denver Acquisition and Logistics Center (DALC) billing, the recent approval for increase of Home Improvement Structural Alterations allowances, and expansion of funding for the addition of advancements in new technology.

The accuracy of the NPPD data is critical to informed decision making at the field manager level. Therefore, VHA senior leadership must require field managers regularly update the NPPD database. Lastly, Telehealth continues to be a significant increase in utilization of the prosthetic budget, and PSAS is actively pursuing use of the DALC to reduce the amount of resources required to manage the increased workload. Table 3 shows NPPD costs in FY 2011 with projected new and repair equipment costs for FY 2012.

Recommendations:

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

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all enrolled veterans, including the latest advances in technology so that funding shortfalls do not compromise other programs.

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



CENTRALIZATION OF PROSTHETIC AND SENSORY AIDS SERVICE PURCHASES THREATENS TO NEGATIVELY IMPACT SERVICES TO VETERANS:

The Department of Veterans Affairs must work to make certain that centralized purchasing of prosthetic devices does not negatively impact the quality of prosthetic services for disabled veterans.

The Department of Veterans Affairs (VA) Prosthetic and Sensory Aids Service (PSAS) has announced its plans to centralize the PSAS procurement process. Such a change would create a prosthetics and surgical products contracting center within the VA office of Acquisition and Logistics that would be responsible for ordering prosthetic devices. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that this centralization of PSAS contracts has the potential to result in delayed delivery of prosthetic devices, the diminution of quality service delivery for disabled veterans, and standardized purchasing of some prosthetic items and devices that are highly specialized and designed for unique applications.

For several years PSAS has worked with clinical professionals and veterans to purchase prescribed prosthetic devices. Once VA centralizes the PSAS procurement process, the Office of Acquisition and Logistics will be responsible for purchasing prosthetic items. The IBVSOs are concerned that centralized purchasing of prosthetic devices by VA acquisition staff will result in bureaucratic delays that prevent veterans from receiving prescribed prosthetics in a timely manner.

Moreover, while centralizing prosthetic purchases may allow VA to streamline the purchasing process, such a change may result in standardized, bulk purchasing. This has the potential to result in prosthetics

purchases that do not meet the unique medical and personal needs of veterans requiring customized equipment. Under *VHA Handbook 1173.1*, prosthetic items intended for direct patient issuance are exempted from VHA standardization efforts because a “one-size-fits all” approach is inappropriate for meeting the medical and personal needs of disabled veterans. This remains a matter of grave concern for the IBVSOs, and we would be opposed to the standardization of prosthetic devices and sensory aids if that shift resulted in a diminution of services to severely disabled veterans.

The IBVSOs recognize that the impending shift to a PSAS purchasing process facilitated by the Office of Acquisition and Logistics is an attempt to streamline VA purchasing operations. The IBVSOs strongly encourage VA to work closely with stakeholders in the veteran community and keep veterans and their families apprised of changes that affect their VA benefits and services during this process. We strongly encourage Congressional oversight of VHA PSAS contracting practices to ensure that purchasing decisions are made to optimize the health and independence of veterans, and not solely to cut costs.

Recommendations:

VA should require the Office of Acquisition and Logistics to develop a tracking mechanism to measure the timeliness of the purchasing process. This system should enable veterans to inquire about the status of their prescribed prosthetic items and trigger automatic notifications when orders are delayed.

VA must develop policy guidance for employees within the Office of Acquisition and Logistics to work closely with VA PSAS leadership to identify those standardized prosthetic devices that are clinically adequate and proven to be durable, quality products.

VA must work closely with stakeholders in the veteran community and keep veterans and their families apprised of changes that affect their VA benefits and services.



CONSISTENT ADMINISTRATION OF THE PROSTHETICS PROGRAM:

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

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

To improve communication and consistency, the Department of Veterans Affairs must ensure that every VISN has a qualified prosthetics representative

to be the technical expert responsible for ensuring implementation and compliance with national goals. The VISN prosthetics representative must also maintain and disseminate objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetics policies, including administration and oversight of the VHA’s prosthetics and orthotics laboratories. With the prosthetics representative serving as the main source of direction and guidance for implementation and interpretation of prosthetics policy and services, prosthetics staff can focus on delivering quality care and services.

Additionally, *The Independent Budget* veterans service organizations strongly recommend that VA develop and enforce a structured appeals process.

Specifically, the VHA should review the current policy as outlined under VHA Directive 2006–057 and enact procedures that ensure adequate due process for veterans who are denied a prosthetics request. VHA staff must be informed of this requirement and trained to follow the VA clinical appeals process to ensure that veterans have the opportunity to properly substantiate Prosthetics and Sensory Aids Service prescriptions.

Recommendations:

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

The Veterans Health Administration should review the current policy on VHA clinical appeals as outlined under VHA Directive 2006–057 and enact procedures that ensure adequate due process for veterans who are denied a prosthetics request.



ENSURING QUALITY AND ACCURACY OF PROSTHETICS PRESCRIPTIONS:

The Department of Veterans Affairs must work to ensure that national contracts for single-source prosthetic devices do not lead to inappropriate standardization of prosthetic devices.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop “best practices” to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA’s Prosthetics Clinical Management Program (PCMP). Specifically, we are concerned that the PCMP could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

In the Department of Veterans Affairs, the PCMP requires a single-source contract for specific prosthetic devices, and 95 percent of such devices purchased by the VHA are expected to be of the make or model covered by the national contract. Therefore, for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased “off-contract” (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such a high compliance rate is that inappropriate pressure may be placed on clinicians to meet these goals, and there is no method to ensure that the unique prosthetic needs of patients are properly met. VHA clinicians must be permitted

to prescribe devices that are “off-contract” without arduous waiver procedures or fear of repercussions. The IBVSOs believe national contract awards should be multiple-sourced and based on individual patient needs.

VA must make certain that the issuance and delivery of prosthetic devices and equipment continue to be provided based on the unique needs of veterans, and to help veterans maximize their quality of life. As the VHA undergoes any reorganization, VA must ensure that prosthetic devices do not become subject to issuance restrictions based solely on cost or internal pressures to control spending.

Recommendations:

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

VA must implement safeguards to make certain that the issuance and delivery of prosthetic devices and equipment will continue to be provided based on the unique needs of veterans and to help veterans maximize their quality of life. Such protections will ensure

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

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

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

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

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

The VHA must keep prosthetics standardization separate from other standardization efforts within the VHA since this program deals with items (many uniquely designed) prescribed for individual patients.

VA should provide the necessary resources to Prosthetics and Sensory Aids Service information technology systems to ensure that these functions are enhanced in a timely manner.



FAILURE TO DEVELOP FUTURE PROSTHETICS STAFF:

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

In 2004, the Veterans Health Administration (VHA) developed and requested 12 training slots for the National Prosthetics Representative Training Program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program provides training for prosthetic representatives responsible for management of all prosthetics services within their assigned networks. In 2010 this was increased to 18 training slots due to the number of vacancies of critical staff.

Veterans Integrated Service Networks (VISNs) have also developed their own prosthetics representative training programs. While *The Independent Budget* veterans service organizations support local VISNs conducting such training to enhance the quality of health-care services within the VHA system and increase the number of qualified applicants, we believe local VISNs must also support and strongly encourage participation in the annual National

Prosthetics Representative Training Conference, a one-week intensive prosthetics training forum. Local VISN prosthetics training should be a supplement to and consistent with the national training program. The VHA must also revise qualification standards for prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

The VHA must also make certain that veterans are made aware of employment opportunities throughout the Prosthetics and Sensory Aids Service (PSAS). Employing veterans will ensure a balance between the perspective of the clinical professionals and the personal needs of disabled veterans. VA must ensure that the current and future leadership of the PSAS is appropriately diversified to maintain a perspective that is patient-centric and empathetic to the unique needs of veterans with severe disabilities.

Additionally, each prosthetic service within VA must have trained and certified professionals who can advise other medical professionals on appropriate prescription, building/fabrication, maintenance, and repair of prosthetic and orthotic devices. Because VA is currently in the process of implementing a medical home care delivery model, using patient-aligned care teams, we believe additional prosthetic representatives will be needed. This is particularly important as new programs in polytrauma, traumatic brain injury, and amputation systems of care are implemented and expanded in the VHA.

As the conflicts continue in Afghanistan and Iraq, service members are returning home with complex injuries and in need of highly technological prosthetic devices. PSAS leadership must consist of a well-rounded team, including trained and experienced prosthetics representatives, appropriate clinicians and managers, and position-qualified disabled veterans with significant mobility or other impairments requiring the use of prosthetic devices. We believe the future strength and viability of VA's prosthetics program depends on the selection of high-caliber leaders in the PSAS. To do otherwise could lead to grave outcomes due to the complexity of the prosthetics needs of veterans.

Recommendations:

VA must fully fund and support its National Prosthetics Representative Training Program, expanding it to meet current shortages and future projections, with responsibility and accountability

assigned to the chief consultant for the Prosthetics and Sensory Aids Service (PSAS).

With two national training programs in the PSAS, VA must establish a full-time national training coordinator for the PSAS to ensure standardized training and development of personnel for all occupations within the Prosthetics service line. This assignment will ensure successful educational programs and career development.

The Veterans Health Administration (VHA) and its Veterans Integrated Service Network (VISN) directors must ensure that prosthetics departments are staffed by certified professional personnel or contracted staff who can maintain and repair the latest technological prosthetic devices.

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

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

The VHA must revise qualification standards for both prosthetic representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

PROSTHETICS AND SENSORY AIDS AND RESEARCH:

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

Many of the wounded veterans returning from the conflicts in Afghanistan and Iraq have sustained polytrauma injuries requiring extensive rehabilitation periods and the most sophisticated and advanced technologies, such as hearing and vision implants and computerized or robotic prosthetic items, to help them rebuild their lives and gain independence. According to the Department of Veterans Affairs Office of Research and Development, approximately 6 percent of wounded veterans returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids continues to increase.¹³⁴

Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. The Veterans Health Administration is still contributing to this type of research, from funding basic prosthetic research to

assisting with clinical trials for new devices. As new technologies and devices become available for wide-scale use, the Veterans Health Administration must ensure that these products prescribed for veterans are made available to them and that funding is made available for timely issuance of such items.

Recommendations:

VA must maintain its role as a world leader in prosthetics research and ensure that VA Office of Research and Development and the Prosthetics and Sensory Aids Service work collaboratively to expeditiously apply new technologic development and transfer to maximally restore veterans' quality of life.

¹³⁴Department of Veterans Affairs. http://www.research.va.gov/outreach/research_topics/oef-oif.cfm.



DISABLED VETERANS AND SERVICE DOGS:

The Department of Veterans Affairs must ensure that veterans using approved service dogs are afforded appropriate access to all VA medical facilities.

The term “assistance dog” is a generic term used to describe a dog specifically trained to do more than one task to mitigate the effects of an individual's disability. Therefore, service dogs, hearing dogs, guide dogs, and seizure response dogs all fall under that umbrella of assistance dogs. The presence of a dog for protection, personal defense, or comfort does not qualify that dog as an “assistance dog” under federal law.

Currently, the Department of Veterans Affairs (VA) recognizes service dogs, hearing dogs, guide dogs and seizure response dogs as valid prosthetic devices that may be prescribed to veterans whose quality of life and independence would be improved through the

services these highly trained dogs can render. Since the passage of P.L. 107–135 in 2001, a veteran who receives a medical prescription from a VA physician may be eligible for benefits related to the upkeep of the issued prosthetics devices, including service animals. These benefits include, but are not limited to, veterinary care, annual examinations, and prescribed medications from a licensed veterinarian. Currently, VA neither pays for nor provides assistance dogs. However, VA does refer veterans to Assistance Dog International (ADI) or the International Guide Dog Foundation (IGDF), both accredited agencies, in order to obtain an assistance dog, after which VA pays for the animal's upkeep.

While *The Independent Budget* veterans service organizations (IBVSOs) applaud VA for its recent efforts to address several issues surrounding service and guide dogs, we strongly believe that there is still much work to be done. In particular, the IBVSOs have serious concerns regarding current regulations that outline the policies on access to VA controlled and operated properties. To date, Title 38 Code of Federal Regulations, Part 1, § 1.218 (a)(11) states:

Dogs and other animals, except seeing-eye dogs, shall not be brought upon property except as authorized by the head of the facility or designee.

The IBVSOs find the current language of this regulation to be inconsistent and outdated when compared to the relevant sections of Title 38, United States Code, that govern it. While numerous parts of Title 38, United States Code, specifically Section 1714, are regularly updated to reflect the health care needs of today's veterans, the regulation has been overlooked for more than 20 years. This outdated regulation is denying veterans entrance into VA properties. Furthermore, the IBVSOs believe that a veteran's use of a prosthetic device should not be a factor in determining whether or not he or she is permitted into a VA medical facility to receive care. Blinded veterans using guide dogs have been permitted entrance to all

VA-controlled and -owned facilities since 1985, and we believe it is time to afford that same privilege to disabled veterans using service dogs.

The IBVSOs strongly believe that disabled veterans using service dogs should have the same access right at their VA facilities that they already have in every other private sector hospital in the country.

VA published a directive in March 2011 requiring all medical facilities to publish policy on the access issue as it relates to service dogs. However, we have serious concerns on whether this three-year directive will be enforced consistently. We believe there must be a permanent change to Title 38, United States Code, to ensure no veteran will be denied access to care based on the prosthetic device they utilize.

Recommendations:

VA must improve outreach and education to veterans on the benefits and prosthetic options available to them and educate VA staff on the proper uses of service and guide dogs.

We urge VA to permanently remove the hurdle to care being experienced by many disabled veterans using service dogs when accessing VA care.



HEARING LOSS AND TINNITUS:

The Veterans Health Administration must provide a full continuum of audiology services.

Tinnitus, commonly referred to as “ringing in the ears,” is a potentially devastating condition; its relentless noise is often an unwelcome reminder of war for many veterans. These facts are illustrative of the nature of the problem:

- Tinnitus is currently the most frequent service-connected disability of veterans returning from Iraq and Afghanistan.
- Tinnitus and hearing loss top the list of war-related health costs.
- Since 2000, the number of veterans receiving service-connected disability for tinnitus has increased by at least 18 percent each year.

- The total number of veterans awarded disability compensation for tinnitus as of fiscal year 2006 surpassed 390,933.
- At this alarming rate, 2011 will see 818,811 veterans receiving disability compensation for tinnitus, at a cost of more than \$1.1 billion.¹³⁵

Tinnitus is a growing problem for America's veterans. It threatens their futures with potential long-term sleep disruption, changes in cognitive ability, stress in relationships and employability challenges. These changes can be a hindrance to veterans' transition into their communities, as well as their overall quality of life.

Tinnitus is not mutually exclusive to any one conflict or generation of veterans. Tinnitus is one of the top ten reported Department of Veterans Affairs (VA) complaints from veterans of all eras. With noise exposure, blast trauma, and hearing loss being the top three causes of tinnitus, it is easy to see why this condition is continuing to rise. According to VA, the number of veterans who are receiving disability compensation for tinnitus has been steadily increasing over the past decade and has spiked sharply over the past few years. In 2006, the Veterans Benefits Administration (VBA) reported that service-connected disabilities for tinnitus had increased by 18 percent per year over the previous five years. This growth rate is likely to continue or worsen over the next five years, which would raise tinnitus disability payments by VA to more than \$1.1 billion by late 2011 or early 2012.¹³⁶

Despite the growing magnitude of the problem, most VA medical centers do not provide clinical management for the condition. An estimated 3–4 million veterans have tinnitus, with up to 1 million of them requiring some degree of clinical intervention. Unfortunately, there is currently no cure for tinnitus and the treatment options remain very limited.¹³⁷

How Tinnitus Manifests

The human auditory system consists of the external, middle, and inner ears, as well as the central auditory pathways in the brain. When damage occurs to one or more of these structures, tinnitus and/or hearing loss will occur. The ringing associated with tinnitus is a direct result of inner ear cell damage. The tiny, delicate hairs in the inner ear are designed to move in relation to the pressure of sound waves. However, exposure to intense sound waves can trigger ear cells to release an electrical signal through a nerve from the ear (auditory nerve) to the brain, or if the tiny hairs inside the inner ear are bent or broken, they can “leak” random electrical impulses to the brain, thus causing tinnitus. The brain then interprets these signals as sound. Acoustic trauma has long been part of military life since muskets and cannons were part of the arsenal, and Operations Enduring and Iraqi Freedom and Operation New Dawn (OEF/OIF/OND) veterans are no exception. America’s current fighting forces are exposed to some of the noisiest battlegrounds our military has ever experienced. Improvised explosive devices (IEDs) continue to be the signature weapon of the insurgency and regularly hit patrols, causing a wealth of health problems, including hearing loss and tinnitus. Although the

noise emitted from IEDs is the main source of recent increases of tinnitus within the veteran population, tinnitus can also be caused from head and neck trauma, including traumatic brain injury (TBI). TBI has become one of the signature wounds of recent conflicts and is producing a whole new generation of veterans with both mild and severe head injuries. TBI is reported to have caused approximately 60 percent of VA’s diagnosed cases of tinnitus.¹³⁸ However, aging also plays a role. Due to the fact that we have such a large and growing aging veteran population, it is critical for VA to be provided the necessary resources and staffing level to care for the millions of veterans who already have or will develop tinnitus, be it service or age related.

Measuring Sound in Military Environments

Information on noise sources and noise levels in the military environment is plentiful and detailed but not complete and not easily summarized. Sound levels vary depending on the distance from the sound source and the conditions under which the sound is being generated. Important characteristics of impulse noise include not only the peak sound pressure level, but the time pattern of the impulses and the frequency spectrum. A service member does not have to necessarily be deployed into a combat zone to regularly experience unsafe noise levels and frequencies. Any service member who is exposed to recurring loud noises from aircraft, weapons systems, or vehicles is at risk for developing tinnitus or permanent hearing loss. It also important to remember that hearing loss does not always imply total deafness.

Despite the existence of data on sound pressure levels generated by weapons and equipment and dosimeter estimates of noise exposure for certain personnel, arriving at an estimate of the cumulative noise exposure of any service member or group of service members is nearly impossible.¹³⁹ However, Table 4 displays decibel levels of individual weapons, aiding physicians in forecasting the effects of prolonged exposure.

Tinnitus, Hearing Loss, and Brain Injuries

While the nature and outcomes of brain injuries resulting from blast exposure are not yet fully understood, it is known that TBI causes both acute and delayed symptoms and permanent disabilities. VA has estimated that 90 percent of the mild or moderate TBI cases treated are a direct result of closed head injuries, in which a veteran was exposed to a concussive

Weapon/s	Location	Decibel (dBA) (Impulse Rate)
105mm Towed Howitzer	Gunner	183
MAAWS* recoilless rifle	Gunner	190
Improvised Explosive Devices (IEDs)	Anyone within 50 yards	170+
Grenade	Anyone within 50 feet	164
5.56mm automatic weapon fired from HMMWV**	Gunner	160
Javelin antitank missile	Gunner	172
*Multi-role anti-armor anti-personnel weapon system		
**High mobility multipurpose wheeled vehicle ¹⁴⁰		

wave, but suffered no overt head wounds. In particular, mild TBI often includes tinnitus as a manifestation of injury. As defined by the Department of Defense policy, TBI is the presence of a documented head trauma or blast exposure event, followed by a change in mental and physical status, which includes multiple symptoms, one of which could be tinnitus.

The Invisible Physical Wounds of War

While it is easy to identify returning service members with visible physical injuries, even larger numbers of service members are returning with invisible injuries. These invisible wounds of war are both physical and psychological and can range from minor to life threatening. Tinnitus is one of our nation's most prevalent invisible wounds of war. Tinnitus can range from mild to debilitating, constant or intermittent. It can be insignificant or torturous, depending on the severity and other medical conditions.

For many veterans, tinnitus gets worse at times of high emotion or anxiety. Clinical depression rates are estimated to be more than twice the national average among tinnitus patients.¹⁴¹ Service members are thus dealing with tinnitus and hearing loss coupled with things such as post-traumatic stress disorder or general anxiety disorder, making their recovery that much more difficult.

New and Experimental Treatment Options

While VA has made great advances in treating hearing loss, tinnitus options are still very limited. A VA research team based at the James Haley VA Medical Center in Tampa, Florida, developed the Progressive

Tinnitus Management (PTM) approach to treating tinnitus. The culmination of years of studies and clinical trials, PTM has started to evolve into a national management protocol for VA medical centers.

The model is designed to address the needs of all patients who complain about tinnitus, while efficiently utilizing clinical resources. There are five hierarchical levels of management: triage, audiologic evaluation, group education, interdisciplinary evaluation, and individualized support. Throughout the process, patients work with a team of clinicians to create a personalized action plan that will help manage their reactions to tinnitus and make it less of a problem.¹⁴²

Another aspect of the PTM model provides a form of cognitive behavioral therapy exercises that address the negative reactions tinnitus can trigger. Once referred into the program, patients with tinnitus are given a hearing examination. During the examination, audiologists counsel patients regarding hearing loss and tinnitus and provide veterans with educational materials. According to VA, patients who need more guidance in finding a way to live with tinnitus are referred to group education workshops. Five sessions teach both audiologic and cognitive behavioral coping techniques. Veterans are given a comprehensive self-help workbook with supporting materials, such as worksheets and audio samples. The instructors have the flexibility of using the provided handouts, slides, sound demonstration CDs, and DVDs to teach these workshops.

In 2010, every VA medical facility audiology clinic received copies of the PTM clinical handbook, counseling guide, and hundreds of patient-education workbooks. According to VA, the number of veterans who complete the group education stage of PTM and subsequently need individualized support is very small. PTM's hierarchical approach provides VA medical facilities with the most efficient means to educate veterans and teach them self-management techniques.

While newer options for treatment of tinnitus, such as PTM are emerging, there still is no cure to alleviate the phantom sounds plaguing the veterans' community. This clearly illustrates the importance of continued research and funding in order to find a way to help the millions of veterans suffering from tinnitus.

Recommendations:

The Veterans Health Administration must rededicate itself to programs for treatment of tinnitus.

Congress must continue providing funding for VA and the DOD to prevent, treat, and cure tinnitus.

The Independent Budget veterans service organizations urge the DOD and VA to provide better education to service members and veterans on the importance of protective gear and preventative actions.

¹³³<http://www.ata.org/action-alliance/support-for-veterans>.

¹³⁶The American Tinnitus Association, *What you should know about our military, veterans and tinnitus*. 2009.

¹³⁷Henry JA, Schechter MA, Regelein RT, Dennis KC. Veterans and tinnitus. In Snow, JB, editor. *Tinnitus: Theory and management* (Lewiston, NY: BC Decker, Inc. 2004), p. 337–55.

¹³⁸Stephen Fausti, Debra J. Wilmington, Frederick J. Gallun, et al., "Auditory and Vestibular Dysfunction Associated with Blast-related Traumatic Brain Injury," *Journal of Rehabilitation Research & Development* 46 (November 6, 2009): 797–8.

¹³⁹Larry E. Humes, Lois M. Joellenbeck, and Jane S. Durch, *Noise and Military Service: Implications for Hearing Loss and Tinnitus*. The National Institutes of Health, 2006.

¹⁴⁰Adapted from U.S. Army Center for Health Promotion and Prevention Medicine (2004) (2010).

¹⁴¹<http://www.pbs.org/newshour/updates/science/jan-june11/tinnitus.html>.

¹⁴²<http://www.va.gov/health/NewsFeatures/20110524a.asp>.



THE DEPARTMENT OF VETERANS AFFAIRS BLIND REHABILITATION SERVICE:

The Department of Veterans Affairs Blind Rehabilitation Service seeks to serve the needs of visually impaired and blinded veterans, but improvements need to be made.

The Department of Veterans Affairs (VA) estimates that more than 1 million veterans over the age of 45 are visually impaired. Within this group, approximately 157,000 are legally blind, and over 1 million have low vision. About 80 percent of visually impaired veterans have a progressive disability caused by age-related macular degeneration, glaucoma, or diabetic retinopathy. *The Independent Budget* veterans service organizations (IBVSOs) are pleased that the Veterans Health Administration (VHA) Blind Rehabilitation Service (BRS) has moved forward over the past three years with full implementation of the continuum of care for visually impaired veterans.¹⁴³

VA blind rehabilitation services are structured and geographically located for visually impaired veterans and service members to access the care they need. Blind Rehabilitation Services are delivered at

every VA medical center, with 157 Visual Impairment Service Team (VIST) coordinators who provide care management, and 77 blind rehabilitation outpatient specialists who provide in-home and in-community service. Additionally, VA supports 55 outpatient blind and vision rehabilitation clinics, and 10 inpatient Blind Rehabilitation Centers. A new Cleveland BRS officially opened recently, and two more are scheduled to be activated.¹⁴⁴

The plan for the expanded continuum of care was conceived in 2002 by the Visual Impairment Advisory Board (VIAB), a group of subject matter experts in rehabilitation, eye care, visual impairment and blindness, research, and VA administration. The VIAB recommended responsibilities, staffing, and costs for each level of vision rehabilitation care.¹⁴⁵

The total number of veterans currently on the VIST roster of veterans was 50,574 as of September 30, 2010.¹⁴⁶ Office Blind Rehabilitation projections indicate that by 2014, demand could rise to approximately 54,000 enrolled blind or low-vision veterans although these projections could change due to the rising number of traumatic brain injuries (TBIs) in veterans of Operations Enduring and Iraqi Freedom and New Dawn (OEF/OIF/OND), already numbering 2,098.¹⁴⁷ For more information on eye injuries in our newest generation of veterans, please refer to “The Challenge of Caring for War Veterans and Aiding them in their Transition to Civilian Life,” elsewhere in this *Independent Budget*.

When looking at the aging veteran population, while only 4.3 percent of those 65 and older live in nursing homes, 16 percent are visually impaired and of all veterans who are blind, 40 percent reside in nursing homes. VA rehabilitative low vision and blind training programs that allow safe daily independent living reduce these long-term care costs and prevent injuries from falls and other accidents.

The IBVSOs are concerned that VA beneficiary travel policy negatively affects disabled veterans who must depend on public transportation to utilize blind rehabilitation services.¹⁴⁸ VA provides transportation for service-connected or nonservice-connected direct transfers from one VA medical center to another, but does not provide transportation for outpatients who medically need BRS admission. In these cases, the veteran who wishes to receive medically necessary care must incur public transportation costs, usually airfare, adding to the financial burden that catastrophically disabled veterans on low fixed incomes are unable to absorb. In addition, it is often a logistical and physical struggle for a visually impaired veteran who needs medical care to navigate the public transportation system, often alone, if able to afford it. Unfortunately, some blinded veterans are simply unable to pay airfare to attend a BRC after being told they are accepted for admission. In fiscal year (FY) 2009 VA's BRS reported that 932 veterans would benefit from travel reimbursement changes. The IBVSOs ask Congress to amend Title 38, United States Code, to provide public transportation for veterans accepted for inpatient admission at any BRC.

VA's BRS must continue to provide for critical full-time employee equivalents within each BRC to maintain its current bed capacity and provide comprehensive

residential blind rehabilitation services. Other critical BRS positions, such as the 118 full-time VIST coordinators, and the current 77 blind rehabilitation outpatient specialists (BROS) must also be sustained. These VIST and BROS teams are essential full-time positions that conduct comprehensive assessments to determine whether a blinded veteran needs to be referred to a BRC. They also facilitate important blind rehabilitation training support in veterans' homes.

As other sections of *The Independent Budget* point out, there are growing numbers of VA employees reaching retirement age in the next few years, and without adequate training support, vacant management rehabilitation service positions will negatively impact the operations of these specialized services.

The IBVSOs are concerned that there are private agencies serving the blind that are lacking the psychological expertise to deal with post-traumatic stress and/or depression in veterans are asking the Department of Defense to refer blinded service members to them. VA's BRCs have developed and refined their expertise over decades. Few private agencies for the blind have the resources or capacity needed to adequately care for veterans with combat eye injuries and polytrauma. For these reasons, the IBVSOs recommend that the DOD and VA minimize referrals of blinded veterans to private agencies.

The current Specially Adapted Housing (SAH) requirement from the “Veterans' Housing Opportunity and Benefits Improvement Act of 2006” (P.L. 109–233) enacted in June 2006 uses visual acuity standard for blindness of 5/200 in order to qualify for this VA benefit, in addition to the requirement of loss of use of both hands. The legal standard for blindness for the Social Security Administration and for all 50 states is visual acuity of 20/200 or less. The IBVSOs urge Congress to modify the VBA standard to equal that of Social Security. The current standard severely restricts assistance to veterans who are functionally blinded, including many veterans with traumatic brain injury who have significant comorbid visual impairments. Because they do not qualify for the current 5/200 standard they do not qualify for grants under SAH.

In the 111th Congress, the IBVSOs supported passage of the “Caregivers and Veterans Omnibus Health Services Act” (P.L. 111–163) that improved VA's recruitment and retention of ophthalmic technicians,

specialists who enhance the role of ophthalmologists in eye clinics. Since the legislation was enacted, VA has delayed implementing this new authority, and we ask VA to expedite this change.

Recommendations:

VA must maintain the current bed capacity and full staffing levels in the blind rehabilitation centers to the level that existed at the time of the passage of P.L. 104–262.

Congress should change the visual acuity standard definition of legal blindness to 20/200 or less or to 20 degrees or less of peripheral field loss as a visual acuity standard for Specially Adapted Housing grants.

VA must improve yearly training and require the networks to increase the number of full-time Visual Impairment Service Team coordinators, to include blind rehabilitation outpatient specialists in new recruitment, scholarship, and employee retention programs and continue succession planning and development for specialized rehabilitation programs.

Congress should enact of legislation to provide adequate transportation reimbursement blinded veterans who are accepted into inpatient specialized residential rehabilitation programs.

VA should create contemporary qualifications standards for ophthalmic technicians.

Congress should provide oversight on the implementation of the Vision Center of Excellence, and should oversee the Defense and Veterans Eye Injury and Vision Registry (DVEIVR) for coordination information for all eye care professionals to improve care during seamless transition.

Congress should oversee joint interoperable injury registries that have been mandated by Congress in the “National Defense Authorization Act” for hearing, vision, and limb extremity injuries so they become operational.

Congress should fund the Vision Center of Excellence in the amount of \$18.8 million for FY 2013.

Congress should fund vision research in the amount of \$10 million for FY 2013.

The DOD should maximize use of VA blind rehabilitation and low-vision services for new combat veterans rather than referring those cases to private agencies.

¹⁴³Department of Veterans Affairs, Veterans Health Administration, VHA Handbook 1174.05, (Washington, DC: July 21, 2011). http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2431.

¹⁴⁴Lucille B. Beck, PhD, Chief Consultant, Rehabilitation Services, Office of Patient Care Services and Director, Audiology and Speech Pathology Service, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives, Committee on Veterans Affairs, Hearing, “Healing the Physical Injuries of War” (July 22, 2010).

¹⁴⁵Ibid.

¹⁴⁶Department of Veterans Affairs, Veterans Health Administration, Blind Rehabilitative Services (BR Data Oct. 14, 2010 report).

¹⁴⁷Department of Veterans Affairs, Veterans Health Administration, Blind Rehabilitative Services (BR Data Aug. 2010 report).

¹⁴⁸Department of Veterans Affairs, Veterans Health Administration, VHA HANDBOOK 1601B.05 (Washington, DC: July 21, 2010). http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2275.

SPINAL CORD INJURY/DISORDERS CARE:

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

Statutory Requirement for Maintenance of Capacity in VA SCI/D Centers

The *Independent Budget* veterans service organizations (IBVSOs) are concerned about continuing trends toward reduced capacity in VA's Spinal Cord Injury/Disorders Program. Reductions in beds and staff in both VA's acute and extended-care settings continue to be reported. P.L. 104-262, "Veterans' Health Care Eligibility Reform Act of 1996," mandated that VA maintain its capacity to provide for the special treatment and rehabilitative needs of veterans with spinal cord injury, blindness, amputations, and mental illness within distinct programs. This act required the baseline of capacity for spinal cord injury centers to be measured by the number of staffed beds and the number of full-time employee equivalents (FTEEs) assigned to provide care in such distinct programs.

In addition to the maintenance of capacity mandate, Congress was astute enough to also require that VA provide an annual capacity-reporting requirement, to be certified by, or otherwise commented upon by, the Inspector General. This reporting requirement was to be in effect from April 1, 1999, through April 1, 2001. Congress later passed an extension of the reporting requirement through 2004. Unfortunately, this basic reporting requirement expired in 2004. Since 2004 the IBVSOs have called upon Congress to reinstate the specialized services capacity-reporting requirement and to make this report an annual requirement without a specific end date. We strongly encourage Congress to reinstate this reporting requirement and prevent a future expiration of this fundamental measure of capacity.

SCI/D Leadership

The continuum of care model for the treatment of veterans with spinal cord injury or disorders has evolved over a period of more than 50 years. VA spinal cord injury/disorder (SCI/D) care has been established in a "hub-and-spokes" model. This model has been shown to work very well as long as all patients are seen by qualified SCI/D trained staff. Because of staff turnover and a general lack of education and training in outlying "spoke" facilities, not all SCI/D patients

have the advantage of referrals, consults, and annual evaluations in an SCI/D center.

This is further complicated by confusion as to where to treat spinal cord diseases, such as multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS). Some SCI/D centers treat these patients, while others deny admission. It is recognized that there is an ongoing effort to create a continuum of care model for MS, and this model should be extended to encompass MS and other diseases involving the spinal cord, such as ALS. However, admission to an SCI/D center may not be appropriate for all SCI/D veterans. In December 2009, VA developed and published *Veterans Health Administration Handbook 1011.06, Multiple Sclerosis System of Care Procedures*, which clearly identifies a model of care and health-care protocols for meeting the individual treatment needs of SCI/D veterans. However, VA has yet to develop and publish a Veterans Health Administration (VHA) directive to enforce the aforementioned handbook. Without a directive, the continuity and quality of care for SCI/D veterans could be compromised. The issuance of a VHA directive for the handbook is essential to ensuring that all local VA medical centers are aware of and are meeting the health-care needs of SCI/D veterans. Additionally, no funding has been provided to VA medical centers to implement the guidelines in the handbook.

Nursing Staff

VA is experiencing delays in admission and bed reductions based upon the availability of qualified nursing staff. The IBVSOs continue to believe that the basic salary for nurses who provide bedside care is not competitive with that of community hospital nurses. This results in high turnover rates as these individuals leave VA for more attractive compensation in the community. Historical data have shown that SCI/D units are the most difficult places to recruit and retain nursing staff. Caring for an SCI/D veteran is physically demanding and requires nursing staff to provide hands-on care that involves bending, lifting, and stooping. These repetitive movements and heavy lifting often lead to work related injuries. Caring for veterans with SCI/D often leads to work-related injuries.

Also, veterans with SCI/D often have psychosocial issues as a result of their injury/disorder. Special skills, knowledge, and dedication are required in order for nursing staff to care for SCI/D veterans.

Recruitment and retention bonuses have proven effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans as well as in the morale of the nursing staff. Unfortunately, facilities are faced with the local budget dilemma when considering a recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus taking away from other needed medical programs. A consistent national policy of salary enhancement should be implemented across the country to ensure qualified staff are recruited. Funding to support this initiative should be made available to the medical facilities from the network or central office to supplement their operating budgets.

Patient Classification

The Department of Veterans Affairs has a system of classifying patients according to the hours of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of care required during hospitalization, amount of time spent with the patient, technical expertise, and clinical needs of each patient. Acuity category III has been used to define the national average acuity/patient classification for the SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of FTEs needed for continuous coverage.

The emphasis of this classification system is based on bedside nursing care. It does not include administrative nurses, nonbedside specialty nurses, or light-duty nursing personnel because these individuals do not, or are not able to, provide full-time, hands-on bedside care for the patient with SCI/D.

Nurse staffing in SCI/D units has been delineated in *VHA Handbook 1176.01* and VHA Directive 2008–085. It was derived on 71 FTEs per 50 staffed beds, based on an average category III SCI/D patient. This national acuity average was established over a decade ago. Currently, SCI/D inpatients require a higher level of care than category III due to multiple chronic complications. While VA recognized the IBVSOs' request that administrative nurses should not be included in

the nurse staffing numbers for patient classifications, the current nurse staffing numbers still do not reflect an accurate picture of bedside nursing care. VA nurse staffing numbers incorrectly include non-bedside specialty nurses and light-duty staff as part of the total number of nurses providing bedside care for SCI/D patients. When the minimal staffing levels include nonbedside nurses and light-duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with inadequate nursing staff levels.

VHA Directive 2008–085 mandates 1,399 bedside nurses to provide nursing care for 85 percent of the available beds at the 264 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians. The SCI/D facilities recruit only to the mandated minimum nurse staffing required by VHA Directive 2008–085. At the end of FY 2011, nurse staffing was 1,316. This number is 177 FTEs short of the minimum nursing staff requirement of 1,493.8. The directive calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio of professional nurses to other nursing personnel.

The low percentage of professional RNs providing bedside care and the high acuity of SCI/D patients puts these veterans at increased risk for complications secondary to their injuries. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, development of pressure ulcers, and longer hospital stays. The SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

This nurse shortage has been manifested in VA facilities restricting admissions to SCI/D centers. Reports of bed consolidations or closures have been received and attributed to nursing shortages. When veterans are denied admission to SCI/D centers and then beds are consolidated, leadership is not able to capture or report accurate data for the average daily census. The average daily census is not only important for adequate staffing to meet the medical needs of veterans, but is also a vital component of ensuring that SCI/D centers receive adequate funding. Since SCI/D centers

are funded based on utilization, refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA's ability to address the needs of new incoming and returning veterans. Such situations create a severe compromise of patient safety and serve as evidence for the need to enhance the nurse recruitment and retention programs.

Recommendations:

Congress should renew legislation to require the annual reporting requirement to measure capacity for VA spinal cord care and other specialized services as originally required by P.L. 104–262.

The Veterans Health Administration (VHA) should ensure that the spinal cord injury/dysfunction (SCI/D)

continuum of care model is available to all SCI/D veterans nationwide. VA must also continue mandatory national training for the SCI/D “spoke” facilities.

VA should develop a directive to enforce *VHA Handbook 011.06, Multiple Sclerosis System of Care Procedures*.

The VHA needs to centralize policies and funding for system wide recruitment and retention bonuses for nursing staff.

Congress should appropriate the funding necessary to provide competitive salaries for SCI/D nurses.

Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.



THE DEPARTMENT OF VETERANS AFFAIRS MUST ENSURE THAT CATASTROPHICALLY DISABLED VETERANS HAVE ACCESS TO PRIMARY AND SPECIALTY CARE AT THE SPINAL CORD INJURY/DISORDER CENTER:

The Department of Veterans Affairs must ensure that veterans who have sustained a spinal cord injury or disorder are appropriately referred by VA SCI clinics to VA SCI Centers to receive proper care when needed.

Veterans who have incurred a spinal cord injury or disorder (SCI/D) are entitled to health care through VA's Spinal Cord Injury/Disorders System of Care. This model is often referred to as the “hub and spoke” system of SCI/D care. Specifically, veterans with SCI/D either receive care at a VA SCI/D Center (hub), or a VA SCI/D clinic (spoke). The SCI/D Center provides veterans with primary care and specialty care with a full continuum of acute stabilization, acute rehabilitation, subacute rehabilitation, medical and surgical care, ventilator management and weaning, respite care, preventative services, sustaining health care, SCI home care, and long-term care. The SCI/D clinic provides basic primary and preventative health care. When veterans with a SCI/D are in need of care for recurrent or persistent problems, have complex problems, procedures that require specialized knowledge, major surgeries, or acute rehabilitation, it is essential that they have access to the comprehensive health-care services that can only be provided by a SCI/D Center. To ensure that veterans

receive appropriate, quality SCI/D care, VA must strictly enforce uniform standards for patient referrals from spokes to hubs when acute care is needed, making certain that SCI/D Centers have adequate staff and resources to provide the necessary care to veterans transferred from SCI/D clinics, and ensuring that veterans' access to SCI/D Centers for critical care is not hindered, such as by transportation barriers.

Unfortunately, *The Independent Budget* veterans service organizations are receiving reports that when veterans are in need of acute care within the SCI/D system of care, they are not being referred to SCI/D Centers. Veterans are often informed that they cannot be transferred to a hub because the hub does not have the necessary resources to provide the specialty care that is needed. These resources include nurses, administrative staff, or patient beds. The Veterans Health Administration's (VHA) *Handbook 1176.01, Spinal Cord Injury and Disorders System of Care*, specifically states that “all acute rehabilitation and

complex specialty care must take place at SCI/D Centers, hubs.”¹⁴⁹ As the health conditions associated with SCI/D are often severe and chronic, when veterans do not receive the appropriate care, the result can be life threatening. To avoid such outcomes and provide veterans with quality care, VA must enforce its policy requiring staff at SCI/D clinics to refer veterans in need of acute care to SCI/D Centers. VA and Congress must also work to provide all VA SCI/D Centers with the resources needed to care for veterans with SCI/D.

When SCI/D Centers are lacking resources, such as staff or patient beds, spokes are forced to care for veterans in need of more complex, acute care. Ultimately, the care is substandard because the spokes are only equipped to provide basic primary and preventative health care. Both Congress and VA must work together to identify SCI/D Centers that are in need of the critical resources and currently not able to care for referred veterans, and make certain that all Centers within the VA SCI/D system of care are fully capable of providing the services outlined in VHA policy.

VA policy also identifies transportation as a major component to providing veterans with a SCI/D comprehensive health care. VA reimburses eligible veterans for their travel to and from VA medical facilities. However, when veterans do not meet the eligibility requirements for travel reimbursement, and they do not have the financial means to travel, the chances of their receiving the proper medical attention are significantly decreased. For veterans who have sustained a catastrophic injury, like SCI/D, timely and appropriate medical care is vital to their overall health and well-being. When the necessary care is not available to catastrophically disabled veterans, associated illnesses quickly manifest and create complications that often result in reoccurring hospitalizations and long-term, if not permanent, medical conditions that diminish veterans’ overall quality of life and independence. It is recommended that VA and Congress work together to improve the travel reimbursement benefit to ensure that all catastrophically disabled veterans have access to the care they need. Eliminating the issue of transportation as a barrier to SCI/D care will result in long-term health-care cost savings for VA.

With access to SCI/D Centers, the need for long-term chronic acute care will be decreased, if not prevented. Most important, improving access will help support full rehabilitation of catastrophically disabled veterans and enable them to become healthy and productive individuals.

In the VA SCI/D system of care, spoke clinics are often more accessible for veterans as they are located in areas that do not have a SCI/D Center within close proximity. Nonetheless, the VA SCI/D system of care is not designed to have spokes serve as the single source of SCI/D care. The system was created to provide veterans with a full continuum of SCI/D care. Therefore, the location where veterans seek care, either a hub or a spoke, should be solely dependent on their individual medical and health-care needs. Veterans in need of acute care must have access to SCI/D Center.

Recommendations:

VA must make certain that veterans who have sustained a spinal cord injury/disorder (SCI/D) are appropriately referred by VA SCI clinics to VA SCI Centers to receive proper care when needed.

VA must enforce its policy which requires staff at SCI/D clinics (spokes) to refer veterans in need of acute care to SCI/D Centers (hubs). VA and Congress must also work to provide all VA SCI/D Centers with the resources needed to care for veterans with SCI/D.

Congress and VA must work together to identify SCI/D Centers that are in need of the critical resources and currently not able to care for referred veterans, and make certain that all Centers within the VA SCI/D System of Care are fully capable of providing the services outlined in VA policy.

VA and Congress must work together to improve the travel reimbursement benefit to ensure that all catastrophically disabled veterans have access to the care they need.

¹⁴⁹Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook 1176.01; Section F(5) Types of Care in Non-SCI Setting—Acute Rehabilitation and Complex Specialty Care*, pp 32.

PERSIAN GULF WAR VETERANS:

The Department of Veterans Affairs must aggressively pursue answers to the health consequences of veterans' Gulf War service. VA cannot reduce its commitment to Veterans Health Administration programs that address health care and research or Veterans Benefits Administration programs in order to meet other important and unique needs of Gulf War veterans.

In the first days of August 1990, in response to the Iraqi invasion of Kuwait, U.S. troops were deployed to the Persian Gulf in Operations Desert Shield and Desert Storm. The air assault was initiated on January 16, 1991. On February 24, 1991, the ground assault was launched, and after 100 hours, combat operations were concluded. Approximately 697,000 U.S. military service members served in Operations Desert Shield or Desert Storm. The Gulf War was the first time since World War II in which the reserves and National Guard were activated and deployed to a combat zone. For many of the 106,000 who were mobilized to Southwest Asia, this was a life-changing event.

After their military service, Gulf War veterans reported a wide variety of chronic illnesses and disabilities. Many Gulf War veterans have been diagnosed with chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss, difficulty concentrating, sleep disturbance, and gastrointestinal problems. The multisymptom condition or constellation of symptoms has been referred to as Gulf War syndrome, Gulf War illness (GWI), or Gulf War veterans' illnesses; however, no single unique illness has been definitively identified to explain the complaints of all veterans who have become ill.

According to the VA study "Health of U.S. Veterans of 1991 Gulf War: A Follow-Up Survey in 10 Years" (April 2009), 25 percent to 30 percent of Gulf War veterans suffer from chronic multisymptom illness above the rate of other veterans of the same era who were not deployed. This confirms five earlier studies showing similar rates. Thus, 18 years after the war, approximately 175,000 to 200,000 veterans who served remain seriously ill.

Both the Departments of Defense and Veterans Affairs have invested in conducting research and providing health care and benefits to address the concerns of Gulf War veterans and their families. However, these efforts have lagged in recent months. With the apparent focus of restoring the health of our latest

combat veterans of Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND), VA has not maintained a steadfast commitment or adequate efforts to explore the unanswered questions of this previous generation of combat veterans. In addition, because many Gulf War veterans remain ill, *The Independent Budget* veterans service organizations (IBVSOs) stand firm and urge the DOD and VA not to abandon their search for answers to Gulf War veterans' unique health problems and exposure concerns. We should not attempt to serve one veteran cohort at the expense of others.

Building a Base of Evidence

Since the Gulf War, federal agencies have sponsored numerous research projects related to GWI. Although a number of extremely important studies and research breakthroughs received funding support, overall, federal programs were not focused on addressing the Gulf War research issues of greatest importance.

Need for More High-Quality Evidence

Testimony provided during hearings before the House Committee on Veterans' Affairs pointed to a number of research challenges that have impeded steady progress, including the lack of adequate documentation of exposures, differing case definitions of Gulf War illness, and the weight given to animal and human studies in evaluating research findings for the purpose of determining causation.

The IBVSOs are concerned that, if left unaddressed, GWI research will continue to be hampered and veterans suffering from GWI will not receive proper relief. On April 9, 2010, the Institutes of Medicine (IOM) released *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009*. In this report the IOM expert committee noted that virtually all the reports in the Gulf War and Health series have called for improved studies of Gulf War and other veterans. The committee report stated that future studies of Gulf War veterans—and indeed any veteran population—need to be adequately designed to:

- provide sufficient statistical power (precision);
- ensure validity, including the avoidance of such bias as response bias and recall bias, which lead deployed and nondeployed veterans to participate unequally, depending on general health and symptom presence and severity, or to report symptoms differently according to perceived exposures and health status;
- improve disease measurement to avoid misclassification, for example, including information collected from non-DOD hospitals in studies of hospitalization, obtaining cancer incidence data from existing cancer registries, validating self-reports of health outcomes, and using the least error-prone measures of these outcomes;
- characterize deployment and potential related adverse environmental influences better, for example, by collecting information on the length and location of deployment and on jobs and tasks; and
- measure and adjust for possible confounding factors by, for example, measuring and adjusting for lifestyle factors (such as smoking and risk-taking behaviors) and predeployment physical and psychologic health status.

The Research Advisory Committee on Gulf War Veterans' Illnesses (RAC-GWVI), appointed by the VA Secretary in 2002, was directed to evaluate the effectiveness of government research in addressing central questions on the nature, causes, and treatments of Gulf War-related illnesses. The RAC-GWVI made specific recommendations for VA's GWI research funding announcements for Biological Laboratory Research and Clinical Science Research.¹⁵⁰ The IBVSOs urge VA to adopt these recommendations that will directly benefit veterans suffering from GWI by, among other things, creating a comprehensive research plan and management structure and answering questions most relevant to their illnesses and injuries. Heightening this concern is a critical need for a comprehensive and well-planned program to address other problems faced by disabled Gulf War veterans.

The Direction of VA Research

The RAC-GWVI notes that studies consistently indicate GWI is not significantly associated with serving in combat or other psychological stressors. Moreover, the IOM committee noted in its *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009*, that “[f]rom several lines of evidence,

it can be inferred that the high prevalence of medically unexplained disability in Gulf War veterans cannot be reliably ascribed to any known psychiatric causes or disorders. It is not possible to attribute the high prevalence of medically unexplained disability in Gulf War veterans to somatoform disorder, based on available evidence.” It follows, then, that the Department's research on ill Gulf War veterans should reflect due consideration. Unfortunately, this is not the case.

While the survey instrument for VA's *Follow-Up Study of a National Cohort of Gulf War and Gulf War Era Veterans* does offer some practicality, it requires significant changes to enhance the quality, utility, and clarity of the information to be collected. The RAC-GWVI submitted recommendations that VA suspend current plans to field the large longitudinal survey under development by VA's Office of Public Health and Environmental Hazards, pending extensive revisions of the survey instrument. The RAC-GWVI suggests, as currently designed, the proposed survey fails to collect data on the most pressing health issues related to Gulf War service, while collecting excessive information on more peripheral concerns to include psychiatric disorders.¹⁵¹ The IBVSOs believe VA must reassess its survey instrument to collect the most important types of data required to assess priority health issues specific to Gulf War service.

The IBVSOs are also concerned that the diminishing focus of VA GWI research will divert attention to the urgent issues faced by OEF/OIF/OND veterans. As troops in Southwest Asia continue to fight in the same geographic region as did Gulf War veterans, VA's response to this unique situation was to open the Gulf War Registry to OIF veterans,¹⁵² and broaden the scope of GWI research to include “deployment-related health research.” While it is unclear whether veterans of the current conflicts, or even OIF veterans specifically, should be categorically grouped with veterans of the first Gulf War for purposes of VA research on GWI, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of another, particularly in light of news reports about an open-air “burn pit” at the largest U.S. base in Balad, Iraq, which has been described as an acute health hazard and may have exposed thousands of service members to cancer-causing dioxin, poison, and hazardous medical waste.¹⁵³ Accordingly, the IBVSOs

urge Congress to conduct rigorous oversight on the federal research budget to ensure VA and other federal agencies collaborate to prioritize and coordinate investigations in a progressive manner for both post-deployment groups.

Other concerns have also been raised regarding the rates of birth defects in the children of Gulf War veterans and other adverse pregnancy outcomes. These were part of the scope of review in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* report. In its review of existing literature, the committee found there was inadequate or insufficient evidence to determine whether an association exists between deployment to the Gulf War and fertility problems, specific birth defects, and adverse pregnancy outcomes, such as miscarriage, stillbirth, preterm birth, and low birth weight. VA has the opportunity to gather more information on this matter in its *Follow-Up Study of a National Cohort of Gulf War and Gulf War Era Veterans*. Unfortunately, the VA survey instrument as proposed in the *Federal Register* September 9, 2010, does not include questions related to the health of veterans' family members, specifically, on children's health—both congenital abnormalities and problems that develop later in life (e.g., childhood cancers, developmental disorders of learning and attention)—and information on birth outcomes and fertility.

The Need for Effective Treatment

The position of the IBVSOs is that in addition to stress and hazards of deployment, all combat environments are hostile and traumatic. Gulf War veterans have suffered the effects of combat and environmental exposures, and their bravery in dealing with the aftermath of service should not be discounted, diminished, or stigmatized. A holistic, comprehensive investigation into the causes and the most effective treatments for all illnesses and injuries suffered by Gulf War veterans is the proper path to restoring the health and well-being of those who served.

It has been eight years since Congress mandated¹⁵⁴ the Department of Veterans Affairs to commission the IOM to convene a committee¹⁵⁵ to report¹⁵⁶ on the primary concern of whether Gulf War veterans are receiving effective treatments for their health problems. In its most recent report,¹⁵⁷ the RAC-GWVI states, “treatments that are effective in improving the health of veterans with GWI are urgently needed.” The DOD's Office of Congressionally Directed Medi-

cal Research Programs manages a research program aimed at identifying diagnostic tests and treatments for GWI.

Each year since the dramatic decline in overall research funding for GWI in 2001, the IBVSOs have urged Congress to increase funding for VA and DOD research on GWI. The DOD's Office of Congressionally Directed Medical Research Programs has managed the Gulf War Illness Research Program since fiscal year 2006, but this program did not receive funding until FY 2008, with \$10 million. Since then, Congress has provided funding at various levels.¹⁵⁸ For FY 2013, the IBVSOs urge Congress to provide the funding level necessary for this research program to achieve the critical objectives of improving the health and lives of Gulf War veterans.

The IBVSOs also applaud the VA's Office of Research and Development for issuing the 2009 *Clinical Science Request for Applications for New Treatments*. Although application for grants is publicly available through www.grants.gov,¹⁵⁹ we are concerned that the announcement was made internally rather than publicly. Moreover, we urge VA to ensure there is collaboration and strategic planning with the DOD, which currently has two funding mechanisms to study treatments for GWI this year.

Effectiveness of Compensation, Pension, and Ancillary Benefits

Valid Data Needed

The Gulf War Veterans Information System (GWVIS) report monitors, in part, veterans' use of VA health care and disability benefits. The Veterans Benefits Administration (VBA) indicates that the GWVIS provides the best available current data identifying the 6.5 million Gulf War veterans.

Discrepancies were noted by the Advisory Committee on Gulf War Veterans and identified during a Congressional committee hearing on May 19, 2009, “regarding [a] significant (43%) drop in undiagnosed illness claims processed between the February 2008 and August 2008.”¹⁶⁰ VA confirmed that the GWVIS reports were corrupted and the data discrepancies occurred as a result of data migration from VA's legacy database, the Benefits Delivery Network, to a new corporate database, Veterans Services Network.¹⁶¹ However, the discrepancy occurred before 2008. The migration of claims data was a 25-month (552-day) process that began on May 21, 2007, and ended on

June 30, 2009.¹⁶² This schedule coincides with the reductions in claims highlighted in the March and June 2007 quarterly reports. The IBVSOs question VA claims information from its August 2009 *Gulf War Review*, which states, “More than 3,400 Gulf War veterans have received service connection for their undiagnosed or difficult-to-diagnose illnesses under this authority.”

If this claim is true, less than 1.5 percent of claims for undiagnosed illness have been granted, which suggests that these claims are difficult to prosecute and possibly adjudicate, and that current regulations may be the reason. An equally important question is, if scientific literature suggests 175,000 to 200,000 Gulf War veterans remain seriously ill, how many of them are receiving compensation benefits based on disabilities resulting from military service in the Persian Gulf War? Moreover, as of this writing, the most recent GWVIS reports available data only up to 2008 (March, June, and September) and the issues surrounding the validity of the data remain unresolved.

In addition to compensation and pension benefits, veterans may be eligible for education and training benefits, vocational rehabilitation and employment, home loans, dependents’ and survivors’ benefits, life insurance, and burial benefits. Unfortunately, information regarding utilization of these benefits by Gulf War veterans is unavailable even on GWVIS reports. Clearly, due to the lack of granularity, the GWVIS quarterly report should be made more comprehensive as many unanswered questions remain that can better describe whether VA benefits are meeting the needs of ill Gulf War veterans and whether such veterans are receiving VA benefits they have earned and deserve.

Presumptive Conditions

Under the direction of Congress, VA has a standing responsibility to commission the IOM to assist the Department in making decisions as to whether there is sufficient scientific evidence to warrant a presumption of service connection for the occurrence of a specified condition in Gulf War veterans. On October 16, 2006, the IOM issued a fifth volume of its *Gulf War and Health* series on infectious diseases. On September 29, 2010, more than two years after issuance of the report, VA announced its intention to expand the number of presumed disabilities associated with exposures in the Gulf War. VA has since published the final regulations to include nine

additional infectious diseases on VA’s list of presumptive conditions of Gulf War veterans that cause compensable disability.

The *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* was charged to review and update the *Gulf War and Health, Volume 4: Health Effects of Serving in the Gulf War*, which summarized the overall health effects in veterans and noted which health outcomes were more evident in Gulf War veterans than in their nondeployed counterparts irrespective of the specific exposures experienced by the deployed veterans. This most recent report by the IOM committee was limited to reviewing epidemiologic studies of health outcomes noted in the Volume 4 report but used a different approach for reviewing literature in assigning studies as primary or secondary to support committee conclusions.

Specifically, the committee considered studies that used only self-reports by Gulf War veterans to be secondary studies for most health outcomes; the major exception to this rule was multisymptom illness. Some health outcomes, however, such as fibromyalgia or irritable bowel syndrome, lack objective diagnostic tests and are diagnosed based on symptom reporting that meet accepted criteria (e.g., Centers for Disease Control and Prevention criteria for chronic fatigue syndrome and the Rome criteria for irritable bowel syndrome). When the symptom reporting was sufficiently descriptive to meet the diagnostic criteria for that outcome, those studies were considered to be primary if the other evaluation criteria for a primary study were met. Studies that used objective measures to diagnose a health outcome were also considered to be primary if they met the other evaluation criteria.

The 2009 report finds there is sufficient evidence of a causal relationship between deployment to the Gulf War and post-traumatic stress disorder (PTSD). Furthermore, the committee found sufficient evidence of an association between deployment and other psychiatric disorders, including generalized anxiety disorder, depression, and substance-use disorder, particularly alcohol abuse; gastrointestinal symptoms consistent with gastrointestinal functional disorders, such as irritable bowel syndrome and functional dyspepsia; and multisymptom illness, including chronic fatigue syndrome.

The committee also found limited or suggestive evidence of an association between deployment to the

Gulf War and amyotrophic lateral sclerosis (ALS), fibromyalgia and chronic widespread pain, self-reported sexual difficulties, and mortality from external causes (primarily motor vehicle accidents) in the early years after deployment.

Title 38, United States Code, section 1118 provides that whenever the Secretary determines, based on sound medical and scientific evidence, that a positive association (i.e., the credible evidence for the association is equal to or outweighs the credible evidence against the association) exists between exposure of humans or animals to a biological, chemical, or other toxic agent, environmental or wartime hazard, or preventive medicine or vaccine known or presumed to be associated with service in the Southwest Asia theater of operations during the Persian Gulf War and the occurrence of a diagnosed or undiagnosed illness in humans or animals, the Secretary will publish regulations establishing presumptive service connection for that illness. If the Secretary determines that a presumption of service connection is not warranted, the Secretary is to publish a notice of that determination, including an explanation of the scientific basis for that determination. The determination must be based on consideration of National Academy of Science reports and all other sound medical and scientific information and analysis available to the Secretary.

The IBVSOs commend VA for having formed a task force to address the IOM report and make recommendations to the Secretary with respect to presumptions of service connection based on the IOM committee's findings.¹⁶³ VA should move with all deliberate speed to include the list of those conditions in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* that were found to have at least met the limited or suggestive evidence criteria as presumptive conditions. Furthermore, these conditions for which the committee considered all possible health effects identified in the studies it reviewed were done so, “[r]egardless of the potential cause of the health effect, with the exception of health effects related to or resulting from infectious and parasitic diseases.”¹⁶⁴ We therefore recommend VA amend Title 38, Code of Federal Regulations, section 3.317 by adding those conditions.

Expiring Authority

Because of what appears to be a dismal record of adjudicating claims based on presumptive service connection for GWI, VA's continuing obligation to conduct research on the health effects of serving in the Persian Gulf War, and the lengthy process by which VA makes final decisions based on findings of IOM reports, the IBVSOs urged Congress to provide ill Gulf War veterans the benefit of the doubt by extending indefinitely the presumptive period for service connection for ill-defined and undiagnosed illnesses and protect such presumptive service connection. We thank Congress for extending to October 1, 2015, the protection of compensation based on presumptive service connection as specified in section 1117(c)(2).¹⁶⁵ We also thank VA for extending to December 31, 2016, its authority to evaluate Gulf War veterans for potential compensation for chronic disabilities from undiagnosed illnesses. Nevertheless, to be consistent with this VA extension, Congress should reauthorize section 1118(e) affecting VA determinations of presumption of service connection associated with service in the Persian Gulf theater.

Effectiveness of Health-Care Benefits

Data Needed

Similar to the absence of information about compensation, pension, and other ancillary benefits, the GWVIS report lacks any practical information on health-care utilization or diagnostic data of Gulf War veterans' use of VA health care, particularly when compared to the report *Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans*. Issued quarterly by the Veterans Health Administration (VHA) Office of Public Health and Environmental Hazards, this report provides a revealing description of the trends in health-care utilization and VA workload of OEF/OIF veterans, their diagnostic data, and other helpful information. Such monitoring allows VA to tailor its health-care and disability programs to meet the needs of this newest generation of OEF/OIF war veterans.

Change in VA Health-Care System to Address Needs

Veterans suffering from GWI require a holistic approach to the care they receive in order to improve their health status and quality of life. VA must establish a system of post-deployment occupational health care if it is to meet its mission and deliver veteran-centric care to this population.

VA's War Related Illness and Injury Study Centers (WRIISCs) located in Washington, DC; East Orange, New Jersey; and Palo Alto, California, have a central and important role in VA's health-care program for veterans with post-deployment health problems. Funding comes from the VA Office of Research and Development; the DOD's medical research funding program, the Congressionally Directed Medical Research Program, which recently met in December 2010 to make its final determination for funding of \$8 million in Gulf War illness research proposals; and the National Institutes of Health's National Institute of Neurological Disorders and Stroke and National Institute of Arthritis and Musculoskeletal and Skin Diseases. WRIISCs conduct clinical treatment trials, such as evaluating a cognitive rehabilitation program for ill Gulf War veterans,¹⁶⁶ a treatment feasibility study of complementary and alternative medicine for sleep disturbances in ill Gulf War veterans,¹⁶⁷ and a trial in a complementary and alternative medicine treatment program for veterans with pain, fatigue, and PTSD.¹⁶⁸

Despite this important role, VA has not devoted adequate attention or resources to the education of its non-WRIISC staff, or outreach to veterans, to make them aware of these programs. Since the establishment of the Washington and East Orange WRIISCs in 2001, and Palo Alto in 2008, VA's clinical service has conducted health evaluations in more than 1,400 veterans to date. Many Gulf War veterans who are ill and their private sector providers are generally unaware of the information, opportunity for consultation, or specialized expertise of the WRIISCs. Thus, the IBVSOs believe this national resource remains largely unrecognized and underutilized. VA should better utilize the expertise of the WRIISCs to ensure that their resources are increased to match the growing demand.

Occupational health is a medical specialty devoted to improving worker health and safety through surveillance, prevention, and clinical care activities. Physicians and nurses with these skills could provide the foundation for the VHA's post-deployment health clinics and enhanced exposure assessment programs, and improve the quality of disability evaluations for the VBA's Compensation and Pension Service. VA should consider establishing a holistic, multidisciplinary post-deployment health service led by occupational health specialists at every VA medical center.

Moreover, these clinics could be linked in a hub-and-spoke pattern with the WRIISCs to deliver enhanced care and disability assessments to veterans with post-deployment health concerns. To achieve this objective, the WRIISCs and post-deployment occupational health clinics could be charged with the following:

- to work collaboratively with the DOD environmental and occupational health programs;
- to identify and assess military and deployment-related workplace hazards;
- to track and investigate patterns of military service members' and veterans' occupational injury and illness patterns;
- to develop training and informational materials for VA and private sector providers on post-deployment health;
- to assist other VA providers to prevent work-related injury and illness; and
- to work collaboratively with DOD partners to reduce service-related illness and injury, develop safer practices, and improve preventive standards.

One of VA's core missions constitutes the comprehensive prevention, diagnosis, treatment, and disability compensation services of veterans who suffer from service-related illnesses and injuries. Service-related illnesses and injuries, by definition, are military occupational conditions and exposures. Accordingly, VA should devise systems, identify expertise, and recruit and train the necessary experts to deliver these high-quality occupational health and benefits services.

Likewise, VA needs to improve the capability of its primary care providers to recognize and evaluate post-deployment health concerns. In approaching this task, VA and the DOD jointly developed the Post-Deployment Health Clinical Practice Guideline to assist VA and DOD primary care clinicians in evaluating and treating individuals with deployment-related health concerns and conditions. This guideline uses an algorithm-based, stepped-care approach that emphasizes systematic diagnosis and evaluation, clinical risk communication, and longitudinal follow-up.

Special Treatment Authority

Congress provided a "special treatment authority" in 1993, P.L. 103-210, "[a]n Act to amend Title 38, United States Code, to provide additional authority for the Secretary of Veterans Affairs to provide health care for veterans of the Persian Gulf War," to

empower VA to provide health care to Persian Gulf War veterans who served in the Southwest Asia theater of operations and were therefore presumed to have been exposed to toxic substances or environmental hazards. This special treatment authority is similar to that given to Vietnam veterans who may have been exposed to herbicides in Vietnam. P.L. 105–114, the “Veterans Benefits Act of 1997,” eliminated the requirement that the veteran had to be exposed to toxic substances or environmental hazards but only required documented service in the Southwest Asia theater of operations during the Persian Gulf War. In 1998, the authority was extended through 2001, and P.L. 107–135 (115 Stat. 2446) provided another extension through 2002.

Although this special treatment authority lapsed in 2002, VA has continued to treat these veterans within priority group 6. The IBVSOs appreciate the numerous attempts by VA to correct, before and after the expiration, both special treatment authorities. We understand that expiration of the authority will mean that priority group 8 veterans newly applying for enrollment, who claim exposure to Persian Gulf War hazards with no other qualifying eligibility, may be subjected to enrollment restrictions. Also, being recategorized into lower priority groups subjects those Gulf War veterans to pay required copayments, a situation that may serve as a barrier to VA care for some.

A longitudinal study of Gulf War veterans found that prescription drugs and over-the-counter medicines are by far the most common treatments used for the multisymptom illness of Gulf War veterans.¹⁶⁹ Moreover, established treatment regimens available through VA have been identified that alleviate Gulf War illness symptoms. Section 202 of the House-passed version of H. R. 3219, the “Veterans’ Insurance and Health Care Improvements Act of 2009,” would have eliminated the sunset provision but it did not advance to final passage. Section 201 of S. 1237, the “Homeless Veterans and Other Veterans Health Care Authorities Act of 2010,” includes a provision to extend the sunset date to December 31, 2012. Accordingly, the IBVSOs believe Congress should make permanent or, at the minimum, extend VA’s “special treatment authority” for veterans who served in the Persian Gulf War. Given the benefit of the doubt, sick and disabled veterans in this eligibility category should

not face any barrier to VA health care, especially with respect to copayments.

Education and Outreach

Education and outreach are only effective if the information provided is timely and accurate, and if it penetrates and permeates the target audience. The IBVSOs are appreciative of the work done by VA’s Office of Public Health and Environmental Hazards website to make it more user friendly and provide pertinent information that may be useful to ill Gulf War veterans and their health providers.

As of this writing, the Office of Public Health and Environmental Hazards’ website for Gulf War veterans’ illnesses has but two links for health-care providers who are treating and diagnosing health effects of Gulf War service in veteran patients: the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues* and the IOM Committee Reports—*Gulf War and Health*.¹⁷⁰ The Veterans Health Initiative on Gulf War veterans’ health is an independent study guide developed to provide a background for VA health-care providers on the Gulf War experience and common symptoms and diagnoses of Gulf War veterans. This guide was released and last revised in 2002. The IBVSOs urge that VA review and revise this guide to include the latest research findings and clinical guidelines.

Effective outreach can be a great tool in ensuring that veterans and their providers are kept informed of any pertinent changes or developments that may occur over the years. However, although passive in nature, tools, such as the *Study Guide*, have not been given the needed attention, necessary updates, or priority by the VHA to improve the health and health care of Gulf War veterans. VA’s approach to the needs of this veteran population has become parochial and fragmented.

The IBVSOs believe much work remains to ensure federal benefits and services are adapted to meet the unique needs of veterans suffering from Gulf War illness. VA must meet its obligation to care for the newest and prior generation of disabled veterans without diverting its attention from the actions needed to find the means to diagnose, treat, and cure GWI. We believe the answers lie in medical surveillance, high-quality health care, and research on effective treatments. Where cures remain elusive, VA must provide

timely, accessible, responsive, and equitable benefits and compensation for those who suffer from chronic illnesses and disability as consequences of environmental and toxic exposure. Our nation's veterans deserve no less.

Recommendations:

Congress should reauthorize, through 2016, Title 38, United States Code, section 1118(e) affecting VA determinations of presumption of service connection associated with service in the Persian Gulf theater.

Congress should make permanent or, at a minimum, extend VA's "special treatment authority" for veterans who served in the Southwest Asia theater of operations during the Persian Gulf War.

VA and other federal agencies funding Gulf War illness (GWI) research must ensure research proposals are of high quality based on such considerations as the quality of the design, the validity and reliability of measures, the size and diversity of subject samples, and similar considerations of internal and external validity.

VA, in collaboration with other federal agencies funding GWI research, must create a research program with a comprehensive research plan and management structure, prepared to answer questions most relevant and unique to Gulf War illnesses and injuries.

Congress should conduct rigorous oversight of the federal research budget to ensure that VA and other federal agencies collaborate to prioritize and coordinate investigations in a progressive manner.

Congress should maintain its commitment to provide sufficient funding for VA's research program to permit it to resume robust research into the health consequences of Gulf War veterans' service and to conduct research on effective treatments for veterans suffering from Gulf War illnesses. The unique issues faced by Gulf War veterans should not be lost in the urgency to address other issues related to armed forces personnel who are currently deployed and to veterans more recently discharged.

VA should commission the National Academy of Sciences' Institute of Medicine to update the *2001 Gulf War Veterans: Treating Symptoms and Syndromes*

report to determine whether treatments are effective in veterans suffering from GWI and whether these veterans are receiving appropriate care.

VA should issue a report containing practical information on utilization and trends of health care and diagnostic data, as well as other helpful information that would allow the Department to tailor its health-care programs to meet the unique needs of ill Gulf War veterans.

VA should review and revise the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues* and the IOM Committee Reports—*Gulf War and Health* to include the latest research findings and clinical guidelines.

To properly assess and tailor existing VA benefits for ill Gulf War veterans, VA should gather more meaningful data that will result in an accurate database than that currently available from the Gulf War Veterans Information System.

VA should move with all deliberate speed to include the list of those conditions in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* that were found to have at least met the limited or suggestive evidence criteria as presumptive conditions. These conditions should also be listed separate and distinct from those disabilities due to undiagnosed illnesses.

The Veterans Health Administration should establish post-deployment health clinics, enhance exposure assessment programs, and improve the quality of disability evaluations for the Veterans Benefits Administration's Compensation & Pension Service. To deliver high-quality occupational health services, VA should consider establishing at every VA medical center a holistic, multidisciplinary post-deployment health service led by occupational health specialists.

¹⁵⁰ www1.va.gov/RAC-GWVI/docs/Committee_Documents/CommentsAndRecommendations_VA-GWI-research-program_111709.pdf.

¹⁵¹ www1.va.gov/RAC-GWVI/docs/Committee_Documents/RACSurveyRecs_Final110210.pdf.

¹⁵² As of May 2009, more than 111,000 have participated in VA's Gulf War Veterans' Health Registry Examination, of which more than 7,000 veterans are from the current conflicts.

¹⁵³ Kelly Kennedy, "Burn Pit Fallout; Military Official: Situation Improving; Troops Report Complications from Asthma to Cancer," *Army Times* (November 7, 2008).

¹⁵⁴ P.L. 105-368 § 105; P.L. 105-277 § 1603.

¹⁵⁵ Committee on Identifying Effective Treatments for Gulf War Veterans' Health Problems, Board on Health Promotion and Disease Prevention.

¹⁵⁶ *Gulf War Veterans: Treating Symptoms and Syndromes* (National Academies Press, July 26, 2001).

¹⁵⁷ *Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations* (U.S. Government Printing Office, November 17, 2008).

¹⁵⁸\$5 million (FY 2006), \$0 (FY 2007), \$10 million (FY 2008), \$8 million (FY 2009–2011), \$10 million (FY 2012).

¹⁵⁹<https://apply07.grants.gov/apply/UpdateOffer?id=12353&is2006=true>.

¹⁶⁰House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, *Gulf War Illness Research: Is Enough Being Done?* Hearing (May 19, 2009). 111th Cong., 1st Sess. (Washington, DC: Government Printing Office, 2009).

¹⁶¹Post-hearing response by the Secretary of Veterans Affairs.

¹⁶²<http://www.privacy.va.gov/docs/SSnApr2008FinE.pdf>.

¹⁶³*Gulf War Review Newsletter* 17, no. 1 (July 2010) <http://www.publichealth.va.gov/docs/gulfwar/gulfwar-newsletter-jul10.pdf>.

¹⁶⁴*Ibid.*, 5.

¹⁶⁵P.L. 111–275, the “Veterans’ Benefits Act of 2010.”

¹⁶⁶Proposal submitted to VA Clinical Sciences Research and Development Service.

¹⁶⁷Proposal to be submitted to VA Health Service Research and Development Service.

¹⁶⁸*Ibid.*

¹⁶⁹H. Kang, Preliminary findings: Reported unexplained multisymptom illness among veterans who participated in the VA Longitudinal Study of Gulf War Era Veterans. Presentation at Research Advisory Committee on Gulf War Veterans’ Illnesses meeting, Washington, DC (September 21, 2005).

¹⁷⁰www.publichealth.va.gov/docs/vhi/gulfwar.pdf.



LUNG CANCER SCREENING AND EARLY DISEASE MANAGEMENT PROGRAM:

Lung cancer has a disproportionate impact on veterans, especially those exposed to carcinogens during active duty service. Low-dose computed tomography screening has now been proven to reduce lung cancer mortality in a high risk population. VA must move expeditiously to integrate low-dose computed tomography lung cancer screening into the VA health-care system.

National Cancer Institute Trial Validates LDCT Screening Reduces Lung Cancer Mortality

On July 29, 2011, the results of an eight-year National Lung Screening Trial (NLST) were published in the *New England Journal of Medicine*. The study found that the 53,000-person randomized controlled trial had proven definitively that screening a population at high risk (55–74 years of age with a 30-pack/year history) for lung cancer with low dose computed tomography (LDCT) scans results in 20 percent fewer deaths than screening with chest X-rays. To put this in context, the overall mortality impact of mammography screening for breast cancer is 15 percent. Prostate-specific antigen screening for prostate cancer showed a 20 percent difference in European trials but failed to show a benefit in the U.S. trial. This is the most significant advance in the history of lung cancer and lung cancer screening. Currently, the five-year survival rate for lung cancer remains only 15 percent.

The number of lung cancer deaths in those screened by CT scans is significantly lower than in those screened by chest X-rays.

The NLST results also indicated that deaths from all causes were 7 percent lower in the CT arm, indicating that CT scanners could be diagnosing heart and other lung diseases, as well as lung cancer, at an early, treatable stage. Given the improvements in imaging and imaging protocols that have occurred since the launch of the NLST, the actual mortality

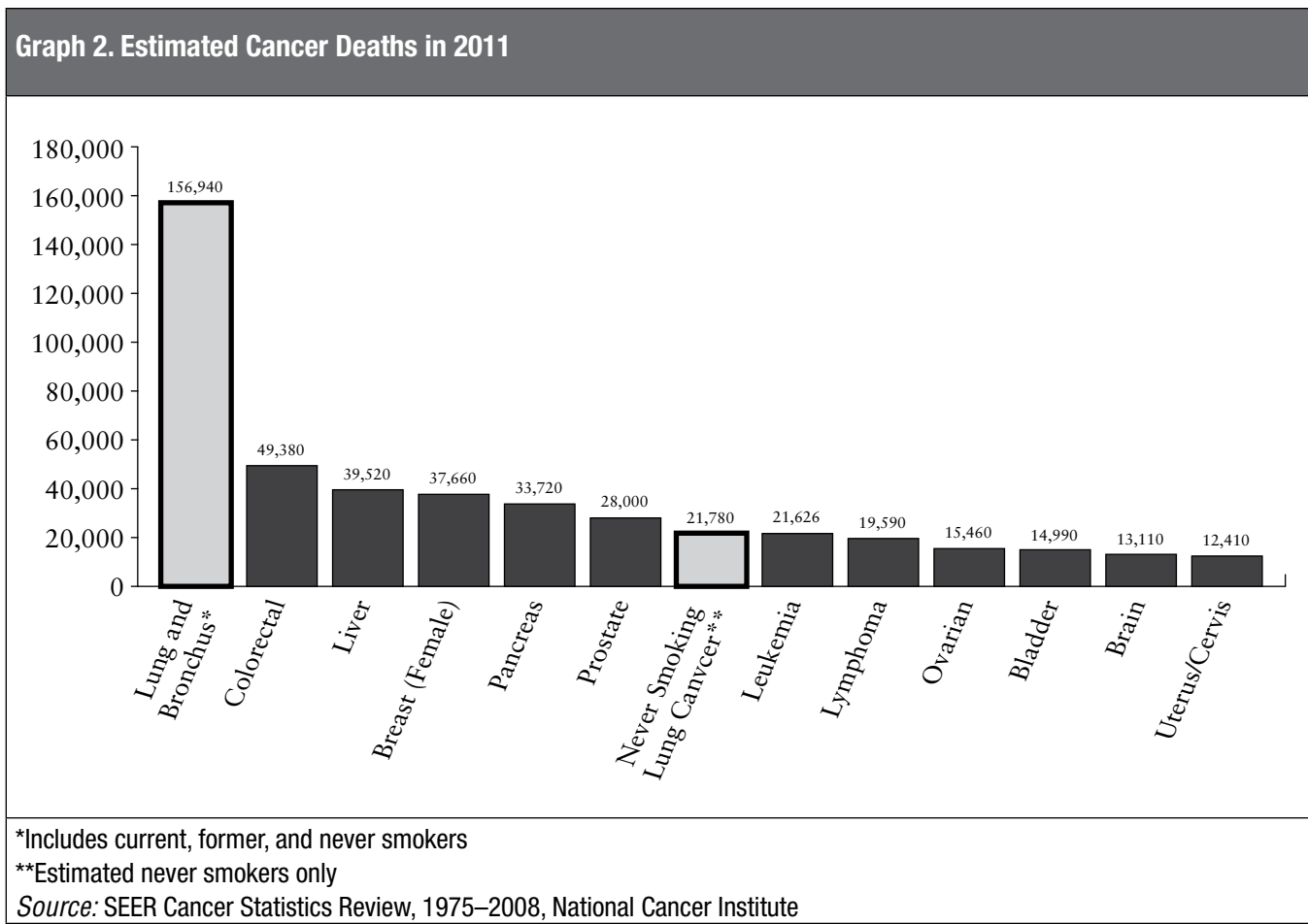
benefit of LDCT screening could reach 50 percent or more. This would track the growing body of evidence from other national and international studies, including the International Early Lung Cancer Action Program, which has pioneered CT screening research since 1993.

Since lung cancer takes more lives than breast, prostate, colon, and pancreatic cancers combined, the impact of a 20 percent reduction in lung cancer deaths will be profound. A recent study published in the *Journal of Clinical Oncology* estimates that the incidence of lung cancer will increase by 52 percent over the next 20 years.

Impact on Veterans

Studies spanning wars from WWII to Korea, Vietnam, and the Gulf have indicated that veterans are at significantly higher incidence and mortality risk for lung cancer than the civilian population. The Department of Defense routinely distributed free cigarettes and included cigarettes in K rations until 1976 and still makes cigarettes readily available at reduced rates. The 1997 Harris Report to the Department of Veterans Affairs documented a higher prevalence of smoking and carcinogenic exposure among the military, with estimated costs to VA and TRICARE of billions of dollars per year.

Asbestos, Agent Orange, Gulf War battlefield emissions, fumes from burn pits and other toxins are some carcinogenic factors adding to the overall exposure burden. A 2004 report by the Health Promotion and



Disease Prevention (HPDP) program of the Institute of Medicine, titled “Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer,” concluded that the presumptive period for lung cancer is 50 years or more.

Vietnam Veterans

More than one-third of living veterans are from the Vietnam era. More than 70 percent of Vietnam veterans ever smoked, twice the civilian ever smoked rate of 35 percent. The disparate impact of lung cancer among Vietnam veterans was first noted in a study by the VA in 1988 (“Proportionate Mortality Study of U.S. Army and U.S. Marine Corps Veterans of the Vietnam War, P. Breslin et al, *Journal of Occupational Medicine*, Volume 30, Number 5, May 1988) The data indicated that former Marine ground troops in Vietnam died of lung cancer at a 58 percent higher rate than marines who did not serve in the war. In 1994 VA conceded that all veterans diagnosed with lung cancer who served in country between 1962 and

1975 are automatically entitled to full compensation with no limit on the presumptive period.

Gulf War Veterans

Gulf War veterans are already showing a higher risk of lung cancer, which was the only cancer to evidence excess risk in a study published in the *Annals of Epidemiology* in 2010. The 2004 HPDP report on Gulf War exposures to carcinogens confirmed the association with lung cancer and the update report in 2008 assigned “high priority” to continued review.

Afghanistan and Iraq Veterans

In September 2011, a study published in the *Journal of Occupational and Environmental Medicine* found that many soldiers returning from Iraq or Afghanistan have a newly recognized condition—Iraq/Afghanistan War Lung Injury IAW-LI—which requires lung function testing. The higher smoking rate among those personnel (35 percent) could not alone explain IAW-LI, which researchers said could be caused by inhaling sharp and coarse dust grains,

Graph 3. Cancer Screening Comparison



Source: Lung Cancer Alliance

toxins, and allergens in the polluted combat environment and smoke from open burn pits and incinerated plastics.

VA and Lung Cancer

Lung cancer usually takes decades to develop. While it may have been initially triggered during service under the DOD, the burden of treatment falls heavily on VA for those veterans who receive care under the VA health system. Without screening, more than 70 percent of lung cancer cases are being diagnosed at late stage when lung cancer is twice as costly to treat as early stage and invariably unsuccessful. The DOD routinely provides chest X-rays as part of discharge physicals. However, military personnel at high risk for lung cancer because of smoking history and/or active duty exposure to carcinogens should be given LDCT scans upon release from duty by the DOD. Having these baseline scans included in electronic health records will facilitate the early detection of lung cancer.

The highly credited Veterans Health Information Systems and Technology Architecture (VistA) already includes the DICOM protocol utilized for CT scans. In addition, VA has the equipment and imaging capacity, as well as the multidisciplinary diagnostic and treatment teams needed to institute screening. Following a review by the Office of Quality

and Performance last year, a lung cancer consortium within VA is already taking steps to improve its quality management and timeliness of care for lung cancer. This is the opportunity to incorporate the best standards and guidelines for LDCT screening so this life-saving benefit can be offered to at-risk veterans as quickly, efficiently, and cost-effectively as possible.

Recommendation:

VA should initiate low-dose computed tomography screening programs based on the International Early Lung Cancer Action Program protocol at selected sites in order to bring the benefits of screening immediately to veterans at high risk for lung cancer and to enable VA to develop a rigorous, efficient, and cost-effective regimen tailored to the needs of the VA system.

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Women Veterans

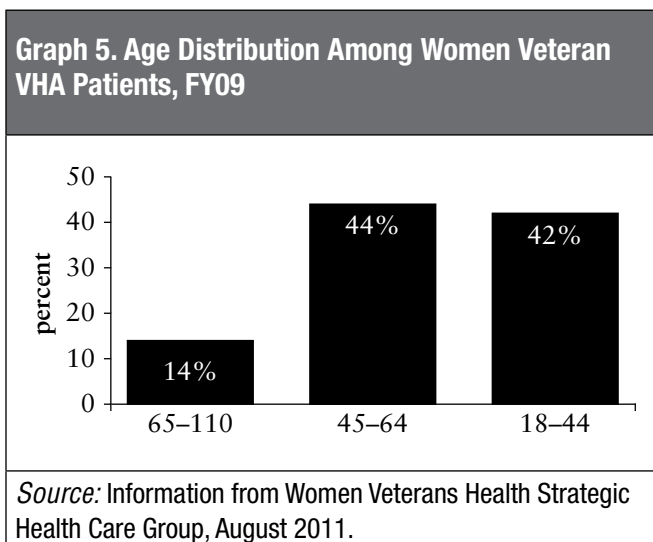
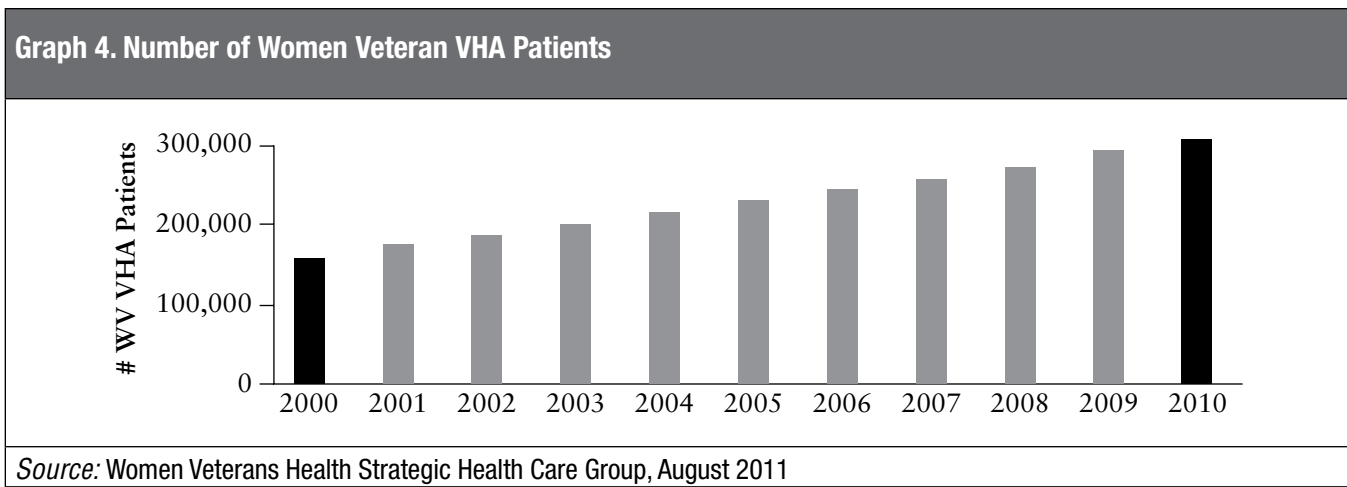
WOMEN VETERANS' HEALTH AND HEALTH-CARE PROGRAMS:

Availability and quality of health care for women veterans still vary widely across the VA health-care system. Although progress is evident, women veterans continue to experience inequity in both quality and services.

More than 1.8 million women are veterans of military service. Today women make up more than 15 percent of our active forces and constitute 18 percent of the National Guard and reserve components—and altogether they account for 20 percent of new military inductees. Over the past decade, their military roles and responsibilities have been broadened and the number of women serving has risen significantly.¹⁷¹ As these women leave the military and transition into civilian life we also see a rising trend

in their enrollments into and utilization of services from the Department of Veterans Affairs, including VA's health-care system, the Veterans Health Administration (VHA).¹⁷²

Between FYs 2000 and 2010 the number of women veterans as VA patients has doubled from approximately 150,000 to more than 300,000. VA projects that, by 2020, women will constitute 10 percent of the overall veteran population and make up 9.5



percent of VHA's patients.¹⁷³ Women who have served in Operations Enduring and Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND), our long-running military deployments in Iraq and Afghanistan, have added more than 80,000 women to the VHA system over the past decade¹⁷⁴—and approximately 50 percent of this group of women veterans has enrolled in VA health care.¹⁷⁵ VA reports that women veterans who use the VA health-care system are more likely to have a service-connected disability than their male counterparts—55 percent compared to 41 percent, and women patients also require more frequent health-care visits than men.¹⁷⁶

There has also been a shifting age distribution in women veterans enrolling in VA health care over the past decade.¹⁷⁷ This changing demographic clearly evinces implications for both policy and clinical

practice in the VA health-care system—specifically, *The Independent Budget* veterans service organizations (IBVSOs) agree that VA must continue to increase capacity in women's clinical services and ensure VA health providers are trained and competent in women's health and can provide high-quality care to their female patients. Since more than half of women veterans under VA care are service-disabled, and among that group many young women are in their childbearing years, VA must reallocate resources and ramp up specialized training to be prepared to provide women lifelong and specialized care as high-priority VA beneficiaries.¹⁷⁸

Choosing an Appropriate Health-Care Model for Women Veterans

Three years ago, a specially convened VA internal workgroup concluded that with the significant increase of women veterans turning to VA for care, establishment of coordinated models of service delivery was warranted to meet this population's needs. The group further noted that while women will always remain a minority group in an overwhelmingly male VA system, they represent a critical mass whose needs must be addressed in focused service delivery and improved quality of care.¹⁷⁹ VA recently announced a goal to change its institutional culture to be more accepting and understanding of women veterans and their unique needs and to ensure every woman veteran has access to proper and accessible care of high quality. The IBVSOs acknowledge the need for that culture change and urge VA to redouble its efforts to begin to achieve it.

The IBVSOs are pleased that many of the recommendations made in the FY 2012 *Independent Budget*

are being addressed by VA through steady implementation of its own recommendations put forth in the groundbreaking publication, *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*. This report was published in November 2008 and released in 2009. The report has been subject to strong Congressional oversight and close monitoring by our organizations and others. As directed by the VA Under Secretary for Health, the women's primary care workgroup had been charged with defining the actions necessary to ensure that every woman veteran gained access to a VA primary care provider who was competent to meet all her primary care needs. The workgroup reviewed the current organizational structure of the VHA's women's health-care delivery system, uncovered impediments to delivering that level of high-quality care in the VHA, identified current and projected needs, and then proposed a series of recommendations and actions for the most appropriate organizational initiatives that would achieve the Under Secretary's goals.

The most pressing challenges the workgroup identified in its report include:

- developing the appropriate health-care model for women in a system that is disproportionately male oriented;
- increasing numbers of women enrolling in VA care;
- addressing the impact of changing demographics of women in VA care; and
- eradicating the well-recognized gender disparities in VA quality of care for women veterans versus men.

The IBVSOs are pleased with the thoroughness of this report, and with the optimism of its recommendations to improve women's health. We are also pleased with VA's five-year strategic plan for women's health and its measurable progress in implementing many of the report's recommendations to date, to ensure that:

- women veterans receive coordinated, comprehensive, primary care at every VA facility from clinical providers who are trained to meet their needs;
- mental health is integrated with women's primary care in each clinic that treats women;

- innovation is promoted in women's health programs;
- capabilities of all staff interacting with women veterans in VA health-care facilities are enhanced; and
- gender equity is achieved in the provision of clinical care within VA facilities.

To enhance the skills of its primary care providers, VA reports that it continues to conduct two-and-a-half days of case-based learning and hands-on training in "mini-residency" training sessions on women's health. As of September 2011, 1,100 providers had been trained in these sessions and methods.¹⁸⁰ The IBVSOs concur that this type of training is essential to providing comprehensive primary and gender-specific care for women veterans and we urge VA to accelerate, refine and supplement its mini-residency training with basic, advanced, and continuing education modules for these providers to ensure all clinicians providing care to women are trained and maintain their clinical competence in treating women in primary care.

Redesigning VA Primary Care for Women

Although steady progress is evident, unfortunately, availability of specialized services and quality of care for women veterans still vary widely across the VA health system, resulting in inequity for women. Today, without further improvements, women veterans cannot be confident that their health-care needs will be consistently met by VA.

The IBVSOs remain concerned about the self-determined fragmentation of care and disparities in care that exist for women in VA health care. According to VA, 51 percent of women veterans who use the VA system divide their care by using both VA and non-VA providers. Additionally, a substantial number of women veterans receive VA-authorized care in the community via fee-basis and contract out-placements and referrals. Women's health researchers have noted that little is known about the quality of that VA-purchased care.¹⁸¹ For these reasons, we believe additional studies are needed to evaluate the overall quality of care delivered to women veterans. Employing the results of this research evaluation, VA should focus on developing a new model of care that takes into account both a comprehensive, fully integrated primary care model, and incorporates specific

case management and care coordination programs for women veterans.

The IBVSOs are particularly concerned for the well-being of women who use VA fee-basis or a combination of VA and private care, and exhibit comorbid mental health conditions. These patients need specific care coordination to ensure they receive quality care. VA women's health researchers have evaluated differing models of care and determined which approaches deliver quality care and higher patient satisfaction. Results clearly indicate that women veterans are significantly more satisfied with providers who are knowledgeable about women's health, especially when care is provided in a gender-specific clinic, than they are with care in mixed-gender primary care settings. When asked the question of provider gender as a factor in satisfaction with care, women responded with a preference for a provider with expertise in women's health, male or female. However, the highest satisfaction ratings were reported when providers reflected the characteristics of primary care/women's health expertise and female gender.¹⁸² Given these findings, the IBVSOs strongly support VA's initiative to provide training to VA clinical staff of both genders to increase their expertise in women's health care. VA also needs to increase its efforts to identify, recruit, retain, and educate clinicians of both genders who are proficient and interested in treating women veterans. The IBVSOs urge VA to employ and train at least one clinician provider with women's health-care expertise at each VA medical center and community-based outpatient clinic and more when warranted by workload demand.

We are pleased to note that VA is adapting a new model of health-care delivery, patient-aligned care teams (PACTs) based on the patient-centered medical home model. This integrated model of care, which incorporates mental health providers, pharmacists, case managers, and other health-care professionals into the primary care team, has already been implemented in many VA primary care clinics. We believe the adaptation of the PACT model, combined with concepts emerging in comprehensive primary care for women veterans, brings promise to enhancement of integrated primary care, specialty care, and readjustment and mental health services for women veterans. These new models of care are critical to eliminating the fragmentation of care for women veterans and in reducing the disparities in care that researchers and external reviewers have observed.

Women veterans are often the principal caregivers in their families and extended families and routinely put off maintaining their own health and well-being. Therefore, VA health-care providers need to become sensitive to the significant health-related barriers women face, particularly when they are unmarried employed heads of households, parents, and caregivers of other family members. Last year the IBVSOs recommended that VA develop a pilot program to provide child care services for veterans who are the primary caregivers of children while they receive intensive health-care services for post-traumatic stress disorder (PTSD), mental health, and other therapeutic programs requiring privacy and confidentiality. We were pleased that when Congress enacted P.L. 111-163 it mandated such a pilot program. VA established free drop-in child care pilots at three VA medical centers in Northport, New York; Tacoma, Washington; and Buffalo, New York. According to VA, these pilots will operate for two years and then will be evaluated.¹⁸³ We are hopeful these pilots will be successful since numerous prior surveys of women veterans have clearly documented that the absence of a VA child care resource is a continuing and significant barrier that prevents access to VA care.

Another provision in P.L. 111-163 that is extremely important to women veterans required the Department to furnish reimbursement for post-partum health-care services for the newborns of women veterans enrolled in VA who are receiving maternity services. The IBVSOs are pleased that VA reports the policies and procedures for newborn reimbursement are fully developed and operational under a fee-basis arrangement and that VA is monitoring data on these services.

Quality—Privacy and Safety Policies

VA Report Card—Gender-Specific Quality

According to the 2010 VHA "Facility Quality and Safety Report Card," the quality of care provided to women is considerably higher in the VA health-care system than the private sector for many gender-specific and gender-neutral measures. VA noted that VA screening for breast and cervical cancer substantially exceeded that in other settings, including privately managed health-care systems as well as in Medicare and Medicaid. Despite these positive results, VA acknowledges a challenging and persistent gap in the quality of care in several measures separating men and women veterans under VA care, including testing rates for LDL cholesterol control for at-risk

and nonrisk populations. In addition, VA notes that rates of prevention measures including those for vaccinations, colorectal cancer testing, and depression screening continue to be lower in women veterans, although considerable variation was found in the magnitude of these differences across the Veterans Integrated Service Networks (VISNs) and individual medical facilities. On a positive note, VA reports that some historic disparities between women and men are shrinking—for example, the difference in influenza vaccine administrations between men and women is now only 1 percent.

VA reports that gender-related gaps in care have also been recognized in private sector health-care systems and that the VHA has been striving to understand and close these gaps for women veterans by specifically examining patient, provider, and systemic organizational factors that might influence how care is being provided to women veterans.¹⁸⁴

The IBVSOs are pleased that VA has taken the initiative of adding women's health outcomes to performance plans of VA medical center executives. Although this is a positive step forward, in order to ensure transparency of the process with the goal of the highest quality of care, veterans and other stakeholders must gain access to reported performance as measured against this new standard. The IBVSOs believe that VA should provide regular quarterly performance reports by facility and VISN. In fact, we believe all executive, facility, and VISN performance data that affect direct patient care should be stratified by gender and reported in an accessible, public, and transparent manner.

Teratogenic Agents Pose a Risk for Young Women Veterans in VA Care

A significant majority of women veterans enrolled in VA health care are predominantly of child-bearing age; therefore, they are at risk for potential exposure to teratogenic agents (these substances can cause developmental deformities, fetal death, and major birth defects in newborns of mothers who are exposed during pregnancy). Exposure to well-recognized teratogenic agents in VA environments must be addressed as a critical VA health-care quality and patient safety issue for young women veterans. VA health-care providers should routinely question young women about pregnancy status and their reproductive plans, and become more knowledgeable about minimizing teratogenic exposure risks for young women patients on

an equal footing with health promotion, disease prevention and intervention, and current trends emerging in women's health and treatment regimes. Likewise, VA health-care providers and facility managers and executives should make every effort to reduce young women's unnecessary exposure to radiation, known pharmaceutical teratogens, pesticides, herbicides, and other chemicals that produce these dangerous risks to young women (including VA employees and visitors). VA should facilitate providers' ability to identify such compounds associated with an increased risk of birth defects and revise VA's automated polypharmacy module to provide women's caregivers alerts for potential teratogens that are unknowingly prescribed to women veterans younger than 50 years of age. The IBVSOs are disappointed to learn that a planned information technology solution that could resolve this issue for VA providers and young women veterans is to date still not implemented. We urge VA to use interim measures to ensure safety of young women veterans until the technology solution is implemented and installed nationwide. Equally critical is that every VA facility should have the ability to obtain an urgent beta-HCG pregnancy test so that informed health-care decisions can be made swiftly without endangering a veteran or her fetus. In addition, women veterans should be offered a sexual function and safe-sex practices screening annually.

In 2010, the Government Accountability Office (GAO) found that some VA facilities' self-reported compliance levels in response to VA directives dealing with privacy, safety, and other accommodations for women did not match the actual conditions the GAO sampled during its VA facility site visits. The GAO and the IBVSOs conclude that VA's reliance on self-reported, unaudited facility and network information on these questions of privacy and safety does not provide sufficient assurance that facilities are actually in full compliance. Therefore we suggest that VA improve its oversight of compliance with these directives concerning women's privacy, dignity, sense of security, and safety considerations. All VA facilities should be obligated to accommodate and support women veterans in safe and secure sleeping, bathing, and restroom arrangements, including routine use of locked doors, installation of "panic buttons," availability of VA police officers, and physical proximity to VA staff members, among other protections for women who may be vulnerable. For these reasons, VA should continue to deploy regional inspection teams to VA facilities to ensure compliance and

standardization of requirements listed in the newly revised VHA publication, “Handbook on Health Care Services for Women Veterans.” Ongoing objective program assessments are needed to ensure that all aspects of VA’s women’s health programs are implemented fully and equitably at each VA medical center according to the handbook. Also, significant improvement to facility infrastructure planning needs to be made a higher priority in each VISN so that VA will be positioned to better serve women today and also be prepared for the projected growth in VA women’s health workloads in the near future.¹⁸⁵

Mental Health: PTSD and Post-Deployment Readjustment Issues for Women

VA Mental Health Services and Women Veterans

According to VA, 37 percent of women veterans using VA outpatient services used mental health services in 2009. Twelve percent of these women had more than six mental health visits in any year.¹⁸⁶ According to the Office of the VA Inspector General, the percentage of OEF/OIF/OND veterans now enrolled in the VA health-care system is historically high compared to prior military service eras—and among VA-enrolled OEF/OIF/OND veterans, 51 percent have received a mental health diagnosis. Rates of post-deployment-related post-traumatic stress disorder (PTSD) and depression have also risen as a result of the nature of contemporary warfare and multiple deployments for many service members.¹⁸⁷ Studies have shown that women present unique symptoms when it comes to PTSD and are more likely to have psychological reactivity to trauma cues, a startle response, restricted affect, depression, and an avoidance of trauma cues. Women may also be more likely to present with the specific comorbidities of depression, panic disorder, eating disorders, and somatic complaints. In the case of treating women with PTSD, research studies and clinical experience have shown that women may develop chronic PTSD and may have slower recoveries but may be more likely to seek treatment for their problems. The treatments noted for being most successful in PTSD include cognitive behavioral therapy with a combination of psychotherapy and pharmacotherapy, prolonged exposure, cognitive processing therapy, and family therapy.¹⁸⁸ VA notes that women who use VA mental health services tend to make more visits compared to men, suggesting that mental health care for women often requires more high-intensity services.¹⁸⁹

Military Sexual Trauma— Not Only a Women’s Issue

All veterans coming to VA for care are screened for military sexual trauma (MST). According to VA, 22.4 percent of women and 1.2 percent of men seen in VA health care in 2010 reported having experienced military sexual trauma. However, the size of each clinical population in VA reporting MST is nearly equal at 58,733 women and 49,388 men.¹⁹⁰

Across a range of studies, veterans with histories of MST report more mental health problems, such as depression, anxiety, and substance-use disorders, as well as more physical symptoms and health problems.¹⁹¹ In a 2010 report, the Government Accountability Office (GAO) identified an issue regarding lack of communication between directors of mental health and MST residential and inpatient programs. One clinician noted that in the first year of one of VA’s specialized MST trauma programs, space was available for additional patients; however, patients in the region were being referred to distant facilities because area VA providers were unaware of the existence of the local program.¹⁹²

Likewise, the GAO found that many veterans appeared to be unaware of VA’s specialized programs and treatment options for MST. VA has stated that one of its goals is to transform the agency to serve veterans more efficiently, yet complaints were reported that VA’s website was difficult to navigate and did not provide information about the specialized treatment programs available. In response to these concerns, VA officials noted that it was preferential for a woman veteran to contact the Women Veterans Program Manager (WVPM) or MST coordinator at her local facility to get help in identifying treatment needs. However, the GAO found that contact information for WVPM or MST coordinators was either missing or hard to find on most of the facility-specific web pages.

Since the report was issued, VA has reported that it has developed a number of initiatives to address these concerns, including:

- establishment of a new MST homepage on the VA internet (www.mentalhealth.va.gov/msthme.asp);
- a systematic review of VA national websites to ensure that information about services and

programming specific to MST is more widely available to veterans;

- a national review of the accessibility of MST coordinators; and
- development and distribution of new educational handouts, MST posters, and brochures to educate veterans about VA services, to normalize symptoms associated with sexual trauma, and to highlight the availability of effective treatments.

While VA has established a specific web address for MST programs, the IBVSOs still find it difficult to navigate to the page from VA's home page. Additionally, contact information on a WVPM or MST coordinator could actually offer assistance is still not available. We encourage VA to reevaluate the site to make it more user-friendly and to ensure basic information on how to get help is up listed up front. Given the sensitive nature of this issue and the general reluctance of victims of sexual trauma to come forward and ask for help, VA may want to consider establishing a unique 1-800 number for MST survivors.

VA reports it has established a number of other initiatives to assist MST coordinators in increasing their visibility within their facilities and improving veterans' ability to access MST-related services. For example, according to VA, the MST Support Team has produced a variety of resources—such as “tip sheets,” posters, handouts, and contact cards—providing suggestions and practical tools MST coordinators can use to publicize their names and contact information throughout their facilities. Emphasis has been placed on the importance of ensuring this information is available at key entry and access points (e.g., telephone operators, information desks, clinic clerks, facility websites).

The IBVSOs are pleased with the progress VA has made in this regard and are hopeful that the increased attention on MST-related information encourages veterans to have more informed conversations with VA staff about available services, benefits, and treatment options.

Other challenges uncovered by the GAO were that VA facilities are still having problems hiring providers with the specialized training and experience needed to provide services to veterans suffering after-effects of MST and that VA lacks clear guidance on the appropriate training for providers who treat survivors of MST.

Since the 2010 GAO report, VA indicates it has taken a number of steps to address this issue. The Office of Mental Health Services (OMHS) currently has a number of initiatives designed to disseminate evidence-based practices for several conditions associated with MST, including PTSD, anxiety, and depression. According to mental health experts, a significant period of training and subsequent work with a mentor are essential for MST therapists to develop and hone the appropriate skills and understanding of evidence-based therapies and other techniques that are required to effectively treat this often challenging and complex patient cohort. We are pleased to learn that structured and comprehensive evidence-based training modules for treatment of PTSD, depression, and anxiety disorders and family counseling are currently available to all mental health providers. The clinician's training module for evidence-based practices is comprehensive and includes a two-to-four-day workshop and an ongoing structured mentoring program to build mastery of these specialized techniques. However, the OMHS agrees that a working knowledge of the special challenges MST survivors may face in recovery can help further tailor care to each veteran's particular needs. The IBVSOs are pleased to know that VA is seeking to implement a national mandatory training requirement for all mental health and primary care providers to ensure all have baseline knowledge of issues important to their work with veterans who experienced MST.

Provisions in Section 202 of P.L. 111–163 required VA to train and certify mental health providers on screening and treatment for veterans suffering from conditions related to MST and PTSD. VA reports that a two-hour mandatory training module for mental health clinicians has been developed and is available on the VA's Talent Management System website. A half-hour training focused on issues specific to providing primary care services to veterans who experienced MST is also currently available for the use of VA staff.

We understand that all MST coordinators have completed the mental health training but that there are administrative issues to be worked out with respect to mandating completion of the training for all mental health and primary care providers. The IBVSOs urge VA to resolve these issues as quickly as possible to ensure all providers complete the mandatory training.

With the upcoming mandatory trainings and increased attention to this issue, the MST coordinator position is becoming more and more important, making it crucial to ensure they have dedicated time to fulfill their responsibilities. Currently VHA policy specifies that MST coordinators must be given protected time to fulfill the responsibilities of the role and that this protected time should be commensurate with the facility's specific administrative needs related to MST. However, VHA policy does not specify a defined amount of time that MST coordinators should uniformly be allocated for the demands of this role. For this reason, implementation of this protected time requirement remains inconsistent. It is reasonable to expect that MST coordinators at facilities with more sites or with more veterans who have screened positive for MST would need more protected time than MST coordinators at other facilities. The IBVSOs recommend that Congress and the VA Central Office provide oversight of this issue to ensure there is an appropriate way to monitor and ensure that MST coordinators are allotted appropriate amounts of time based on the MST population size and demand at each location.

Women Veterans' Post-Deployment Readjustment Issues

For the first time in history, with the ongoing conflicts in Iraq and Afghanistan, women have been routinely exposed to the dangers associated with a war zone and combat deployments. Women are an integral part of the military's mission, serving as helicopter and jet pilots, truck drivers, medics, military police, civil affairs liaisons, civil engineers, and as part of female engagement teams. With more women serving in combat theaters of operation in OEF/OIF/OND than at any other time in U.S. history, it is critical that VA health professionals gain a clear understanding of the personal experiences and sacrifices of women in today's armed forces, and that specialized programs and services be developed to meet their unique needs post-deployment. Researchers have found that many women veterans need help reintegrating back into their normal lives after repatriating from war. Some women have reported feeling isolated, experiencing difficulties in communicating with family members and friends, and not getting enough time to readjust when they return home. Post-deployment women often complain of difficulties reestablishing bonds with their spouses and children and resuming their role as primary parent or disciplinarian. Women reported they routinely felt out of sync with children

and partners/family members and felt that they had missed so much. Employment concerns were also expressed by women and included financial issues either due to making less money as a civilian than while in the military or about finding employment in the civilian sector that utilized their military skills.¹⁹³

Likewise, researchers found that women experience difficulty finding support systems upon returning home and need additional support from the military and VA to assist them with post-deployment reintegration. While progress has been made, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans fully readjust. P.L. 111-163 included provisions that required VA to conduct a pilot program of group counseling for women veterans newly separated from the armed forces in retreat settings. VA reports that it is now conducting these pilot retreats through its Readjustment Counseling "Vet Center" Service program and that three retreats have been completed to date, with three more planned. VA Vet Center program worked with the Women's Wilderness Institute to develop the locations and agenda for the retreats. We understand feedback from women veterans participating in the retreats thus far has been very positive and we expect the remaining retreats will be very successful.

Another challenge some women veterans are facing in their post-deployment lives is sustained housing. The October 2011 Supplemental Report to the 2010 Annual Homelessness Assessment Report noted that women veterans are at a particularly high risk of experiencing homelessness compared to nonveterans: shockingly, in fact, they are reported to be twice as likely to become homeless. The risk increases significantly for female veterans living in poverty. The IBVSOs find the increasing trend of homelessness among women veterans particularly disturbing, but we congratulate the Secretary of Veterans Affairs on his initiative to end homelessness in the veteran population by 2015 and its successes to date. This comprehensive initiative has led to numerous stand-downs throughout the country over the past several years and appears to be beneficial for many veterans in this situation. However, we urge VA to focus also on the unique needs of women veterans who experience homelessness and to develop specialized services, particularly for women with children. Although VA cannot provide direct service to children, it can

partner with community homeless assistance providers to ensure homeless women veterans are able to find housing that accommodates both them and their children.

Early interventions and access to a full continuum of mental health services, including treatment programs for PTSD, TBI, substance-use disorders, and co-occurring mental health conditions, are essential to avoiding long-term mental health problems, homelessness, and in creating the conditions associated with suicidal ideation. Another troubling finding affecting women veterans is a National Institute of Mental Health five-year research study with the goal of identifying soldiers most at risk of suicide. Findings released in 2011 note that the female soldier suicide rate triples when at war from 5 per 100,000 to 15 per 100,000.¹⁹⁴

The “signature injuries” for the current wars are traumatic brain injury (TBI) and polytrauma injuries involving multiple extremities and/or the brain. According to VA, approximately 8 percent of all polytrauma patients from OIF/OEF are women.¹⁹⁵ For this reason, the IBVSOs also urge VA to concentrate on improving services for women with serious physical disabilities such as spinal cord injury, burns, traumatic brain injury, amputations, and blindness. The physical space and size of examination rooms, the need for specialized equipment, the overall setting, and safety issues should also be evaluated against women’s needs throughout the VA health-care system. The IBVSOs are pleased with the work of the Women’s Prosthetic Workgroup, which is evaluating all items in VA’s Prosthetic and Sensory Aids Services to ensure all routine and specialized items and gender-specific items are available to women veterans who are amputees or need other custom prosthetic or orthotic appliances.

Given the unique post-deployment challenges women veterans face, VA should evaluate all VA’s specialized services and programs, including those for polytrauma rehabilitation and transitional services, substance-use disorders, homelessness, domestic violence, and post-deployment readjustment counseling, to ensure women have equal access to these exceptional programs. Likewise, VA researchers should continue to study the impact of war and gender differences on medical and mental health post-deployment to determine the best models of care, rehabilitation,

and treatment to address the unique needs of women veterans.

Women Veterans Program Managers

The IBVSOs are pleased the Women Veteran Program Manager (WVPM) position was made a full-time position at all VA medical centers several years ago. These managers fill a critical role in implementing VHA women’s health policy and programs, providing increased outreach to women veterans, improving quality of care, and developing best practices in the delivery of care to women veterans throughout the VA health-care system. We are pleased to learn that most (144) VA medical centers have implemented the full-time WVPM position as envisioned; however, we still have a number of concerns based on the 2010 GAO report and urge Congress to maintain oversight of this important issue.

In the March 2010 GAO report on women veterans, some WVPMs noted their ability to effect changes to improve care for women veterans had been limited by lack of authority to directly exercise their judgment or report directly to senior facility leadership to discuss key priorities they had identified. In certain cases, efforts to expand or make changes to improve gender-specific services for women were denied, even when supporting evidence highlighted the need for change. At the time of this writing, we continue to receive information about ongoing leadership issues and persistence of a VHA culture that sometimes fails to fully value women’s health programs. For these reasons, we urge Congress to monitor full-time WVPM positions throughout the system to ensure these positions are maintained. Additionally, we suggest annual hearings be held to gain insight from women veterans themselves about access to VA services and programs, satisfaction with care, and perceived barriers or gaps in services.¹⁹⁶

Additionally, we suggest that a full-time WVPM should also be present at every large multispecialty VA community-based outpatient clinic and an alternate WVPM position be formally assigned to cover responsibilities at a facility when the primary WVPM is unavailable, to ensure continuity of services and care. Furthermore, each Veterans Integrated Service Network should appoint a lead WVPM who is involved in VISN-level leadership committees and planning.

The Way Forward

Overall, we are pleased with the progress that has been made over the past several years and we laud VA's goals for transforming its women's health programs and services. It is appropriate and timely that the VA Women's Health Program office is leading a VA-wide initiative to improve communications to and about women veterans with the goal to change the language, practice, and culture of VA to be more inclusive of women veterans. We are also pleased to see the establishment of a women veterans' task force to explore how VA can better serve women. Another positive step is VA's intended women's outreach initiative, with a goal to telephone every woman veteran to increase her knowledge about services and benefits and expand women veterans' enrollment into and use of the VA health-care system. We also congratulate VA on its Women's Health Evaluation research initiative, which has furnished and continues to provide vital data on current demographics and women veterans' use of VA care, and the short- and long-term effects of military service on women veterans, especially our newest generation of war veterans.

Summary

Although there are still a number of gaps in the system related to women's health services, the IBVSOs acknowledge that VA has made measurable progress on many of the recommendations and action items listed in its *Provision of Primary Care to Women Veterans* report. VA fully recognizes that the population of women veterans is undergoing exponential growth and that the culture of VA needs to be transformed now to provide high-quality health-care services to women veterans at all care sites.

We urge VA to step up its efforts to adapt to the changing demographics of its women veteran patients—taking into account their unique characteristics related to their military experience as war veterans and as young working women, many with both child care and elder care responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care become equal between women and men. Advent of VA's PACT model may present special challenges for women's care in VA and thus VA needs to pay special attention to ensure the new PACT approach does not diminish progress VA has steadily made in women's health.

We see the need for VA to reevaluate its programs and services for women veterans and to increase attention to a more comprehensive view of women's health beyond reproductive health needs to include heart disease, breast, colorectal and other cancers, and osteoporosis. A plan should be established that addresses the increased overall demands on ambulatory care, access to after-hours or urgent care, hospital and long-term care, gender-specific services, and mental health programs, recognizing the unique and often complex health needs of women veterans. Mental health integration into primary care is also essential for provision of comprehensive women's health care.

Implementation of full-time WVPs in every VA medical center and all large multispecialty community-based outpatient clinics, training to increase staff knowledge of the state of the art in women's health, and mental health care and treatment should be fully realized this year. Women should have access to comprehensive primary care services from competent providers, including gender-specific care, at every VA facility, or direct access to services in the community when warranted. The IBVSOs also recommend that VA continue to focus on its women's health research agenda to specifically tailor its strategic planning initiatives, policy and program planning, as VA develops new ways to deliver care to women veterans.

Recommendations:

VA should enhance its programs to ensure that women veterans receive high-quality comprehensive primary care services (including gender-specific care) in a safe and sensitive environment at every VA health-care facility.

VA should redesign and implement an appropriate health-care delivery model for women veterans and establish an integrated system of health-care delivery that covers a comprehensive continuum of care.

VA needs to ensure that every woman veteran gains and keeps access to a qualified, concerned primary care physician who can provide gender-specific care for all basic physical and mental health conditions prevalent in women veterans.

Using the patient-aligned care team model, and to improve the quality and continuity of care, VA should establish collaborative approaches for women who use a combination of VA and VA-authorized contract and fee-basis care. Systems should be put in place to coordinate care to ensure continuity, quality, safety, and patient satisfaction.

VA should adopt a policy of transparent information sharing and initiate quarterly public reporting of all quality, access, and patient satisfaction data, including a report on quality and performance data from VA facilities stratified by gender.

VA should continue its program to educate all VA employees about the contributions of women veterans and their unique health-care needs and preferences. VA efforts to transform the internal culture of VA that obstructs integration of women as equals should be accelerated, measured, and reported.

VA should make every effort to reduce unnecessary exposure of women of childbearing age to radiation, chemical, and pharmaceutical teratogens; identify compounds associated with an increased risk of birth defects, fetal exposure, injury, and death; and immediately revise polypharmacy software to provide alerts and protections for potential teratogens prescribed to women veterans under 50 years of age.

VA should enhance its military sexual trauma treatment programs by mandating consistent, sufficient, and continuing training of health-care personnel across primary care and mental health disciplines and disseminating evidence-based clinical practice guidelines to clinicians who care for veterans with a history of military sexual trauma.

VA should monitor and report on its pilot program to provide child care services for veterans who are the primary caregivers of children while they receive treatment for post-traumatic stress disorder and other mental health services requiring privacy and confidentiality.

VA should concentrate on improving services for women with serious physical disabilities and evaluate all of VA's specialized services to ensure women have equal access to these programs and receive responsive services and support to help them properly rehabilitate.

VA should reform its capital investment planning and construction design guidelines to include criteria and standards to ensure that new construction projects and ongoing maintenance efforts in VA facilities meet privacy, dignity, safety, and security standards for women patients, visitors, and staff.

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¹⁷²Donna Washington, *National Survey of Women Veterans*, PowerPoint presentation (March 31, 2011).

¹⁷³Department of Veterans Affairs, Press Release, "VA Creates Women Veterans Call Center" (July 7, 2011). <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2129>.

¹⁷⁴Department of Veterans Affairs, Veterans Health Administration, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, "On the Frontlines of VA Women's Health" (Washington, DC: August 2011).

¹⁷⁵Lucille Beck, Chief Consultant, Rehabilitation Services, Office of Patient Care Services, Veterans Health Administration, Department of Veterans Affairs, Testimony before the U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Health, Hearing, "Caring for Severely Injured OEF/OIF Veterans and Service members" (July 22, 2010).

¹⁷⁶Department of Veterans Affairs, Veterans Health Administration, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, "On the Frontlines of VA Women's Health" (Washington, DC: August 2011).

¹⁷⁷Department of Veterans Affairs, Veterans Health Administration, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, Sourcebook: Women Veterans in the Veterans Health Administration, Vol. 1: Sociodemographic Characteristics and Use of VHA Care. Executive Summary Key Findings (Washington, DC: December 2010).

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¹⁷⁹Department of Veterans Affairs, Veterans Health Administration, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans* (Washington, DC: November 2008), 6, 15.

¹⁸⁰Department of Veterans Affairs, Veterans Health Administration, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, *On the Frontlines of VA Women's Health* (Washington, DC: August 2011).

¹⁸¹E. Yano, *Translating Research Into Practice—Redesigning VA Primary Care for Women Veterans*, PowerPoint presentation, DAV National Convention (Las Vegas, NV: August 2008).

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¹⁸³P. Hayes, *Meeting the Needs of Women Veterans*, PowerPoint presentation (September 22, 2011).

¹⁸⁴Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Safety, *2010 VHA Facility Quality and Safety Report* (Washington, DC: October 2010) pp. 6, 22. <http://www.va.gov/health/docs/HospitalReportCard2010.pdf>.

¹⁸⁵U.S. Government Accountability Office, *VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes*, GAO-10-287 (2010).

¹⁸⁶Department of Veterans Affairs, Veterans Health Administration, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, *On the Frontlines of VA Women's Health* (Washington, DC: August 2011).

¹⁸⁷John Daigh, Jr., Asst. Inspector General for Healthcare Inspections, Office of the Inspector General, Department of Veterans Affairs, Testimony before the United States Senate Committee on Veterans Affairs, Hearing, "VA Mental Health Care: Closing the Gaps" (July 14, 2011).

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ENDING VETERANS’ HOMELESSNESS:

If the trend in reducing the number of homeless veterans is to continue, the Department of Veterans Affairs must sustain funding for supportive services and housing, improve prevention strategies aimed toward at-risk veterans, continue collaboration with community partners, and make a variety of additional investments.

The Department of Veterans Affairs, the nation’s largest single provider of homeless treatment and benefits assistance services to homeless veterans, provides health-care services to almost 150,000 homeless veterans each year, and associated services to more than 112,000 veterans in its specialized homeless programs. In association with these programs, VA social workers and clinicians work with community and faith-based partners to conduct extensive outreach programs, make clinical assessments, provide medical treatments, counsel for alcohol and drug abuse, and provide employment assistance and referrals.¹⁹⁷

Generally, three issues are central to veterans becoming at risk for homelessness: health, finances, and affordable housing. According to the National Coalition for Homeless Veterans, veterans face additional hurdles when trying to overcome these personal hardships. When on active duty, they often are called upon to leave their families and social support networks for extended periods of time while engaging in highly stressful training and military operations. For half the men and women called to serve in Operations Enduring and Iraqi Freedom (OEF/OIF), the specter of multiple deployments undermines their ability to fully decompress and reintegrate into society after deployments. Once they leave active duty, the limited transferability of their military skills, the resultant diminished opportunity to develop relationships in the civilian community—often cited as key to future offers of employment—combined with a lack of understanding by civilian employers of what

veterans can do in the workplace, may have a negative impact on finding employment.

Often, particularly for junior enlisted grades, combat-related skills are not readily transferable to the civilian workforce, and many young veterans with families must struggle to pursue training and education that will increase their earning potential. Even for those veterans who are able to increase their earning potential and overcome the other stresses of separating from the military, the downturn in the nation’s economy and housing market collapse since 2008 have created added pressure that can have greater impact on younger veterans than their more established military contemporaries.¹⁹⁸

In November 2009, VA convened a national summit and developed a goal to end veterans’ homelessness in five years through combined efforts of government, business, veterans service organizations, and the private sector. The comprehensive plan that resulted multiplied the weight of VA, its federal agency partners, and hundreds of community- and faith-based organizations that provide housing and supportive services to the nation’s homeless and at-risk veterans. The five-year plan depends on sustained progress on two fronts: the effective, efficient provision of housing and supportive services to homeless veterans and those in recovery programs, and increased availability of preventive measures to enable at-risk veterans and their families to remain in permanent housing.¹⁹⁹

While there is no exact measure of the number of homeless veterans, the following best estimates help define the scope of the intervention and prevention needs of VA homeless programs:

Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report (AHAR) to Congress estimates that on any given night 75,609 Veterans were homeless. An estimated 149,635 Veterans spent at least one night in an emergency shelter or transitional housing program over the course of the year. Many other Veterans are considered at risk because of poverty, lack of support from family and friends and precarious living conditions in overcrowded or substandard housing.²⁰⁰ According to the 2011 supplement to the AHAR, released December 13, 2011, there were 67,495 Veterans who were homeless in the United States on a single night in January 2011.²⁰¹ This is a 12 percent reduction from last year's single night count of 76,329 and another indicator of the positive progress made as a result of the current Administration's effort to end veteran homelessness by 2015.

According to a study conducted by the National Center on Homelessness among veterans, the following was noted:

- Veterans were overrepresented in the homeless population. Among the homeless population, approximately 14 percent of adult males and 2 percent of adult females were veterans. For males, this proportion was about 30 percent greater than the proportion of veterans in the general population, and twice as large as the proportion of veterans in the population living below the poverty threshold. Similarly among the female homeless population, veterans were overrepresented compared to the general population by a factor of two, and by a factor of three when compared to the population living in poverty.
- The number of homeless veterans accounted for approximately 1 percent of male veterans and 2 percent of female veterans in the general population. These rates were higher for veterans identifying as black (4% for males, 5% for females). When looking only at veterans living below the poverty threshold, homeless veterans were 15 percent (regardless of gender) of this population, with this rate increasing to 30 percent when only looking at black veterans living in poverty.
- In multivariable analyses, veteran status was associated with increased risk of homelessness. For instance, after controlling for poverty, age, race, and geographic variation, female veterans were three times as likely as female nonveterans to become homeless, and male veterans were twice as likely as male nonveterans to become homeless.
- In terms of age, across the general homeless population (veterans and nonveterans), males had the highest risk for homelessness in the 45–54 year age group. For females, risk for homelessness was highest among the 18–29 year age group and risk declined as age increased. Black race (compared to all others) was consistently identified as a strong risk factor for homelessness, with little variation across sex.²⁰²

According to VA's five-year plan to end veteran homelessness, six strategic pillars will be built:

- **OUTREACH**—VA will aggressively reach out to and educate veterans—both those who are homeless and those who are at risk of becoming homeless—about VA programs, finding those who are already homeless and those who are at risk for homelessness.
- **TREATMENT**—VA will ensure treatment options are available, whether for primary, specialty, or mental health care, including care for substance-abuse disorders.
- **PREVENTION**—VA will bolster efforts to prevent homelessness. Without a prevention strategy, effectively closing the front door into homelessness, VA will only continue responding after veterans become homeless and therefore continue to manage the problem.
- **HOUSING/SUPPORTIVE SERVICES**—VA will increase housing opportunities and provide appropriate supportive services tailored to the needs of each veteran.
- **INCOME/EMPLOYMENT/BENEFITS**—VA will provide greater financial and employment support to veterans and work to improve benefits delivery for this vulnerable population.
- **COMMUNITY PARTNERSHIPS**—VA will continue expanding community partnerships because success in this venture is impossible without them.²⁰³

VA continues to expand its existing programs and develop new initiatives to prevent veterans from becoming homeless and to aggressively help those who already are by providing housing, offering health care and benefits, enhancing employment opportunities, and creating residential stability for more than 500,000 veterans. This further expansion began in FY 2011 and will continue through FY 2014, subject to the availability of appropriations.²⁰⁴

According to VA, the agency plans to:

- increase the number and variety of housing options, including permanent, transitional, contracted, community-operated, and VA-operated;
- provide more supportive services through partnerships focused on prevention of homelessness, improving employability, and increasing independent living options for veterans;
- improve access to VA and community-based mental health, substance-abuse, and support services.²⁰⁵

More than 40,000 homeless veterans receive compensation or pension benefits annually. Also, VA and its community partners have secured nearly 15,000 residential rehabilitative and transitional beds and an additional 30,000 permanent beds for homeless veterans.

A Government Accountability Office (GAO) report released shortly before publication of this *Independent Budget* demonstrated the challenge and difficulty of veterans' homelessness in the case of women veterans. The GAO reported that VA possesses limited data on their number and needs; homeless women are not always aware of available services; VA is unevenly implementing referrals to emergency shelter until women are admitted into transitional or permanent housing programs; VA facilities have difficulty providing for children of homeless veterans, and VA lacks minimum standards for privacy, safety, and security of women veterans in mixed-gender housing facilities.²⁰⁶ The Senate Veterans Committee is planning hearings on these problems at this writing. We strongly concur with that plan.

VA homeless programs, which number more than a dozen, are varied, and many are models for reaching out to the homeless in the general populace. Some of the programs that are noteworthy for their

effectiveness in caring for this often hard-to-reach population include:

- *Health Care for Homeless Veterans (HCHV) Program* operates at 135 sites, where extensive outreach, physical and psychiatric health exams, treatment, referrals and ongoing case management are provided to homeless veterans with mental health problems, including substance abuse. This program makes assessments and referrals for more than 40,000 veterans annually. In FY 2010, HCHV teams conducted 42,371 initial clinical assessments of veterans nationally. This represents an increase in initial clinical assessments of approximately 5 percent from FY 2009 (40,216) and FY 2008 (40,422). At the end of the second quarter of FY 2011, HCHV teams had conducted 21,404 initial clinical assessments of veterans nationally.
- In FY 2011, HCHV expanded its Contract Residential Treatment Program. This program places a priority on services to homeless veterans transitioning from street homelessness, those being discharged from institutions, and veterans who recently became homeless. Through the end of the second quarter of FY 2011, increased funding levels have enabled HCHV to add 512 new transitional and emergency housing beds, a 25 percent increase in operational capacity from FY 2010.²⁰⁷
- *Domiciliary Care for Homeless Veterans (DCHV) Programs* provide residential care for homeless veterans. DCHVs provide rehabilitation in a residential setting on VA medical center grounds or in the community to eligible veterans who have a wide range of problems, illnesses or rehabilitative care needs which can be helped by medical, psychiatric, vocational, educational or social services. Clinical care is provided by interdisciplinary teams in supportive, therapeutic milieus which foster veterans' functional independence and mutual support. DCHVs provide a 24/7 structured and supportive residential environment as part of the rehabilitative treatment process. There are more than 2,200 beds available through the program at 44 sites. The program provides residential treatment to nearly 7,900 homeless veterans each year. DCHVs provide outreach and referral; admission screening and assessment; medical and psychiatric evaluation; treatment, vocational counseling and

rehabilitation; and post-discharge community support.²⁰⁸

- *Veterans Industry/Compensated Work-Therapy (CWT) and Compensated Work-Therapy/Transitional Residence (TR) Programs* offer structured work opportunities and supervised therapeutic housing for at-risk and homeless veterans with physical, psychiatric, and substance abuse disorders. VA contracts with private industry and the public sector for work by these veterans, who learn new job skills, relearn successful work habits and regain a sense of self-esteem and self-worth. Veterans are paid for their work and, in turn, pay a program fee that is applied toward maintenance and upkeep of the residence. At the end of FY 2010, there were 635 operational beds across 43 programs. Among the approximately 1,000 veterans discharged from CWT/TR programs during FY 2010, 85 percent were homeless upon admission, 87 percent had a substance use disorder and 38 percent of veterans were diagnosed with a serious mental illness (defined as PTSD, other anxiety disorder, schizophrenia, other psychotic disorder, bipolar disorder, major affective disorder and other depressive disorder).²⁰⁹
- *HUD-VA Supported Housing (VASH) Program* is a joint effort between the Department of Housing and Urban Development and VA. HUD provides housing assistance through its Housing Choice Voucher Program (Section 8) that allows homeless veterans to rent privately owned housing. VA offers eligible homeless veterans clinical and supportive services through its health-care system across the 50 states, the District of Columbia, Puerto Rico, and Guam.

From FY 2008 through FY 2011, HUD has allocated funding to local public housing authorities to provide more than 37,000 Housing Choice Vouchers to homeless veterans, while VA has hired dedicated VA case managers to assist homeless veterans in securing and maintaining permanent housing through intensive case management.²¹⁰
- *Stand-downs* are one- to three-day outreach events that provide homeless with a variety of services and allow VA and community-based service providers to reach more homeless veterans. Stand-downs give homeless veterans a temporary refuge where they can obtain food, shelter, clothing, and a range of community and VA assistance. In many locations, stand-downs provide health

screenings, referral and access to long-term treatment, benefits counseling, ID cards, and access to other programs to meet their immediate needs. There were 196 stand-downs held during 2010 that served 44,325 veterans and 7,695 family members of veterans. More than 27,000 volunteers participated in stand-down events.²¹¹

- *Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups)* for veterans brings together consumers, providers, advocates, local officials, and other concerned citizens to identify the needs of homeless veterans and to work to meet those needs. CHALENG is designed to be an ongoing assessment process that describes the needs of homeless veterans and identifies the barriers they face to successful community reentry. In a 2010 report, data were compiled from 19,847 respondents, including 13,432 survey responses that were completed by homeless veterans.²¹²
- *VA's Homeless Veterans Dental Program* has been managing a funded initiative that provides dental treatment for eligible veterans receiving residential service in five of VA's homeless programs, and VA is working to provide dental care to all eligible veterans within this initiative.²¹³
- *Supportive Services for Veteran Families Program* provides grants and technical assistance to community nonprofit organizations to work with veterans and their families in order to maintain them in their current housing. This national program provides grants to nonprofit agencies to provide support services, such as legal aid, rent subsidies, child care, and vocational services. In July 2011, VA awarded grants to 85 community agencies in 40 states and the District of Columbia.²¹⁴
- *National Call Center for Homeless Veterans (NCCHV)*, launched by VA in December 2009, provides homeless veterans or veterans at risk for homelessness with 24/7 access to trained responders. The NCCHV is intended to assist homeless veterans and their families, VA programs, the Department of Defense, and other federal, state, and local partners, and community agencies. Since its inception in March 2010, the NCCHV has assisted more than 38,000 veterans, more than 23,000 veterans at risk, and linked more than 25,000 veterans to VA homeless programs nationwide.²¹⁵

VA, by using its resources or in partnerships with others, has secured nearly 15,000 residential rehabilitative and transitional beds and an additional 30,000 permanent beds for homeless veterans nationwide. Social workers and clinicians working in the community and with faith-based partners conduct extensive outreach programs, clinical assessments, medical treatments, alcohol and drug-abuse counseling, and employment assistance. Nearly 20,200 veterans of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) have been identified as homeless by VA during the past five years; the number of homeless veterans who have served in Iraq and Afghanistan is increasing, but makes up 5.5 percent of the overall homeless population.²¹⁶ VA has awarded more than 700 grants to public and nonprofit groups to assist homeless veterans in every state, the District of Columbia, Puerto Rico, Guam, and tribal lands to provide transitional housing, service centers, and vans to provide outreach and transportation to services for homeless veterans.²¹⁷

As part of its drive to end homelessness among veterans by 2015, VA announced on October 12, 2011, the launch of a nationwide outreach initiative, “Make the Call,” to spread the message about its special programs to help homeless veterans and their families. Twenty-eight communities across in 23 states will host special programs highlighting local services for homeless veterans, their families, and those at risk of becoming homeless. VA is encouraging family, friends, and citizens in the community to “Make the Call” and help prevent and end homelessness among veterans. Since March 2010, VA has offered a toll-free telephone number, staffed around the clock by trained professionals, to help homeless veterans, their families, and at-risk people.²¹⁸

The Independent Budget veterans service organizations (IBVSOs) are pleased about VA’s goals to end veteran homelessness and its commitment to work in partnership with other agencies and all stakeholders to achieve this laudable goal. We are also pleased that VA officials acknowledge the need to address not only the basic needs of food and shelter for this vulnerable population but underlying mental health issues. Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder (PTSD) or have addictions acquired during or worsened by their military service.

A recent study of OIF/OEF veterans first seen at VA health-care facilities found that 25 percent received mental health diagnoses, such as PTSD, depression, anxiety disorders, or substance-abuse disorders. More than 50 percent of them had more than one co-occurring mental health disorder, with PTSD being the most common, affecting 13 percent of all veterans. This is well above the rate of 3.5 percent found in the general American population. While these numbers are concerning, research to date with OIF/OEF veterans indicates that for those identified as having problems, most received their diagnosis within days of their first VA clinic visit, which is early on, when the opportunity for providing early evidence-based treatments is greatest. However, veterans who are experiencing mental health problems have a low rate of actually seeking mental health services—about 23–40 percent of those who need these services.

Based on earlier research focused on Vietnam veterans, it is likely that the mental health burden from OIF/OEF will rise as time goes on, with new cases becoming evident and untreated problems becoming chronic. About 29 percent of OIF/OEF veterans have already enrolled in VA health care, which exceeds the estimated 10 percent rate observed after repatriation of Vietnam veterans. As the number of OIF/OEF veterans grows, their continued care will remain a national concern. It is important to remember that the burden of illness spans beyond symptoms to functional disability and applies not only to those who have served in the military and suffer from deployment-related problems, but also to their families, who may go from feelings of apprehension during deployment to a sense of confusion and helplessness when their loved ones return with PTSD.²¹⁹

Among women veterans of the conflicts in Iraq and Afghanistan, almost 20 percent have been diagnosed with PTSD. We also know the rates of PTSD in women Vietnam veterans. An important study found that about 27 percent of women Vietnam veterans suffered from PTSD sometime during their postwar lives. To compare, in men who served in Vietnam, the lifetime rate of PTSD was 31 percent.²²⁰

While most homeless veterans served during prior conflicts or in peacetime, significant numbers of veterans from the latest wars are returning home with post-deployment readjustment issues and war-related conditions, including traumatic brain injury and

serious wounds, which may put them at a higher risk for becoming homeless. Mental and physical health problems in addition to economic hardships can interrupt veterans' ability to keep jobs, find homes, establish savings and, in some cases, maintain family stability. Veterans' family, social, and professional connections may have been strained or broken as a result of their military service.²²¹

VA reports a total of 20,184 veterans of the more than 2 million personnel deployed to Iraq and Afghanistan have been seen in VA homeless outreach during the past five fiscal years, and as the number of homeless veterans reporting OEF/OIF military service is growing, they constitute 5.5 percent of the overall homeless population.²²² Poverty, lack of support from traditional social networks, high unemployment rates, and unstable living conditions in overcrowded and substandard housing may also be factors contributing to these veterans' need for assistance. With greater numbers of women serving in combat operations, along with increased identification of and a greater emphasis on care for victims of sexual assault and trauma (male and female), better outreach and availability of new and more comprehensive services, housing, and child care services are needed.

The IBVSOs applaud VA efforts and gains in serving the homeless veteran population, but if the trend in reducing the number of homeless veterans is to continue, more funding is needed for supportive services and housing options to ensure low-income veterans exiting grant and per diem programs can access housing, and veterans who served in Afghanistan and Iraq receive the low-threshold assistance they need to reduce their risks of becoming homeless. Additionally, increased appropriations for VA homeless veteran assistance programs will likely spur development of more local community-based prevention strategies.

Recommendations:

Congress should ensure sufficient and sustained resources to strengthen the capacity of VA health-care services for homeless veteran programs to enable VA to meet the physical, mental health, and substance-abuse rehabilitation needs of this population, including vision and dental care services.

Congress should increase appropriations for the Homeless Veterans' Reintegration Program to the authorized level of \$50 million.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers when such services are not available within VA.

Congress should ensure that the DOD assesses all service members separating from the armed forces to determine their risk of homelessness and provide life skills training to help them avoid homelessness.

Congress should ensure that VA facilities—in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursements)—develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing arrangements and supportive services. Discharge planning protocols should include information about VA resources and assisting persons in applying for income security and health security benefits (such as Supplemental Security Income, Social Security Disability Insurance, VA disability compensation, pension, and Medicaid) prior to discharge.

VA should enhance its outreach efforts to help ensure homeless veterans gain access to necessary VA health and benefits programs—including a national media campaign aimed at prevention for at-risk veterans.

Congress should increase appropriations for the Veterans Workforce Investment Program.

¹⁹⁷Department of Veterans Affairs, Office of Public Affairs and Media Relations, *Fact Sheet: VA Programs for Homeless Veterans (September 2011)*.

¹⁹⁸National Coalition for Homeless Veterans, Facts and Media, *Veteran Homelessness Prevention Platform* (March 26, 2009) http://www.nchv.org/news_article.cfm?id=515.

¹⁹⁹Department of Veterans Affairs press release, "Secretary Shinseki Details Plan to End Homelessness for Veterans" (November 3, 2009) <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1807>.

²⁰⁰Department of Veterans Affairs press release, "VA Programs for Homeless Veterans," September 2011.

²⁰¹2011 supplement to the Annual Homeless Assessment Report.

²⁰²U.S. Department of Veterans Affairs, *Prevalence and Risk of Homelessness among U.S. Veterans: A Multisite Investigation*, August 2011, pages 3–4.

²⁰³http://www.fadaa.org/FLSHC/conference/2010/documents/VA-Natl_Center_on_Homelessness_Among_Vets.pdf.

²⁰⁴Pete Dougherty, director, Homeless Programs, Department of Veterans Affairs, Testimony before the United States Senate, Committee on Veterans Affairs, Hearing on Ending Homelessness Among our Nation's Veterans (March 24, 2010).

²⁰⁵Pete Dougherty, director, Homeless Programs, Department of Veterans Affairs, Testimony before the United States Senate, Committee on Veterans Affairs, Hearing on Ending Homelessness Among our Nation's Veterans (March 24, 2010).

²⁰⁶Government Accountability Office: “Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing,” GAO-12-182, Dec. 23, 2011. <http://www.gao.gov/products/GAO-12-182>.

²⁰⁷Department of Veterans Affairs Fact Sheet, “Programs for Homeless Veterans” (Sept. 1, 2011). nchv.org/docs/VA%20Homeless%20Veteran%20Fact%20Sheet.pdf.

²⁰⁸Ibid., 3.

²⁰⁹Ibid.

²¹⁰Ibid.

²¹¹Ibid., 5.

²¹²Ibid., 6.

²¹³Ibid.

²¹⁴Ibid., 5.

²¹⁵Ibid., 1.

²¹⁶Ibid.

²¹⁷Ibid., 2.

²¹⁸VA, Office of Public Affairs Press Release, VA Launches Outreach Campaign to Eliminate Homelessness Among Veterans, Oct 12, 2011.

²¹⁹Statement by Thomas R. Insel, MD, Director National Institute of Mental Health National Institutes of Health Department of Health and Human Services on Post-Traumatic Stress Disorder Research at the National Institute of Mental Health, United States House of Representatives, Committee on Oversight and Government Reform. <http://www.hhs.gov/asl/testify/2007/05/t20070524a.html>, last revised April 19, 2011.

²²⁰VA National Center for PTSD, Traumatic Stress in Women. <http://www.ptsd.va.gov/public/pages/traumatic-stress-female-vets.asp>.

²²¹R. Rosenheck, Homeless Veterans: *Epidemiology and Outcomes 1987–2009*, PowerPoint presentation, VA Homeless Veterans Summit (November 3, 2009).

²²²VA, Office of Public Affairs Press Release, VA Programs for Homeless Veterans, Sept. 2011, page 2.



Long-Term Care Issues

LONG-TERM CARE:

The VA Office of Geriatrics and Extended Care is responsible for meeting the diverse long-term care needs of America’s aging veteran population.

To fulfill this responsibility, the Department of Veterans Affairs must follow Congressional mandates and be responsive to organizations representing veterans.

The Aging of America’s Veterans

According to the Veterans Health Administration (VHA), the projected total number of veterans most likely to require geriatric and extended-care services in the coming decade—predominantly those ages 85 and older, and those of any age with significant disabilities due to chronic diseases or severe injuries—will remain about 1 million strong. The Department of Veterans Affairs projects the total veteran population ages 65 and older will be nearly 9.6 million in 2013 and will slightly decrease to 8.2 million by 2023. Notably, VA expects in 2013 that veterans from the Vietnam era and more recent conflicts ages 65 and older will outnumber World War II and Korea-era veterans.²²³

Looking at the enrollee population, VA projects a peak in 2014 and gradual decline over the next five years. However, the number of veteran enrollees who exhibit limitations in one or more activities of daily living will remain more than 1.2 million. That is, VA can expect that as these veterans with functional limitations age, they will need long-term care services and will most likely increase VA’s long-term care workload.

Women veterans age 65 and older in the national veteran population will increase by 41 percent between 2013 and 2023 to approximately 508,000, despite the fact that the total veteran population older than 65 will decrease by 14 percent to 8.2 million. Even though older women veterans have enrolled less than older male veterans or younger veterans, they are expected to increase modestly in the coming years. About 100,000 women over 65 were enrolled for VA care in 2002 and that number is expected to increase to 126,000 by 2013, representing 3.2 percent of all enrollees age 65 and older.

The higher rate of young female veteran enrollment and health-care utilization, combined with longer life expectancy for women, suggests there will be rising demand in VA geriatric and extended-care settings for gynecological care and management of chronic disorders more prevalent among older women, such as osteoporosis and breast cancer.

VA is and will continue to be challenged in providing long-term care services as never before by the diversity of the veteran population in terms of gender and age, the unprecedented increases in the aging veteran population, and the medical complexity associated with elder care.

VA Community Living Center Capacity

With the exception of nursing home care, the majority of geriatric and extended-care programs are part of VA's uniform health benefits package and are available to all enrolled veterans as outlined in P.L. 104–262, the “Veterans’ Health Care Eligibility Reform Act of 1996,” and P.L. 106–117, the “Veterans Millennium Health Care and Benefits Act of 1999” (Millennium Act). The Millennium Act directed VA to expand noninstitutional (home and community-based) long-term care, maintain the “level and staffing of extended-care services” that existed in 1998,²²⁴ and provide nursing home care services, as warranted, to a subpopulation of its enrolled veteran population based on medical need.

In its consideration to mandate nursing home care, Congress noted in 1999 that aging veterans’ access to primary and acute-care services had expanded significantly since the publication in 1984 of a VA needs assessment titled “Caring for the Older Veteran.”²²⁵ In contrast, VA extended-care and long-term care programs were found not to have experienced comparable growth. Thus, Congress concluded that veterans who enjoyed markedly improved access to primary and hospital care had been put at greater risk with respect to needed nursing home care or alternatives to that care.

Congress also recognized then that the decentralization of decision making in VA on both regional policy and funding priorities conspired to make nursing home care a discretionary program. Congress found that VA's nursing home care units had been subjected to significant bed reductions. The result was marked variability from network to network in veterans’ access to VA nursing home care and nursing home care alternatives.²²⁶ Similar issues remain today that existed during passage of the Millennium Act in 1999. These challenges continue to affect VA in its institutional and noninstitutional care programs.

VA is a supply-constrained health-care system that operates on a global budget. The allocation of these finite resources promotes organizational behaviors of the VA health-care system and ultimately affects the choices of veterans who are enrolled in VA health care. How those resources are allocated, the national policies and directives that affect them, the employment of performance measures, the way workloads are credited, the management of bed capacity, and

the availability of services favor the provision of some VA health-care services over others. These factors have pushed to the forefront the problems attributable to the absence of policies regarding VA extended-care programs that meet the patients’ preferences and clinical needs versus what services are made available. Because of these often conflicting internal VA influences, *The Independent Budget* veterans service organizations (IBVSOs) believe that resources and services in VA long-term care programs are not synchronized, nor are they collaborative, and that veterans’ interests are not being best served as a consequence.

Certainly, VA has been increasing its capacity to provide noninstitutional long-term care as intended by its performance measure²²⁷ and increasing resources being directed to expand these services. While more needs to be done to stimulate VA extended-care services and ensure such services are tailored to meet patients’ needs, the IBVSOs also applaud the Office of Geriatrics and Extended Care for formally recognizing the need for change, clarity, and better coordination in its 2009 Strategic Plan. Notably, the plan recognizes the eligibility mismatch between inpatient and noninstitutional long-term care and possible adverse impact on VA's extended-care program.

The eligibility mismatch is based on which extended-care services are available to the enrolled veteran population. According to the Millennium Act, VA is required to provide nursing home care to a subpopulation of enrolled veterans that includes any veteran in need of such care due to a service-connected disability and to veterans enrolled in priority group 1(a)—any veteran rated 70 percent service-connected disabled or more, or one who is rated unemployable due to service-connected conditions, and who needs institutional nursing home care. Veterans in all other priority groups who need nursing home care, however, are considered by VA to be “discretionary,” where such care would be provided only if resources are available.

Unlike nursing home care, VA makes available in its medical benefits package noninstitutional long-term care to all veterans who are enrolled for VA health care based on medical need. Despite VA's recognition of these inconsistent eligibility policies, the IBVSOs are greatly concerned with the strategic plan's assumptions in crafting the description of the

problems created by such policies and VA's apparent lack of assertiveness in solving them by proposing a legislative remedy.

According to VA's strategic plan, the eligibility mismatch "disadvantages those that the policies were written to benefit; both [eligibility policies] inadvertently direct resources imprudently; and both should be critically reassessed and revised."²²⁸ Certainly, the IBVSOs agree that VA extended-care eligibility policies must be reformed, either within VA with administrative action, or more likely by Congress. We also note that VA has been continuing to downsize its institutional long-term care capacity and is not meeting the 1998 average daily census mandate imposed by law.

VA suggests that because of its limited resources, the eligibility mismatch in the law forces it to pit institutional care programs against noninstitutional care alternatives. VA has attempted to meet the demand for nursing home care in the most cost-effective manner by favoring the use of community nursing home providers. This shift in capacity, by intent or accident, is evidenced by a five-year shift from VA-provided nursing home care to care provided by community nursing homes under VA contracts and to state veterans' homes. Despite this shift and even given policy directives^{229, 230} calling for all VA medical centers to provide the full array of noninstitutional services,²³¹ we are unaware of any VA medical center that has met this requirement to date.

The IBVSOs believe Congress should further investigate this inconsistent eligibility policy and VA's inability to meet mandated capacity levels. We also believe VA has itself contributed significantly to these issues. First, VA has historically failed to request the appropriate level of resources since enactment of the Millennium Act for its extended-care programs despite knowing that the demand for VA community living center beds by priority group 1(a) veterans would soon outstrip current bed capacity. Second, decentralized decision making across the VHA has turned the capacity mandate from a floor, as Congress legislated it, into a ceiling. Third, VA has not met the Millennium Act's requirement to develop and deploy a practical, user-friendly means for collecting, tracking, and analyzing characteristics of veterans served in VA's extended-care programs. Finally, VA has not created or fostered an environment that

would stimulate innovations in long-term care to meet all enrolled veterans' needs and to lower costs and improve the quality of care.

Until such time as the Administration requests and Congress provides the resources necessary for VA to meet the current and projected demand for geriatric and extended-care services, both institutional and noninstitutional, and VA and Congress have addressed the fundamental flaws outlined above, the IBVSOs will continue to oppose any proposal to eliminate the minimum bed capacity for VA community living centers. We strongly recommend that Congress enforce its average daily bed census mandate for VA to provide institutional care and provide adequate funding to allow VA to expand its noninstitutional care services to meet current and future demand. Without restoration of the bed floor already required by law, this elder population of veterans and their growing needs for the full array of VA long-term care programs will test VA's ability to meet them in the future.

Continuing Concerns with VA's Inadequate Planning for Long-Term Care

The VHA Office of Geriatrics and Extended Care (GEC) initiated a process of strategic planning with a national State of the Art (SOTA) Conference in 2008. On December 24, 2008, the GEC released its long-awaited strategic plan. The future of VA long-term care was seen then as centered squarely on its stated mission statement, "VA will be the national leader in providing, improving, evaluating, teaching, and researching excellence in geriatrics and extended care for settings that are patient centered, integrated, and informed by individual preferences for settings that are safe, affordable, and as home-like as possible."

The IBVSOs believe VA has the potential to become the national leader in long-term care, but this achievement would be dependent upon the GEC's ability to implement its own strategic plan. The IBVSOs offer our support to this effort, but such a plan requires the involvement and participation of the veteran community.

VA's long-term care strategic plan contains four goals, 10 strategies for achieving them, and 82 specific recommendations for addressing the strategies. Recommendations are being implemented now as part of VA's current plan to present a cohesive

approach, integrated with and dependent upon ongoing activities to address the needs of caregivers as well as mental health issues, dementia care, care in rural settings, and extended-care challenges of Operation Enduring Freedom and Operation Iraqi Freedom injured veterans.

Additionally, VA's Strategic Plan identified seven critical "key recommendations" as the initial steps necessary to set in motion a series of improvements for more effective services. Full implementation of key recommendation number six, to "[d]evelop and deploy a practical, user-friendly means of collecting, tracking, and analyzing characteristics of the veterans served in extended-care programs, as called for by the Millennium Act and the 2003 VA Long-Term Care State-of-the-Art (SOTA) Conference," would be a giant step in the right direction.

Although the IBVSOs want to support the most recent strategic plan, if we consider the Millennium Act, the 2003 SOTA Conference, and the Government Accountability Office (GAO) recommendations to improve VA's long-term care planning along with VA's decision to implement the patient-aligned care team (PACT) initiative, we must conclude that VA may be unable to move key recommendation six forward.

At the direction of both the House and Senate Committees on Veterans' Affairs, from 2003 to 2006, the GAO examined various aspects of VA long-term care programs. The reports, which continued to find limitations with VA long-term care program data for planning and oversight, remain a cause of great concern. The GAO also reported significant variation in availability of long-term care from network to network.

The GAO reported, in 2004,²³² numerous problems that prevented VA from gaining a better understanding of its program's effectiveness. In a follow-up report²³³ issued in 2006, the GAO reiterated the need for VA to estimate who will seek VA nursing home care and what their needs will be, including estimating the number of eligible veterans based on law and VA policy, and the extent to which these veterans will be seeking care for long and short stays.

The GAO recommended that VA collect data for community nursing and state veterans' homes that are comparable to data collected on residents in VA

community living centers, including their bed residence characteristics. The GAO also recommended that VA collect data on the number of veterans in these homes it is required to serve based on the Millennium Act.

VA's position is that data other than eligibility and length of stay, such as age and disability, are most crucial for its strategic planning and program oversight. To best serve the veteran population, the IBVSOs believe Congressional oversight is equally important to VA's need to manage and plan for its long-term care benefits package, particularly in light of shifting patient workload with nearly 70 percent of that care burden now being met by community nursing and state veterans' homes.

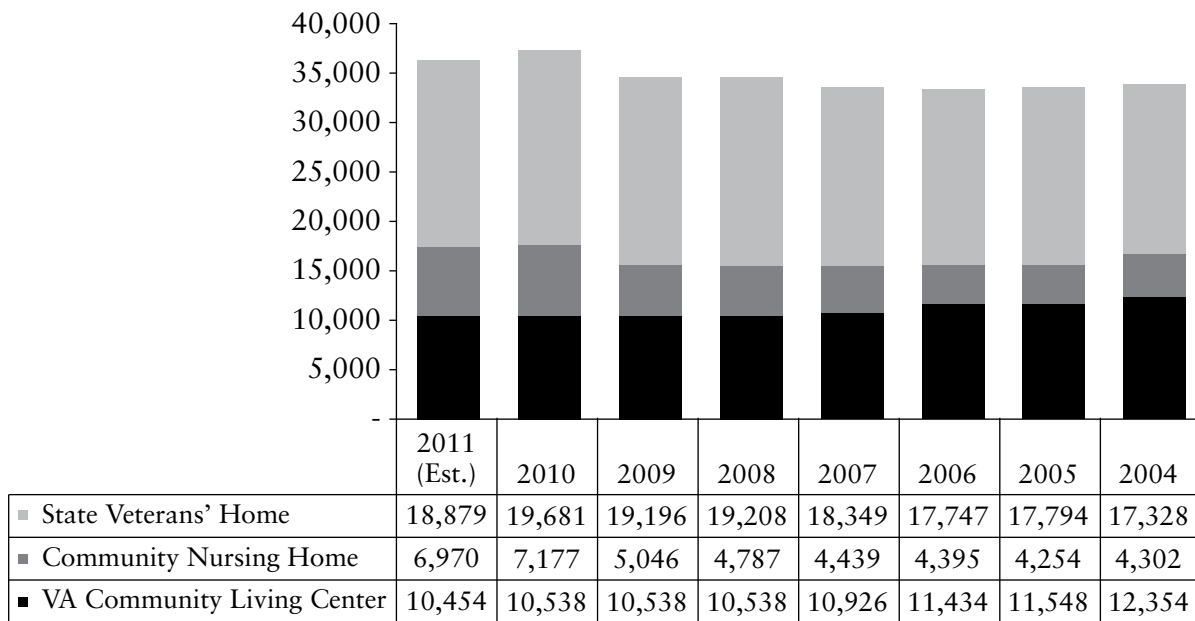
To meet the GAO recommendations, VA is taking a more sensitive approach to its Long-Term Care Demand Model. VA is estimating the demand for non-institutional home and community-based extended-care services and VA's timeline for meeting the full demand, comparing the planned noninstitutional workload with the recent census, and planning total nursing home workload, including care provided to veterans on a discretionary basis.

The model is based on the size and demographic characteristics of the enrolled veteran population and is updated periodically to reflect changes in the veteran population and in utilization rates for long-term care. It also estimates both the total demand of this veteran population cohort and then VA demand (the proportion of total demand that would be expected to seek VA services).

To this end, VA has indicated it will use the targeted demand described in the most recent strategic plan. The plan indicates a range of demand for noninstitutional care from 72,000 to 109,000 over the three-year period 2009–2011. VA's FY 2012 budget submission revealed a failure to meet these average daily census (ADC) targets for two of those years. VA also estimates a significant drop in the annual increase of noninstitutional care workload for 2012 and 2013.

During the development of VA's most recent strategic plan, the GAO reported, "VA's estimated noninstitutional spending for fiscal year 2009 appears to be unreliable because it is based on a cost assumption

Graph 6. VA Institutional Long-Term Care Workload Average Daily Census (ADC)



that appears unrealistically low and a workload projection that appears unrealistically high, given recent VA experience.”²³⁴

In 2011, the GAO reported²³⁵ on VA’s strategic planning and budgeting, concluding that VA was employing unrealistic assumptions in making long-term care projections.

In light of VA’s inability to meet legislative and self-imposed capacity requirements, the IBVSOs are concerned about the delicate balance VA must achieve between institutional and noninstitutional services to provide for veterans’ needs. VA should collect and report better information to support more consistent policy decisions and justify future budget requests.

Until the necessary programmatic and patient population information is collected, validated, and analyzed, the IBVSOs believe VA will continue to struggle to effectively plan and provide for the immediate and future long-term care needs of veterans. VA retains a duty to clearly advise Congress about the needs and requirements to provide long-term care. Without clear advice and advocacy by VA, Congress is unable to conduct proper oversight. We believe VA should be

the advocate for veterans’ long-term care needs, not simply a provider.

Venues of VA Long-Term Care

VA provides institutional short- and long-term nursing care, respite, and end-of-life care in three venues to eligible veterans. These are VA community living centers (CLCs), purchased care in community nursing homes (CNHs), and in state veterans’ homes.

VA also provides an array of noninstitutional (home- and community-based) alternatives to nursing home care designed to support veterans in their own homes. Additionally, VA’s philosophy is to provide services in the least restrictive setting.

VA reported in the FY 2012 budget that the institutional care ADC would increase from 35,000 to 37,000 for the period 2008 through 2010. However, the VA CLC share of ADC declined over the same period from 31 percent to 28 percent, while CNH and state veterans’ homes shares have been growing. VA projects this trend to continue through 2013, when VA’s share will constitute slightly more than 25 percent.

The VHA's experience with providing nursing home care in CLCs to service-connected veterans suggests that 76–90 percent of those eligible will choose VHA-provided care, primarily due to cost and geographical considerations. In addition, VA projects the number of veterans to whom it is mandated to provide institutional care will increase annually through 2018. These findings support projections that demand from this population will outstrip VA's CLC bed capacity.

VA's current policy to increase noninstitutional services is supported by veterans, their families, and by organizations that represent them, including the IBVSOs. However, the reality is that VA's own data forecast that demand for long-term care services will continue to grow over the next decade. VA has projected the noninstitutional care ADC is increasing from 109,000 to 119,000 from 2011 through 2013.²³⁶

Clearly, much work remains to be done in VA's long-term care program; however, Congress should conduct oversight of VA's long-term care program, and VA must maintain a safe margin of CLC capacity that

will meet the needs of elderly veterans who can be expected to transition from VA noninstitutional care programs to VA nursing home care in the near future.

VA Community Living Centers

VA community living centers provide excellent care and are usually co-located with VA medical centers, facilitating prompt and efficient access to VA medical services for a population of veterans that often has complex medical needs. VA operates 133 CLCs nationwide, ranging in size from 20 beds to 240 beds per site. As mentioned previously, VA's CLC ADC in 2011 is below that of the previous year. VA's 2011 nursing home care workload reflected an ADC of 10,454.

To continue its excellent history in caring for elder and aging veterans, VA is continuing its cultural transformation in delivery of nursing home care. This national initiative is a paradigm shift from a medical model to one that focuses on the resident's life and participation in his or her community.

Table 5. VA Noninstitutional Care Programs

Programs*	2005	2006	2007	2008	2009	2010	2011	I/D Over 2010
HBPC	11,594	12,641	13,222	16,523	20,621	24,143	27,102	2,959
PSHC	3,075	2,490	2,656	3,319	4,093	4,378	4,412	34
HHHA	6,584	5,867	6,631	9,321	13,307	15,804	16,033	229
VA ADHC	15	335	327	335	348	13		
C-ADHC	1,762	1,304	1,884	2,019	2,544	2,806	3,001	195
S-ADHC				21	21	21	N/C	
SCI-HC			598	721	749	758	9	
HH	194	427	553	858	949	973	1,105	132
HR	99	118	254	418	672	681	700	19
GEM Clinic	52	53	CRC	6,810	3,692	5,069	4,248	4,550
CCOOR/TH								22,539
TOTAL		26,539	30,284	37,639	50,096	49,980	53,533	3,553

*Home-based primary care, purchased skilled home care, homemaker/home health aide, VA adult day health care, community adult day health care, state veterans home adult day health care, spinal cord injury home care, in-home hospice care, in-home respite care, geriatric evaluation and management clinic, community residential care, care coordination/telehealth.

Note: I/D = Increase or (Decrease) 2011 from 2010, N/C = No Change. In 2010 the total noninstitutional care workload numbers were lower than the total for 2009 because VA did not report the workload numbers for the GEM, CRC, CCOOR/TH programs. In 2011 VA did not report the workload numbers for the CRC and CCOOR/TH programs, which makes the workload numbers for 2011 total 53,533.

In a culturally transformed VA CLC, the approach to care places the resident's quality of life at the forefront. This approach is facilitated and reinforced by VA's national policy that identifies barriers to resident-centered communal living and provides means to achieve cultural transformation. The new resident focus involves three factors: the environment of care, work practices, and care practices.

- The goal of this new environment of care is to personalize elder care by redesigning the nursing home so that “form follows function.” Deinstitutionalizing the environment means changing the focal point of the environment from facilitating the delivery of care to the resident. Removal or remodeling of the nursing station, which is the pivotal hub in a nursing home, is encouraged and would be in keeping with a more homelike environment.
- The change in work practices includes policy and practice that supports consistent staff assignments. Staff assigned to the resident remains the same as long as the veteran is a resident. Rethinking staffing patterns is also encouraged to include alternatives to the traditional three-shift model for nurse assignments.
- The change care practices include respecting, rather than designating, individual residents' sleep/wake cycles, and inviting or negotiating care rather than imposing care. To respect resident privacy, except in cases of emergency, staff and visitors are asked to always announce their presence and request permission to enter. The resident is also involved in his or her care planning to the fullest extent possible, and if the resident lacks decision-making capacity, a surrogate decision maker must be involved. In addition, other family members and friends need to be involved if the resident so desires.

VA is now employing a “small house” model at three CLC locations (the cottages at Tuscaloosa VA Medical Center (VAMC), small house model at Danville VAMC, and Green House at North Chicago VAMC). These employ one or more units designed and constructed to replicate that of a household for 10 to 12 veterans and to provide residents more privacy and control over their lives with private bedrooms and bathrooms, a communal living room, kitchen, and dining room.

The IBVSOs are hopeful this cultural transformation will address our concern as well as the Congressional mandate²³⁷ for VA to accommodate the generational differences between OEF/OIF veterans, a new cohort of Vietnam veterans, and older veterans, including veterans of World War II and other conflicts. To this end, we are pleased with the new physical space arrangements intended to address age-appropriateness.

For its commitment to employing evidence-based practices, the VHA is conducting studies on the impact of the transformation of the culture of care moving from the traditional model to the new small house models of care. The studies will explore care delivery before, during, and after major renovation to a household model of care.

VA CLCs are also participating, along with 7,600 other nursing homes nationwide, in the campaign entitled Advancing Excellence in America's Nursing Homes. This two-year campaign began in 2006 and is now in its second phase. Its mission is to help nursing homes achieve excellence in the quality of care and quality of life for more than 1.5 million nursing home residents. The campaign is focused on eight mission-related goals.²³⁸ VA is represented on the campaign steering committee, and VA CLCs are submitting data into the campaign's database.

The IBVSOs applaud VA for its leadership in caring for aging and elder veterans. We are aware that all Veterans Integrated Service Networks (VISNs) are participating in the VA cultural change initiative, but to varying degrees. We urge VA to expand its transformation efforts in all of its CLCs. In addition, we urge VA to continue studying the measurable outcomes of cultural transformation and participate in the nursing home quality campaign, and we look forward to the analysis of its performance among VA CLCs and with other non-VA nursing homes.

VA's Contract Community Nursing Home Care Program

Since 1965, VA has provided nursing home care under contracts or purchase orders. VA has contracts with more than 2,500 private community nursing homes (CNHs). In 2005 the ADC for VA's CNH program represented 13 percent of VA's total nursing home workload. The CNH program often brings care closer to where the veteran actually lives and closer to his or her family and friends. The CNH program

has maintained two cornerstones: veteran choice in selecting a CNH and local oversight.

As confirmed by reports of the Government Accountability Office, the IBVSOs remain concerned about the quality of VA contract community nursing home care.²³⁹ Once veterans are placed in CNHs, with exception of annual home inspections, VA is challenged to directly monitor veterans' health status and quality of care or to ensure that these veterans receive their rightful benefits. VA must do more to ensure that the quality of care in these facilities meets the highest standards and that it remains the responsible party to facilitate medical information transfer and coordination of other VA benefits and services. Veterans and their families must be assured that all aspects of care meet the individual veteran's needs. For example, veterans with catastrophic disabilities, such as spinal cord injury/dysfunction (SCI/D), blindness, post-traumatic stress disorder (PTSD), and other mental health challenges, must receive care from specially trained staff. Their unique medical care needs require access to physicians, nurses, and social workers who are knowledgeable about the specialized care needs of these patients.

VHA Handbook 1143.2 provides instructions for initial and annual reviews of CNHs and for ongoing monitoring and follow-up services for veterans placed in these facilities. First introduced in 2002, the handbook updates new approaches to CNH oversight, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

VA Nursing Home Care Provided in State Veterans' Homes

The State Veterans Home Program currently encompasses 133 nursing homes in 50 states and Puerto Rico, with more than 28,000 nursing home and domiciliary beds for veterans and their dependents. State veterans' homes provide the bulk (more than 50 percent of VA's total workload) of nursing home care to the nation's veterans.

VA holds state homes to the same standards it applies to the nursing home care units it operates. State homes are inspected annually by teams of VA examiners, and the VA Office of Inspector General also audits and inspects them when determined necessary. State

homes that are authorized to receive Medicaid and Medicare payments also are subject to unannounced inspections by the Centers for Medicare and Medicaid and to announced and unannounced inspections by the Inspector General of the Department of Health and Human Services.

VA pays a small per diem payment for each veteran residing in a state home, less than one-third of the average cost of that veteran's care. The remaining two-thirds is a mix of funding, including state support, Medicaid, Medicare, and other public and private sources.

By right, service-connected veterans should be the top priority for admission to state veterans' homes, but traditionally they have not considered state homes an option for nursing home services because of the lack of VA financial support and personal liability for cost-sharing. To remedy this disincentive, Congress provided authority for full VA payment in P.L. 109-461. Unfortunately, during the implementation of this law, the intent of Congress was lost and the result was that many state homes actually saw funding decrease for their care of the most seriously disabled service-connected veterans. In addition, state homes that were interested in providing care to these most deserving veterans concluded that they could not afford to admit them due to the inadequate rates that would be paid by VA.

Over the past two years, VA and state homes have sought a way to resolve this unintended outcome. Working together with Congress, a solution was agreed upon last year, and legislation was subsequently introduced that would allow state homes to enter into contracts or agreements with VA for the care of veterans who have service-connected disabilities rated at 70 percent or greater. It will be imperative that this new solution be enacted and implemented as quickly as possible in order to stop the financial losses at state homes that are already caring for seriously disabled veterans, and provide new opportunities for seriously disabled veterans to receive care at state homes.

In addition to per diem support, VA helps cover the cost of construction, rehabilitation, and repair of state veterans' homes, providing up to 65 percent of the cost, with the states providing at least 35 percent. Unfortunately, in FY 2007 the construction grant

program was funded at only \$85 million, the same amount Congress had provided in FY 2006.

Based on a current backlog of nearly \$1 billion in grant proposals (including hundreds of millions in pending life and safety projects) and with thousands of veterans on waiting lists for state beds, *The Independent Budget for Fiscal Year 2008* recommended no less than \$150 million for this program. The IBVSOs are grateful Congress responded and provided \$165 million for FY 2008.

For FY 2009, *The Independent Budget* recommended \$200 million for the state veterans' home construction grant program, and Congress provided \$175 million. In FY 2010, Congress provided \$100 million for this program and in the "American Recovery and Reinvestment Act," Congress provided an additional \$100 million for state home construction grants. We remain grateful for these helpful allocations. VA recently reported that 49 approved construction projects to create new, expand, or renovate and modernize existing state homes are currently under way. Congress then provided \$85 million in FY 2011 and FY 2012.

The Independent Budget recommended the state extended-care construction grant program be funded at \$200 million for FY 2012 to keep pace with the need to make these important facilities safe, modern, and available for veterans who choose them for their long-term care. However, we recognize that, with 49 construction projects under way now, VA and the states—many of which are in budgetary deficit—may not be able to wisely spend any higher level of funding than \$85 million, which we recommend for FY 2013.

VA Noninstitutional Long-term care Services

VA offers a wide spectrum of noninstitutional long-term care services to veterans enrolled in its health-care system. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include adult day health care (provided in VA, state, and community facilities), home-based primary care, community residential care homemaker and home health aide services, hospice and palliative care, respite care, skilled home care, spinal cord home care, and telehome health.

In recent years, VA has been increasing its noninstitutional (home- and community-based) services and

spending through the use of special initiatives and applying key performance measures. The Department is measuring its success based on an annual percentage increase of noninstitutional long-term care average daily census, using 2006 as the baseline of 43,325 ADC. Simply using the percentage increase²⁴⁰ based on the ADC of veterans enrolled in noninstitutional care programs does not adequately incentivize VA facilities to increase access to these services.

VA must also take action to ensure that these programs, mandated by the Millennium Act, are readily available in each VA network. We applaud VA for publicly recognizing this challenge and for taking deliberate and measured steps to offer a standardized menu of services across all of its sites of care. We strongly urge VA to continue its efforts to develop and disseminate a Handbook of Uniform Services in Geriatrics and Extended Care.

The IBVSOs support the expansion of VA's noninstitutional long-term care services and the adoption of innovative approaches to expand this type of care. In many cases, noninstitutional long-term care programs can obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost-effective. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

Adult Day Health Care

The "Veterans Healthcare Act of 1983," P.L. 98–160, authorized an Adult Day Health Care (ADHC) Program in selected VA Medical Centers to be provided directly by the Department as well as through community facilities under VA contract (C-ADHC). The "Veteran's Health Care Eligibility Reform Act of 1996," P.L. 104–262, requires that ADHC services be available to all enrolled veterans who need such services, either through VA-operated onsite centers or through contract care at community-based facilities. Section 342 of the law also authorized VA to establish a per diem program to state homes providing ADHC to veterans (S-ADHC).

ADHC is a prominent element in the continuum of long-term care services. ADHC provides stabilization of the patient's health status, rehabilitation to improve or maintain a functional level that allows

the patient to remain at home, remotivation to participate actively in self-care, and support and respite for the caregiver.

While ADHC is perceived as a “day respite” program, which provides socialization, health surveillance, and caregiver support, the program has strong appeal for veterans who have part-time family caregivers (due to employment or other obligations). However, initial efforts to develop this program did not have a clear advantage based on the results of the 1991 evaluations.²⁴¹ This two-phase evaluation of VA-ADHC and C-ADHC offered possible consideration of three options: not to offer ADHC, to target ADHC to those types of patients who may benefit, and to reduce ADHC costs.

Since FY 2006, VA has made the expansion of noninstitutional care in its medical benefits package a priority by first planning an annual percentage increase in ADC. Beginning in FY 2009, VA changed its performance measure to the strategic target ADC in its Long-Term Care Strategic Plan. Yet despite such focus, the availability of VA purchased or provided ADHC is limited and many families needing such services experience difficulties transporting veterans to and from existing programs.

Efforts to expand access to this program across the three venues remain incomplete. According to VA, the unchanged ADC for ADHC is primarily due to fiscal limitations and existing staffing requirements. VA regulations for S-ADHC are limiting state participation because the medical model required is cost prohibitive. The only real expanded use of ADHC is evidenced in the purchase of such service from the community. VA currently offers 19 ADHC programs, C-ADHC at 113 locations, and one S-ADHC.

Primary Care for Older and Aging Veterans

As VA continues to focus on providing more noninstitutional care and provides veterans with care closer to home, it is expected that the demand for VA purchased and provided nursing home care will decline, and demand for outpatient services by older and aging veterans will rise.

VA's transformation since the mid-1990s of its health-care delivery model from emphasizing hospital and specialty care to a model that integrates ambulatory and acute care has made primary care the setting to provide health promotion, disease prevention

and disease management. Every patient is assigned a primary care provider who assumes responsibility of overseeing all of a veteran's health-care needs. The ascent of primary care can be illustrated in FY 2011 data showing veterans made nearly 68 million outpatient visits to VA's hospital- and community-based clinics.²⁴² However, some elderly, frail veterans present complex medical needs and extensive health histories that do not fit well into VA's primary care model.

It is widely accepted that successful geriatric ambulatory care includes a comprehensive geriatric assessment, an interdisciplinary team approach, provider continuity, surveillance by case management and follow-up, and a viable home support system such as home visits, home assistance, and telephone contact. VA's current primary care model is not designed to provide such care. VA primary care providers generally have no specialized training in geriatrics and are constricted by the amount of time allotted for a primary care patient panel to properly evaluate and provide effective treatment that usually requires consultations with several specialties and subspecialties.

Specialized care for such veterans requires appointments to be made far in advance, but veterans might be denied an appointment in the interest of supporting performance measures based on open access/same-day scheduling. Moreover, due to a higher prevalence of cognitive impairment in the aging veteran population, open access/sameday scheduling, which requires veterans to call a VA facility to make a follow-up appointment, is not a suitable surveillance method.

To use VA's primary care model with older and aging veterans who suffer from cognitive impairment, severe mental health conditions, or who have complex comorbid conditions, programs such as Geriatric Evaluation and Management (GEM) units emerged, Geriatric Primary Care (GPC), and Home-Based Primary Care (HBPC). The specialized care GPC and GEM programs can be utilized by consultation from the patient's primary care providers or by transferring primary care responsibilities over to GPC or HBPC. When the responsibility of care is transferred to these programs, veteran patients are able to remain and participate in their community substituting reduced admission and related inpatient services for other less costly care.

Unfortunately, access to these program services that would give to the veteran patient the most effective care in the least restrictive setting remains limited based on their availability at VA medical centers (VAMCs) and community-based outpatient clinics (CBOCs) and the lack of providers specializing in geriatric care.

Because of its limited numbers, VA is addressing access to geriatricians through clinical education efforts such as the Geriatric Scholars program, which enhances team-based geriatric management skills. Geriatric Research Education and Clinical Centers (GRECCs) also play a key role by providing onsite CBOC and primary care team training in geriatrics, as well as providing learning experiences disseminated onsite, online, through periodicals, and by hosting conferences.

A critical part all of these efforts is the ability to refer veterans with the most complex and challenging circumstances to the most appropriate providers. With VA's newest transformational initiative—the Patient-Aligned Care Team (PACT)—it is not yet clear how it will affect VA's current chronic care model and the inclusionary/exclusionary criteria of referral, and what that model of care over time will be like. We urge Congress to conduct oversight hearings on the effects of PACT on VA's geriatric primary care programs.

Geriatric Evaluation and Management, and Geriatric Primary Care

VA helped pioneer GEMs in the United States and at one point mandated that every facility must have a GEM. VA currently operates 80 GEM programs that provide a comprehensive and multidimensional assessment, therapeutic interventions, rehabilitative care, and appropriate interdisciplinary plan of care. They primarily serve aging veterans with multiple medical, functional, and psychosocial problems and those with particular geriatric problems such as early stage dementia, urinary incontinence, unsteady gaits with episodes of falling, polypharmacy threats, and sensory impairments. An interdisciplinary team of physician, nurse, social worker, and other health professionals skilled in assessing and treating geriatric patients staffs these programs.

GEM units provide frail, complex patients with comprehensive assessment and management in both

inpatient and outpatient settings. Outpatient management and follow-up is provided because the primary care team is unable to follow the care plan for which the GEM unit was consulted.

Similarly, VA's 60 GPC sites are able to provide a comprehensive geriatric assessment, integrate available providers, and can integrate and coordinate traditional ambulatory and institution-based health-care services with a variety of community-based options to allow veteran patients to remain and participate in their community despite compounding cognitive, psychosocial, and medical impediments.

The longitudinal care provided by GEM, GPC, and HBPC coordinates care of local VA and non-VA community resources. These multidisciplinary team-based programs provide continuity of care from inpatient and long-term care settings, and educate and collaborate with family and other caregivers to veteran patients who are able to self-manage between visits.

Despite its proven effectiveness of providing interdisciplinary geriatric assessments to create tailor-made plans of care, timely intervention, treatment, and surveillance for medically complex veterans at risk of nursing home placement, the availability of GEM units and GPC remains limited.

Home-Based Primary Care

VA home-based primary care (HBPC) has been in operation for more than 30 years and is a unique program that provides comprehensive, interdisciplinary, primary care for veterans with complex medical, social, and behavioral conditions who are at high risk for recurrent hospitalization or nursing home placement and for whom routine clinic-based care is not effective.

In contrast to other home care programs that target patients with short-term remediable needs and provide episodic, time-limited and focused skilled services, HBPC targets patients with complex, chronic, progressively disabling diseases and provides comprehensive care.

To further expand the reach of this program to serve rural veterans, the Department awarded funds in May 2009 to start HBPC satellites in 25 rural community-based outpatient clinics and 14 Indian Health Service facilities with funding support from VA's Office of

Rural Health. These projects are located in New York, North Carolina, Oklahoma, Oregon, New Mexico, California, Mississippi, Minnesota, and two locations in South Dakota. Access to VA HBPC for American Indian and Alaska Native veterans is provided through collaboration with the Indian Health Service and tribal health facilities, and is facilitated with the improvement of an interagency partnership on health information and the use of telehealth.

The HBPC model has also been adapted in 73 percent of sites to incorporate telehealth to serve polytrauma/TBI veterans from Operations Enduring and Iraqi Freedom (OEF/OIF) conflicts who reside in areas of HBPC operation. Notably, rural HBPC incurs about the same costs per day as does HBPC in urban settings that have lesser distances and drive times to veteran patients. The major challenge for rural HBPC is sufficient staffing. Some accommodations have been made to make up for staffing shortages through alternative means.

The value of this program is evidenced by a reduction in hospital days by 62 percent at more than 200 locations, a reduction in nursing home days by 88 percent and in overall costs by 24 percent. This program provides patient-centered care coordination and received an 83 percent patient satisfaction rating, the highest in any VA health-care program.

Out of the 152 VA medical centers, HBPC currently operates in 132 (with 22 in designated rural settings). However, out of the more than 800 CBOCs, HBPC is in only 150. Although access is limited in a relatively few CBOCs, HBPC is able to treat more than 17,000 chronically ill veteran patients. Accordingly, the IBVSOs urge VA to expand this program's availability in its CBOCs beyond current levels.

We also urge VA to leverage GPC in its PACT initiative to provide the best personalized care of its older patients and a safety valve for harder-to-manage patients.

Hospice and Palliative Care

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings for persons in the terminal phases of disease. Hospice is intended to allow these individuals to live as fully and as comfortably as possible. The program emphasizes managing pain and

other physical symptoms, addressing the psychosocial problems, and providing for the spiritual comfort of the patient and the patient's family or significant others. Services are provided by an interdisciplinary team of trained professionals and dedicated volunteers. Bereavement care is also available to the family following the death of the patient. Hospice services are available 24 hours a day, seven days a week, and are provided across multiple VA and community settings and in veterans' private residences.

While hospice and palliative care are part of VA's medical benefits package, only in recent years was hospice made into a formally structured program. Expansion and outreach was greatly assisted through the Hospice-Veteran Partnership, a local coalition of VA facilities, community hospices, veterans service organizations, and volunteers. Community agencies have been made aware of this VA benefit through the Hospice-Veteran Partnership and are actively identifying veterans within the populations they serve.

VA is now providing hospice and palliative care to a growing number of veterans throughout the country. More than 8,000 veterans were treated in designated hospice beds at VA facilities in fiscal year 2010, and thousands of other veterans were referred to community hospices to receive care in their homes. In addition, the number of veterans receiving hospice care in their homes paid for by VA increased by 6 percent this past fiscal year.

The IBVSOs applaud VA for its commitment to make this service available to all veterans who require such compassionate care. Although such services are provided at only about one-fourth of all hospitals, nearly half of all veterans who died in VA facilities received care from a palliative care team. Because of the large number of World War II and Korean War-era veterans and a tripling of the number of veterans over the age of 85, the increase in the need for hospice care and palliative care is expected to continue. Furthermore, we applaud Congress's recent efforts to improve access to VA hospice and palliative care services by prohibiting VA from collecting copayments for hospice care provided to enrolled veterans in all settings.²⁴³

Some gaps remain that are a cause for concern with respect to hospice. Through the use of palliative care consultation services at each of its medical centers

and inpatient hospice care in many of its nursing homes, VA is providing hospice and palliative care to a growing number of veterans throughout the country. While VA hospice and palliative care are available by direct provision or by purchase in the community, VA must ensure all its medical centers have a palliative care consultation team consisting of, at a minimum, a physician, nurse, social worker, chaplain, and administrator.²⁴⁴

When a veteran who is dually eligible for VA hospice and Medicare/Medicaid hospice is referred to a community hospice agency, the veteran is given a choice as to which will pay for hospice care. Although the IBVSOs believe a veteran's choice should be honored, we are concerned that differences in reimbursement policies could affect the types of services provided, the quality of care, and financial expenses the veteran and dependents may incur. VA hospice is the greater benefit when contrasted with Medicare since it is a comprehensive medical care benefits package designed to be patient-centric and to treat the whole patient. For example, when a veteran chooses Medicare as the payer of hospice care, Medicare will not pay for any treatment or medications not directly related to the hospice-related diagnosis. We believe the community hospice should inform the veteran and his or her spouse or significant other which treatments or medications are or are not covered. Further, under the Medicare hospice benefit, all care that veterans receive for their illness must be given by the community hospice. Therefore, the veteran must be discharged out of Medicare hospice before any other treatments or medications can be given to ensure comfort and quality of life.

Finally, the IBVSOs believe both the community hospice agency and VA must ensure that when the veteran dies, his or her survivors are made aware of all VA benefits to which they may be entitled.

Medical Foster Homes

The medical foster home program identifies families who are willing to open their homes and care for veterans who need daily assistance and are no longer able to remain safely in their own homes but do not want to move into a nursing home. It is provided as an adult foster home arrangement on a permanent basis, supported by VA's home-based primary care team that provides oversight and regular visitation.

VA considers this is a long-term commitment between the veteran and the caregiver. The veteran may live in foster care the remainder of his or her life, and the partnership between VA's foster care program and home-based primary care is a safeguard against abuse. The first foster home program was started in Little Rock, Arkansas, in 1999, followed by programs in Tampa, Florida, and San Juan, Puerto Rico. Using New Clinical Initiative Funding in 2000, VA developed medical care foster homes and provided minimal funding for two years. In 2002, VA had 35 foster homes and 45 patients. Currently, there are 55 VA medical centers with medical foster home programs and an additional 32 in some phase of program development. There are 347 medical foster homes in 34 states, and in 2008, Congress granted funds for 33 additional sites.

Medical foster homes can be owned or rented by the caregiver, and the home is limited to three or fewer residents (veterans and nonveterans) receiving care. The range of fee payments to medical foster home caregivers has increased from \$1,000 to \$1,800 per month in 2002 to \$1,500 to \$4,000 based upon the level of care needed by the veteran—for example, a cost of \$1,500 for someone with mild cognitive impairment who is independent in activities of daily living but requires supervision, to \$4,000 for someone who is incontinent, bed-bound, and needs to be turned every four hours. This payment is made by the veteran directly to the caregiver monthly and includes room and board, 24-hour supervision, assistance with medications, and whatever personal care is needed.

VA believes medical foster homes to be cost-effective alternatives to nursing home placement because veterans must pay for their medical foster care using personal finances such as Social Security, private pensions, VA pensions, service-connected disability compensation, or other sources of funds. This arrangement is based on the statutory authority, Title 38, United States Code, §1730. This section provides VA the authority to assist the veteran in obtaining placement in a Community Residential Care (CRC) facility for which payment of any care or services provided by the facility “[i]s not the responsibility of the United States or of the Department.”²⁴⁵

Furthermore, operating under this authority requires VA to reinterpret the original intent of the law to fit its need to provide this innovative program. Section 1730(f) describes a CRC facility as one [t]hat provides room and board and such limited personal care for and supervision of residents as the Secretary determines...are necessary for the health, safety, and welfare of residents.” A medical foster home provides a greater level of care than a CRC facility, while allowing veterans to live in a homelike setting and maintain a greater degree of independence. For example, the eligibility criteria for CRC include veterans who do not need hospital or nursing home care, whereas veterans must meet VA’s nursing home level of care. We applaud VA for realizing this need and having proposed regulations on May 19, 2011, to specifically govern medical foster homes.

However, the IBVSOs are concerned with the statutory authority requiring veterans living in the medical foster home to pay for care and services in medical foster homes using personal funds, including their VA compensation payments. The expanding use of Section 1730 authority to other noninstitutional care programs works against VA’s ability to provide patient centered care. The attractiveness of the medical foster home program is clear. More than 1,200 veterans benefited from this program since its inception despite personal financial liability, and the program yields high patient satisfaction scores. This program also draws the newest generation of veterans who have different expectations than their counterparts of the past. In general, they are technologically oriented, well educated, want more involvement in their own care, and want to control their own destinies. Since the program’s inception, 21 OEF/OIF veterans have been served.

Notably, more than 280 priority group 1(a) veterans, a population of enrolled veterans for which VA is required to pay or provide nursing home care should the veteran so choose, have chosen to reside in medical foster homes. Priority group 1(a) veterans would rather spend their own personal funds for the care, independence, and quality of life offered in a medical foster home than reside in a nursing home at VA expense. Despite the program’s appeal, however, for some priority group 1(a) veterans, such financial cost acts as a disincentive. In this instance, these veterans end up having to choose to remain in a nursing home,

which is not their preferred residential environment, at a higher cost to the government. Younger veterans with catastrophic injuries must be supported by forward-thinking administrators and staff who can adapt services to youthful needs and interests.

The IBVSOs also believe Congress must be equally responsive to the needs of younger and aging veterans in need of noninstitutional long-term care. Section 1705 of P.L. 110–18, the “National Defense Authorization Act of 2008,” requires VA in collaboration with the Defense and Veterans Brain Injury Center of the Department of Defense to conduct a five-year pilot program to provide assisted living services for veterans with traumatic brain injury.

In the continuum of care, assisted living bridges the gap between in-home care and nursing homes. It provides services for those who are not able to live independently, but do not require the level of care provided by a nursing home. Assisted living is less costly compared to skilled nursing facilities, and in certain instances, home care can be more expensive than residing in an assisted living facility or community.

The IBVSOs urge Congress to amend existing statutory authority to end any further fragmentation of VA’s long-term care benefits provided under Section 1730. We believe the medical foster home and other residential care programs should be part of the array of noninstitutional long-term care services in VA’s medical benefits package, and not a viable alternative available only to those who can afford it.

Respite Care

According to VA, respite care is a program in which brief periods of care are provided to veterans by VA in order to give veterans’ regular caregivers a period of respite, or rest. Respite care services are primarily a resource for veterans whose caregivers are neither provided respite services through, nor compensated by, a formal care system (i.e., community residential care program agreements, Medicaid waiver programs, hospice programs, and others for which the veteran is dually eligible).

The National Family Caregiver Support Program²⁴⁶—along with Aged/Disabled (A/D) Medicaid Home and Community-Based (HCBS) waivers and state-funded

respite care and family caregiver support programs that provide the bulk of public financing to support family caregiving, including respite care—defines respite care as a service to provide temporary relief for caregivers from their care responsibilities. Respite care is considered the dominant service strategy to support and strengthen family caregivers under the A/D Medicaid HCBS waiver program. In a survey conducted on A/D Medicaid waiver programs that asked respondents to choose from a list of 20 items the services their program provides specifically to family caregivers, respite care received a 92 percent positive response, followed by information and assistance, homemaker/chore/personal care, and care management/family consultation at 48 percent each.²⁴⁷

The Department of Defense provides respite services to injured active duty service members, including National Guard/reserve members injured in the line of duty. TRICARE now offers primary caregivers of active duty service members rest, relief, and reprieve, authorized by section 1633 of P.L. 110–181, the “National Defense Authorization Act for Fiscal Year 2008.” This respite benefit helps homebound active duty service members who need frequent help from their primary caregivers. If the injured service member’s treatment plan requires a caregiver to intervene more than twice in an eight-hour period, the caregiver can receive respite services for a maximum of eight hours per day, five days a week. Active duty service members or their legal representatives can submit receipts for reimbursement of respite care services that began on or after January 1, 2008, by a TRICARE-authorized home health agency. This benefit serves to mirror other supplementary TRICARE benefits that provide respite services to active duty family members under TRICARE Extended Care Health Option (ECHO)²⁴⁸ and TRICARE ECHO Home Health Care, which are created to better align the DOD’s existing unlimited home health agency and skilled nursing facility benefits to mirror the benefits and payment methodology used by Medicare.

VHA Handbook 1140.02, released on November 10, 2008, seeks to address concerns about the availability of respite in both institutional and noninstitutional settings; however, some limitations are still problematic. For example, while VA policy allows respite care services to be provided in excess of 30 days per annum, requested extensions must be justified by unforeseen difficulties and must be approved by the VA medical center director with jurisdiction.

Moreover, long-term care copayments are required for respite care regardless of the setting or source of such care.

The IBVSOs believe VA should enhance respite services to reduce the variability across the Department’s continuum of care by, at minimum, enabling attending physicians to approve respite care in excess of the annual limit when medically necessary, adding flexibility and discretion. Also, we recommend eliminating copayments for respite because they act as a disincentive to an already underutilized service. We urge VA to explore the A/D Medicaid HCBS waiver program as it has done in its emerging Medical Foster Home program to provide noninstitutional respite care services to caregivers of veterans.

VA’s Care Coordination/ Home Telehealth Program

VA’s intent is to provide care in the least restrictive setting that is appropriate for the veteran’s medical condition and personal circumstances. Further collaboration between programs within Geriatrics and Extended Care and those of the Office of Telehealth Service can continue to produce positive results by providing services that are tailored to meet individual veterans’ needs.

VA has been investing in a national Care Coordination/Home Telehealth (CCHT) program since 2006 and its workload was projected to double from 2010 to 2012. Of the 46,000 veterans served in 2010, about 31,000 are considered to have received CCHT as noninstitutional care.

The program monitors veteran patients with chronic illness residing at home and addresses their needs before they become acute. Veteran patients with chronic diseases, such as diabetes, heart failure, post-traumatic stress disorder, and chronic pulmonary disease, are monitored at home using telehealth technologies. The goal is to address their needs before they become acute and thus reduce complications, hospitalizations, clinic or emergency room visits.

CCHT takes place in three ways: using a range of technologies to send and receive health information to and from the veteran’s home based on their needs, using videoconferencing technologies between VA medical centers and clinics, and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2–3

percent of patients who are frequent clinic users and could require urgent hospital admissions if their conditions deteriorate. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse, or a social worker. Sometimes physicians serve as care coordinators in the case of complex patients.

As veterans age and need treatment for chronic diseases, VA's telehome health program has the ability to monitor a veteran's condition on a daily basis and provide early interventions when necessary. This early medical treatment can frequently reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

CCHT is particularly effective for veterans with dementia, and the IBVSOs urge VA to provide facilities with sufficient funds to ensure such veterans are provided these services. We are also aware that effort is underway to address the inadequate capturing of CCHT workload in Veterans Equitable Resource Allocation (the primary system to allocate funds to VISNs). Because this program positively impacts a veteran's quality of life and has proven its cost-effectiveness, we urge VA to continue this effort to ensure facilities have the resources to expand this program.

VA Long-Term Care for Veterans with Spinal Cord Injury/Disorder

The spinal cord injury/disorder (SCI/D) veteran population is aging. Approximately 6,000 Paralyzed Veterans of America members are now over the age of 65 and another 7,000 are between the ages of 55–64. Individuals with SCI/D develop characteristics and medical problems commonly associated with the aging process at a much younger age. Many of these aging veterans are experiencing an increasing need for VA long-term care. The number of SCI/D veterans is soaring, due in part to medical advances and care that make near normal life expectancy possible. But the increasing life expectancy raises another set of issues. At the same time as increasing life expectancy, secondary complications in this veteran population are complex and costly, and VA does not seem prepared to address this critical issue. There are obvious needs for more SCI/D long-term care beds so these veterans are not relegated to veterans' or nursing homes, where they cannot receive the specialized care they need.

Currently, VA operates only five designated long-term care facilities for patients with SCI/D, and none of these facilities is located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (36 staffed beds); Hines Residential Care Facility, Chicago (28 staffed beds); Cleveland, Ohio (22 staffed beds); and at the Tampa SCI/D Center (30 staffed beds). Unfortunately, these 113 beds are usually filled, and there are waiting lists for admission. These five VA SCI/D long-term care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA CARES initiative has called for the creation of additional long-term care beds in three new locations—20 in Memphis, 20 in San Diego, and 30 in Long Beach, California—these additional services are not yet available and would provide only 50 beds west of the Mississippi River. If established, these new long-term care beds would present an opportunity for VA to refine the paradigm for SCI/D long-term care design and to develop a new SCI/D long-term care staffing model.

VA SCI/D veterans are being taken care of at home, in non-SCI/D nursing home care units, and in state veterans' homes where there are minimal nursing care resources and, most important, these providers are not SCI/D trained. Veterans with SCI/D have special needs and require specialized care in order to maximize their functional ability and to prevent secondary medical conditions associated with SCI/D. Older SCI/D veterans are especially vulnerable to complications and secondary medical conditions. They require more specialized resources to provide them with quality long-term care.

A major concern in the aging SCI/D veterans is their increased risk for pressure sores. Simple pressure sores become large, complicated, and infected wounds when proper care is not given. Many of these wounds ultimately require surgical intervention and take months or even years to heal. Veterans often die because their wounds are not treated properly. Their wounds become infected and they often get sepsis. Community nursing homes and veterans' homes are not equipped to care for SCI/D veterans with these complex issues. SCI/D long-term care beds are needed for these patients as they have staff that are trained in SCI/D care and are competent to care for them.

Respiratory problems are the leading cause of death in persons aging with SCI/D. Aging lungs have a decrease in the number of alveoli (air sacks), a loss of natural elasticity, and diminished respiratory reserves. For this reason, it is expected that people with SCI/D may gradually become more vulnerable to respiratory infections and other lung complications as they age. Some patients become ventilator dependent. It is nearly impossible to find any kind of placement for an SCI/D patient on a ventilator. Again, there must be an increase in the number of available SCI/D long-term care beds to provide needed care for the ventilator-dependent SCI/D patient. Many are now being housed in acute beds in SCI/D centers or in intensive care units. This is not cost-effective and does not provide proper continuum of quality care these veterans deserve.

Another major issue of concern is the fact that in 2003 a VA survey indicated that an estimated 990 veterans with SCI/D were residing in non-SCI/D designated VA nursing homes. However, VA still has not identified the exact locations of these veterans in its long-term care strategic plan. The special needs of these veterans are only discovered when the patient requires admission to a VA medical center for treatment. This is unacceptable. VA is not properly addressing this critical issue. It is imperative that a program be developed to locate and identify veterans with SCI/D who are receiving care in non-SCI/ long-term care facilities. The need for long-term care beds for these veterans is obvious and must be addressed.

Assisted Living

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living or the instrumental activities of daily living. Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, VA reported to Congress the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by P.L. 106-117. The Assisted Living Pilot Program (ALPP) was carried out in VISN 20. VISN 20 includes Alaska, Washington, Oregon, and the western part of Idaho. It was implemented in seven medical centers in four states: Anchorage; Boise; Portland; Roseburg, Oregon; White City, Oregon; Spokane; and Puget Sound Health-Care System (Seattle and American

Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

The VA report on the overall assessment of the ALPP stated, “[t]he ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care.”

VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority to provide assisted living services, believing this is primarily a housing function. The IBVSOs disagree and believe that housing is only one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is one part. VA already provides housing in its domiciliary and nursing home programs, and is providing housing by definition in all its homeless veterans' assistance programs. An assisted living benefit should not be prohibited by VA on the basis of its housing component.

The IBVSOs acknowledge and appreciate that Congress authorized a new VA assisted living pilot project in Section 1705 of Title XVII of the “National Defense Authorization Act for FY 2008.” The IBVSOs are hopeful that VA and the DOD will move forward to establish this program, understanding that its intent is aimed at providing alternative therapeutic residential facilities to severely injured OEF/OIF veterans. However, this new program also provides an important new opportunity to further study the feasibility and worth of assisted living as an alternative to traditional institutional services for all veterans, young and old, who may need these valuable services.

Summary

While they exhibit numerous parts and functions as explored above, and provide vital services to hundreds of thousands of veterans at significant cost each year, VA long-term care programs are functioning today in a fractious, discordant manner within the VHA, and therefore they are not operating at an optimal level to serve the best interests of veterans. Veterans with severe service-connected disabilities (those 70 percent disabled or more, or unemployable, and those who need care for service-connected disabilities) are now reported to be saturating VA's existing community

living center bed capacity, in effect blocking other veterans from the in-house VA nursing care CLC option (even for temporary convalescence after hospitalization). Some of those veterans are being referred to community nursing homes initially under VA contract, and ultimately under Medicaid financing for those eligible who need longer term bed stays, while others are referred to VA Home-Based Primary Care (HBPC) for home visits and case management (or to a VA bed in an acute or subacute care bed section). The IBVSOs are concerned that the HBPC program in most VA locales is available only to veterans in need who reside within a reasonable driving distance from the host VAMC. This means that veterans who live any considerable distance away from the HBPC team cannot avail themselves of this important alternative to institutionalization. The HBPC program is clearly a part of long-term care but is not consistently available. Thus, the IBVSOs conclude that care coordination for these patients can be challenging to all concerned.

Also, very few veterans, whether service-connected or not, are referred directly by VA facilities to state veterans' homes as a VA aftercare option, whether for short-term convalescence or longer terms of residency. Although they term their relationship a "partnership," a wall of separation exists between VA and the states on long-term care. Also, for individuals who are service-connected, some of the state homes (those participating in Medicaid—about 63 facilities to date) will not accept these veterans or greatly restrict their admissions because of the stalemate with VA over implementation of P.L. 109-461 and reimbursement policy from that act. In medical foster homes, all veterans, including service-connected veterans, are being required to defray major parts of the cost. Finally, in respite, strict time limits and copayments serve as a disincentive to the caregivers who might want and need to use that benefit, thus making it unavailable to many who need it.

The IBVSOs sense a friction or tension between and among these efforts that, unless reformed, could impart harm to the very veterans these programs were designed to serve. We believe strong justification exists for Congress to provide intensive oversight of these fractious elements of VA's long-term care programs, in an effort to make them more logical, seamless, and coordinated, for the veterans VA is charged to serve, so that veterans in need of long-term care can be placed in the most appropriate setting to receive these services.

After investigation, Congress may find that legislation is warranted to take corrective action or remove inconsistencies or obstacles in either current statutory language, or in VA's flawed implementation of Congressional intent in establishing and maintaining VA's vital long-term care programs. The IBVSOs invite that attention.

Recommendations:

Congress must enforce its average daily census mandate for VA to provide institutional care and enact adequate funding to allow VA to expand its noninstitutional care services to meet current and future demand.

Congress should conduct oversight in VA's long-term care programs and VA must maintain a safe margin of community living center (CLC) capacity to meet the needs of elderly veterans.

VA should expand its transformation efforts in all of its CLCs and continue studying the measurable outcomes of cultural transformation and participate in the nursing home quality campaign.

Congress should fund the state extended-care construction grant program at \$85 million for FY 2013.

VA should continue its efforts to develop and disseminate a Handbook of Uniform Services in Geriatrics and Extended Care.

VA's adult day health care program (ADHC) should include amending VA's beneficiary travel regulations to provide veterans' greater access to ADHC, provide ADHC outside normal business hours, revise current policy to foster broader development of VA-ADHC and community adult day health care, and should amend current regulations for state ADHC to provide greater flexibility in offering ADHC to veterans.

VA must develop a program to locate and identify veterans with spinal cord injury/disorder (SCI/D) who are receiving care in non-SCI/D long-term care facilities.

VA and Congress must work together to immediately proceed with opening additional SCI/D long-term care beds. This is imperative in order to provide quality long-term health care to the aging SCI/D veteran

population and provide them with the specialized care required to meet their needs.

VA should expand the current 60 Geriatric Evaluation and Management programs to 150 sites.

VA should expand home-based primary care capacity and the HBPC programs in its community-based outpatient clinics beyond current levels.

Congress should amend existing statutory authority to end any further fragmentation of VA's long-term care benefits provided under Section 1730, Title 38, United States Code.

VA should enhance respite capacity and services to reduce the variability across the its continuum of care.

VA should expand its provision of home care programs for veterans enrolled in VA health care. VA should study models of home care provided to veterans in other coalition nations, such as Canada.

VA should provide facilities with sufficient funds to ensure eligible veterans are provided Care Coordination/Home Telehealth services.

²²³VA, Patient Care Services, *Geriatrics and Extended Care Strategic Plan*, December 24, 2008.

²²⁴The average daily census (ADC) at that time of 13,391 for its Nursing Home Care Units (now renamed "Community Living Centers").

²²⁵Veterans Administration, *Caring for the Older Veteran* (Washington, DC: U.S. Government Printing Office, July 1984).

²²⁶Conference Report 106-237 (July 16, 1999).

²²⁷Measure of annual percent increase of noninstitutional long-term care average daily census using FY 2006 as baseline (43,325 ADC), versus the FY 2011 census of 92,567.

²²⁸Department of Veterans Affairs, *Geriatrics and Extended Care Strategic Plan*, (Washington, DC, December 24, 2008), 4.

²²⁹IL 10-2004-005, Under Secretary for Health's Information Letter, *Noninstitutional Extended Care* (May 3, 2004).

²³⁰Noninstitutional Extended Care within VHA, VHA Directive 2001-061 (October 4, 2001).

²³¹Home-based primary care, purchased skilled home health care, homemaker/home health aide, adult day health care, geriatric evaluation, respite care, and hospice and palliative care.

²³²GAO-05-65.

²³³GAO-06-333T.

²³⁴GAO-09-145.

²³⁵GAO-11-205 and GAO-11-622.

²³⁶FY 2012 VA Budget Submission.

²³⁷P.L. 110-181, section 1706.

²³⁸Minimize Staff Turnover; Consistent Staff Assignment; Reduce Use of Physical Restraints; Prevent and Appropriately Treat Pressure Ulcers; Prevent and Minimize Moderate or Severe Pain; Advance Care Planning; Resident/Family Satisfaction; and Staff Satisfaction.

²³⁹GAO-01-768.

²⁴⁰Annual percentage increase from 2006 baseline of 43,325 average daily census of noninstitutional long-term care.

²⁴¹Required by P.L. 98-160: Evaluation of Effectiveness and Costs of ADHC: Phase I, VA ADHC (Identification Number: SDR #85-007), and Evaluation of Effectiveness and Costs of ADHC: Phase II, Contract ADHC (Identification Number: SDR #85-071).

²⁴²FY 2012 VA Budget Submission.

²⁴³P.L. 110-387, Title IV, § 409.

²⁴⁴Additional support may be provided by pharmacists, rehabilitation therapists, recreation therapists, mental health professionals, and other specialists.

²⁴⁵38 U.S.C. § 1730(b)(3).

²⁴⁶Enacted under the Older Americans Act Amendments of 2000.

²⁴⁷L. Feinberg, and S. Newman, *Medicaid and Family Caregiving: Services, Supports, and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S.* (New Brunswick, NJ: Rutgers Center for State Health Policy, May 1, 2005).

²⁴⁸Formerly Program for Persons with Disabilities. See "National Defense Authorization Act of 2002."



Medical and Prosthetic Research

FUNDING FOR VA MEDICAL AND PROSTHETIC RESEARCH:

Funding for VA research must be sufficient, timely, and predictable to meet current commitments and enable growth in areas of timely importance.

The VA Medical and Prosthetic Research program leverages the taxpayer's investment via a nationwide array of synergistic relationships with academic affiliates, nonprofit organizations, and for-profit industry participants. Adding to these partnerships, VA researchers successfully compete for funding from the National Institutes of Health, the Department of Defense, and other federal agencies. The VA research program leverages its relatively modest annual VA

appropriation into a \$1.8 billion national research enterprise that has sponsored three Nobel laureates and six recipients of the Lasker Award (often called the "American Nobel"). The VA research program produces a significant number of scientific papers annually, with more than 9,000 examples in 2011, many of which are published in the most prestigious national and international peer-reviewed scientific journals.

Examples of VA contributions to innovative technologies include the nicotine patch; an improved prosthetic ankle that better mimics a normal gait; and the “DeKA Arm,” a collaborative prosthetic invention involving VA and Department of Defense scientists and private entrepreneurs that enables upper extremity amputees to achieve remarkable rotation and dexterity using a robotic hand. In addition, recently VA announced more new developments:

- Development of an artificial lung prototype that mimics the structure of a natural lung and is described as a “significant step toward creating the first truly portable and implantable artificial lung systems.”
- A determination that prazosin, an inexpensive generic drug already used by millions of Americans for high blood pressure and prostate problems, improves sleep and lessens trauma nightmares in veterans with post-traumatic stress disorder (PTSD).
- Initial work on a computerized vision system to make handheld GPS devices accessible to blind users, offering additional mobility and independence for veterans with vision loss.

The VA Research Program had a historic year of accomplishments in FY 2011 that will contribute to improving the lives of our nation’s veterans. From women’s health to the study of how genes affect illness, VA Research is actively involved in veteran-centric studies to provide tomorrow’s treatments that are evidence-based. It is part of an integrated health-care system with a state-of-the-art electronic health record that has come to be viewed as a model for superior bench-to-bedside research. The groundbreaking achievements of VA investigators—70 percent of whom also provide direct patient care—have contributed to elevating the standard of care in U.S. and western medicine, surgery, psychiatry and related fields.

The VA Research Program was also active in the development of research initiatives that are in step with VHA health-care priorities and VA transformation initiatives. These advance veterans’ access to quality health-care services—ensuring VA Research continues to be responsive to veterans’ needs, and foundational to the continued excellence of VA health care.

The VA research program’s most recent pioneering accomplishments include:

- launch of the Million Veteran Program (MVP),
- institution of Point of Care Research (POCR),
- formation of Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE),
- creation of Centers of Innovation (COINs), and
- improving Health and Lives of Gulf War Veterans.

Million Veteran Program

The Million Veteran Program (MVP) is an important partnership between VA and veterans, with the goal of enrolling as many as 1 million veterans over the next five to seven years. The goal of the MVP is to better understand how genes affect health and illness in order to improve their health care. As of September 30, 2011, 7,084 veterans were enrolled and had donated samples at 24 operating sites. The MVP has extensive safeguards in place to ensure information security and patient confidentiality are top priorities.

Point of Care Research (POCR)

This novel approach to research will influence the way research is conducted in the future. In POCR, veterans are enrolled in comparative research projects at the time they are receiving usual clinical care. They are randomized to point of care research at a decision point in clinical care where two or more alternative treatments or strategies are considered equivalent. No extra patient visits are required, and the outcomes are obtained by automated extraction of data from the medical record. The approach will allow for faster completion of studies and better engagement of clinicians in the study process, hence improved opportunity for implementation of the results.

Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE)

The CREATE effort is defined as a group of coordinated research projects conducted in a focused research area addressing a high-priority health system problem and conducted by independent, collaborating investigators coordinating with one or more VA local, regional, or national clinical, operations, or health-care system stakeholders (partners). In short, CREATE is a suite of three to five complementary projects conducted simultaneously to fill knowledge

gaps critical to the Veterans Health Administration and to move the field forward during a five-year study cycle. Each individual research project within a CREATE program must be scientifically meritorious and considered a distinct but complementary area of investigation. The individual studies within a CREATE program may vary in start date, size, method, and duration but have a common purpose of advancing knowledge in a focused area of research that is important to VHA stakeholders.

Creation of Centers of Innovation (COIN)

Effective 2012–13, the Office of Research and Development (ORD) plans to establish new program infrastructure to replace Research Enhancement Award Program (REAPs) with a new model, Centers of Innovation (COIN): The COIN program will replace the Centers of Excellence and emphasize high-impact research and an established relationship with a clinical or operational partner. Every COIN must have at least one CREATE and the initial CREATE must be in the COIN's focused area of research and intellectual leadership.

Improving Health and Lives of Gulf War Veterans

ORD funds research that will further the goal of improving the health and lives of veterans who have Gulf War veterans illnesses (GWVI), which refers to the complex of chronic symptoms that affect veterans of the 1990–1991 Gulf War at an excess rate. ORD also funds controlled clinical trials and epidemiological investigations of the effectiveness of new pharmacological or nonpharmacological treatments for GWVI. In addition, ORD is committed to funding research that improves VA's understanding and ability to treat illnesses, such as amyotrophic lateral sclerosis (ALS) and multiple sclerosis (MS), which may occur at higher prevalence in Gulf War veterans. ORD has improved its focus on Gulf War-related research. Staffing for the Gulf War research portfolio has been addressed this year to provide more dedicated personnel. Further, the Gulf War Steering Committee developed a new strategic plan for VA Gulf War research.

As can be seen in its many examples of accomplishment, the highly successful VA research enterprise demonstrates the best in public-private cooperation, but would not be possible without VA-funded research opportunities and VA's laboratories. As such, a commitment to steady and sustainable growth in

the annual research appropriation, and a significant investment in VA's aging research infrastructure, are necessary for maximum productivity, continued achievement, and future recognition of excellence in biomedical research.

Predictable and Sustainable Growth to Meet Current and Emerging Research Needs

Predictable funding enables the national VA Office of Research and Development to stabilize its planning, and increases investigator confidence in continuous funding for thousands of important research projects in VA. Should availability of research awards decline as a function of budgetary policy, VA risks having to terminate ongoing research projects and new initiatives, including some of those listed above. It also risks losing from VA ranks physician-researchers and other clinical investigators who are integral to providing direct care for our nation's veterans and programs for veterans' specialized needs.

To maintain the current level of VA research activity, inflation in biomedical research and development is assumed at 3.1 percent for FY 2013. The basis for this assumption is the annual change in the Biomedical Research and Development Price Index, which is developed and updated annually by the Bureau of Economic Analysis and the Department of Commerce. It is used by federal research agencies, including the National Institutes for Health, to estimate changes in funding levels necessary to maintain purchasing power.

Beyond anticipated inflation, additional VA research funding is needed to (1) address the critical needs of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and others who were deployed to combat zones in the past; (2) take advantage of opportunities to improve the quality of life for our nation's veterans through "personalized medicine"; and (3) maximize use of VA's expertise in research conducted to evaluate the clinical effectiveness, risks, and benefits of medical treatments.

Funding Growth Will Aid New Discoveries and New Treatments

Additional funding is needed to expand research on strategies for overcoming the devastating injuries suffered by veterans of OEF/OIF. Urgent needs are apparent for improvements in prosthetics technologies and rehabilitation methods, as well as more effective treatments for polytrauma, traumatic brain

injury (TBI), significant body burns, damage to the eye, and mental health consequences of war, including PTSD, depression, and suicide risk. Funding more studies and accelerating ongoing research efforts in all of these critical areas can deliver results to make a measurable difference in the quality of life of thousands of our newest generation of sick and disabled war veterans and their families.

Through personalized medicine research VA is well-positioned to revamp modern health care and to provide progressive and cutting-edge care for veterans. VA is uniquely capable of leading personalized medicine research, including genetics-based research or “genomics.” VA is the largest integrated health system in the world, employs an industry-leading electronic health record, and has an enrolled treatment population of millions of veterans to sustain important research. VA combines these attributes with rigorous ethical standards and standardized practices and policies. Innovations in personalized medicine will allow VA to:

- reduce drug trial failure by identifying genetic disqualifiers and allowable treatment of eligible populations;
- track genetic susceptibility to disease and develop preventative measures;
- predict responses to medications; and
- tailor the use of drugs and treatments to match an individual’s unique genetic structure.

In 2006, VA launched the Genomic Medicine Program (GMP) to examine the potential of emerging genomic technologies, optimize medical care for veterans, and enhance the development of tests and treatments for relevant diseases. In 2011 VA kicked off the signature feature of VA’s GMP, the Million Veteran Program (MVP), which will establish one of the world’s largest repositories of genetic and health information. Ultimately, this database will be available to VA researchers for projects that will lead to improved treatments while protecting veteran privacy. To enroll 1 million veteran volunteers over five years as planned, and to set up the necessary research infrastructure, VA must be in a position to make a sustained investment in this innovative initiative.

Increased funding would allow VA to conduct additional research to ensure that veterans receive the most effective therapies for their conditions, sometimes at a savings because the less costly treatment

is more effective, or because the patient receives the right treatment more promptly. In addition to the attributes described above, VA already has a fully functional clinical research infrastructure, including:

- five data and statistical coordinating centers,
- four epidemiology research centers,
- a pharmacy coordinating center,
- a health economics resource center, and
- a pharmacogenomics analysis laboratory.

Failures in Contracting, Hiring, and Procurement Impede Research

The Independent Budget veterans service organizations (IBVSOs) are deeply concerned that VA’s inability to contract for necessary research services, hire qualified scientists, and procure supplies and equipment in a timely manner jeopardizes research. In recent years, protracted delays in these areas resulted in the VA medical and prosthetic research account incurring an unanticipated unobligated balance of more than \$70 million at the end of FY 2010. Because VA research appropriations may be obligated for two years post-authorization by Congress, no funds lapsed, but these administrative delays continue to disrupt carefully structured research timelines because each grant award is time-limited. The IBVSOs understand that the carryover funds were the basis for the Administration’s recommending a \$72 million cut in research and development appropriations for FY 2012. However, even if unobligated, all available research and development appropriations were in fact allocated to research programs, so accommodating a cut of such magnitude will necessitate terminating or significantly curtailing already-funded projects and initiatives. Radical reform in VA contracting, hiring, and procurement is needed to prevent similar disruption of research from occurring and to ensure that investigators may accomplish their work on schedule, with fully staffed and equipped laboratories.

VA Research Infrastructure Funding Shortfalls

For decades, VA construction and maintenance appropriations have failed to provide the resources needed by VA to replace, maintain, or upgrade its aging research facilities. Consequently, many VA facilities have run out of adequate research space, or existing space is unable to meet current standards. Ventilation, electrical supply, roof, and plumbing deficiencies appear frequently on lists of urgently needed upgrades, along with significant space reconfiguration. VA reports it

has made some progress to address a few of these deficiencies, but the portfolio of backlogged projects is daunting.

In House Report 109–95 accompanying FY 2006 VA appropriations, the House Appropriations Committee expressed concern that “equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department’s research facilities remain competitive.” In the same report, the committee directed VA to conduct “a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies.” To comply, VA initiated a comprehensive assessment of VA research infrastructure. According to an October 26, 2009, Office and Research and Development report to the VA National Research Advisory Committee, preliminary results indicated “there is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety.”

To prompt VA to complete and publish its long overdue assessment, House Report 111–564 directed VA to provide its final report to Congress by September 1, 2010, and also to detail any recent renovations or new construction. According to VA in a letter to Friends of VA Medical Care and Health Research (FOVA), the required report was to have been completed and presumably ready to transmit to Congress by June 2011. That key report has not, to date, been provided to Congress. *The Independent Budget* veterans service organizations urge Congress to hold VA accountable for failure to submit this report. We hope to ensure that the Administration and Congress become well informed of the deteriorating conditions of VA’s research infrastructure and of its funding needs so that these may be fully considered for the FY 2013 budget formulation process. Additionally, for FY 2013 Congress should (1) allocate funding sufficient to address VA’s five highest priority research facility construction needs as identified in the pending report; and (2) provide a pool of funding for urgently needed maintenance, repair, and upgrades at research facilities nationwide.

VA Lacks a Mechanism to Ensure that Its Research Facilities Remain Competitive

A significant cause of VA research infrastructure’s neglect is that there is no direct funding line for research facilities. Nor does the VA Medical and

Prosthetic Research appropriation contain funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA’s research laboratories. As a result, VA research competes with medical facilities’ direct patient care infrastructure needs (such as elevator replacement, heating and air conditioning upgrades, and capital equipment upgrades and replacements, including X-ray machines and MRIs) for funds provided under either the VA Medical Facility appropriation account or the VA Major and Minor Construction appropriations accounts. VA investigators’ success in obtaining funding from non-VA sources exacerbates VA’s research infrastructure problems because non-VA grantors typically provide no funding to cover the costs to medical centers of housing extramurally funded projects.

Integrity of the Peer-Review Process

Both *The Independent Budget* veterans service organizations and FOVA strongly support leaving all decisions about the selection of particular research projects, and their funding, to the VA scientific peer-review process. Funding for any potential Congressionally mandated VA research, therefore, is neither anticipated nor included in this *Independent Budget* discussion or funding recommendations. We believe any such directed research, if so desired by Congress, should be appropriated separately from the needs we are identifying in this *Independent Budget*.

In addition, it is vitally important that the integrity of the Department’s highly regarded peer-review process be protected. Although outside stakeholders’ carefully considered views on funding priorities should be a consideration, they must not be allowed to unduly influence research funding deliberations or decisions. Ultimately, scientific merit based on careful peer review must be the determining factor in whether a project is funded, not pressure from interest groups or interference in selection of peer reviewers. The IBVSOs and FOVA contend that between VA’s current peer-review system and the public status of this federally funded activity, sufficient accountability is present and that no further outside interference or influence is warranted. *The Independent Budget* veterans service organizations urge Congress and VA to take assertive steps to preserve the quality and transparency of VA’s research funding decisions.

Recommendations:

To keep VA research funding at current-services levels, the VA research program requires at least \$20 million (a 3.1 percent increase over FY 2012) to accommodate biomedical research inflation. However, *The Independent Budget* veterans service organizations believe an additional \$10 million or more in FY 2012, beyond inflationary coverage, is necessary for sustained support of the multiplicity of ongoing VA research initiatives and projects discussed herein. Thus, Congress should increase by at least \$30 million the VA Medical and Prosthetic Research account for fiscal year 2013, for a total of \$611 million, and more if feasible.

Pervasive problems in timely VA contracting, hiring, and procurement negatively affecting VA research should be the focus of a House or Senate Committee on Veterans' Affairs hearing to determine the exact nature of the causes and solutions. If legislative action is warranted, VA should work with the committees to develop the necessary legislative proposals to remedy this sensitive problem that can have the effect of canceling or significantly delaying VA research projects.

Congress should require VA to submit its research facilities capital needs report to the House and Senate Committees on Appropriations and Veterans' Affairs as soon as possible. Further, correction of the known infrastructure deficiencies should not be further delayed. Therefore, *The Independent Budget* veterans service organizations recommend (1) a construction appropriation sufficient to address at least five of VA's highest priority research facility construction needs as identified in its facilities assessment report;

and (2) a pool of \$50 million in minor construction and maintenance and repair funds dedicated exclusively to renovating existing research facilities to address the current and well-documented shortfalls in research infrastructure. Further, Congress should require that research space be addressed as an integral component of planning for every new medical center and that such space plans be designed by architects and engineers experienced in research facility requirements.

The Administration and Congress should establish a new appropriations account in FY 2013 and thereafter to define and separate VA research infrastructure funding needs independently from capital and maintenance funding for direct VA medical care programs. The account should be subdivided for major and minor research construction and for maintenance and repair needs of VA's research programs. This revision in appropriations accounts would empower VA to address research facility needs without interfering with direct health-care infrastructure.

In summary, Congress should fund the VA Medical and Prosthetic Research program in FY 2013 as follows:

- for appropriate program growth, and to cover anticipated inflation, \$611 million or more;
- for capital infrastructure, renovations, and maintenance, \$150 million or more for research construction projects and \$50 million for maintenance and repair (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).

Administrative Issues

THE DEPARTMENT OF VETERANS AFFAIRS MUST STRENGTHEN ITS HUMAN RESOURCES PROGRAM:

The Department of Veterans Affairs must improve priority setting and responsiveness of its human resources functions to ensure that America's veterans receive the benefits and health-care services they have earned and that VA programs operate efficiently.

In recent years the Department of Veterans Affairs has worked to improve its recruitment strategies for mission-critical positions, developed long-term Department strategic plans to improve service delivery, and reorganized its agencies and offices in an attempt to increase efficiency and improve function. The success of many of these initiatives depends on the quality of VA human resources support services. The Department's failure to appropriately direct human capital resources could undermine many of these new initiatives and ultimately have a negative impact on services for veterans. Therefore, *The Independent Budget* veterans service organizations (IBVSOs) believe that the VA Office of Human Resources Management must provide the necessary support for these important initiatives, and that local human resources offices in the Veterans Health Administration and Veterans Benefits Administration must adhere to these priorities in supporting VA's missions. This support includes adequate staffing of new and existing positions, as well as personnel training and continuing education opportunities for VA employees. Specifically, to make certain that the aforementioned changes result in improved quality of VA services, VA must refine and modernize human capital policies and procedures in areas of recruitment, retention, and succession planning and provide and create satisfying work environments that encourage scholarship, professional development, and career advancement. Many such policies emanate from local human resources offices through management levels; therefore, the IBVSOs believe that function is a critical link to VA's achieving many of its goals for veterans.

As service members repatriate from the military conflicts in Afghanistan and Iraq, and veterans from previous and future military service seek VA health care and benefits, VA must make certain that it is adequately staffed with a well-trained workforce committed to providing veterans with high-quality care

and services. VA's ability to sustain a full complement of skilled and motivated personnel requires assertive, creative, and competitive hiring strategies that enable VA to be successful in local and national labor markets for scarce career fields. To be successful, human resources management programs of both the VHA and the VBA, as well as a multiplicity of other VA offices, require attention by the highest levels of VA leadership, the use of effective tools and strategies with measureable outcomes, and monitored by strong oversight by an engaged Congress.

Current VA Workforce and Its Future Needs *Veterans Health Administration*

One of the greatest challenges confronting VA is dealing effectively with succession of working generations—especially in the health sciences and technical fields that so characterize contemporary American medicine and health-care delivery. The VHA has an increasing percentage of workers becoming eligible for retirement, and a growing number of VA personnel are staying beyond their eligible retirement ages." In 2010, the VHA 2010 Workforce Succession Strategic Plan reported that the VHA faces a succession challenge unprecedented in its history. With respect to health care, the VHA also reports that between FY 2009 and FY 2015, 94,700 VHA employees, 40 percent of its total workforce, will be eligible for retirement, and predicts that 51,900 of those employees will in fact retire. It is projected that by 2016, 40 percent of the VHA workforce will be eligible for retirement and that an estimated 21 percent will take retirement during that time. This stark prediction only underscores the need for the VHA to market itself vigorously to appeal to all age groups as a preferred employer.

Today's health-care professionals need improved benefits, such as competitive salaries and incentives, child care benefits, flexible scheduling, generous continuing education allowances or reimbursements, and

education and training opportunities that enhance their career mobility. Given VHA's position as a nationwide health-care system, it must work assertively to improve recruitment, promotion, and retention strategies for health-care professionals, technical fields, crafts and trades, and the administrative ranks.

Concerns about "Hybrid Title 38–Title 5" Appointments

The VA hybrid employee status removes employees from a Title 5 competitive service status system and empowers VA to create and interpret rules for hiring and promoting employees exclusively under its own hiring authority, in Title 38, United States Code (U.S.C.). In P.L. 107–135, Congress provided the VHA this authority to qualify, classify, hire and promote outside the strictures of Title 5, U.S.C. (the U.S. government's hiring authority for the civil service) to respond to critical shortages in a variety of career health-care fields. More recently in enacting P.L. 111–163, Congress granted VA additional authority to place almost any health-care career field, as determined by the VA Secretary, under the hybrid Title 38–Title 5 employment system. While the IBVSOs support this recent change, we believe that VA must create and enforce policy that governs hiring and promotion standards and qualifications used by VA selecting officials. For instance, specific VA policy is needed that requires VA supervisors and managers who are responsible for making selections to these positions to honor veterans' preference requirements when hiring applicants as mandated by Title 5. If the liberal authority in use for hybrid positions conflicts with Title 5 on veterans preference, we urge Congress to clarify its intent in legislation so that qualified veteran applicants working in these fields will receive employment preference as Congress intended in Title 5 appointments throughout the federal government. We also recommend that VA periodically review its compliance with the authority to ensure the hybrid program is being carried out uniformly, and report its results to Congress, to recognized labor representatives and to the IBVSOs. VA should utilize this system as a tool to improve the recruitment of high-caliber health-care professionals and the promotion of qualified employees. Establishing clear policy and guidance on the hybrid Title 38–Title 5 system should help ensure consistent interpretation of qualification and classification standards used within the hybrid system in all VHA facilities nationwide.

Veterans Benefits Administration

The VBA continues to face an unprecedented backlog of veterans' disability claims, a supremely labor-intensive requirement. With Congressional authorization, over the past four years the VBA has hired thousands of new claims adjudication staff. Unfortunately, as a result of senior VBA officials' retirements during that period, an increase in disability claims received, rising complexity of veterans' claims, and time required for new employees to become proficient in processing claims accurately, VA has achieved little noticeable improvement in its claims-processing capabilities. The VBA has a major challenge under way in completing the complex training required to gain full productivity of thousands of new staff, many of whom are veterans themselves, eager to build careers of service to other veterans.

Considering the training needs of the new adjudication and rating staff, the size of the claims backlog, and the workload pressures on existing staff, the IBVSOs acknowledge that it would be unrealistic to expect an immediate reduction in the backlog. Given the time required for new employees to train and gain necessary experience with claims, and the productivity drain on experienced supervisors who provide much of the needed training in the VBA, it is unsurprising to us that the claims backlog continues to grow. In order to make the best use of new human resources, we believe the VBA must focus on improving training for both new employees learning these complex tasks and more senior employees needing to stay abreast of new laws and technology, while holding supervisors and managers accountable for their progress and simplifying and modernizing the claims process itself.

Many of the core human resource systems problems documented primarily for the VHA in this discussion also pertain to the VBA. As VA approaches solutions to its human resource challenges in its health-care system, it should also incorporate similar solutions where applicable in the human resource policies and practices of the VBA.

Timely Hiring and Improving VA Human Resources Procedures

VA must improve its appointment process by reducing the amount of time to bring new employees on board, and provide its human resource staff adequate support through updated hiring systems and

proficiency training. While VA has recognized the need to improve its timelines, it must begin the next phases of identifying the most promising systems, and implementing these programs or pilots to determine new methods to reduce the hiring timeline. In some professional occupations, months can pass from the date a position vacancy is announced by VA until the date a newly VA-credentialed and privileged professional is on board, receiving compensation, and providing care and services to veterans. The seeming lack of ability to make employment offers and confirm them in a timely manner unquestionably affects VA's success in hiring highly qualified employees and has the potential to diminish the quality of VA health care and VA's overall ability to deliver benefits and services.

In addition to hiring and recruiting new employees as a method for maintaining adequate staff, VA must also establish programs for future succession. In the VHA alone, between FY 2002 and FY 2006, 108,620 new hires (21,724 per year) were needed to maintain the VA health-care workforce. Between FY 2007 and FY 2017, 163,308 new hires will be needed to maintain that workforce (an average of 23,330 new hires per year). While VA has recognized that the employment market is competitive for some positions and is working to provide more professional development opportunities and programs to attract new employees needed to care for veterans, it must begin to put more effort into creating succession plans, since a large percentage of the VA workforce is eligible for or nearing retirement.

VA must also create performance measures and standards that systematically identify when its recruitment and retention goals are achieved and when they are not achieved. Specifically, VA must develop and implement specific goals for recruitment and retention (to also include promotions, continuing education, or other opportunities within their function) as components of human resources staffs' performance plans. VA human resources management staffs are not accountable to direct service providers because the failure to secure needed results by other offices as planned carries no reward or sanction for human resources staffs.

Performance of human resources personnel is not measured by the degree to which they meet hiring and recruitment goals. As a consequence, failure to fill a critical vacancy in a timely manner carries no adverse

effect on the involved human resources management staff, but that failure could directly impact on VA's ability to provide services to veterans in VA programs. VA should adopt performance measures that include evaluation of VA human resources employees meeting VA recruitment, promotion, and similar goals. Such evaluation should then be tied to the receipt of awards, promotions, and performance bonuses, as well as sanctions for poor performance. Such a system of connecting relevant human resources work with results at the direct service level could allow VA human resources offices as well as facility management to identify areas in need of improvement and also provide new motivations and incentives for a more responsive VA human resource program to those who provide direct services to veterans.

Additionally, VA continues to struggle to collect relevant data from VA exit interviews regarding the reasons why individuals decide to resign from VA employment. These data are needed in order to determine why certain scarce medical occupations, as well as VBA service representatives, leave VA employment. Retaining high-quality VA employees is critical to providing quality services to veterans. In the current economic environment VA must be cognizant of the fact that recruiting and training VA employees is costly, and losing employees to resignation not only impacts mission critical operations but diminishes services for veterans and adds to VA's operational costs. Better information from exit interviews could help VA officials at all levels identify ways to improve the workplace environment, create a more satisfying work environment, and ultimately retain quality VA employees.

Competitive Employment Opportunities

Compensation

Adequate compensation for VA employees is a tool for both recruitment and retention. VA must provide its employees with salaries that are comparable to private sector earnings if it is to become and remain an employer of choice. VA must combine competitive compensation packages with new employee incentives, such as signing bonuses, retention incentives, scholarships, education loan repayment, and attractive benefits. The IBVSOs are concerned that Congress and the Administration have determined that all federal employees, including VA's 310,000 employees, will be denied economic comparability increases in both FY 2012 and 2013. Given the state of the U.S. economy and that of the federal deficit

and debt, we understand the rationale of this decision; however, denying VA employees any recourse for their calculated inflationary costs of living makes VA's human resources management challenges even more difficult.

Congress and VA must work together to ensure that sufficient resources are available to VA managers to offer competitive salary and employment packages to new appointees. For instance, in 2004, Congress passed P.L. 108-445, the "Department of Veterans Affairs Health Care Personnel Enhancement Act." The act was intended to aid VA in recruitment and retention of VA physicians, especially scarce subspecialty practitioners, by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. VA has fully implemented the act, but the IBVSOs believe the act may not have provided VA the optimum tools to ensure that veterans will have available the variety and number of physicians VA needs. We urge Congress to provide oversight and to ascertain whether VA has adequately implemented its intent or if VA needs additional tools to ensure full employment for qualified physicians as it addresses its future staffing needs. Additionally, to aid VA in recruiting and retaining medical subspecialists who provide care in VA's highly specialized clinical disciplines (such as spinal cord injury and dysfunction, blind rehabilitation, physiatry, surgical subspecialties, etc.) Congress should consider implementing an additional Title 38 specialty pay incentive to better compensate these scarce medical specialties.

Personnel Training, Debt Reduction, and Education Are Important Human Resources Tools

Maintaining a high-caliber professional staff is critical to the successful delivery of high-quality VA services. VA must make continuing education and training programs and associated incentives available to all qualified employees. VA leadership must make certain that existing staff and potential employees are aware of these opportunities and benefits for career development within the Department.

Last year VA increased the maximum award amount for its Employee Incentive Scholarship Program to \$37,494, from the earlier limit of \$35,900. This increase will help many existing VA employees who wish to further their education and hopefully can serve VA as a retention tool to retain valuable employees; however, other incentive programs,

such as the VA Education Debt Reduction Program (EDRP), are in need of award increases since educational costs continue to rise and new professional graduates are entering the workforce with historic educational debt. A higher EDRP award could serve as an effective recruitment tool to attract new graduates and students in numerous degree programs in VA's affiliated health professions universities and colleges to VA employment.

The level of reimbursement for continuing medical education expenses for VA physicians and dentists has remained unchanged since 1991 at \$1,000 per calendar year, and should be adjusted to remain competitive with policies of other health-care employers. In addition to increasing existing reimbursements, this philosophy of reimbursing physicians and dentists should be extended to additional VA health career fields as determined by the VA Secretary and Under Secretary for Health. Such reimbursements would serve two purposes: to improve the capabilities of VA professional employees in caring for veterans, and to serve as a strong incentive for retention.

Veterans and VA Employment

VA has a long tradition of employing veterans, including service-disabled veterans who successfully complete VA vocational rehabilitation programs. In establishing the Veterans Employment Coordination Service in 2008, VA reiterated its commitment to "advance efforts to attract, recruit, and hire veterans into the VA, particularly severely injured veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom," through a network of regional employment coordinators.

However, VA must take action to ensure that veterans have greater opportunities to enter and remain part of the VA workforce. First, VA should seek out jobless veterans for positions for which they are qualified. Particularly, in the health-care field veterans and people with disabilities are often viewed as patients receiving care; they can also be potential VA employees who deliver care and services. Veterans with disabilities are an untapped resource of health-care providers since many have already served in their capacity while in the service as nurses, aides, medics, emergency medical technicians, medical records administrators and staff, respiratory therapists, in transportation systems, and in many other allied health care fields. Second, Congress should reverse a federal appeals court decision

holding that Title 38 appointments are not covered by the “Veterans Employment Opportunities Act.” (*Scarnati v. Department of Veterans Affairs*, 344 F.3d 1246 (Fed. Cir. 2003)). Third, VA should ensure that veterans’ preference-eligible individuals receive proper credit for their accomplished military occupational specialties when they seek VA employment (for example, medics or corpsmen applying for licensed vocational or practical nurse positions in VA should receive significant credit for their prior military experience). To ensure that these protections are enforceable, VA human resources management officials should adopt a tracking system, similar to the system used for tracking employment discrimination data, to ensure qualified veterans remain an employment priority for the Department. In many cases veterans with service-incurred disabilities have direct experience with military and VA health systems and bring those competencies into their employment opportunities. These unique attributes have the potential to enrich VA service delivery while improving veteran unemployment—a major goal of Congress and the Administration in 2012.

Summary

The Department of Veterans Affairs must improve its human resources programs to ensure that America’s veterans receive the benefits and services they have earned. VA must revamp its recruitment and appointment systems to make the hiring process timely and efficient; update salary and compensation scales to levels that are competitive in the current employment market; and ensure that adequate training, continuing education, and debt reimbursement opportunities are offered and made available to all recruits and current employees for career mobility.

Congress and VA must work to strengthen and energize VA’s human resources management programs to recruit, train, educate, and retain qualified employees; to identify new tools to enable VA to gain equality with other employers in attracting a new generation workforce for the care of veterans; and to provide their vital services. VA human resources should set the standard of excellence when it comes to providing services for America’s veterans. Ultimately, VA must provide efficient, safe, and productive work environments and conditions of employment that attract and retain high-caliber professionals in order to successfully execute the VA mission: caring for America’s veterans.

Recommendations:

VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process, and avoid recruitment delays that serve as barriers to VA employment.

VA must implement an energized succession plan in VA medical and regional office facilities and other VA offices that utilizes the experience and expertise of current employees, as well as improve existing human resources policies and procedures that promote succession.

VA should adopt performance measures that tie the results obtained by human resources staffs, managers, and facility executives—to meet service recruitment goals and needs, for elements that provide direct services to veterans—to their own performance evaluations, awards, performance bonuses, and performance sanctions.

VA facilities must fully utilize recruitment and retention tools, such as hiring, relocation, and retention bonuses; equitable locality pay for VA nurses; physician compensation improvements; reimbursement for continuing medical education and scholarship; and educational loan repayment programs, as broad-based employment incentives, in both the Veterans Health Administration and Veterans Benefits Administration.

Congress should implement an additional Title 38 specialty pay enhancement for medical professionals who provide care in VA’s subspecialized services areas, such as in spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury programs.

Congress should enact legislation to reverse a federal appeals court decision holding that VA employees appointed under Title 38 authorities are not covered by the “Veterans Employment Opportunities Act.”

As indicated in the discussion above, the Administration and Congress should take appropriate actions to ensure VA provides ample opportunities for veterans to secure VA employment.

ATTRACTING AND RETAINING A QUALITY NURSING WORKFORCE:

While the supply of nursing personnel has been addressed in the short term, a larger nursing shortage looms that the Department of Veterans Affairs has not addressed.

Retention and recruitment of high-caliber health-care professionals and other staff is critical to the mission of the Veterans Health Administration (VHA) and essential to providing safe, high-quality health-care services to sick and disabled veterans. During the current economic recession and slow recovery, employment of full-time nurses has grown; however, relief is likely to be temporary, and health policy planners need to focus on how the current workforce is changing and consider the implications for future imbalances in the labor market. Over the long term, research predicts the development of another nursing shortage, one that will be larger than any experienced previously. Given the impact of this impending nationwide shortage and the resulting difficulty in filling nursing and other key positions within VHA, this challenge will continue for the Department of Veterans Affairs.

Addressing the National Nursing Shortage

Over the past 20 years, VA has undertaken the most significant transformation in its history with the transition from a hospital, bed-based system to an ambulatory care-based system with primary care as the focus of patient treatment in both outpatient and inpatient settings. The success of this transition depended, in part, on achieving an appropriate mix of health-care staff. Recruitment efforts within VHA focus on strategies to attract and hire registered nurses (RNs) into the organization. The VHA's Healthcare Retention & Recruitment Office continues to coordinate systemwide comprehensive programs for recruiting RNs, including high school outreach nursing programs, internships for nursing students, recruitment and retention incentives, scholarships, and loan repayment programs. The Healthcare Retention & Recruitment Office conducted an analysis of past scholarship programs that demonstrated their positive impact on retention, showing that loss rates for nurse scholarship participants (7.5 percent) were lower than turnover for nonscholarship recipients (10 percent) and that fewer than 1 percent of nurses completing their one-to-three-year service obligation ultimately left VA. VHA has established a specific initiative, the National Nursing Education Initiative (NNEI), to provide education incentives for VA nurses. Educational assistance, such as that

afforded under Employee Incentive Scholarship Programs (EISP), is an excellent recruitment and retention tool, wherein the salary replacement capability of the EISP is utilized to meet identified critical workforce occupation specific goals.²⁴⁹ This year, the funding for NNEI scholarships is severely limited; *The Independent Budget* veterans service organizations are concerned that diminished funding in EISP will depress recruitment.

Since 2002, nursing enrollments have increased so rapidly that each year approximately 30,000 or more qualified applicants have been turned away from nursing education programs primarily because of shortages of faculty, clinical sites, and classroom space. The American Association of Colleges of Nursing has reported that three-fourths of the nation's schools of nursing acknowledge faculty shortages along with insufficient clinical sites, lack of classroom space, and budget constraints as reasons schools of nursing deny admission to qualified applicants.²⁵⁰

The aging nursing workforce significantly contributes to the overall nursing shortage. According to the 2008 National Sample Survey of Registered Nurses released in September 2010, the average age of the RN population in 2008 was 46, up from 45.2 in 2000. With the average age of RNs projected to 44.5 years by 2012, nurses in their 50s are expected to become the largest segment of the nursing workforce, accounting for almost one-quarter of the RN population.²⁵¹ The cohort of RNs over the age of 50 has expanded 11 percent annually over the past four years.

The current recession has induced older nurses to delay retirement, and others to rejoin the workforce. Since 70 percent of RNs are married, many had little choice because their spouses had lost their jobs or feared that they might be in jeopardy of losing employment. According to a study published in 2009, RN employment increased by 18 percent between 2001 and 2008; however, RNs older than 50 accounted for 77 percent of that increase, the age group that is growing the fastest within professional nursing.²⁵² Because RNs older than 50 will soon be the largest age group in the nursing workforce, their retirements over the next decade will lead to a projected shortfall

developing by 2018 and growing to approximately 260,000 RNs by 2025. The magnitude of the 2025 deficit would be more than twice as large as any nursing shortage experienced since the mid-1960s. These projected shortages will fall upon a much older RN workforce than previous shortages.

With the passage of the “Patient Protection and Affordable Care Act in 2010,” more than 32 million Americans will soon gain access to health-care services, including those provided by RNs and advanced practice registered nurses. In November of 2011, the U.S. Bureau of Labor Statistics reported that the health-care sector of the economy is continuing to grow, despite significant job losses in recent months in nearly all other major industries. Hospitals, long-term care facilities, and ambulatory care settings added 12,000 jobs in October, following a gain of 45,000 in September. As the largest segment of the health-care workforce, RNs likely will be recruited to fill many of these new positions. The BLS confirmed that 313,000 jobs have been added in the health-care sector within the last year.²⁵³

A March 2011 *New England Journal of Medicine* report indicated that insufficient nurse staffing was related to higher patient mortality rates. This report analyzed the records of nearly 198,000 admitted patients and 177,000 eight-hour nursing shifts across 43 patient care units at large academic health centers. The data show that the mortality risk for patients was about 6 percent higher on units that were understaffed as compared with fully staffed units and also found that when nursing workload increases because of high patient turnover, mortality risk also increases.²⁵⁴

A succession plan which incorporates the nurse manager, assistant chief, and chief nurse executive positions will be a keystone to VA’s successful nursing recruitment plans. Support of a VA mentoring program and other opportunities to educate and support our emerging nursing leaders is an important element of this success. The relationship between the chief nurse executive and the chief of staff at the facility level adds value to quality, safety, and redesign efforts. Continued support in building upon this relationship would be helpful in modeling a shared practice environment, focused on nurse-physician collaboration.

The average age of a new graduate nurse increased from 23.8 years prior to 1984 to 29.6 years during 2000 to 2004. However, projections by Buerhaus conclude that future cohorts will enter the nurse workforce at ages 23–25.²⁵⁵ Nursing education programs could experience an increase in demand because some people who are attracted by the relative job security and earnings offered in nursing seek to become RNs, while the capacity of state-subsidized education programs could be affected negatively by state budget deficits. Faced with the projected nursing shortage, the nation’s ability to expand the long-term supply of RNs is in doubt.

Over the past several years, the VHA has been trying to attract younger nurses into VA health care and creating incentives to retain them in the VA system. New nursing graduates are currently experiencing difficulty finding jobs. Findings of a 2009 study by the National Student Nurses’ Association revealed that 51 percent of diploma graduates, 50 percent of associate degree graduates, and 38 percent of baccalaureate graduates were unable to find jobs. In addition, 41 percent of respondents reported that there were no jobs available for new graduates in their areas.²⁵⁶ In July 2010, the Tri-Council for Nursing released a joint statement, entitled “Recent Registered Nurse Supply and Demand Projections,” which cautioned stakeholders about prematurely declaring an end to the nursing shortage. While the downturn in the economy has led to an easing of the shortage in many areas, the Tri-Council concluded this relief to be temporary. In the statement, the Tri-Council raised concerns about any decline in graduation rates for new RNs given the projected demand for nursing services, particularly in light of health-care reform.²⁵⁷ The IBVSOs understand that the Office of Nursing Services in VA Central Office successfully completed a RN residency pilot program and is making plans for full implementation. An effort to increase consistency in the work environment should include participation in improvement programs such as the Robert Wood Johnson Foundation’s Transforming Care at the Bedside (TCAB) initiative. The TCAB program encourages nurses to develop interventions and design new processes that improve care. The IBVSOs believe that every VA health-care facility should explore similar opportunities to participate in these kinds of programs. These efforts have been shown to improve patient outcomes as well as patient and nurse satisfaction.

VA's Travel Nurse Corps (TNC) is now completing its fourth year of operation. This program offers a valuable service by providing RNs to VA facilities in need of RNs on a temporary basis. These nurses receive their initial orientation at the Phoenix VA Health Care System. RNs from this program have been on assignments from Alaska to Puerto Rico, including more than 50 VA medical centers in 19 networks. The host VA facilities reimburse salary, travel and per diem of TNC RNs as well as administrative charges. Nurses who participate in this program have informed the IBVSOs that VA reimbursement rates for their travel and subsistence are inadequate and should be increased. VA should reimburse these nurses' expenses appropriately, first to enhance the success of the program, and second, to ensure that the individuals participating are not forced to pay their own way.

The Office of Nursing Services initiated a nationwide program to support nurses in obtaining certification in their specialty areas. Nurse executives were educated on existing authorities and provided with resources to encourage nurses in their facilities to pursue certification. In addition, the clinical nurse leader position was established in another initiative supported by the Office of Nursing Services, to enhance education for nurses and patients in the clinical arena. The clinical nurse leader role is designed to deliver clinical leadership in all health-care settings and to respond to individuals and families within a microsystem of care.

The Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health*, is a thorough examination of the nursing workforce and, since its release in October 2010, it has remained the top-visited report on the IOM's website. The recommendations offered in the report focus on the critical intersection between the health needs of diverse, changing patient populations across the lifespan and the actions of the nursing workforce. These recommendations are intended to support efforts to improve the health of the U.S. population through the contributions nurses can make to the delivery of care. The recommendations are centered on three main nursing issues:

- practice to the full extent of education and training;
- achieve higher levels of education and training through an improved education system that promotes seamless academic progression; and

- become full partners with physicians and other health-care professionals in redesigning health care in the United States.

The report also emphasized effective workforce planning and policy making to improve data collection and information technology (IT) infrastructure.²⁵⁸ The IBVSOs fully concur with the IOM's vision for the future of nursing in health care, and urge VA to adopt this vision in its own strategic planning programs.

Clinical Nurse Leader

The clinical nurse leader (CNL) role was designed to meet an identified need for expert clinical leadership at the point of care. Foreseeing the value of this pivotal clinical leader at the point of care to meet the complex health-care needs of America's veterans and shape health-care delivery, the VHA became an early proponent. Impact data were collected and assimilated from seven VA medical centers to support how CNLs impact the delivery of quality and safe patient care and how practice changes could be sustained. The new CNL role was implemented in a variety of settings in the VHA system. Integration of the CNL role in all areas of practice in every care setting promises to streamline coordination of care for veterans across the spectrum.²⁵⁹ The CNL role will contribute to VA's efforts to promote value and high reliability through its impact on efficiency and effectiveness. These defining areas of practice include implementation of evidence-based practice at the point of care, risk anticipation and assessments, identification and collection of care outcomes, implementation of quality improvement initiatives, and creative leadership in team-based care. Additionally, CNLs further contribute to high reliability by applying evidence that challenges existing protocols, procedures, and policies, and creating a culture of patient safety through collaborative and team-based efforts.

VA Nursing Academy

The VA Nursing Academy (VANA) is a five-year pilot currently in its final year, scheduled to end in the spring of 2012. VANA consists of 15 academic partnerships with 18 VA facilities and 16 universities and colleges. Outcomes of the VANA partnership include an increase in baccalaureate graduates, enhanced and cost-effective recruitment and retention of graduate nurses and faculty, and professional development for VA-based faculty as well as clinical

practice and educational innovations. VANA graduates overwhelmingly prefer VA employment and significantly lower expenses of VA recruitment and retention. Given the looming RN vacancy predicted due to retirement and increased demand, VANA fills a sorely needed workforce succession planning gap.

All current partnerships have achieved the objectives of the program along with significant additional collateral value in facilitating and enabling VA transformative objectives. These partnerships have enabled veteran- and military-centric curriculum revisions, increased access to mental health and interventions for homeless veterans, cost-efficient shared educational services with the Department of Defense, as well as cost avoidance and revenue enhancement opportunities due to practice and educational innovations.

Continued funding beyond the pilot program is needed to provide this benefit to additional VA facilities. The IBVSOs also urge VA to examine the effectiveness of this approach and to make expansionary plans as warranted by the results obtained in that review.

VA Nursing Workplace Issues

VHA staff will need to have new skills and competencies to treat the new generation of veterans, particularly in areas such as rehabilitation, mental health, and primary care. Those working in primary and ambulatory care settings will need to be able to screen combat veterans for post-traumatic stress disorder, depression, substance-use disorder, maladaptive coping, and various other mental health challenges, and will need to know how to refer these veterans for appropriate care and treatment. Those working with veterans with amputations will need to know how to work with the latest technologies in prosthetic limbs. Staff will need to be able to provide female-specific health-care services. Also, VA nurses will need better training in assessing veterans for military sexual trauma, and to provide appropriate referrals to ensure they receive adequate care for that highly sensitive problem. New roles for RNs such as in primary care as care managers are also critical to the emerging patient-aligned care team model.

As addressed more thoroughly in our discussion of human resources management elsewhere in this *Independent Budget*, and similar to other health-care employers, the VHA must actively address those

factors known to affect recruitment and retention of all health-care providers, including nursing staff, and take proactive measures to prevent crises before they occur. While the IBVSOs applaud what VA is trying to do in improving its nursing programs, competitive strategies have yet to be fully developed or deployed in VA. We encourage the VHA to continue its quest to deal with shortages of health manpower in ways that keep it at the top of the standards of care in the nation. Nursing informatics, nursing data, and nurse-sensitive outcomes are critical to our nursing workforce today. The ability to review data on patient outcomes and to measure efficiency and effectiveness in the areas of quality and safety are essential in today's health-care arena. The IBVSOs recommend sustained support of ongoing and additional projects to support the necessary nursing informatics to achieve these results.

We also fully endorse enhanced physician-nurse collaboration to achieve VA's goals for health care. The impact of collaborative physician-nurse partnerships in clinical, research, academic, and leadership areas should not be underestimated, and is a major part of the blueprint for reform of all health care in the future.

Recommendations:

Congress must provide sufficient funding and strong oversight to support programs to recruit and retain critical nursing staff in VA health care, and in particular, to support enlargement of the Nursing Academy if warranted by expected results in the existing pilot program.

Congress should support changes in per diem and travel requirements to ensure the viability of the VA Travel Nurse Corps program.

Congress should provide support to ensure sufficient nurse staffing levels to regulate and ultimately reduce to a minimum VA's use of mandatory overtime for nurses.

Congress should provide sufficient funding so that all VA facilities can participate in workforce environmental improvement programs, such as recommended by the Robert Wood Johnson Foundation's "Transforming Care at the Bedside."

Congress should support funding to continue and expand the Office of Nursing Services' registered nurse residency pilot program.

VA should expand information technology efforts in nursing informatics, and promote opportunities for VA physician-nurse collaborations in clinical and academic, research and leadership.

²⁴⁹Department of Veterans Affairs, Veterans Health Administration, VHA Handbook 1020, (Washington, DC: May 14, 2010). http://www.va.gov/vha-publications/ViewPublication.asp?pub_ID=2241.

²⁵⁰The Joint Commission, Robert Wood Johnson Foundation Initiative on the Future of Nursing, Testimony at the Institute of Medicine, (February 23, 2010). http://www.jointcommission.org/assets/1/18/RWJ_Future_of_Nursing.pdf.

²⁵¹U.S.Department of Health and Human Services, Health Resources and Services Administration, *The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses* (September 2010). <http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyfinal.pdf>.

²⁵²P. Buerhaus, D. Auerbach, and D. Staiger, "The Recent Surge in Nurse Employment: Causes and Implications." *Health Affairs* (Project Hope). July–August, 2009, 28(4):w657–68.

²⁵³Bureau of Labor and Statistics, U.S.Department of Labor, News Release: The Employment Situation October 2011 (November 4, 2011). <http://www.bls.gov/news.release/pdf/empisit.pdf>.

²⁵⁴Jack Needleman, PhD, Peter Buerhaus, PhD, RN, et al., Special Article: "Nurse Staffing and Inpatient Hospital Mortality," *N Engl J Med* 2011; 364:1037–1045 <http://www.nejm.org/doi/full/10.1056/NEJMsa1001025>.

²⁵⁵P. Buerhaus, D. Auerbach, and D. Staiger, "The Recent Surge in Nurse Employment: Causes and Implications." *Health Affairs*, (Project Hope). July–August, 2009, 28(4):w657–68.

²⁵⁶D. Mancinno, "Entry Level Positions for New Graduates: Real-Time Dilemma Requires Real-Time Solutions." Dean's Notes, September/October, 2009, 31(1): 1–4.

²⁵⁷Tri-Council for Nursing, "Joint Statement from the Tri-Council for Nursing on Recent Registered Nurse Supply and Demand Projections" (July 13, 2010). <http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/MediaBackgrounders/Registered-Nurse-Supply-and-Demand-Projections.aspx>.

²⁵⁸Institute of Medicine, "The Future of Nursing: Leading Change, Advancing Health" (October 5, 2010). <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>.

²⁵⁹Karen M. Ott, et al. "The Clinical Nurse Leader: Impact on Practice Outcomes in the Veterans Health Administration," *Nurse Econ*. 2009; 27(6):363–70.



VOLUNTEER PROGRAMS:

The Department of Veterans Affairs needs to provide sufficient dedicated staff at each VA medical center to promote volunteerism and coordinate and oversee voluntary service programs and manage donations given to the medical center.

Since its inception in 1946, volunteers have donated in excess of 736.7 million hours of volunteer service to America's veterans in VA health-care facilities and cemeteries through the Veterans Affairs Voluntary Service (VAVS) program. As the largest volunteer program in the federal government, the VAVS is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of more than 65 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and their auxiliary components, which report to the VA Under Secretary for Health.

Veterans Health Administration volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

VAVS volunteers assist veteran patients by augmenting staff in such settings as VA hospital wards, nursing homes, end-of-life care programs, outpatient clinics, community-based volunteer programs, national cemeteries, veterans' benefits offices, and veterans' outreach centers. With the expansion of VA health

care for patients in the community setting, additional volunteers have become involved. During FY 2012, VAVS volunteers contributed more than 12 million hours to VA health-care facilities. These volunteer hours represent hundreds of millions of dollars had VA needed to hire employees to fill these volunteer roles.

At national cemeteries, VAVS volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on gravesites for Memorial Day and Veterans Day. Hundreds of thousands of hours have been contributed to improve the final resting places and memorials that commemorate veterans' service to our nation.

VAVS volunteers and their organizations also contribute millions of dollars in gifts and donations annually in addition to the value of the service hours they provide. The combined annual contribution made in 2011 to VA is estimated to be more than \$90 million. These significant contributions allow VA to assist direct-patient care programs, as well as support services and activities that may not be fiscal priorities from year to year. Monetary estimates aside, it is impossible to calculate the amount of caring and

comfort that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers continues to increase dramatically as more demands are placed on VA health-care staff. The way in which health services are provided is changing, providing opportunities for new and less traditional roles for volunteers. Unfortunately, many core VAVS volunteers are aging and are no longer able to volunteer. Likewise, not all VA medical centers have designated a staff person with management experience to recruit volunteers, develop volunteer assignments, and maintain a program that formally recognizes volunteers for their contributions. It is vital that the Veterans Health Administration keep pace with utilization of this national resource.

Recommendations:

VA should require each Veterans Health Administration (VHA) medical center to designate sufficient staff with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions. The positions must also include experience in maintaining, accepting, and properly distributing donated funds and donated items for the medical center.

Each VHA medical center should develop nontraditional volunteer assignments, including assignments that are age appropriate and contemporary.



VA PURCHASED CARE:

The Veterans Health Administration should develop an integrated program of care coordination for veterans who receive care from private health-care providers at VA expense.

Current law authorizes the Department of Veterans Affairs to purchase health care to ensure a complete continuum of medical care is provided to veterans in specified situations, such as where Veterans Health Administration (VHA) facilities are geographically inaccessible to veterans, patient demand for health care exceeds VHA facility capacity, scarce medical specialists unavailable in VA facilities are needed, and to satisfy wait-time requirements. This authority to purchase care is a supportive tool that should be used to supplement the VA health-care system when VHA facilities do not have the resources to provide necessary care to veterans.

The Independent Budget veterans service organizations (IBVSOs) believe this authority is necessary to ensure continuity of and access to health care, but it should be used judiciously and only in these specific circumstances so as not to endanger VHA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. We have consistently opposed blanket proposals to expand VA's purchasing care on a broader basis. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serve larger

veteran populations, may not ensure cost-effectiveness where procurement is weighed against maintaining and operating like services in local VHA facilities. Ultimately, such proposals only serve to dilute the quality and variety of VA services for new as well as existing patients.

VA recognizes that use of more than one health-care system to obtain care is common among veterans who seek care at VA, whether it is paid for by VA, by third-party health insurance carriers, Medicaid/Medicare, or out-of-pocket. Regardless of the source of payment, the IBVSOs believe VA has the responsibility to ensure the health-care service it buys is provided in a coordinated manner.

For veteran patients who have health insurance and use non-VA providers in their communities, VA policy is to use a "co-managed care" or "dual care" approach where the veteran's assigned VA primary care team is responsible for managing all aspects of care and services available through VA and will assist in coordinating care outside the VA system. This approach requires veterans to inform both VA and non-VA providers that they want to have their care

coordinated. They must complete a “release of information” in order for VA to access the veteran’s health information from private providers and inform the primary care team of all names and contact information of non-VA providers as well as prescribed medications.

The IBVSOs commend this policy, as opposed to our concerns with how the care is provided through the Department’s Fee Care program, which is not managed or coordinated. In the Fee Care program, for example, VA does not track its related costs by veteran, monitor the quality of care, health outcomes, and veteran satisfaction, or ensure patient safety. Our growing concern about how care is delivered through this program is further raised by the rate of increasing expenditures for non-VA purchased care surpassing the rate of increase in VA’s medical care budget.

In FY 2009 VA spent about 12 percent of its medical care budget, or nearly \$5.4 billion, to purchase health-care services from non-VA entities for eligible veterans. In FY 2010, VA spent about \$6.3 billion, 13 percent of its medical care budget. VA purchases care through a variety of means but uses two major mechanisms to provide care outside its health-care system. These include (1) contracts on a competitive basis or by agreements; and (2) noncontracted medical care reimbursed on a fee-for-service basis (fee care) from providers in the community.

Need for Care Coordination

There is abundant evidence demonstrating the favorable outcomes of care coordinators assisting targeted individuals and their support systems in navigating the health-care system, communicating with providers and payers, minimizing potential for conflicting plans of care, easing transitions between sites of care, and promoting patient and family education.

Whether the non-VA care provided to veterans is through partnerships with other federal agencies, such as the Department of Defense Military Treatment Facilities, partnerships with university or college health professions affiliates, or purchasing care in the community through contracts, agreements, or on fee basis, VA retains the obligation to coordinate all such care.

Many veterans are currently disengaged from the VA health-care system when receiving health-care

services from private physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to health care through coordination of community-based care. The IBVSOs urge VA to develop an effective care coordination model that achieves both its health-care and financial objectives. Doing so will enhance the quality of and access to non-VA care and allow the Department to use limited resources more wisely.

The IBVSOs recommend that VA implement a program for veterans receiving non-VA care services to ensure:

- care is received in a timely manner
- care is appropriate to and centered around the veteran’s needs
- care is delivered by fully licensed and credentialed providers
- electronic sharing of pertinent medical information occurs between the Department and non-VA providers
- monitoring of the veterans’ continuity of care, and
- veterans are directed back to the VA health-care system for follow-up when appropriate.

Components of a coordinated care program should also include the following:

- A single care/case manager assigned to assist every veteran and each VA medical center (VAMC) when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran’s needs, the manager could address both appropriateness of care and continuity of care resulting in a truly integrated seamless health-care delivery system.
- Access to a catalog of providers and provider networks that complement the capabilities and capacities of each VAMC. This would facilitate identification of community resources to address timeliness and access to credentialed providers and offer a “surge” capacity in times of increased need to address cost-effectiveness in both urban and rural environments.
- Alternative types of care, including nonclinical coaching via telephone, messaging, secure e-mail, web-based programs, and other forms of communications.

- Mandatory requirements that non-VA providers to meet, including timely communication access to care issues and clinical information to VA; proper and timely submission of electronic claims, and incentives when meeting applicable performance standards.
- Mandatory requirements for VA, including ongoing management of veterans' health-care needs, and proper review and timely payment of appropriate claims.

If implemented successfully, a care-coordination system also could improve veteran satisfaction with non-VA services and optimize workload for VA facilities and their academic affiliates. A key to success in this effort is the coordination of care by VA and non-VA providers and implementation of the veterans' care plan.

VA has a number of such programs as well as established specialized systems of care and primary care teams with specialty trained practitioners for veterans who have incurred spinal cord injury or disease, blindness, amputations, polytrauma injuries, and chronic mental health challenges. Unfortunately, no such programs of similar scale exist with the agency's purchased care environment.

The IBVSOs have been advocating care coordination for many years in order to reconnect veterans receiving care in the community with their primary care managers in VA. These VA care managers should be overseeing care received in the community and working to find ways to return the veteran into VA when possible, while ensuring the care being provided is of high quality and is cost-effective. We urge VA to ensure its purchased care program acts to enhance the effectiveness of patient-aligned care teams (PACTs) discussed later in this section.

Coordination of care is especially critical for chronically ill and complex patients, such as those with cancer, diabetes, chronic obstructive pulmonary disease, and end-stage renal disease. A particularly compelling need is for patients with end-stage renal disease who require dialysis for survival. These patients often have three to four comorbid conditions in addition to their kidney disease (e.g., diabetes, hypertension, cardiovascular disease). They are typically on seven to 10 prescribed medications and are often referred to non-VA providers for dialysis. These patients are

extremely frail and should be afforded more convenient access to these specialized facilities for a treatment regime that is generally three days per week for four hours each day.

Coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians is essential to improving clinical outcomes and reducing the total costs of care. The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations that frequently cost more than the total cost of dialysis treatments. These interventions also focus on behavioral modification and motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial for VA.

The IBVSOs understand that some community dialysis providers are piloting the integrated care management concept among their veteran population. The IBVSOs believe that VA should encourage more community dialysis providers to provide integrated care management by properly funding pilot programs that can test and demonstrate the value of such an approach to VA and the veterans it serves. VA should also ensure that these care management platforms fully integrate with the VA case managers and in-house providers, which could be accomplished through the health information exchange (HIE) or a HIE type of interface.

Fee-Basis Care

Historically called the Fee Care program, care provided may include dental and mental health services; outpatient, inpatient, and emergency care; and medical transportation for veterans enrolled in VA and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Eligible veterans who are authorized fee-based care, are allowed to choose their own medical providers.

VA's Fee Care program spent more than \$3 billion in FY 2008 and \$4.44 billion in FY 2010—a 47 percent increase, while the number of unique patients served increased from approximately 820,000 to 952,000, a 16 percent increase. A number of VA

Office of Inspector General audit reports in recent years have pointed to problems in the business practice of the Fee Care program. This growth, however, has not been matched with supporting resources and management.

Business Processing Issues

To address the growth of purchase care spending on services without a contract or agreement, VA issued a final rule in December 17, 2010, to apply Medicare payment methodologies to all non-VA inpatient and outpatient health care professional services and other medical charges associated with non-VA outpatient care. These charges include ancillary and facility costs, such as those that are reimbursed using the established Medicare payment systems or fee schedules. According to VA's FY 2012 budget submission, VA is projected to save \$315 million in 2012 and \$362 million in 2013 with the Medicare fee schedule.

Management of fee claims is predominantly a manual process that generates significant payment errors, resulting from fee clerks with no access to automated payment reimbursement information and data entry mistakes based on complex fee claims as they key in the invoices before sending them to VA's Financial Management System, in Austin, Texas, for payment by check, credit card, or electronic funds transfer. Over the years, VA taken many steps to address existing variability in processing non-VA medical care claims.

With exception of Veterans Integrated Service Network (VISN) 6, which is a pilot site for a 3M Corporation-developed fee software, VA deployed the Vista Fee Basis Claims System (FBCS) at all fee claims processing sites to assist in correct and consistent payment. FBCS features electronic management reports, data capturing and processing, automated claims review, claims scrubbing tools, and workload assignments. However, while it is an improvement, FBCS is an interim solution to address the more than 20-year-old VistA Fee limitations. FCBS acts as a user interface to VistA Fee and carries the same inherent limitations. Fee staff is therefore required to use both FBCS and VistA Fee simultaneously to perform their duties.

Furthermore, there is still no single national database for Fee Care program business operations despite having deployed FBCS nationally. As mentioned

previously, FBCS is hosted at claims processing sites, which can be either at a VISN or facility level.

For the CHAMPVA program, VA implemented a "Medicare Crossover" agreement and the receipt of electronic claim submissions through the Centers for Medicare and Medicaid (CMS) contractor will reduce manual input of claims data and significantly reduce errors related to other health insurance.

VA also has other initiatives estimated to yield \$200 million in savings in each of FY 2012 and 2013. These include the use of the Preferred Pricing program (discussed below), use of contract and blanket ordering agreements, decrease contract hospital average daily census, decrease duplicate payments, decrease interest penalty payments, and increase revenue generation through the use of automated tools.

Moreover, VA has implemented a national fee-training program for local fee staff as well as certification for authorization and claims processing. Field assistance teams have been deployed to work directly with the field fee offices and facilities to provide standardization in business practices and target specific improvements as requested from the field.

As VA attempts to address the human capital aspect of automating fee claims processing, it is our understanding that the VHA intends to shift some of the approximately 2,000 VHA facility-level fee staff toward care and case management to perform such functions as overseeing the referral process, assisting veterans with obtaining appointments from private providers, conducting follow-up to such appointments, and sending and receiving clinical information. Other fee staff will work more closely on cost-benefit analysis of purchasing non-VA care or increasing VA capacity.

In reviewing several Office of Inspector General (OIG) health-care inspections, we have noticed increased use at VA community-based outpatient clinics (CBOCs) of "short-term fee-basis" care, which is generally a consult for examinations or for complete episodes of treatment within a designated, concise period of time, usually 60 days. As with fee care in general, veterans who are authorized for short-term fee-basis care are allowed to choose a physician for the services required. In the absence of this selection, facility staff will arrange for treatment by a qualified

physician located within a reasonable distance of the veteran's residence.

However, there is currently no publicly available written policy to implement a standard process for short-term fee-basis consults. This only serves to aggravate the inability to manage the overall program.

By initiating improvements to its business practices, VA has begun to address material weaknesses to its fee care program, but accuracy problems linger. Some temporary stand-alone information technology systems have been put in place to assist fee staff, but they lack the functionality for centralized reporting, recording, and decision support systems. Clearly, what leadership expects of IT today to manage this program for decision making, policy change, etc., is not being provided by the interim solution. In light of the need for significant changes to be made to the overall infrastructure, the short-term "band-aid" approach may be adequate, but it is not in the best interest of veteran patients or VA to provide timely access to quality health-care services.

Clinical Care Issues

VA's fee care offers very little in the way of care coordination—other than preauthorizing the care and claims reimbursement processing—to ensure the non-VA care is appropriate, protects patient safety, allows for health information sharing, or is measured for quality. For example, while it is VA policy for all consults including Fee Care consults to be addressed within seven days, referring providers are not automatically notified if, when, or with whom an appointment is made. Further, the fee care provider's results that are sent to the clinic are not always present in the patient's medical record.

A June 2010 OIG report dealing with the care provided at the Orlando VAMC reported that after it had assumed all operational activities, it was determined that the medical center did not have an adequate care management system to coordinate care between VA providers and fee-basis providers, which led to delays in care. OIG also found instances where medical care was affected or delayed due to communication breakdowns between VA and non-VA providers.

VHA's Dentistry and Geriatrics and Extended Care (GEC) clinical programs represent the largest pur-

chasers of non-VA care. It is all the more concerning that veterans in need of services from GEC generally suffer from chronic conditions for which care coordination is widely recommended as the best practice to result in better health outcomes and improved health status as well as lowering costs of care.

Many of the same challenges hold true for women veterans who use the VA health-care system. According to VA, 51 percent of women veterans who use the VA system split their care across VA and non-VA systems of care. Additionally, a substantial number of women veterans receive care in the community via fee-based and contract care, and little is known about the quality of that care. The IBVSOs' concerns about the fragmentation of care and disparities in care that exist for women are more fully described in "Women Veterans' Health and Health-Care Programs" in this *Independent Budget*.

Other veteran patients face a variety of challenges because of the lack of care coordination. Veterans under the Fee Care program are sometimes unable to secure treatment from a community provider because of VA's lower payment, less-than-full payment, and delayed payment for medical services. The IBVSOs are especially concerned that service-connected disabled veterans who are authorized to use non-VA care are at times required by the only provider in their community to pay for the care in advance.

In these instances, health-care providers frequently charge a higher rate than VA is willing to reimburse, resulting in veterans having to pay out-of-pocket fees for the medical care they need and are not reimbursed by VA. In addition to access and related cost issues, VA does not oversee other aspects of care veterans receive through Fee Care, such as health outcomes, the quality of the provider, or veteran satisfaction levels.

Because VA at times approved only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, it makes incorrect payments for outpatient fee care, and some veterans who seek reimbursement from VA are paying for part of their care. The wide variations in how VA facilities paid facility charges and the lack of clear policies and procedures occur because the Code of Federal Regulations did not address how VA

should pay outpatient facility charges. We are hopeful VA's recent regulations to apply Medicare payment methodologies to fee care will address this issue.

The IBVSOs urge VA to make significant changes to this program: The Fee Care Program management is the responsibility of VHA's Chief Business Office (CBO), which is aligned under the Deputy Under Secretary for Health for Operations and Management. We also understand that VISNs have operational authority and responsibility for their fee programs, and most VAMCs independently administer the Fee Care program for their areas.

The decentralized nature of this program produces inefficiency. However, decentralization provides flexibility to meet local needs. The IBVSOs believe if this organizational structure remains in place, significant support from VA leadership and Congressional oversight will be needed to make any changes.

The VHA CBO is responsible for the Fee Care program. The CBO's authority to properly guide and manage this program is not unlimited. Unlike many clinical care programs in VA, managing the Fee Care program does not include certain tools, particularly in information technology, data reporting, and performance metrics. The program also lacks clear written guidance.

Currently, there is only one publicly available policy and procedure document of significance to address non-contract fee care: VHA Manual M-1, Part 1, Chapter 18, "Outpatient Fee," dated July 20, 1995. According to the OIG, "VHA's National Fee Program Office drafted new policies to replace M-1 and submitted them to VA General Counsel for review in Fall 2008. VA General Counsel returned the policies with additional revisions to the National Fee Program Office in May 2009, and as of June 2009, the policies had not been issued...[and] the draft policies do not sufficiently address requirements for VAMCs to justify and authorize fee care to ensure that fee care meets the legislative intent and is economical and efficient. Furthermore, according to OIG Report No. 08-02901-185, the VHA has not developed detailed written procedures suitable for fee staff to use as their day-to-day instructions for processing claims and meeting VHA policy requirements."

The IBVSOs recommend that VA establish clear and reportable national standards for fee care and in particular, short-term fee-basis consults, that require care coordination, health information sharing, patient satisfaction and safety, and as well as quality of care standards (such as timeliness of referral, receipt of care, follow-up care, and patient notification) for both the VA and non-VA provider. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should also evaluate the fee care program's organizational structure. In addition to considering business functions in this evaluation, VA must integrate care coordination and other clinical aspects fundamental to but not currently emphasized in the Fee Care program to address the fragmented and inconsistent quality of fee care.

VA has initiated the non-VA care coordination (NVCC) pilot in VISNs 11, 16, and 18. We believe VA plans to operationalize this program by the end of FY 2012. This initiative is focused on improving management of consult and referral, appointment scheduling, and claims management.

The IBVSOs urge VA to establish and develop a mechanism for keeping a current inventory of fee services and contracts in all states. This would serve to (1) assist the veteran in choosing a community provider; (2) identify needs and gaps in services provided in the communities; and (3) minimize barriers for VA to timely develop contracts with select entities as the need arises. Such contracts would serve as a vehicle to facilitate care coordination between VA and the community provider to enhance the quality and access to care while reducing cost.

We also urge the Department in FY 2012 to work with key stakeholders as these events unfold to ensure a smooth transition to retain a full complement of skilled and motivated personnel. To date, outreach has been lackluster and even a proactive approach on has yielded little information. We urge VA to provide policy documents for this initiative to ensure transparency and to conduct proper oversight.

The IBVSOs are pleased to see that VA is moving toward improvements in the Fee Care program, particularly with regard to electronics management of repricing, as outlined in the FY 2012 Budget Request. In fact, VA estimates that it will achieve \$200 million in savings in FY 2012 and FY 2013 through improvements to the Fee Care program. However, it is critically important that strict oversight be applied to the various measures that VA has outlined. Additionally, we urge Congress to continue to track the ability of VA to achieve these savings as VA has historically failed to meet many of its cost-savings targets in the past.

Preferred Pricing Program

The IBVSOs believe it is critical for VA to implement a program of purchased care coordination that includes integrated clinical, record, and claims information for the veterans it authorizes to receive care from non-VA providers. Even though these veterans are not receiving care at a VA facility, the authorization is a clinical decision made by a VA provider. Such a decision does not relieve the Department from the responsibility of being an active participant in the veterans health-care system or for ensuring the quality and cost of the care provided meets VA standards.

Under the Preferred Pricing program (termed by VA as “claims repricing”), each VAMC can save precious resources spent under the Fee Care program by allowing veterans to use non-VA medical services.

In this program, VA selects billed charges it receives from community providers and sends them to contractors. The contractor reprices each claim to agreed-on network rates when the claim is from a network provider. The claim is then returned to the VA Fee Claims Office with a pricing sheet showing the network price. VA compares the network price against the Department’s allowed amount to determine the amount it will pay the provider.

The IBVSOs were pleased that VA made participation in its Preferred Pricing program mandatory for all VAMCs in 2005. In addition, the Claims Repricing program began shifting to electronic process during fiscal year 2010, and in early 2011, all remaining VISNs on the FBCS converted to the electronic process.

Today, 20 out of all 21 VISNs are submitting claims through electronic data interchange. The only VISN that currently submits 100 percent of claims on paper is VISN 6, which is converting to the electronic process. The implementation of electronic data interchange across all VAMCs allows this program to expand and create additional savings for VA by allowing more claims to be submitted to the Preferred Pricing service-disabled veteran-owned contractors.

As mentioned previously, VA changed its payment methodology for outpatient claims in February 2011. Notwithstanding the impact of the projected savings of \$68 million in FY 2011 from this new payment schedule, the Preferred Pricing program claims volume increase more than 330 percent in FY 2011 and yielded a discount of more than \$191 million.

Since the program’s inception, the Claims Repricing program has reduced VA Fee Care program expenditures by more than \$590, providing more funding to support purchased care programs and the needs of veterans.

Overall, the IBVSOs believe the national Preferred Pricing program/Claims Repricing is a foundation upon which a more proactive coordinated care program could be established that would not only save significantly more funding when buying care, but, more important, could provide VA a sound mechanism to fully integrate purchased care into its health-care system. By partnering with an experienced managed care contractor, VA could define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value for VA.

Care Coordination in Project HERO

In accordance with language from House Report 109–305 accompanying P.L. 109–114, VA was directed “to implement care management strategies that have proven valuable in the broader public and private sectors.” Congress deemed it essential that care purchased from private sector providers for enrollees of the VA health-care system be secured in a cost-effective manner, in a way that complements the larger VHA system of care, and preserves important agency interest, such as sustaining a partnership with academic affiliates.

The report also requires VA to establish through competitive award by the end of calendar year 2006, at least three managed care demonstration programs designed to satisfy a set of health system objectives related to arranging and managing care.

VA subsequently developed an initial set of objectives to enhance the existing fee-basis care program:

- Increase the efficiency of VHA processes associated with purchasing care from commercial or other external sources;
- Reduce the rate of cost growth associated with purchased care;
- Implement management systems and processes that foster quality and patient safety and make contracted providers virtual, high quality extensions of the VHA;
- Control administrative costs and limit administrative cost growth;
- Increase net collections of medical care revenues where applicable;
- Increase enrollee satisfaction with VHA services;
- Sustain partnerships with university affiliates; and
- Move toward the integration of the use of VA's electronic health record with the episode of care in the contracted setting. This is integral to VA's ability to manage care in contracted settings.

VA awarded a contract in October 2007 to Humana Veterans Healthcare Services (HVHS), a subsidiary of Humana Military Healthcare Services, Inc. In January 2008, contract services for dental care under Project HERO (Health Effectiveness through Resource Optimization) were to be made available through Delta Dental.

Contracts for this demonstration project have a base year with four option years, and are in the fifth and final year of implementation. Under this demonstration, participating VISNs 8, 16, 20, and 23 are to provide primary care and, when circumstances warrant, must authorize referrals to HVHS for specialized services in the community. These specialty services initially included medical/surgical, diagnostics, mental health, dialysis, and dental.

Unlike VA's Fee Care program, the agency is able to address care coordination through negotiated

contract agreements. According to VA, contract requirements of Project HERO that address quality of care include providers that must be certified or licensed and must practice in facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations or other similar accrediting institutions. Continuity of care is monitored where patients are properly directed back to the VA health-care system following private care and a process is in place for reporting patient safety, complaints, and satisfaction.

An important aspect to care coordination is patient perception of the care they receive. The IBVSOs applauded the Department when a survey mechanism was implemented in February 2010 to ask veterans about their satisfaction with the health-care services provided by VA as compared to Project HERO. Results of this survey through March 2011 indicate a higher overall patient satisfaction for veterans participating in Project HERO.

The IBVSOs have continually advocated for timely sharing of clinical information with private providers and the return of clinical information to VA. Under Project HERO, all participating VA facilities have electronic (but not computable) clinical information sharing available with HVHS and Delta Dental—unheard of in other non-VA purchased care programs. The IBVSOs applaud VA, HVHS, and Delta Dental for facilitating electronic sharing of health information, including radiological images performed by Delta Dental, which are scanned and transmitted to VA through a secure website. Because of its privacy and security standards for health information, VA has provided HVHS read-only access to pertinent veterans' medical records in VA's Computerized Patient Record System, which is annotated with the care provided, and the associated pharmaceutical, laboratory, radiology, and other key information relevant to the episode(s) of care.

Under the Project HERO program, VA asserts it will improve its capacity to care for veterans at the more than 1,400 sites of care it currently operates and will take steps to ensure that community providers to whom it refers veterans meet VA's quality and service standards. However, VA's design of Project HERO had several key flaws. For example, the 90-day start-up period was insufficient to ensure a successful launch; the lack of defined utilization goals impeded

the contractor's ability to plan efficiently; VA competition for providers hindered the development of a non-VA provider network; and the lack of standardization in referrals, authorization, and fee procedures created problems and inefficiencies. To the credit of HVHS, it was able to deliver tangible results, including the following:

- Clinical documentation is returned to VA electronically so that it can be uploaded to VA's Computerized Patient Record System.
- The "no show" appointment rate is only 4 percent versus the industry average that ranges from 14 to 24 percent.
- The median appointment distance is 13 miles, even though more than 40 percent of referrals and authorizations that VA sends to HVHS are for veterans living in rural or highly rural areas.
- To address patient safety, HVHS operates a clinical quality management program to respond to all patient safety events and grievances filed by veterans.

One aspect of concern to Congress and the veteran community is its impact on the VA health-care system. Currently, the measurement used under Project HERO is the number of "VHA full-time equivalent employees (FTEEs) in Project HERO VISNs" and the "volume of authorizations to academic affiliates."

The most recent information provided by VA indicates an increase of VHA FTEEs within the four VISNs. However, staffing needs are based on an evidence-based approach and analysis of the relationships among staffing numbers, mix, care delivery models, and patient or resident outcomes for multiple points of care. Therefore, without proper evaluation on whether the process used to calculate staffing needs is able to isolate Project HERO's impact, we believe this metric is inadequate.

VA also cites payment to academic affiliates for care provided within and outside VA facilities. The IBVSOs do not believe these are adequate measures of Project HERO's impact on affiliates because such relationship is more than just dollars paid—the relationship is also about education and training of health professions students and residents to enhance the quality of care provided to veteran patients. In any case, we have yet to see a comparison of this metric with traditional fee basis.

Cost analysis is another key factor in Project HERO and portends implications for eventual implementation of care coordination in non-VA services. VA has indicated its contract pricing is comparable to or lower than market rates. Notably, most of the contracted pay rates are discounted below the Medicare rate when the value-added fees are removed for a fair and representative comparison with the Department's Fee Care program. However, when factoring in the value-added costs per claim, aggregate price exceeds market rates.

An independent evaluation by Corrigo Health Care Solutions determined these value-added costs are different than current industry standards for administrative fees. VA's standards for patient safety, information sharing, timeliness, coordination, and quality of care, as well as numerous reporting requirements, are additional requirements of HVHS and Delta Dental that come at a cost. The IBVSOs urge VA to carefully consider the benefits of these requirements that add value in quality of care veteran receive when it is facing a whole-system redesign challenge as it looks to the future of its purchased care program.

The IBVSOs believe the enhancements (identification of certified/credentialed/accredited providers, appointment scheduling, sharing of medical information, and other quality metrics) resulting from required VA standards in Project HERO should be appended to all non-VA contract care. Adding such features would ensure veterans receive high-quality care provided by non-VA providers in the community. We further believe that in conducting market research for future contracts the Department should conduct an analysis of cost-effectiveness wherein outside procurement is compared to creating, maintaining, and operating like services within VA facilities, and that the frequency of their use also be considered. The end goal should be to adopt such enhancements across all of non-VA purchased care and create a standardized method of providing non-VA purchased care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to VA, preserves agency interests, and most important, preserves the level of service veterans have come to rely on inside VA.

Patient-Centered Community Care

In assessing future options for contract care coordination, VA used a lessons-learned survey and an independent evaluation of Project HERO performed by Corrigo Health Care Solutions to create

an enterprisewide system for veterans to receive care from community providers that is truly patient-centered when VA services are not available.

According to VA, the vision of patient-centered community care (PCCC) is to create a system which provides veterans coordinated, timely access to high-quality care from a comprehensive network of VA and non-VA providers, in which providers will have current clinical information for each patient regardless of location of care and there are standardized processes across VA to reduce local variation and manage outcomes through data transparency and enforcement of contracts.

In a November 2011 announcement, VA invited interested participants to an information and planning event for PCCC. Through contractual agreements, VA intends to enhance opportunities for collaboration with non-VA providers and ensure veterans receive coordinated, evidence-based care. These contracts are to be available for all VAMCs and will be centrally supported by the VHA CBO.

VA also intends these contracts to include all medical and surgical services, excluding primary care, dialysis, and mental health. Other health-care services will eventually be included to allow VAMCs to have the capability to provide all services in the VA Medical Benefits Package through PCCC.

The results of Project HERO show that contract care coordination offers more return on investment than fee-basis care. However, VA will be facing a critical period when external factors such as health-care reform, the decreasing rate of veterans entering the VA health-care system, and the shrinking veteran population may collaborate to diminish the Department's critical mass of patients.

Part of the foundation of VA health care as a direct provider of care is its patient population. VA needs a robust case mix in a wide range of clinical care programs to sustain high quality and reinforce its academic programs, including a strong biomedical research program. The IBVSOs believe as this new national initiative moves forward, that Congress and VA both must be sensitive to ensure use of non-VA purchased care supplements that do not undermine or supplant the VA health-care system.

Care Coordination and Patient-Aligned Care Teams

The VHA is redesigning primary care around the patient-centered medical home (PCMH) model designed to deliver efficient, comprehensive, and continuous care through active communication and coordination of health-care services. Achieved through a patient-driven, team-based approach, the patient-aligned care teams, or PACTs, will require an expanded role of nurses, nurse practitioners, and physician assistants in coordinating care, as well as from the patients in health-care decision making. According to VA, most VHA primary care practices have already adopted many features of patient-centered care and the medical home, but complete achievement will involve strategic assessment and redeployment of resources, realignment of priorities, and a cultural shift. The IBVSOs believe the VHA should pay special consideration to this new model of health-care delivery in developing an integrated program of contract care coordination where veterans receive assistance with referrals to network providers, scheduling appointments, and return of clinical information into VA's Computerized Patient Record System.

Recommendations:

VA should provide Congress and the veteran community a final analysis and evaluation of Project HERO to address both the concerns raised in Congressional hearings as well as the instructions provided in House Report 109–305, the conference report to accompany P.L. 109–114, and its implications in developing an integrated care-coordination model.

VA should develop an effective integrated care coordination model for all non-VA purchased care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to the VA, preserves agency interests, and most important, preserves the level of service veterans have come to rely on inside VA. As part of the integrated care coordination model, VA should assign a single individual of a veteran's VA health-care team the coordination of all non-VA purchased care.

VA should fund an integrated care management pilot program for veterans requiring dialysis. The program should leverage proven, existing approaches to prevention, coordination of care, and patient activation

for end-stage renal disease, and utilize a multi-disciplinary team made up of the veteran's dialysis provider and VA and non-VA-providers. VA should establish process, clinical outcome, and metrics to ensure the program improves the quality of care.

VA should establish clear and reportable national standards for fee care and in particular, short-term fee-basis consults, that require care coordination, health information sharing, patient satisfaction and safety, and as well as quality of care standards (such as timeliness of referral, access to care, follow-up care, and patient notification) for both the VA and non-VA provider. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should also establish and develop a mechanism for keeping a current inventory of fee services and contracts in all states. This would serve to (1) assist the veteran in choosing a community provider; (2) identify needs and gaps in services provided in the communities, and (3) minimize barriers for VA to timely develop contracts with select entities as the need arises. Such contracts would serve as a vehicle to facilitate care coordination between VA and the community provider to enhance the quality of and access to care while reducing cost.

As VA shifts fee staff toward care and case management, it should work with key stakeholders before this event unfolds to ensure a smooth transition to retain a full complement of skilled and motivated personnel.

Congress should provide oversight and the necessary resources to facilitate development and implementation of an appropriate information technology infrastructure for VA's non-VA purchased care program.

VA should provide the necessary support and place a higher priority on a long-term solution to standardize business practices in the non-VA purchased care program to address vulnerabilities, such as overpayments and efficient and timely processing of claims.

For care acquired through contract, VA should develop a set of quality standards contract care providers must meet that promote care coordination and ensure the care they provide is equivalent to the quality of care veterans receive within the VA system.

VA should develop identifiable measures to assess its integrated care coordination model for all non-VA purchased care. The evaluation should be shared with Congress and the veteran community.

Congress and VA must ensure the use of non-VA purchased care supplements and does not undermine or supplant the VA health-care system.

VA should consider the patient-aligned care team model in developing and integrating non-VA purchased care coordination.



INFORMATION TECHNOLOGY:

Centralized management with sensitivity to critical needs and rising, sustained involvement by end users in development in the Veterans Health and Veterans Benefits Administrations can improve the Department of Veterans Affairs' overall record in information technology and improve services and benefits for veterans.

Background

As reported in previous editions of *The Independent Budget*, the history of VA's Office of Information and Technology (OI&T) has been characterized by both enormous successes and catastrophic failures. Prominent examples of these failures are large Department-level information technology efforts,

including the integrated financial management and logistics system, called CoreFLS, led by the VA Office of Finance, and the outpatient scheduling upgrade, titled Replacement Scheduling Application (RSA) program,²⁶⁰ under OI&T management since VA's major realignment in 2006. These programs were so mismanaged, delayed, or internally flawed that in

the end they could not be salvaged, resulting in the waste of hundreds of millions of dollars that otherwise could have funded needed veterans' benefits and services, or more worthy IT projects to support those benefits and services. Even more recently, the successor effort to the failed CoreFLS, titled "Financial and Logistics Integrated Technology Enterprise" (FLITE), had been identified on numerous occasions by the VA Inspector General as a candidate for failure.²⁶¹ In fact, in July 2010, FLITE was canceled, for many of the same reasons as earlier large-scale failures.²⁶²

In contrast to these significant Department-level IT failures, the Veterans Health Administration (VHA) over more than 30 years successfully developed, tested, and implemented a world-class comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on the VHA's self-developed Veterans Health Information Systems and Technology Architecture (VistA) public domain software, sets the standard for EHR systems in the United States and has been publicly praised by the President and many independent observers.²⁶³

The importance and effectiveness of VistA and its use in protecting quality and promoting improvements in veterans' health was best reiterated by a 2009 news report:

The VA's system allows doctors and nurses at more than 1,400 facilities to share a patient's history, which means they can avoid ordering repeat MRIs or other unnecessary tests. But the system isn't just a warehouse to store patient data. More important, it has safeguards to improve care quality. The system warns providers, for example, if a patient's blood pressure goes beyond a targeted level, or if he or she is due for a flu shot or cancer screening.

It also helps the VA monitor patient care at home, especially for people with complex, chronic illnesses, such as diabetes and heart failure. VA gives those patients special gadgets free of charge to measure weight, heart rates, blood pressure and other conditions, and the daily results are automatically transmitted into the VA's medical-record system, says cardiologist Ross Fletcher, chief of staff at the VA medical center in Washington. If the numbers exceed target levels, a nurse is notified.²⁶⁴

Moreover, public domain and commercial versions of VistA have been installed by public and private sector entities into the patient care systems of a number of U.S. and foreign health-care provider networks, including state mental health facilities and community health centers in West Virginia; long-term care facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and health systems in a number of foreign nations (including Colombia, Finland, Germany, Mexico, Nigeria, and Jordan). One nation is conducting a trial implementation of VistA as its national EHR system.²⁶⁵

VistA has been a critical tool in VHA efforts to improve health-care quality, continuity, and coordination of care. This EHR system literally saves lives by reducing medication errors and enhances the effectiveness and safety of health-care delivery in general. Therefore, *The Independent Budget* veterans service organizations (IBVSOs) are acutely aware of the critical importance of effective IT management to veterans' health care and to their very lives. In the past, we have questioned the wisdom of the IT reorganization and centralization of VA's IT management, development processes, and budgeting because these actions were seen to potentially threaten the continued success of VHA IT development and the EHR itself. However, in 2009, the Secretary of Veterans Affairs announced that centralization of VA's IT enterprise that had been instituted by his three predecessors would continue. Because the Secretary is a strong proponent of the Virtual Electronic Lifetime Record (VLER) of which the EHR is a critical component, we remain optimistic that some of the critical changes needed will be accomplished, in both the IT organization itself, and in centralization efforts to sustain the VHA's preeminence in health-care delivery.

Evolving History of IT Centralization

Despite its superiority and historic success, more than 10 years ago VHA officials recognized that VistA was aging and needed to be modernized if it were to serve veterans' health-care needs in the 21st century. However, myriad efforts to "re-platform" and update the VHA's electronic health system and its component parts have lagged during the off-again, on-again IT reorganizations and various centralization efforts.²⁶⁶

In 2002 the VA Secretary issued a memorandum that mandated centralization of all VA IT functions and programs, and centralized appropriated funding

under a Department-level chief information officer. However, four years were consumed to fully structure a centralized VA IT organization and management system. By April 2007, all IT resources and staff were centralized to the Department level, including thousands of field staff supporting health information technology programs in VA's 153 medical centers and systems of care, 57 regional benefits offices, an insurance office, and hundreds of point-of-service clinic locations throughout the nation. This restructuring created changes and significant challenges to the maintenance of reporting relationships, roles, and responsibilities with regard to IT strategic planning, programming, budgeting, IT security, equipment procurement, software development, and provision of service to user groups that interacted with veterans in need of VA's health services and benefits. A key to the past successful deployment and use of VistA was the involvement of clinical and administrative end users throughout the development cycle of the software. In that case the reorganization created a severe chasm in this involvement because of the demarcation of clinical staff that was no longer playing an active role in development due to the rigid demarcation of IT staff, who reported to leadership in Washington, DC.

The role of the VHA shifted from being in control of its IT planning, solutions development, and budgeting, to being only one (albeit a very large one) of a multitude of the national OI&T's "customers," including the VBA, the National Cemetery Administration, and a variety of staff and executive offices in Washington and elsewhere. Health-care solutions and quality of care IT software (whether new or old) are no longer assured of receiving the highest priority and attention from VA's IT development and operations/maintenance enterprise. Recent examples are the initiatives to better monitor and manage VA's homeless assistance programs and to create a virtual "registry" of homeless veterans, very high priorities of the VA Secretary.²⁶⁷ Some of this kind of evolution is understandable, given VA's competing priorities and limited funds for IT development and deployments. Additionally, IT leaders have been thrust into simultaneously managing a complex reorganization process, creating their own functional operating units, and working in collaboration with skeptical managers from VHA and other administrations as well as staff offices, whose focus is accomplishing their IT priorities quickly.

Despite the time and resources that have been devoted to these efforts, much critical work still remains to be done by OI&T to align roles and responsibilities, define IT governance processes (a key requirement that is still not developed after three years),²⁶⁸ fill existing gaps, and ensure that Administration "business owners" are appropriately represented on IT departmental and interagency committees and planning and development activities. Failure to appropriately involve business owners in IT decision making has resulted in catastrophic VA failures in the past. To ensure the success of future IT development and deployment, business owners must be integrated and involved in each step of the process.

The IBVSOs urge the Assistant Secretary of OI&T to enhance user organization collaboration and resolve lingering interagency coordination challenges. Effective IT programs are vital to VA's achievement of its core missions—certainly in the VHA, but also in other benefits and services arenas important to America's veterans and to us.

VHA VistA: World-Class Electronic Health Record

The VHA's unparalleled success in integrating use of its comprehensive EHR system into its day-to-day health-care delivery process has been a critical factor in the VHA's transformation to becoming the national leader in health-care quality, safety, prevention, and clinical effectiveness. Among health-care and IT industries worldwide, VistA is one of the most successful and remarkable health IT and EHR systems and a critical enabler of the VHA's ability to deliver consistently high-quality and safe health care to more than 6 million veterans annually. In fact, the VHA's electronic health record system has earned the reputation as "world class" and is acknowledged by most observers as the most successful EHR operating in the world today, although current failures and lack of progress in moving to the next generation of EHR are quickly and alarmingly jeopardizing that position. It is also important to recognize that the VHA's EHR is not simply an IT system, but rather is a health-care tool that is just as vital a component of the VHA's successful health-care delivery capability as its cardiac catheterization laboratories or its magnetic resonance imaging technologies. Without its EHR system, the VHA would be unable to deliver 21st century veteran-centered health care. Therefore, VistA should not, and cannot, be viewed as a standard IT system of network servers and operating systems,

but rather as a medical device. In fact, Food and Drug Administration policies consider the VistA system to be a medical device for its regulatory purposes.

In the 10 years since the VHA determined to take the course of replacing VistA with a modernized web-based version called “HealtheVet,” maintenance of, and upgrades to, VistA and related infrastructure have lagged. In a zero-sum budget environment, funds devoted to new developmental initiatives, such as CoreFLS, RSA, FLITE, and other IT initiatives, effectively drained funds that could have been used to replace aging VHA private branch exchange equipment, install wireless capabilities throughout VA health-care facilities, and update or upgrade VHA’s data warehouses, among hundreds to thousands of other unmet IT infrastructure needs across the vast VHA landscape. Current planning at VA suggests HealtheVet ultimately will be scrapped in favor of a wholly new approach relying on “open source” software,²⁶⁹ but the current direction still seems vague to the IBVSOs. The Assistant Secretary for Information and Technology stated: “So, let’s be clear; in my view, VA over the past 10 years has tried to replace VistA. I don’t think that’s possible. It would be like Microsoft [Corporation] trying to replace Windows with not an evolutionary product, but with something brand new, but it has to come out and it has to be better the day it’s introduced. That, basically, was the criteria for what VA was trying to do. That program was called HealtheVet. I have stepped VA away from HealtheVet, and what we’re now looking at is how we continue the evolution of VistA.”

Assistant Secretary Baker continued: “It [VistA] is the best electronic health record system in the United States, at this point, especially if you focus on it from a patient-care standpoint. So, how do we then get back to moving the innovation forward in VistA, and that’s really what the whole open source campaign is all about. Medical records systems have moved forward a tremendous amount, in the United States, since the time that VistA was started. And the private sector is doing a lot of stuff that we need to be able to incorporate into VistA. So, our thought is that by being part of an open source community based around VistA, VA can encourage private sector folks to either directly contribute the open source—you know, make improvements. Or integrate their products with the open source, so we can very easily buy a working product, instead of having to go down the government route.”

Assistant Secretary Baker’s conclusion: “The reason that, I believe we’ve got to go the open source route, is that we have two important projects to integrate private sector packages into VistA going on inside the government right now—one is for laboratory and one is for pharmacy. Both of those projects are going on five years, to integrate the private sector product into VistA because we’re doing it the government way. That is far too long. We need to be able to go out and say, ‘I’m interested in a pharmacy package, in six months I’m going to buy one that I prefer, from all the ones integrated with the open source—let’s go.’ And when an organization like VA says it’s going to buy, that could be 200 or 300 million dollars. So, you know generating the private-sector interest in it. I just think we’re going to move VistA innovation forward much more quickly if we go the open source route.”²⁷⁰

In consonance with Assistant Secretary Baker’s view, we believe that in addition to providing veterans with a world-class health record, upgrading the VistA system can provide an EHR that meets national health IT standards with public domain, open source programming code. The potential benefits of a modernized open source VistA to veterans and the nation could be significant if successful. VA must give these efforts the highest priority, and pursue this goal with the vigor, dedicated effort, resources, and persistence they will undoubtedly require. Nevertheless, in our view, this work must also integrate updates to existing and near-obsolete IT and related infrastructure that now powers VistA and the VA health-care system. Whatever roadmap governs the next VistA, VA’s IT infrastructure will still serve as the means to achieve it.

The “Blue Button”

In August 2010, the Administration announced the “Blue Button” capability, an electronic means of allowing veterans to download their personal health information from their My HealtheVet account. VA developed the Blue Button in collaboration with the Centers for Medicare and Medicaid Services (CMS), the Department of Defense, and others.

The My HealtheVet personal health record is composed of self-entered health information (blood pressure, weight, heart rate, etc.), emergency contact information, test results, family health history, military health history, and other health-related information. The Blue Button extract that veterans can

download is a so-called “ASCII text file,” the easiest and simplest electronic text format. Blue Button personal health records can be printed or saved on computers and portable storage devices. Having control of this information enables veterans to share these data with health-care providers, caregivers, or people they trust.²⁷¹

The IBVSOs fully support this development because it gives the veteran the opportunity and direct means to help document his or her own record and health status to provide a basis for better overall health care. However, we are disappointed that with 6 million active veteran patients, the IBVSOs understand that only 197,000 individuals have obtained the clearance to log on with the Blue Button.²⁷² Thus, while innovative, the Blue Button is still very much an experiment and in effect constitutes a tiny demonstration project. The IBVSOs urge VA to find ways to accelerate the number of veterans who participate in Blue Button participation.

Slow Progress in VA-DOD Health Information Sharing

VA and the DOD have been working on electronic health information sharing for well more than a decade. Even as far back as 25 years ago, VA oversight leaders in Congress were calling for VA and the DOD to share VA’s then-fledgling Decentralized Hospital Computer Program, an early precursor to today’s VistA. Despite strong and consistent Congressional mandates and oversight over those years, these efforts remain fragmented and have proceeded at a glacial pace. The DOD and VA continue to lack a consistent approach to electronic health record development and as a result have moved in divergent directions in their efforts. Significant differences in policy, programs, and approach at least partially explain the lack of timely progress toward health record interoperability across the DOD and VA systems of care. Currently, VA and the DOD do not share all electronically available health records; while some records are shared in a computable form, others are imaged but are only viewable. VA captures all health information electronically; however, many DOD medical treatment facilities are still using paper-based health records. Unlike the VHA’s single, comprehensive, integrated electronic health record, the DOD continues to use many different legacy information systems, relying on different (and proprietary) platforms, and the DOD lacks a consistent, uniform approach across service branches in the

Army, Navy, and Air Force health records systems. Most DOD electronic health record software was commercially developed and therefore the products lack developmental involvement by their clinician end users. The Armed Forces Health Longitudinal Technology Application (AHLTA) serves as the primary DOD outpatient records system; however, the earlier Composite Health-Care System, which once was the DOD’s primary EHR, is still used to capture pharmacy, radiology, and laboratory information.

More than 10 years ago, VA and the DOD began development of their information-sharing initiatives with the development of the Government Computerized Patient Record program. In 2004 the Federal Health Information Exchange (FHIE) was fully implemented. The FHIE enables the DOD to electronically transfer service members’ electronic health information to VA when the members leave active duty. Since 2002, the DOD has collected information on 4.8 million service members from its various electronic systems and forwarded those data to VA once these individuals were discharged from active duty. The Laboratory Data Sharing Interface allows DOD and VA facilities to share laboratory orders and test results, but the system is in use at only nine locations. In addition, in 2004 the Bidirectional Health Information Exchange (BHIE) was developed to allow VA and DOD health-care providers to view records on patients who receive care from both departments. The BHIE has been used successfully to provide viewable access to records of some of the seriously injured service members wounded in Iraq and Afghanistan. Unfortunately, many VA outpatient clinicians report that they are unaware of or do not know how to use the BHIE. Those who are aware of the BHIE often report that they cannot access the patient records that they need most or that the system is so slow that it is virtually unusable in their busy clinics.

The IBVSOs believe VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records and medical images. Additional discussion about this issue can be found in “The Continuing Challenge of Caring for War Veterans and Aiding Them in Their Transitions to Civilian Life” in this *Independent Budget*.

Joint IT Test Bed at VAMC North Chicago— Naval Health Clinic Great Lakes

As we indicated in *The Independent Budget for Fiscal Year 2012*, Congress authorized VA and the DOD to execute by memorandum of agreement a formal merger of the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes into one consolidated regional federal health-care center, the James A. Lovell Federal Health Care Center.

The creation of the facility under a single joint VA-Navy management system for the beneficiaries (veterans, DOD active duty, and DOD retirees and their dependents) of the two previously segregated federal facilities creates a unique full-service capability that did not exist previously.

There have been considerable struggles in the frustrating efforts of VA and the DOD to integrate, or link interoperably, their respective electronic health record systems, and in the case of DOD service branches, to create and sustain the AHLTA EHR as an effective, user-friendly, interactive medical tool across Army, Navy, and Air Force health programs. This North Chicago merger presents both a challenge and a remarkable opportunity to determine whether the significant Navy, Marine Corps, dependent, and veteran enrolled populations in the Lake County and Waukegan communities can be served with equity of access, quality, safety, cost-effectiveness, and satisfaction in a combined VA-Navy facility using merged capabilities of VA VistA and DOD AHLTA electronic health records.

First Navy/VA Joint Federal Health-Care Center

The Lovell Federal Health Center is the first fully integrated VA and DOD entity, combining manpower and resources from the North Chicago VA Medical Center and Naval Health Clinic Great Lakes. The shared mission of the federal health-care center means active duty military, their family members, military retirees, and veterans will be cared for at the facility by one unified staff and management, a laudable accomplishment.

A unified electronic health record is key to the success of this joint facility. VA and the DOD, aided by multiple contractors, are working on six critical functions for an integrated EHR utilizing VistA and AHLTA. The IBVSOs are advised that in several instances, the governance, policies, business processes, and

terminology have not been aligned between VA and DOD systems. This lack of alignment has resulted in delayed interoperability of pharmacy, laboratory, and radiology record systems.

Outside the agreed-on list of potential operational joint functions, pharmacy and consult orders will continue to be done separately by each agency, according to VA. VA maintains that separation of these systems protects patient safety. Nevertheless, lack of progress on the pharmacy package interoperability has resulted in an inability to do electronic medication reconciliation, with significant negative impacts on staffing and patient safety. While local efforts at work-arounds and new software development will result in full joint operational capability, these efforts have taken much longer than originally projected and have been impeded by a lack of national policy decisions and program support.

The IBVSOs understand that several modules were seen as nonessential for operational functionality at the combined site when the health-care clinics were formally integrated in December 2010. It is proposed that these applications be developed and implemented as resources become available. These yet-to-be-completed modules are orders portability (consults and allergies); outpatient appointment scheduling; financial reporting; and material management. While we appreciate the continuing challenges facing a joint VA-DOD activity, we are concerned that some of these modules may, in fact, turn out to become critical gaps, causing untold problems, and we urge that they be made high priorities for production and implementation.

We have learned that facility working groups have identified the baseline EHR interoperable capabilities that will be needed for efficient joint health-care operations and that a common services approach is being taken to implement these capabilities. Common services provides an environment in which functions can be standardized and used across systems and processes, and would enable the DOD and VA to develop business and data services only once, utilizing those services within the DOD-VA continuum of care. Common services would enable the DOD and VA to improve quality and continuity of care through virtual longitudinal EHRs. A common services approach further supports nationwide EHR goals to develop the foundation for an interoperable, secure, and standards-based health information exchange

to potentially conduct business and communicate patient care information with providers outside the DOD and VA, and to do so on an efficient basis.

The IBVSOs applaud this unprecedented progress in North Chicago, and urge VA and the Navy to strongly support these efforts with continued significant IT funding and oversight so that the currently incomplete IT projects identified as of December 2010—projects that may become critical to operational success of the joint facility—will be accomplished in a timely manner.

Also we strongly urge the DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees of both Congressional chambers, to continue monitoring the IT management aspects of this merged health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Finally, North Chicago and its accomplishments may move the federal IT interoperability goals (as well as health resources sharing in general) in a significant and positive new direction.

National Health Information Technology Standards

VA and the DOD are continuing to develop standards for the electronic exchange of clinical information. In recent years, these efforts have been integrated with the Health Information Technology (HIT) Standards Committee led by the Office of the National Coordinator. These efforts are aimed at producing standards, implementation specifications, certification criteria for electronic information exchange, and prescribed uses of health information technology that align with meaningful use of EHRs required for providers to be eligible for payment incentives from Medicare and Medicaid.²⁷³

P.L. 111-5, the “American Recovery and Reinvestment Act,” provided funding (\$19 billion) and a variety of new incentives and regulatory requirements for health-care providers nationwide to adopt compatible EHR systems. Early adaptors of EHR systems that meet federal criteria for consistency and interoperability will be rewarded with funding, but providers that do not move forward on EHR within a prescribed period eventually will face financial penalties in Medicare and Medicaid reimbursement rates.

Given this development, it is critical that VA and the DOD participate and comply with federal standards for electronic health records since many veterans receive care in VA, the DOD, and from private sector systems and providers. VA participates as a member of the American Health Information Community, the Health IT Policy Council, and the Healthcare Information Technology Standards Panel. Both VA and the DOD are developing software solutions that are compliant with existing standards and will seek national HIT certification by the Certification Commission for Healthcare Information Technology.

Virtual Lifetime Electronic Record System

As an example of VA's movement to develop electronic health records consistent with larger national developments, in April 2009 the President announced the creation of the VA virtual lifetime electronic record (VLER). The VLER is envisioned to facilitate comprehensive, real-time sharing between the DOD and VA of military service and VA records. As it is currently defined, the VLER will enable the DOD and VA to electronically access and manage the health, personnel, benefits, and administrative information required to efficiently deliver seamless health care, services, and benefits to service members, veterans, and their dependents where appropriate. The IBVSOs fully support the development of the VLER, provided privacy and confidentiality concerns can be appropriately addressed and protected. As the DOD and VA move forward with the development and implementation of the VLER, it will be critical to have in place appropriate governance, coordination, and oversight mechanisms to ensure the project's success. This will require VA and the DOD to develop joint policies, budget processes, and dispute-resolution mechanisms to support flexible and efficient IT development and implementation. In the past these issues have slowed or blocked needed change. Technology is available to support the VLER vision, so VA and the DOD should not allow cultural and policy differences to impede progress on joint systems development of a lifelong electronic records system for veterans. VA and the DOD must overcome these barriers and expedite completion of this vital effort to better serve the active military, retirees, veterans, and their family members. Recently, VA announced expansion of the initiative beyond the original test sites to six addition sites of coordination between a VA facility and private provider hospitals and health information networks, bringing the total sites participating to eleven.²⁷⁴ While noting that DOD does not seem to

be involved in most of these sites, we are encouraged by this progress and urge VA to continue this expansion of an important new development in making a smoother transition of military personnel to veteran status, and of their lifetime care and services provided by VA and others.

Caution: Lessons Learned, from an Informed Expert

Tom Munneke provided this compelling testimony before the U.S. Senate Committee on Veterans' Affairs, in October 2010.

VistA was developed directly as a clinical tool, by clinicians, for direct patient care. While there are many administrative needs of an enterprise for logistics, cost accounting, billing, payroll, and the like, these are a fundamentally different kind of computing.

Lesson Learned: Decentralization works. The extensive end-user [a.k.a. "business owner"] collaboration was a key factor to the success of VistA.

When I first started at the VA, I ran into the bureaucratic "stovepipe" mentality everywhere I went, even though everyone had a supposedly common goal of providing health care to our veterans. Recalling the words of the sheriff in *Cool Hand Luke*, it seemed that the core problem could be expressed as: "What we have here is a failure to communicate."

In college, I was struck by the Sapir-Whorf hypothesis that language shapes our thought. I began to focus my attention on ways of using IT to overcome the failure to communicate. This led to the development of an integrated data dictionary that served as a "roadmap" to the patient data. Today, this would be called a "Semantic Web" (see <http://www.caregraf.org/semanticvista> for a modern semantic web interface to the VistA database). We integrated electronic mail directly into the clinical interface, allowing database activities to generate email messages through an email/discussion/workflow system called MailMan. I was amazed at how heavily used MailMan was—in some cases, 25 percent of the traffic in a VistA system was email traffic. This demonstrated how communications-intensive clinical care is, even outside the formal communications traffic in the

specific applications, such as pharmacy, laboratory, or radiology. I think that VistA broke down many of the bureaucratic stovepipe barriers, allowing people to focus on what was best for their clinical practice.

Lesson Learned: The fundamental goal in health IT should be to improve communications. The medical record is but one form of communication.

All of the initial developers of VistA were employed in the field [in VA medical facilities], working closely with end users. Riding the elevator with a gurney headed to the morgue was a sobering experience, and helped keep me focused on the implications of the software I was developing. The trust we placed in the VistA community was well-placed. People felt respected and acted accordingly, knowing that they were contributing to a larger, more successful whole.

The goal of our system was to produce a constantly improving, evolutionary system. Our goal was to get something "good enough" out into the field, and then begin the improvement process. We had neither money nor time for gold-plated requirements and specifications. Our motto was, "generations, not specifications." We didn't claim to know the end point of the system when we started, but rather created tools for users to adapt. Someone used to waterfall/requirements driven life cycle process might find this appalling—that users could interactively develop a system in tandem with developers—but it was a key factor to the success of VistA.

Lesson Learned: Generations, not specifications. Start with "good enough" and allow it to continuously improve through end user interaction.²⁷⁵

While the IBVSOs agree that project management and accountability are critical in today's environment, we have received reports that confusion and frustration still run high among field facilities about how to maintain conformance with the Program Management Accountability System (PMAS), while moving existing and future critical health IT projects forward. Some have suggested that PMAS is canted or biased toward failure rather than serving as the means to push and achieve success in IT development. In fully implementing PMAS, now in place more than a year, VA leadership must ensure that VA clinicians

and program managers at all levels are better educated in navigating this operating environment, and that, in respect to iterating the next VistA, developers remain mindful of Munnecke's wise admonitions.

The IBVSOs continue to believe that IT in the VHA serves as a *medical device* that manages health-care delivery and its myriad decision support processes, without which the VHA would be poorer and unable to deliver 21st century veteran-centered health care. Agreeing with Mr. Munnecke, we continue to believe that health IT does not fit the standard concept of a business IT project because when health IT fails, patient care fails. When patient care fails, veterans needlessly suffer. Therefore, while we cannot object to VA's current management model for controlling the future of HIT, the PMAS must not ignore the demands of health-care delivery and must assign it proper weight in prioritizing IT projects, whether within VHA or in other cases.

VA Medical and Prosthetic Research: A Special Case for IT

Reports continue to surface from within VA's staff of several thousand biomedical, basic sciences, and health services researchers of extreme difficulty and unconscionable delays in their quests to obtain the automated equipment, software, and other IT implementations to support VA-awarded intramural research projects. In fact, as indicated in the Medical and Prosthetic Research discussion elsewhere in this *Independent Budget*, researchers who had worked for years to perfect their hypotheses and develop high-quality research projects and who in fact were granted their awards based on merit, saw those funds lapse because they were unable to obligate research funds awarded due to long delays in obtaining consents to procure IT resources or could not meet stringent IT security policies. Altogether, \$100 million or more in obligations may have been delayed. Much of this challenge has been attributed to the centralization and security-heightened environment of today's VA IT operations. Whatever its source, the IBVSOs request that the Assistant Secretary for Information Technology deal with the needs of VHA's important clinical and health researchers to ensure that IT procurements associated with time-sensitive and important biomedical research awards are dealt with in an expeditious manner so that their critical work is not further frustrated.

Other Important VA IT Considerations

The Veterans Benefits Administration (VBA) has embarked on a significant transformation effort to solve its age-old benefits claims-processing problems with new solutions that rely heavily on IT. We have highlighted and discussed the importance of these reforms elsewhere in this *Independent Budget*. Dozens of initiatives are under way across the VBA system to test a variety of methods to make claims processing more accurate and efficient. The most important new initiative is the new Veterans Benefits Management System, which is continuing its field test at the regional office in Providence, Rhode Island. The VBA has long struggled to successfully employ comprehensive IT solutions as a foundation for the processing of veterans' claims. The centralization decision discussed above also affected the VBA dramatically, and we think it is fair to conclude that the VBA is also struggling with trying to develop and deploy new IT solutions in a centralized IT management environment.

The IBVSOs and the millions of veterans we represent depend on the VBA to make accurate decisions on disability, pension, insurance, education, and other benefit claims from veterans. Those decisions must first and foremost accurately reflect the entitlements Congress granted them in exchange for their honorable service in uniform. We urge the Administration to keep in mind that as these IT reforms proceed, the IBVSOs are monitoring them closely to ensure that veterans' rights to benefits are being protected and reaffirmed throughout VA's efforts to develop and implement more timely and efficient means to process claims.

Summary

Despite our concerns about the transitional status we detect in VA IT reforms four years post-reorganization, the IBVSOs remain confident that VA's IT and management teams will continue to address the numerous challenges before them and bring VA's IT community of interests up to the level of performance expected by veterans who must rely on VA health care, benefits, and other services, while being sensitive to necessary priorities and user needs, in particular in the VHA and VBA. As the current Secretary has indicated, "Leveraging the power of information technology to accelerate and modernize the delivery of benefits and services to our nation's veterans

is essential to transforming VA to a 21st century organization that is people-centric, results-driven, and forward thinking.” The IBVSOs agree with the Secretary’s commentary, and most certainly with his stated intent, and urge the VA Office of Information Technology and other Administration officials and staff to meet his challenge to lead the Department’s IT systems to the levels of excellence veterans expect.

Recommendations:

The Assistant Secretary of VA’s Office of Information & Technology should continually improve and actively address effective OI&T-Administration collaboration and important interagency coordination challenges.

VA should modernize and update the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record system to provide an electronic health record that meets national health information technology standards, relying on public domain, open source programming code, assuming that is the most appropriate way to proceed.

VA should improve participation rates of VA’s 6 million enrolled veterans in its Blue Button initiative in personal electronic health records, with the goal of participation of a majority of VA’s enrolled veterans, and 100 percent of new veterans.

VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records and medical images.

While VA has ramped up concern about the efficiency, cost-effectiveness, and success of IT projects through use of the Performance Management and Accountability System mechanism, it has allowed myriad needed IT infrastructure upgrade projects to languish. When a given project being monitored by PMAS fails or runs under projected cost, VA should shift the funds associated with that project (or with underages) to infrastructure so that its IT system receives proper maintenance and upgrades in preparation for new VistA technologies to be developed.

VA and the Navy must strongly support the efforts of the joint VA North Chicago-Great Lakes Navy health facility consolidation with continued significant IT funding and oversight so that the currently incomplete IT projects, which may become critical to the ultimate operational success of the joint facility, will be accomplished at the earliest possible date.

The DOD and VA Secretaries, as well as the Armed Services and Veterans’ Affairs Committees, should continue monitoring the IT management aspects of the merged North Chicago health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Also, the North Chicago pilot test and its accomplishments may move the federal IT interoperability goals in a significant new and positive direction.

VA should continue to seek a national leadership role in developing crucial health information technology efforts prompted by the “American Recovery and Reinvestment Act” and by health insurance reform legislation (P.L. 111–148), now in its late implementation phase.

VA and the DOD, in conjunction with other federal and private sector partners, should develop a virtual lifetime electronic record (with inclusion of an electronic DD 214).

VA and the DOD, with the assistance of strong Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have been barriers to past efforts in formulating the virtual lifetime electronic record.

Congress should closely monitor the Veterans Benefits Administration’s decision making on reliance on IT solutions as the means to achieve claims processing reform. Congress should also evaluate VA’s prioritization of IT projects across administrations to ensure balance and fairness in application and execution.

The VA Assistant Secretary for Information Technology, in conjunction with the Veterans Health Administration chief research and development officer, should find ways to speed procurements of IT

equipment and software that support VA's Medical and Prosthetic Research program to avoid the loss of funds and to ensure that these IT procurements associated with time-sensitive and important biomedical research are dealt with in an expeditious manner.

²⁶⁰VA Under Secretary for Health Memorandum, March 20, 2009. www.govexec.com/nextgov/RSAMemo.pdf.

²⁶¹Belinda J. Finn, Office of Inspector General, Testimony before the U.S. Senate Committee on Veterans' Affairs, October 6, 2010.

²⁶²<http://www.fiercegovernentit.com/story/audio-roger-baker-and-vivek-kundra-announce-cancellation-va-financial-management-project/2010->
<http://www.examiner.com/technology-in-washington-dc/veteran-administration-flite-modernization-effort-has-been-canceled>.

²⁶³Joint Commission on Accreditation of Healthcare Organizations (JCAHO), *Guiding Principles for the Development of the Hospital of the Future* (2008). http://www.jointcommission.org/NR/rdonlyres/1C9A7079-7A29-4658-B80D-A7DF8771309B/0/Hospital_Future.pdf.

²⁶⁴"The Digital Pioneer," *The Wall Street Journal* (October 27, 2009). <http://online.wsj.com/article/SB10001424052970204488304574428750133812262.html>.

²⁶⁵Reuters, "Jordan Unveils State of the Art Healthcare Technology in Hospital Trial" (October 27, 2009): www.reuters.com/article/pressRelease/idUS200273+27-Oct-2009+PRN20091027.

²⁶⁶VA Under Secretary for Health Memorandum, note 289.

²⁶⁷Hearing before the Committee on Veterans Affairs, United States Senate, March 2, 2011, p. 171. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=112_senate_hearings&docid=f:65905.pdf.

²⁶⁸Finn, Testimony.

²⁶⁹<http://www.govhealthit.com/news/va-open-source-agent-set-go-live>, August 29, 2011.

²⁷⁰Fierce Government, *Q&A: Roger Baker on the future of VistA and VLER* (October 25, 2010). <http://www.fiercegovernentit.com/story/q-roger-baker-future-vista-and-vler/2010-10-25>.

²⁷¹VA's Blue Button Initiative <http://www4.va.gov/bluebutton/>.

²⁷²Briefing to veterans service organizations, "Blue Button," by Office of the VA Secretary, March 30, 2011.

²⁷³http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204.

²⁷⁴News Release "VA Announces Expansion of Virtual Lifetime Electronic Record," September 8, 2011.

²⁷⁵Mr. Tom Munnecke, Testimony before the U.S. Senate Committee on Veterans Affairs, October 6, 2010.



PHYSICIAN ASSISTANT RECRUITMENT AND RETENTION:

Physician assistants are a critical component of health-care delivery yet the Department of Veterans Affairs is not addressing programs and policies to take full advantage of this important resource.

The physician assistant (PA) profession has a special relationship with veterans. The first physician assistants to graduate from PA educational programs were former corpsmen and medics who served in Vietnam and wanted to apply their knowledge and experience in a civilian role. Today, there are 147 accredited PA educational programs across the United States and nearly 2,000 PAs are employed by the Department of Veterans Affairs (VA), making VA the largest single employer of PAs. These PAs work in medical centers and outpatient clinics, providing medical care to thousands of veterans each year. They work in both ambulatory care clinics, emergency medicine, and in wide variety of other medical and surgical subspecialties. Many are veterans themselves.^{276, 277}

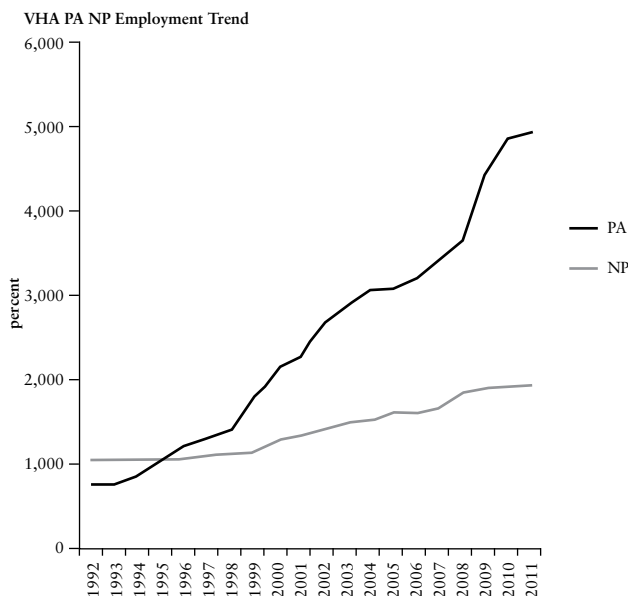
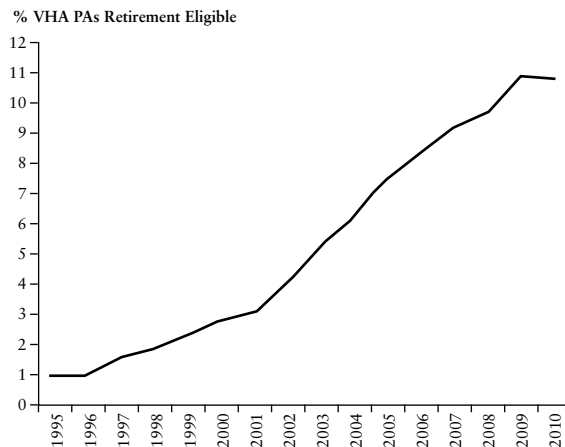
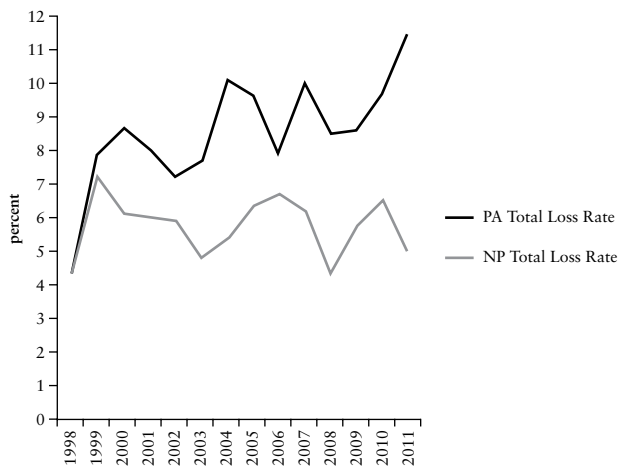
For several years, *The Independent Budget* veterans service organizations (IBVSOs) have recommended that Congress authorize a full-time PA director in VA Central Office. We achieved this goal in P.L. 111–163, and we appreciate Congressional support for that accomplishment.

In the VA system about a quarter of all primary care patients treated are seen by a PA.²⁷⁸ Since the first graduating class at Duke University in 1967, PAs have been treating patients and providing many of the same services that physicians offer—filling a critical need, given the shortage of other health-care personnel in some parts of the United States. The IBVSOs maintain that PAs are a critical component of VA health-care delivery and have consistently recommended that VA include them in all health-care staffing policy.

VA is simply not competitive with the private sector for new PA program graduates. This field has been listed as one of the 50 best careers in 2011 due to increasing demand for health-care services, the impending retirement of baby boomers, and broader efforts to limit health-care costs.²⁷⁹

Approximately 40 percent of PAs currently employed by VA are eligible to retire in the next five years. The PA workforce has grown by less than other physician extender positions within VA; therefore, the IBVSOs are concerned about the future of this program and

Graphs 7–9. VA Physician Assistant Employment Trends



demonstrated success of the programs. The goal of the pilot is to increase the available pool of residency-trained and credentialed PAs to assist in the care of veterans in the patient-aligned care teams (PACTs). The project hopes to demonstrate that the training of PAs within VA will promote their recruitment and retention within the PACTs.²⁸⁰ Currently, the 147 accredited PA training programs are searching for qualified facilities for clinical sites, and VA could use this opportunity to recruit new student graduates rotating through VA clinics, based on the presumed success of this demonstration. The IBVSOs are encouraged by this progress, but still concerned that the use of recruitment incentives within VA is at the discretion of the hiring facility and is not standardized across the VA system. The Office of VA Healthcare Retention and Recruitment reported that in FY 2009 and the first half of FY 2010, less than \$30,000 was spent to support PAs in the Employee Incentive Scholarship Program (EISP). To effectively address the barriers to PA recruitment and retention, VA must ensure that employee incentive programs, such as the EISP and the VA Employee Debt Reduction Program are made consistently available to PAs.

the role it is expected to play in reducing VA costs and improving access for veterans.

In June 2011, VA issued a program announcement requesting proposals for a Physician Assistant Residency Pilot for Academic Year 2012–2013 (FY 2013). This pilot program has funding planned for up to 12 resident positions to be located in three to six sites. Continuation beyond three years will be dependent on accreditation, availability of funding, and

On October 26, 2011, the Administration announced its commitment to providing support to unemployed veterans and highlighted the PA profession as a prominent target career path for new combat veterans who had served as medics and corpsmen. Under

this initiative, the Administration will promote incentives to create training, education, and certifications veterans need in transition to a civilian application of military skill, or to pursue higher education.²⁸¹ The IBVSOs are pleased that the Administration is making this a national priority.

VA Critical Occupations

VA's mission statement for human resources is to recruit, develop, and retain a competent, committed, and diverse workforce that provides high-quality service to veterans and their families. VA identifies specific occupations as "critical occupations" based on the degree of need and the difficulty in recruitment and retention. These occupations are identified in annual evaluations by VA recruitment patterns and projections from data provided by VA's 21 Veterans Integrated Service Networks. VA notes that workforce and succession planning encompasses a substantial part of VA's human resources program.²⁸² For additional information on IBVSO concerns with regard to VA's human resources programs, see our broader discussion elsewhere in this *Independent Budget*.

According to the American Academy of Physician Assistants (AAPA) 2010 Census Report, 2010 was a record year for the number of practicing PAs in the United States. The report found 83,466 practicing PAs, doubling the number of 10 years ago. The census report noted that even in a down economy the profession continues to grow quickly.²⁸³ While this is true for the country at large, the AAPA's annual census reports of the PA profession showed that nearly 22 percent of the total profession was employed by the federal government in 1991, and has since documented a steady and significant decline, with the percentage dropping to 9 percent in 2008, where it has remained. New graduate census respondents were even less likely to be employed by the government (17 percent in 1991, down to 5 percent in 2008).²⁸⁴

Recommendations:

VA should implement recruitment and retention tools targeting Employee Incentive Scholarship Program and Employee Debt Reduction Program funding to include physician assistants (PAs) and provide succession plans to Congress for this occupation.

Veterans Health Administration human resources should update and issue new personnel employment policies for PAs.

Congress should request a specific VA plan on including PAs in the Locality Pay System or legislate special pay provisions to address this VA's long-standing problem with PA recruitment and retention.

The Veterans Health Administration should strengthen academic affiliations and expand new agreements to provide clinical rotation sites for PA students.

VA should include the PA as a critical occupation in view of this occupation's vital role in providing a variety of primary clinical services.

²⁷⁶William Fenn, PhD, PA, Vice President, American Academy of Physician Assistants, Testimony before the United States Senate Committee on Veterans Affairs, Hearing on S. 1155, "A bill to elevate the VA's PA Advisor to a full-time director of PA services in VA central office" (October 21, 2009).

²⁷⁷Physician Assistant Education Association, Letter to Senate Majority Leader Harry Reid and Speaker of the House Nancy Pelosi (January 15, 2010). <http://www.paeonline.org/index.php?ht=a/GetDocumentAction/i/99520>.

²⁷⁸American Academy of Physician Assistants, Press Release (March 5, 2011). http://www.aapa.org/news_and_publications/pa_pro_now/item.aspx?id=1917.

²⁷⁹*US News and World Report*, Best Careers 2011: Physician Assistant (December 6, 2010). <http://money.usnews.com/money/careers/articles/2010/12/06/best-careers-2011-physician-assistant>.

²⁸⁰Department of Veterans Affairs, Office of Academic Affiliations, Veterans Health Administration, Request for Proposals (Washington, DC: June 2011). www.va.gov/oaa/archive/rfp_phy_asst_20110627.doc.

²⁸¹American Academy of Physician Assistants, Press Release (October 26, 2011). http://www.aapa.org/news_and_publications/news/item.aspx?id=3079.

²⁸²The Department of Veterans Affairs, Human Resource Strategic Plan 2005–2010. http://www.va.gov/ofcadmin/docs/HRA_Strategic_Plan.pdf.

²⁸³American Academy of Physician Assistants, Physician Assistant Census Report: Results from the 2010 AAPA Census (2011). http://www.aapa.org/uploaded-Files/content/Common/Files/2010_Census_Report_Final.pdf.

²⁸⁴American Academy of Physician Assistants, Physician Assistant Census Report: Results from the 2009 AAPA Census (2010). http://saaapa.aapa.org/images/stories/Data_2009/National_Final_with_Graphics.pdf.

SUPPORT FOR FAMILY AND CAREGIVERS OF SEVERELY INJURED VETERANS:

Given the prevalence of severely disabled veterans and their specific needs, the Department of Veterans Affairs should move forward rapidly to establish a series of new programs to provide support and care to immediate family members who are devoted to providing these veterans with lifelong personal care and attendance.

A miraculous number of veterans from Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND) are surviving what surely would have been fatal events, but many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal support.²⁸⁵ Eventually, most of these veterans will be able to return to their families, at least on a part-time basis, or will be moved to an appropriate therapeutic residential care setting—but with the expectation that family members will serve as lifelong caregivers to facilitate rehabilitation and as personal attendants to help them compensate for the dramatic loss of physical, mental, and emotional capacities as a result of their injuries.

The primary caregiver of a severely injured veteran shoulders the greatest burden as he or she experiences individual challenges, and, if a spouse, marital stress as well. The injury, the result of an unexpected event, throws the family unit into a situational crisis, not something that is a part of normal family development. Events like these are likely to be perceived as more stressful than giving care to an elderly family member, simply because it is “off-time”—away from the “normative life cycle.”²⁸⁶

For the first time, a study was conducted by the National Alliance for Caregiving on caregivers of veterans injured while serving in the military from World War II, the Korean and Vietnam Wars, Operation Desert Storm, and Operations Iraqi and Enduring Freedom. The purpose of the Caregivers of Veterans—Serving on the Homefront (COV) study was to assess the experiences and challenges of family caregivers of veterans, the impact of caregiving on their lives, and what programs and services would support and assist them.

The picture portrayed by the COV survey is remarkably different from what has been found nationally among the general population.²⁸⁷ Caregivers of veterans are overwhelmingly women, 96 percent compared to 65 percent nationally. In addition, given the prevalence of spousal relationships,²⁸⁸ it is not

surprising that caregivers of veterans are more than three times as likely as family caregivers in general to live in the same household as the person for whom they provide care and far more apt to be the primary caregiver.²⁸⁹ These findings have significant policy implications since research has found the role of primary caregiver as well as cohabitation to be highly predictive for increased caregiver burden.

Providing care to a veteran with a service-related condition has widespread impacts on the caregiver’s health. The COV study found nearly 90 percent report increased stress or anxiety and nearly 80 percent experience sleep deprivation. Caregivers of veterans report declines in healthy behaviors—such as exercising (69 percent), eating habits (56 percent), and going to one’s own doctor and dentist appointments on schedule (58 percent), and similar proportions have weight gain/loss (66 percent) or experience depression (63 percent). Seven in 10 caregivers of veterans also feel isolated and more than half hesitate to take the veteran outside the home for a variety of reasons.

In the veteran population, cognitive and behavioral issues play a striking role in caregiver burden. A study of female partners of veterans with post-traumatic stress disorder (PTSD) found that significant others also suffer from caregiver burden. The partners in this study exhibited high levels of psychological stress, with their clinical stress scale scoring above the 90th percentile.²⁹⁰ In the COV study, seven of 10 caregivers reported that their loved ones experience depression or anxiety, and six of 10 reported they their loved ones experience symptoms of PTSD, compared to the national measure (where 28 percent of care recipients suffer from mental or emotional health problems).

According to the Department of Veterans Affairs, limited empirical research exists that details the specific relationship challenges that couples must face when one of the partners has PTSD. However, clinical reports indicate that significant others are presented with a wide variety of challenges related to

their partner's PTSD. Spouses of PTSD-diagnosed veterans tend to assume greater responsibility for household tasks (e.g., finances, time management, house upkeep) and the maintenance of relationships (e.g., children, extended family).²⁹¹

Caregivers of the severely injured and ill often must give up their own employment (or withdraw from school in many cases) to care for, attend to, and advocate for their injured veterans. They often fall victim to bureaucratic mishaps in the shifting responsibility of conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation). Also, they rely on this much-needed subsistence in the absence of other personal income. Many of them consequently struggle financially, even to the extent of approaching bankruptcy.²⁹²

Of the caregivers of veterans who were employed at some point while serving as a caregiver, a large share experiences employment changes that result in a loss of income or benefits. Six in 10 caregivers in the COV survey cut back the number of hours in their regular schedule and almost half stopped work entirely or took early retirement. Fewer than one in 10 nationally reported neither of these impacts. Fifty percent of caregivers of veterans report feeling a high degree of financial hardship, compared to 13 percent nationally.

With the increased burden of care, it is not surprising that the impact of caregiving on their lives and the life of the family is greater than for other caregivers in general. Of those currently married, separated, or divorced, three-quarters say caregiving or the veteran's condition placed a strain on their marriage. The COV study found that three in 10 caregivers who participated in the survey fell into the classic "sandwich generation"—balancing their caregiver role between the veteran and their children under the age of 18.

In these households more than two-thirds report having spent less time with their children than they would have liked and nearly 60 percent report that their children or grandchildren had emotional or school problems as a result of their caregiving or the veteran's condition. Many of these impacts of caregiving are manifest more frequently among caregivers who provide care to a veteran with PTSD, traumatic brain injury, or mental illness, such as depression or anxiety.

These findings indicate caregivers of severely injured veterans bear a heavier burden compared to caregivers in the broader U.S. population. Notably, a National Alliance for Caregiving study on caregiving nationwide found that more than 10 million people are caring for veterans, and nearly 7 million of those caregivers are themselves veterans.²⁹³ Clearly, the tremendous sacrifices made by caregivers of severely injured veterans have gone unrecognized and their needs have been unmet for decades, until the passage of P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act of 2010."

Support for the Caregiver

Congress passed an historic law that provides benefits and services to caregivers of certain severely disabled veterans and service members. Under P.L. 111–163, VA is required to create a caregiver support program, in which caregivers of veterans of all eras would receive supportive services, such as caregiver training and education, counseling and mental health services, and age-appropriate respite care (including 24-hour, in-home respite care). Caregivers will also gain access to telehealth services and other available technologies; techniques, strategies, and skills for caring for a disabled veteran; counseling, and referral services to community and other support programs.

VA's Caregiver Support program will provide additional caregiver support benefits to those caring for certain eligible OEF/OIF veterans. This supplemental benefit includes lodging and subsistence payments when accompanying the veteran on medical care visits; health-care coverage through VA's Civilian Health and Medical Program (CHAMPVA), and a monthly living-wage stipend based on the level of care they provide.

VA is also required to submit a report to Congress advising on the extension of the more comprehensive benefits provided to the caregivers of OEF/OIF/OND veterans to caregivers of veterans of all other eras, no later than two years after the implementation of the program. We urge Congress to follow up with VA to ensure that it meets this critically important reporting requirement.

On May 3, 2011, VA published the interim final rule for implementing the Family Caregiver Program under P.L. 111–163, and began taking applications from eligible veterans effective May 9, 2011.

The program is managed by VA's Office of Care Management and Social Work, which is under the Office of Patient Care Services.

Caregiver support coordinators (CSCs), located at all VA medical centers, are responsible for implementing the program at their local facility. CSC is a social work program coordinator whose primary responsibilities are to provide clinical evidence-based services and interventions; program development; caregiver, veteran, and staff education on caregiver issues; community outreach; resource development; continuous quality improvement activities; and evaluation/consultation. They also assist family caregivers with the psychosocial and emotional stressors of caring for an ill, injured, or disabled veteran as well as providing social service resources linking the caregiver to VA health-care and community services.

VA has also established a national Caregiver Support Line,²⁹⁴ on February 1, 2011. VA Support Line staff provides counseling, support, and assists caregivers of any disabled veteran, regardless of whether they are receiving benefits from VA's Caregiver Support program, connect to needed resources and services in their local community.

In FY 2011, VA received 3,160 applications of which 688 were disapproved.²⁹⁵ Of the remaining 2,472 applications, 1,385 were approved and 1,087 were in process at the end of the fiscal year. September 2011 marked the first stipend payments, averaging \$1,600 to \$1,800, to 1,309 recipients.²⁹⁶ More than 320 caregivers are enrolled in CHAMPVA based on the eligibility requirements under this program. Similar to the COV survey, 92 percent of caregivers are women—69 percent are spouses and 13 percent are mothers.

To educate eligible caregivers, VA and Easter Seals collaborated to create the Caregiver Core Curriculum Training containing six modules. These aids are available via face-to-face classes throughout the nation, a workbook with DVD, and on-demand web access. Eligible caregivers are certified by their local VA Caregiver Support Coordinators to receive this training. Those certified and completing the training will be eligible for benefits under the Family Caregiver program.

While VA is in the midst of implementing the new caregiver support program, the IBVSOs continue to have concerns about existing services caregivers of severely injured veterans are currently using. We urge VA to pay particular attention to the findings in the COV survey, which highlights those programs and services that caregivers of veterans would prefer to receive to assist them in their role.

Furthermore, VA has received several public comments to its interim final rule. We urge Congress to ensure VA exhibits the required good faith and seriously considers post-promulgation comments.

Provisional Access to Caregiver Benefits and Services

While caregivers of service members are able to apply for benefits and service under this new program, the IBVSOs are concerned that the interim final rules require eligibility for a primary or secondary caregiver if the service member has been found unfit for duty due to a medical condition by his or her military service's Physical Evaluation Board (PEB) and a date of medical discharge has been issued.²⁹⁷ For example, even if the service member is found medically unfit for duty, family caregivers are unable to access VA's Caregiver Core Curriculum Training unless the service member has received a date of medical discharge. Severely injured service members can be placed on Department of Defense Temporary Disability Retirement for five years at most. The IBVSOs believe such service members and their family caregivers would benefit from VA's Caregiver Support program while they wait for a date of medical discharge.

We urge VA to ensure service members who are found medically unfit for duty is able to apply for a primary or secondary caregiver in order for such caregiver to utilize VA caregiver support benefits and services. Because VA and the DOD are able to share medical information and collaboratively care the same severely disabled service members, VA should be able to make a predetermination to grant on such applications and allow the caregiver access to VA's Caregiver Support program. Further, we note that both Departments are able to collaborate the discontinuance of DOD's Special Compensation for Assistance with Activities of Daily Living²⁹⁸ benefit when it receives notice that VA has commenced stipend payment to the family caregiver.

Care/Case Manager: Through Congressional oversight and independent reports, VA and the DOD have placed tremendous emphasis on care or case managers to assist in the rehabilitation and transition process. Half of caregivers in the COV report who say the veteran in their care has one or more care managers recognize them as a potential support resource. However, 65 percent of caregivers of veterans say the care manager has been at least somewhat helpful in locating, arranging, and coordinating care and resources for the veteran, and only 43 percent feel the care manager has been helpful in finding support for the caregiver. In general, care managers have proven more helpful for the veteran than for the caregiver.

This surprising finding—that the presence of one or more care managers does not appear to ease caregivers' situations in terms of lowered stress, lower likelihood of isolation, greater ease of finding resources that they seek, or reduced impacts on employment—places a greater burden on caregivers to advocate for themselves when their primary focus is on meeting the needs of their veteran and family.

Clinical Assessment Tool and Stipend Tiers: Concerns were raised about the assessment tool used to determine the amount of caregiver hours to determine the stipend amount. While the current tool has 14 questions, and is derived from three validated instruments,²⁹⁹ they have yielded variable results, as discussed in the July 11, 2011, hearing before the House Committee on Veterans' Affairs.

VA should re-evaluate its current assessment instrument to ensure that it reflects the real world requirements for caring for severely injured veterans. VA should eliminate the 40-hour limit used in determining the stipend amount. It is an arbitrary limitation for which VA has not provided any evidence in support.

Respite Care: Considered one of the most beneficial and frequently requested services, respite care is used to support and strengthen caregivers, sustain family stability, and reduce the likelihood of abuse and neglect.^{300, 301, 302}

VA's respite care can be provided in home,³⁰³ in the community,³⁰⁴ or in an institutional setting.³⁰⁵ VA's authority to provide respite care is under Title 38,

United States Code, section 1720B, and is a fundamental benefit in the Department's extended-care services under section 1710B.

Interestingly, the COV survey found the likelihood of the caregiver receiving respite care does increase in relation to the number of care managers. Of great concern to the IBVSOs is that the large majority, 82 percent, of caregivers indicate they have not received any respite services from VA or any other organization in the past year, and only 15 percent have. Although caregivers with a high burden of care are nearly twice as likely to receive respite as those with a medium burden, only about 20 percent of those high-burden caregivers receive respite care. Furthermore, only 11 percent of caregivers of veterans suffering PTSD received respite services.

P.L. 111–163 requires VA to provide to eligible primary caregivers respite care that is medically and age-appropriate and include in-home care of not less than 30 days annually, including 24-hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite. Other caregivers under this program are to be provided respite care under section 1720B that is medically and age-appropriate and includes in-home care including 24-hour per day care

According to VA's respite care handbook,³⁰⁶ the administrative policy for respite care continues to provide the benefit for up to 30 days in a calendar year. Furthermore, the admission criteria for respite care based on the handbook is inconsistent with respite care provided as part of VA's Caregiver Support program. The IBVSOs urge VA to revise its respite care handbook to include the new requirement of P.L. 111–163.

The law clearly recognizes the benefits of respite care and emphasizes the importance of providing such service to caregivers of severely disabled veterans. However, the law does not provide equal benefits to caregivers of severely disabled veterans injured before September 11, 2001. We urge Congress to correct this inequity and provide strict oversight on VA's respite care program, which has a history of variable access and underutilization in the VA health-care system.

We applaud VA for establishing the Volunteer Respite program, which prepares volunteers to provide

temporary relief to primary caregivers of veterans. The trained volunteer is intended to be a vital part of a support network of family, friends, social service, and health professionals who provide comfort and assistance to homebound veterans. Through this program, volunteers provide a much-needed break to the caregivers so they can renew their energy and spirit and provide compassionate support to ill and injured veterans in their homes.

The local VA medical center voluntary service specialist has primary responsibility for establishing and operating a community-based volunteer home respite program to benefit OEF/OIF veterans and their primary caregivers. They also directly support the Volunteer Caregiver Support Network program, a collaborative effort between VA Voluntary Service and the Office of Care Coordination. They will support the mission of expanding Respite and Caregiver Support service options for veterans and their families. The IBVSOs recommend VA expand the number of voluntary service specialists throughout its Veterans Integrated Service Networks and VA medical centers.

Furthermore, we believe state veterans' homes can play a small but vital role in greatly increasing access to services and can offer a less intensive alternative to VA medical facilities in serving as a source of respite for families of those severely injured. Since availability has historically been an issue in providing respite care and the COV survey shows caregivers of veterans have used little respite care, VA should work with state veterans' homes in reviewing its relationship including the referral and payment processes to gain needed capacity and increase the likelihood caregivers will use this critical support service.

We urge VA to explore the Aged/Disabled Medicaid Home and Community-Based Services (HCBS) waiver program as it has done in its emerging Medical Foster Home program to provide noninstitutional respite care services to caregivers of veterans. Not only does respite care have to be accessible, the IBVSOs believe it should be affordable and therefore urge Congress to eliminate applicable copayments.

Transportation: In some instances veterans and their family caregivers have to travel over long distances to receive medical care. The IBVSOs are also concerned about the accessibility and availability of

transportation for the veteran, which would provide significant relief in time and effort, particularly with caregivers who are trying to remain employed.

VA may authorize special modes of transportation³⁰⁷ to veterans eligible for beneficiary travel³⁰⁸ if medically necessary and approved before travel begins. However, since the term "medically indicated" is not explicitly defined, the use of this benefit varies considerably.

Mental Health: According to the COV survey, 77 percent of participating caregivers say they have no life of their own, 72 percent feel isolated, and 63 percent suffer from depression. Three-quarters found counseling or therapy for the caregiver or his/her family is helpful. Eighty-four percent of caregivers with veterans under the age of 45 were more apt to rate counseling as helpful compared to those with a veteran ages 45 to 64 (75 percent) or 65+ (73 percent). The study notes that the presence of several medical conditions is perhaps related to receptivity to counseling: PTSD (81 versus 71 percent with no PTSD), TBI (83 versus 75 percent), and depression/anxiety (81 versus 69 percent).

P.L. 110–387, the "Veterans' Mental Health and Other Care Improvements Act of 2008," significantly amended VA authority to provide counseling, training, and mental health services for immediate family members under Title 38, United States Code, sections 1701 and 1782. This authority is referenced in P.L. 111–163 for caregivers of veterans other than the primary caregiver. Services covered under this authority are certainly a critical part of the support services for caregivers, but it has concerning limitations.

P.L. 111–163 provides primary and secondary caregivers, "counseling...and such mental health services as the Secretary determines appropriate."³⁰⁹ VA is also required to provide general caregivers "[c]ounseling and other services under section 1782 of this title." However, such services can only be provided to caregivers if it is in connection with the veteran's treatment plan.³¹⁰ Moreover, VA's current authority is silent on providing prolonged support services for other than primary caregivers beyond acute or sub-acute treatment and rehabilitation of the veteran.

The IBVSOs believe that, in implementing these services under P.L. 111–163 and P.L. 110–387, VA

should deploy such services in every location in which it treats veterans who have caregivers, and at a minimum should provide such services at every VHA access point, including all medical centers and substantial community-based outpatient clinics. When warranted by circumstances, these services should be made available through other means, including the use of telehealth technology and the Internet. For more information on these rural telehealth issues and challenges, see “Veterans Rural Health Care” in this *Independent Budget*. When necessary because of scarcity or rural access challenges, VA’s local adaptations should include consideration of the use of competent community providers on a fee or contract basis to address the needs of these families.

Other In-Home Support: Through its purchased HCBS programs, VA provides in-home and community-based care that includes skilled home health care, homemaker home health aide services, community adult day health care, and home-based primary care. Nearly 60 percent of caregivers of veterans who participated in the COV survey said they received help from other unpaid caregivers, but only one-third have received help from paid caregivers.

The IBVSOs are deeply concerned over the low utilization of HCBS that would directly support the caregiver and allow the veteran to live in the community. While all enrolled veterans are eligible for the full range of services covered under the Veterans Health Administration’s (VHA) Uniform Benefits Package, we have received reports of planned reductions in the HCBS program.

The sources for such reductions are as varied as they are many, but the primary cause is that demand is far exceeding available capacity and budgetary resources. Couple this with the confusion among VA medical facilities as to the appropriate hours of HCBS services that are to be provided to veterans and their caregivers, and the IBVSOs are concerned that veterans and caregivers will unduly suffer. We strongly encourage the VHA to provide evidence-based guidelines in determining the amount of support and types of services that should be used to ensure the veteran is able to remain at home as long as possible and improve the quality of life of the veteran and caregiver.

Information, Education, and Training: Three in 10 caregivers report that VA or Department of Defense military systems proactively gave them information

or links to information to help them understand the veteran’s condition, treatment, or services. This appears to help caregivers feel more confident in their first six months of caregiving.

However, at least two-thirds of caregivers who participated in the COV survey indicate their top challenges include not knowing what to expect medically with the veteran’s condition; not being aware of VA services that could help; not knowing how to address PTSD or mental illness (among those who report that such a condition is present); difficulty getting through bureaucracies in order to obtain services; not knowing where to obtain financial assistance; not knowing where to turn to arrange a break from caregiving; and not knowing where to obtain specialized care. Several of these challenges are more commonly noted by caregivers of veterans who have TBI.

According to VA, caregivers have a number of challenges when living with a veteran who has PTSD. Wives of PTSD-diagnosed veterans tend to take on a bigger share of household tasks such as paying bills or housework. They also do more taking care of children and the extended family. Partners feel that they must take care of the veteran and attend closely to the veteran’s problems. Partners are keenly aware of what can trigger symptoms of PTSD. They try hard to lessen the effects of those triggers.³¹¹

It is not surprising that caregivers of veterans in the COV survey say they resort to word of mouth as the most commonly used source of information when looking for caregiver resources and information. Additionally, while more caregivers of veterans turn to VA and non-VA health providers as resources, 73 percent are more likely to consider non-VA providers as helpful compared to VA (43 percent for the VHA and 41 for the Veterans Benefits Administration). Other sources of information are not used as frequently, but each is considered as helpful by at least two-thirds of caregivers, including online forums, groups, or blogs; disease-specific organizations; and in-person support groups.

We applaud VA for dedicating a website to this program. It provides important resources to help caregivers with organizing health, financial, and other everyday issues. It provides caregiving tips and disease-specific information for veterans suffering from Alzheimer’s, PTSD, and TBI. We urge VA to seek feedback from all caregivers of veterans to ensure

this online communication, outreach, and information resource remains pertinent to their needs.

The IBVSOs believe caregivers of severely disabled veterans need practice before they are saturated with responsibilities in caring for their extraordinary veterans. To this end, VA should provide severely disabled veterans and family members residential rehabilitation services, to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans.

Recognizing the tremendous disruption to their lives, this service should focus on helping the veteran and other family members restart, or “reboot,” their lives after surviving a devastating injury. An integral part of this program should include family counseling and family peer groups so they can share solutions to common problems.

The Future for Caregiver Support

As severely injured troops are released from active duty, they are in need of full-time care when they come to VA for medical care. Without caregivers to assist veterans transitioning from military to veteran status and integrating into their community of choice, the options lead to greater dependency on government programs. These include institutional care provided by or paid for by VA or full-time care in the home supported by a VA-provided caregiver.

Were it not for recent laws and initiatives, such as P.L. 110–387; P.L. 111–163, the “Caregiver Assistance Pilot Programs”³¹² authorized in P.L. 109–461; the “Veteran Directed Home and Community-Based Services Program, and the Veteran Community Partnership,” the VA health-care system historically offered little recognition of the sacrifices being made daily by spouses and families in taking over the care of their wounded loved ones at home.

We urge the VHA to consider this in times when resources are limited and facilities may directly or indirectly delay or deny needed services. For example, clearly recognizing the urgency of need, VA providers give a significant amount of training, instruction, counseling, and health care to caregivers of severely injured veterans who are attending veterans during their hospitalizations. The IBVSOs are concerned this work is going without recognition within VA’s resource allocation system. VA facilities are in essence being penalized for doing the right thing where scarce

resources that are needed elsewhere are being diverted to those needs.

In the implementation of the new caregiver support program, the IBVSOs are greatly concerned that just as there is marked variability in the availability of the full array of noninstitutional long-term care benefits designed to meet the needs of severely disabled veterans in the community, so, too, will it be with benefits and services for caregivers of veterans. Known criticism of community-based VA care involves the availability of services generally not being provided, lack of flexibility of existing services, lack of local availability of services, varied quality of services received, and trust and privacy issues of VA and non-VA staff. Therefore, as the IBVSOs applaud VA’s leadership on the effort it is investing to implement the caregiver support program, it is critically important that Congress conduct rigorous oversight on the agency’s implementation plan, the access to, as well as the availability and effectiveness of benefits and services for caregivers of veterans.

The IBVSOs thank Congress for passing P.L. 111–163, which recognizes the role caregivers play in providing the highest quality of life possible for their severely injured veterans. Certainly, the law requires VA to submit to Congress a report no later than February 2012 on the feasibility and advisability of expanding the caregiver benefits to those veterans injured before September 11, 2001; however, as the COV survey finds, these support services are needed by caregivers of veterans regardless of when they served or were injured.

Moreover, the IBVSOs believe making and planning policy to better serve caregivers of severely injured veterans should depend on statistically representative data that can be used to determine validity, reliability, and statistical significance. We note that in passing P.L. 111–163, the provision to authorize VA and the DOD to contract for a national survey of family caregivers of seriously disabled veterans and service members and report to Congress with their findings was not included. VA estimates the survey would cost approximately \$2 million over the four-year period. As evidenced by the information derived from the COV and other surveys, such as the Informal Caregiver Survey,³¹³ we urge Congress and VA to conduct a study to assess the caregiver population being served, their challenges, needs, and whether existing programs are meeting those needs.

Caregivers of severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical³¹⁴ and emotional problems³¹⁵ of the severely injured veteran plus deal with the complexities of the systems of care³¹⁶ that these veterans must rely on, while struggling with disruption of family life, interruptions of personal and professional goals and employment, and dissolution of other “normal” support systems because of the changed circumstances resulting from the veteran’s injuries and illness. While caregivers may be driven by empathy and love, they are also dealing with guilt over the anger and frustration they feel. The very touchstones that define their lives—careers, love relationships, friendships, even their goals and dreams—are often being sacrificed.

Finally, the IBVSOs remain concerned about the VA’s lack of financial commitment to the caregiver provisions of P.L. 111–163. As discussed in the section “Sufficient, Timely, and Predictable Funding for VA Health Care,” we believe that there will be a significant funding need in order for VA to properly implement this program. During consideration of the legislation, the costs were estimated to be approximately \$1.5 billion between FY 2010 and FY 2015. This included approximately \$60 million indentified for FY 2010 and approximately \$1.54 billion between FY 2011 and FY 2015. However, no funding was provided in FY 2011 to address this need. Moreover, VA only requested \$207 million in FY 2012 and \$248 million in FY 2013 for total implementation of P.L. 111–163, well short of the estimated funding needed for this law. Congress absolutely must provide greater funding than the resources already provided to ensure proper administration of the caregiver program. As we stated previously, *The Independent Budget* recommends approximately \$284 million to fund the provisions of P.L. 111–163 in FY 2013.

The organizations that coauthor *The Independent Budget* intend to be vigilant to ensure that VA’s response to the new statute extending benefits and services to caregivers of veterans fulfills the nation’s pledge to these American heroes.

Recommendations:

Congress must correct the inequity in the eligibility of VA caregiver support benefits and services.

Congress must ensure and VA must demonstrate the required good faith and serious consideration of post-promulgation comments.

VA should allow for provisional or predetermination granting caregivers of service members who are found medically unfit for duty but awaiting medical discharge access to caregiver support benefits and services.

VA should re-evaluate its current assessment instrument to ensure that it reflects the real world requirements for caring for severely injured veterans.

VA should eliminate the 40-hour limit used in determining the stipend amount. It is an arbitrary limitation for which VA has not provided any evidence in support.

VA should establish clear policies outlining the expectation that every VA nursing home and adult day health-care program will provide appropriate facilities and programs for respite care for severely injured or ill veterans. These facilities should be restructured to be age appropriate, with strong rehabilitation goals suited to the needs of a younger population, rather than expecting younger veterans to blend with the older generation typically resident in VA nursing home care units and adult day health-care programs. VA must adapt its services to the particular needs of this new generation of disabled veterans and not simply require these veterans to accept what VA chooses to offer.

VA should revise its respite care handbook to include the new requirement of P.L. 111–163, “Caregivers and Veterans Omnibus Health Services Act of 2010.”

VA should explore the Aged/Disabled Medicaid Home and Community-Based Services waiver program as it has done in its emerging Medical Foster Home program to provide noninstitutional respite care services to caregivers of veterans.

VA should work with state veterans' homes in reviewing its relationship, including the referral and payment processes, to gain needed capacity and increase the likelihood caregivers will use respite care.

Congress should eliminate applicable respite care copayments.

VA should expand the number of voluntary service specialists throughout its Veterans Integrated Service Networks and VA medical centers to expand the its Volunteer Caregiver Support Network program.

VA should seek feedback from all caregivers of veterans to ensure its online communication, outreach, and information resource remains pertinent to caregivers' individual needs.

VA must provide evidence-based guidelines in determining the amount of caregiver support and types of services that should be used to ensure the veteran is able to remain at home as long as possible and improve the quality of life of the veteran and caregiver.

VA must ensure that workload credit is assigned and is captured in its resource allocation system for all caregiver support services provided by VA health-care providers.

VA should provide severely disabled veterans and family members residential rehabilitation services to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans.

VA must ensure there is standard availability and accessibility of caregiver support services, with particular consideration for veterans residing outside a Veterans Health Administration (VHA) catchment area.

Congress and VA should review the detailed findings of the "Caregivers of Veterans—Serving on the Homefront" survey and address the recommendations contained therein.

VA should develop a stronger social and advocacy support for caregivers of severely injured veterans, including peer support groups, facilitated and/or assisted by committed VA staff members; appointment

of caregivers to local and VA network patient councils and other advisory bodies within the VHA and the Veterans Benefits Administration; a monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled veterans of Operations Enduring and Iraqi Freedom, through My HealthVet or another appropriate web-based platform.

Congress should require the Government Accountability Office to examine the current Civilian Health and Medical Program of Veterans Affairs to ensure the health coverage available to primary caregivers is adequate.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys to assess the caregiver population being served, their challenges, needs, and whether existing programs are meeting those needs. The study should be designed to yield statistically representative data for policy and planning purposes.

VA must request and Congress must provide sufficient funding to ensure proper implementation and administration of the caregiver program.

²⁸⁵Congressional Research Service, U.S. Military Casualty Statistics: Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom (September 28, 2010).

²⁸⁶Tracey A. Revenson, "Scenes from a Marriage: Examining Support, Coping, and Gender within the Context of Chronic Illness," in *Social Psychological Foundations of Health and Illness*, ed. J. Suls and K. Wallston, 530–59 (Oxford, England: Blackwell Publishing, 2003).

²⁸⁷National Alliance for Caregiving and AARP, *Caregiving in the US* (November 2009).

²⁸⁸80 percent to 23 percent nationally.

²⁸⁹82 percent to 53 percent nationally.

²⁹⁰G. Manguno-Mire, F. Sautter, J. Lyons, et al., "Psychological distress and burden among female partners of combat veterans with PTSD," *Journal of Nervous Mental Disease* 195, no. 2 (February 2007): 144–51.

²⁹¹Jennifer L. Price and Susan P. Stevens, "Partners of Veterans with PTSD: Research Findings," http://www.ptsd.va.gov/professional/pages/partners_of_vets_research_findings.asp.

²⁹²U.S. Department of Veterans Affairs, Advisory Committee on Disability Compensation, Transcript (McLaughlin Reporting, October 19, 2009).

²⁹³National Alliance for Caregiving and AARP, *Caregiving in the US* (November 2009).

²⁹⁴(855) 260–3274.

²⁹⁵424 veterans did not meet the September 11, 2011, requirement; 145 did not meet the clinical requirement, and; 119 were administratively ineligible.

²⁹⁶Tier 1 (lowest level) has 264 recipients; Tier 2 has 412 recipients, and; Tier 3 (highest level) has 709 recipients.

²⁹⁷38 C.F.R. § 71.20(a)(2).

²⁹⁸NDAA of 2010, P.L. No. 111–84, §603 (2010). This provision would recognize that family members are making life altering sacrifices in order to care for service members at home. By aligning the authority available under this provision with the authority to provide aid and attendance compensation for veterans under section 1114 of Title 38, United States Code, the conferees expect there to be no gaps in coverage and care for catastrophically injured service members transitioning from the Department of Defense to the Department of Veterans Affairs. (Conference Report 111–288).

²⁹⁹The Katz Basic Activities of Daily Living Scale; the UK Functional Independence Measure and Functional Assessment Measure; and the Neuropsychiatric Inventory.

- ³⁰⁰ George, L.K., & Gwyther, L.P. (1986). Caregiver Well-Being: A Multidimensional Examination of Family Caregivers of Demented Adults. *The Gerontologist*, 26(2), 253–260. As cited by Scharlach, A.E., Lowe, B.F., and Schneider, E.L. (1991). *Elder Care and the Work Force: Blueprint for Action*. Ontario, Canada: Lexington Books.
- ³⁰¹ L. Feinberg and S. Newman, Medicaid and Family Caregiving: Services, Supports, and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S. (New Brunswick, NJ: Rutgers Center for State Health Policy, May 1, 2005).
- ³⁰² National Alliance for Caregiving & AARP (1997). *Family Caregiving in the U.S.: Findings From a National Survey*. Bethesda, MD: Authors, 1997.
- ³⁰³ VA purchased Homemaker/Home Health Aide (H/HHA) and VA's Volunteer Respite Program.
- ³⁰⁴ Adult Day Health Care.
- ³⁰⁵ VA Community Living Center and Community Nursing Home.
- ³⁰⁶ DVA Veterans Health Administration, Respite Care, Handbook 1140.02 (Washington, DC: November 10, 2008).
- ³⁰⁷ Special mode transportation is defined in 38 C.F.R. §70.2 as an ambulance, ambulette, air ambulance, wheelchair van, or other mode of transportation specially designed to transport disabled persons (this would not include a mode of transportation not specifically designed to transport disabled persons, such as a bus, subway, taxi, train, or airplane). A modified, privately owned vehicle, with special adaptive equipment and/or capable of transporting disabled persons is not a special mode of transportation.
- ³⁰⁸ 38 C.F.R part 70, and DVA Veterans Health Administration, Beneficiary Travel, Handbook 1601B.05 (Washington, DC: July 21, 2010).
- ³⁰⁹ 38 U.S.C. § 1720G(a)(3)(i)(III) and (a)(3)(ii)(II).
- ³¹⁰ 38 U.S.C. § 1782(a) and (b).
- ³¹¹ <http://www.ptsd.va.gov/public/pages/partners-of-vets.asp>. Accessed: November 16, 2011.
- ³¹² P.L. 109–461, Title II, section 214, Pilot Program on Improvement of Caregiver Assistance Services.
- ³¹³ The Informal Caregiver Survey (ICS) of the National Long Term Care Survey (NLTC).
- ³¹⁴ Stacy A. Brethauer, Alex Chao, et al., “U.S. Navy/Marine Corps Forward Surgical Care During Operation Iraqi Freedom,” *Archives of Surgery* 143 no. 6 (2008): 564–69.
- ³¹⁵ T. Tanielian and L. Jaycox, eds., “Executive Summary,” in *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corp., Center for Military Health Policy Research, 2008).
- ³¹⁶ Atul Gawande, “Casualties of War: Military Care for the Wounded from Iraq and Afghanistan,” *New England Journal of Medicine* 351, no. 24 (2004): 2471–75.

Construction Programs

With an infrastructure that is more than 60 years old, the Department of Veterans Affairs (VA) has a monumental task of maintaining and improving its vast network of facilities to ensure the Veterans Health Administration can provide accessible, high-quality health care to our nation's veterans. Currently, VA owns 5,300 buildings and manages more than 800 leases. In 2005, VA began using the Federal Real Property Council Tier 1 performance measures to assess its capital portfolio goals.¹ The two measures that directly affect patient services are utilization and condition. In 2004, VA's utilization was at 80 percent, well below capacity. That utilization grew to 121 percent in 2010, and is projected to grow even more in the coming years. During the same time period, the condition of VA's infrastructure decreased from 81 percent to 71 percent.² These trends show that funding for the next few years will be critical for VA to fulfill its mission.

VA has developed the Strategic Capital Investment Plan (SCIP) to address the critical deficiencies in its infrastructure. SCIP uses six criteria to assess deficiencies, or gaps, in its ability to deliver efficient, high-quality, accessible services and care for veterans. The six gap criteria are access, utilization, space, condition, energy, and other (which includes safety, security, privacy, and seismic corrections).³ After conducting the gap analysis, VA found there were 4,808 capital projects that needed to be completed to close all gaps. It was also determined that to close all these gaps it would cost between \$53 billion and \$65 billion.⁴

The two categories that concern *The Independent Budget* veterans service organizations (IBVSOs) the most are condition and access. To determine and monitor the condition of its facilities, VA conducted a Facilities Condition Assessment (FCA). These assessments include inspections of building systems, such as electrical, mechanical, plumbing, elevators, and structural and architectural safety; and site conditions consisting of roads, parking, sidewalks, water mains, and water protection. The FCA review team can grant ratings of A, B, C, D, and F. Assessment ratings A through C conclude the assessed is in new to average condition. D ratings mean the condition is below average, and F means the condition is critical and requires immediate attention. To correct these deficiencies, VA will need to invest nearly \$10 billion.⁵

To close the gaps in access, VA will need to invest between \$30 billion and \$35 billion in major and minor construction and leasing. The remaining \$20 billion is needed to close the remaining nonrecurring maintenance deficiencies.

The IBVSOs 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 have sufficient funding.

¹ FY 2012 Budget Submission, Construction and 10 Year Capital Plan, February 2011, Vol. 4 of 4, p. 9.3-11, 12.

² Ibid., 9.3-13, 14.

³ Ibid., 8.2-4.

⁴ Ibid., 81-1.

⁵ Ibid., 9.3-14, 15.

MAJOR CONSTRUCTION ACCOUNTS:*Underfunding major construction reduces quality and access to care.*

By estimation of the Department of Veterans Affairs, to implement all currently identified gaps in major construction, Congress will have to authorize and appropriate \$20 billion–\$24.5 billion over the next 10 years. Currently, there are 35 major construction projects that are authorized, dating back as far as 2004. Only three of these projects are funded through completion. The total unobligated amount for all currently congressionally budgeted major construction projects is \$2.7 billion.⁶ Yet the total funding requested for FY 2012 major construction accounts was only \$725 million.

At this level of funding, it will take VA more than 25 years to complete its current 10-year capital investment plan. *The Independent Budget* veterans service organizations (IBVSOs) understand that fiscally difficult times call for spending restraints, but without quality, accessible medical centers, VA will not be

Table 6. Major Construction Recommendations

Category	Recommendations (\$ in Thousands)
Major Medical Facility Construction	\$2,307,000
NCA Construction	\$67,500
Advanced Planning	\$142,000
Master Planning	\$15,000
Historic Preservation	\$20,000
Miscellaneous Accounts	\$142,200
TOTAL	\$2,693,700

able to deliver quality, accessible care. The IBVSOs recommend \$2.7 billion to complete all partially funded and future major construction needs to close all identified gaps by 2021.

⁶ Ibid., 2–85.

**MINOR CONSTRUCTION ACCOUNTS:***Underfunding minor construction delays much-needed improvements to existing infrastructure.*

To close the minor construction gaps within its 10-year timeline, the Department of Veterans Affairs will need to invest nearly \$8 billion in Veterans Health Administration minor construction alone.⁷ Minor construction projects allow VA to address issues of functional space within existing buildings and improve facility conditions at cost less than \$10 million. In past years VA and Congress requested and appropriated nearly 10 percent of the total need to close the minor construction gaps. However, the Administration and Congress decreased funding for minor construction by about \$250 million over the past two years. If this rate of investment is continued, it will take more than 16 years to complete all current minor construction gaps. Congress and VA must put minor construction back on track by investing 10 percent of the total cost to complete the 10-year minor construction plan. With this in mind, *The*

Table 7. Minor Construction Recommendations

Category	Recommendation (\$ in Thousands)
Veterans Health Administration	\$789,000
National Cemetery Administration	\$68,000
Medical Research Infrastructure	\$150,000
Veterans Benefits Administration	\$48,600
Staff Offices	\$13,400
TOTAL	\$1,069,000

Independent Budget recommends \$1.1 billion in FY 2013 to achieve this goal.

⁷ Ibid., 1–4.

NONRECURRING MAINTENANCE ACCOUNT:

The deterioration of many VA properties requires increased spending on nonrecurring maintenance.

Even though nonrecurring maintenance (NRM) is funded through VA's Medical Facilities account and not through the Construction account, it is critical to VA's capital infrastructure. 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. Nonrecurring maintenance 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. Accordingly, to fully maintain its facilities, the Department of Veterans Affairs needs an NRM annual budget of at least \$2.1 billion.

Given the low level of funding NRM accounts have historically received, *The Independent Budget* veterans service organizations (IBVSOs) are not surprised that basic facility maintenance remains a challenge for VA. In addition, we have long-standing concerns about how this funding is apportioned once received

by VA. Because NRM accounts are organized under the Medical Facilities appropriation, they have 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, and 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 intense. The IBVSOs are encouraged by actions the House and Senate Veterans' Affairs Committees have taken in recent years requiring NRM funding to be allocated outside the VERA formula, and we hope this practice will continue.

Table 8. Nonrecurring Maintenance (NRM) Recommendations

Category	Recommendations (\$ in Thousands)
NRM	\$2,100,000
TOTAL	\$2,100,000



CAPITAL LEASING:

The Department of Veterans Affairs must ensure that increased use of leasing does not disrupt veterans' continuum of care.

The Department of Veterans Affairs enters into two types of leases. First, VA leases properties to use for each agency within VA, ranging from community-based outpatient clinics (CBOC) and medical centers to research and warehouse space. These leases do not fall under the larger construction accounts, but under each administration's and staff offices operating accounts.⁸

The second type of lease, called enhanced-use lease (EUL), allows VA to lease property it owns to an outside-VA entity. These leases allow VA to lease properties that are unutilized or underutilized for projects such as veterans' homelessness and long-term care. Proper use of leases provides VA with flexibility in providing care as veterans' needs and demographics change.

VA has moved to leasing many of its CBOCs and specialty clinics to increase access to primary and specialty care in local communities as well as a way to be more modular as veterans' demographics change. *The Independent Budget* veterans service organizations (IBVSOs) see the value in providing quick, accessible health care, but caution against a leasing concept that will rely on contracting inpatient care. Not having accessible inpatient care can—and has—left VA looking for ways to treat veterans in their greatest time of need. As Strategic Capital Investment Planning continues to move forward and more leases are entered into, some of which may have inpatient alternatives, the IBVSOs will continue to be vigilant to ensure that VA has viable contingency plans for inpatient care.

EUL gives VA the authority to lease land or buildings to public, nonprofit, or private organizations or companies as long as the lease is consistent with VA's mission and the lease "provides appropriate space for an activity contributing to the mission of the Department."⁹ Although EUL can be used for a wide range of activities, the majority of the leases result in housing for homeless veterans and assisted living facilities. In 2013, VA has 19 buildings or parcels of land that are planned for EUL.¹⁰ The IBVSOs encourage VA to continue to improve the transparency of potential EUL properties. Improving dialogue with veterans in the communities will reduce the backlash that often occurs when VA property is being repurposed.

Recommendations:

Congress must appropriate \$2.84 billion to adequately fund VA's major construction accounts.

Congress must appropriate \$919 million to adequately fund VA's minor construction accounts.

Congress must appropriate \$2.1 billion to begin reducing the nonrecurring maintenance backlog as well as invest between 2 percent and 4 percent per year to maintain the plant replacement value of VA's infrastructure.

Portions of the Nonrecurring Maintenance account should continue to be funded outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that have the greatest maintenance needs, rather than based on other criteria unrelated to the condition of facilities.

Congress should require VA to submit its research facilities capital needs report to the House and Senate Committees on Appropriations and Veterans' Affairs as soon as possible. Further, correction of the known infrastructure deficiencies should not be further delayed.

Congress should a construction appropriation sufficient to address at least five of VA's highest priority research facility construction needs as identified in its facilities assessment report (with an appropriation of \$150 million for those purposes) and create a pool of \$50 million in maintenance and repair funds dedicated exclusively to renovating existing research facilities.

Congress should require that research space be addressed as an integral component of planning for every new medical center.

The Administration and Congress should establish a new appropriations account in FY 2013 and thereafter to define and separate VA research infrastructure funding needs independently from capital and maintenance funding for direct VA medical care programs.

⁸ Ibid., 8.2–88.

⁹ Title 38, U.S.C., paragraph 8162, as amended through P.L. 112–7, enacted March 31, 2011, printed May 2, 2011.

¹⁰ FY 2012 Budget Submission, Construction and 10 Year Capital Plan, February 2011, Appendix 10 Year Capital Plan, p. 10–46–10–49.

EMPTY OR UNDERUTILIZED SPACE AT MEDICAL CENTERS:

The Department of Veterans Affairs must use empty and underutilized space appropriately.

The Department of Veterans Affairs maintains approximately 1,100 buildings that are either vacant or underutilized. An underutilized building is defined as one where less than 25 percent of space is used. It costs VA from \$1 to \$3 per square foot per year to maintain a vacant building.

Studies have shown that the VA medical system has extensive amounts of empty space that can be reused for medical services or reapportioned for another use. It has also been shown that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not. Medical facility planning is complex. It requires intricate design relationships for function, as well as the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor used as a medical surgical unit, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect on everything around it. These secondary impacts greatly increase construction expense and can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot necessarily be altered. Different aspects of medical care have various requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Laboratories should have long structural bays and function best without windows. When renovating empty space, if an area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient if simply renovated.

Renovating old space, rather than constructing new space, often provides only marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would cost. Factoring in domino or secondary costs, the renovation can end up costing more while producing a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but are rarely economical.

As stated earlier in this analysis, the average age of VA facilities is 60 years. Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing war veteran population are simply unable to be renovated for modern needs. Another important problem with this existing unused space is often location. Much of it is not in a prime location; otherwise, it would have been previously renovated or demolished for new construction.

P.L. 108–422 incentivized VA's efforts to properly dispose of excess space by allowing VA to retain the proceeds from the sale, transfer, or exchange of certain properties in a Capital Asset Fund. Further, that law required VA to develop short- and long-term plans for the disposal of these facilities in an annual report to Congress. With this in mind, VA has begun a review of buildings and properties for finding possible reuse or repurpose opportunities. Building Utilization Review and Repurposing, or BURR, will focus on identifying sites in three major categories: housing for veterans who are homeless or at risk for being homeless; senior veterans capable of independent living; and veterans who require assisted-living and supportive services. The three phases planned include identifying campuses with buildings and land that are either vacant or underutilized; sites visits to match the supply of buildings and land with the demand for services and availability of financing, and identifying campuses using VA's enhanced-use leasing authority. Under the BURR initiative, if no repurposing is identified, VA will begin to assess its vacant capital inventory by demolishing or disposing of buildings that are unsuitable for reuse or beyond their usefulness.

The Independent Budget veterans service organizations have stated that VA must continue to develop these plans, working in concert with architectural master plans, and community stakeholders and clearly identifying the long-range vision for all such sites.

Recommendations:

VA must develop a comprehensive plan for addressing its empty, underutilized, or excess space in non-historic properties so that it can be used for other purposes if it is not suitable for medical or support functions because of its age or location.

VA must have greater transparency when initiating its Building Utilization Review and Repurposing plan and an earlier more extensive community involvement when planning for underutilized space and infrastructure needs.



PROGRAM FOR ARCHITECTURAL MASTER PLANS:

Each VA medical facility must develop a detailed master plan and delivery models for quality health care that are in a constant state of change as a result of factors that include advances in research, changing patient demographics, and new technology.

The Department of Veterans Affairs must design facilities with a high level of flexibility in order to accommodate new methods of patient care and new standards of care. VA must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs. VA must also provide for growth in existing programs based on projected needs through a capital planning strategy.

A facility master plan is a comprehensive tool to examine and project potential new patient care programs and how they might affect the existing health-care facility design. It also provides insight with respect to growth needs, current space deficiencies, and other facility needs for existing programs and how they might be accommodated in the future with redesign, expansion, or contraction.

In many past cases VA has planned construction in a reactive manner. Projects are first funded and then placed in the facility in the most expedient manner, often not considering other future projects and facility needs. This often results in short-sighted construction that restricts rather than expands options for the future.

The Independent Budget veterans service organizations believe that each VA medical center should

develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility; \$15 million should be budgeted for this purpose. We believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility.

VA has undertaken master planning for several VA facilities, and we applaud this effort. But VA must ensure that all VA facilities develop master plan strategies to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

Recommendation:

Congress must appropriate \$15 million to provide funding for each medical facility to develop a 10-year comprehensive facility master plan. The master plan should include all services currently offered at the facility and should also include any projected future programs and services as they might relate to the particular facility. Each facility master plan is to be reviewed every five years and modified accordingly based on changing needs, technologies, new programs, and new patient care delivery models.

ARCHITECT-LED DESIGN-BUILD PROJECT DELIVERY:

The Department of Veterans Affairs must evaluate the use of architect-led design-build project delivery.

VA currently employs two project delivery methods: design-bid-build and design-build. Design-bid-build project delivery is appropriate for all project types. Design-build is generally more effective when the project is of a low complexity level. It is critical to evaluate the complexity of the project prior to selection of a method of project delivery.

Design-bid-build is the most common method of project design and construction. In this method, an architect is engaged to design the project. At the end of the design phase, that same architect prepares a complete set of construction documents. Based on these documents, contractors are invited to submit a bid for construction of the project. A contractor is selected based on this bid and the project is constructed. With the design-bid-build process, the architect is involved in all phases of the project to ensure that the design intent and quality of the project is reflected in the delivered facility. In this project delivery model, the architect is an advocate for the owner.

The design-build project delivery method attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to VA and reduce the project delivery schedule. Design-build, as used by VA, is broken into two phases. During the first phase, an architect is contracted by VA to provide the initial design phases of the project, usually through the schematic design phase. After the schematic design is completed, VA contracts with a contractor to complete the remaining phases of the project. This places the contractor as the design builder.

One particular method of project delivery under the design-build model is called contractor-led design-build. Under the contractor-led design-build process, the contractor is given a great deal of control over how the project is designed and completed. In this method, as used by VA, a second architect and design professionals are hired by the contractor to complete the remaining design phases and the construction documents for the project. With the architect as a subordinate to the contractor rather than an advocate for VA, the contractor may sacrifice the quality

of material and systems in order to add to his own profits at the expense of VA. In addition, much of the research and user interface may be omitted, resulting in a facility that does not best suit the needs of the patients and staff.

Use of contractor-led design-build has several inherent problems. A shortcut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents often do not provide adequate scope for the project, leaving out important details regarding the workmanship and/or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, compromising VA's design standards.

Contractor-led design-build forces VA to rely on the contractor to properly design a facility that meets its needs. In the event that the finished project is not satisfactory, VA may have no means to insist on correction of work done improperly unless the contractor agrees with VA's assessment. This may force VA to go to some form of formal dispute resolution, such as litigation or arbitration.

An alternative method of design-build project delivery is architect-led design-build. This model places the architect as the project lead rather than the builder. This has many benefits to VA. These include ensuring the quality of the project, since the architect reports directly to VA. A second benefit to VA is the ability to provide tight control over the project budget throughout all stages of the project by a single entity. As a result, the architect is able to access pricing options during the design process and develop the design accordingly. Another advantage of architect-led design-build is in the procurement process. Since the design and construction team is determined before the design of the project commences, the request-for-proposal process is streamlined. As a result, the project can be delivered faster than the traditional design-bid-build process. Finally, the architect-led design-build model reduces the number of project

claims and disputes. It prevents the contractor from “low-balling,” a process in which a contractor submits a very low bid in order to win a project and then attempts to make up the deficit by negotiating VA change orders along the way.

In addition to selecting the proper method of project delivery, there is much to learn from the design and construction process for each individual project. It is important for VA to apply these “lessons learned” to future projects.

Recommendations:

VA must establish a category system ranking design/construction project types by complexity. This system should be used to determine if the project is a candidate for the design-build method of project management.

The design-build method of project delivery should only be used on projects that have a low complexity, such as parking structures and warehouses. For health-care projects, VA must evaluate the use of architect-led design-build as the preferred method of project delivery in place of contractor-led design-build project delivery.

VA must institute a program of “lessons learned.” This would involve revisiting past projects and determining what worked, what could be improved, and what did not work. This information should be compiled and used as a guide to future projects. This document should be updated regularly to include projects as they are completed.



PRESERVATION OF VA’S HISTORIC STRUCTURES:

The Department of Veterans Affairs must further develop a comprehensive program to preserve and protect its inventory of historic properties.

The Department of Veterans Affairs has an extensive inventory of historic structures that highlight America’s long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, of those who cared for their wounds, and of those who helped to build this great nation. Of the approximately 2,000 historic structures in the VA historic building inventory, many are neglected and deteriorate year after year because of a lack of any funding for their upkeep. These structures should be stabilized, protected, and preserved because they are an integral part our nation’s history.

Most of these historic facilities are not suitable for modern patient care but may be used for other purposes. For the past eight years, *The Independent Budget* veterans service organizations (IBVSOs) have recommended that VA conduct an inventory of these properties to classify their physical condition and study their potential for adaptive reuse. VA has moved in that direction; historic properties have been

identified. Many of these buildings have been placed in an “Oldest and Most Historic” list and require immediate attention.

The cost for saving some of these buildings is not very high considering that they represent a part of American history. Once gone, they cannot be recaptured. For example, the Greek Revival mansion at the VA Medical Center in Perry Point, Maryland, built in the 1750s can be restored and used as a facility or network training space for about \$1.2 million. The Milwaukee Ward Memorial Theater, built in 1881, could be restored as a multipurpose facility at a cost of \$6 million. These expenditures would be much less than the cost of new facilities and would preserve history simultaneously.

The preservation of VA’s historic buildings also fits into the VA’s commitment to “green” architecture. Materials would be reused, reducing the amount of resources needed to manufacture and transport new materials to building sites.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

The IBVSOs encourage VA to use the tenets of P.L. 108-422, the "Veterans Health Programs Improvement Act," in improving the plight of VA's historic properties. This act authorizes historic preservation as one of the uses of the proceeds of the capital assets fund resulting from the sale or leases of other unneeded VA properties.

Recommendations:

VA must continue to develop a comprehensive program to preserve and protect its inventory of historic properties.

VA must allocate funding for adaptive reuse of historic structures and empty or underutilized space at medical centers.

Education, Employment, and Training

During this time of persistent unemployment in our country, the veterans' community has been hit especially hard. Estimates as recent as October 2011 suggest that the unemployment rate among veterans returning from Iraq and Afghanistan is at least 3 percent greater than the national average.¹ Our veterans have made tremendous sacrifices for our nation, and Congress and the Administration must make a concerted effort to ensure that veterans have access to education, employment, and training opportunities to ensure success in an unfavorable civilian job market.

Unfortunately, given today's gap between civilian and military populations, it seems there are too few employers as well as veterans who know how to translate military skill sets into civilian occupations. Some in private industry may fail to understand the wealth of skills veterans as employees can bring to the workplace considering the wide array of skills they possess, training they've gone through, and disciplined work ethic, all of which are valuable skills in any industry today.

A 2009 CareerBuilder survey asked employers who have hired U.S. veterans or members of the National Guard to list the top attributes military personnel brought to their organization. Survey participants cited the following valuable traits possessed by those employees:

- disciplined approach to work (cited by 68 percent of employers surveyed),
- ability to work as part of a team (63 percent),
- respect and integrity (57 percent),
- leadership (50 percent),
- problem-solving skills (46 percent),
- ability to perform under pressure (44 percent), and
- communication skills (37 percent).²

It is critical that today's military men and women have the ability to correlate their leadership experience and military competencies to nonmilitary job sectors. In recognition of veterans' employment challenges, Congress passed the VOW to Hire Heroes Act, an important step in improving veterans' job prospects.

(Continued)

Assisting those who have honorably served to secure the proper skills, certifications, and degrees so that they can achieve personal success is and should always be central to our support of veterans. In addition, disabled veterans often encounter barriers to entry or reentry into the workforce. The lack of appropriate accommodations on the job can make obtaining quality training, education, and job skills especially problematic. These difficulties, in turn, contribute to low labor force participation rates and leave many disadvantaged veterans with little choice but to rely on government assistance programs. At present funding levels, entitlement and benefit programs cannot keep pace with the current and future demand for such benefits. The vast majority of working-age veterans want to be productive in the workplace, and we must provide greater opportunities to help them achieve their career goals.

¹ U.S. Bureau of Labor Statistics, *Employment Situation, Table A-5. Employment status of the civilian population 18 years and older by veteran status, period, service, and sex, not seasonally adjusted* (October 21, 2011). <http://www.bls.gov/news.release/empst.t05.htm>.

² Have You Hired a Veteran Today?, Aug 26, 2011, p. 1, Employers Targeting U.S. Veterans for Hiring, New CareerBuilder Survey Finds. <http://thehiringsite.careerbuilder.com/2011/08/26/have-you-hired-a-veteran-today/>.



Education

In 2008, Congress enacted the Post-9/11 GI Bill and ensured that today's veterans have greater opportunities for success after their years of voluntary service to our nation. *The Independent Budget* veterans service organizations (IBVSOs) were pleased with the quick passage of this landmark benefit and worked with Congress to quickly correct unforeseen inequities via the "Post-9/11 Veterans Education Assistance Improvement Act of 2010." Since the publication of *The Independent Budget for Fiscal Year 2012*, Congress has amended the Post-9/11 GI Bill and opened eligibility for active duty service under Title 32 National Guardsmen orders, standardized reimbursement rates for students attending private colleges and universities, offered living stipends to distance learners, and increased flexibility for vocational and certificate program reimbursement. Congress has also improved living stipend metrics for Post-9/11 GI Bill-eligible veterans who choose to take advantage of the Vocational Rehabilitation and Employment (VR&E) program.

Unfortunately, only two years into the robust Post-9/11 GI Bill, some aspects of the benefit may be at risk as a result of a small number of predatory, for-profit schools that have chosen to exploit veterans for financial gain, by providing insufficient academic support while veterans are attending classes, as well as poor postgraduation employment assistance.

When it was signed into law, leaders in Congress and in the veterans' advocacy community touted the prospect that the Post-9/11 GI Bill could create a new "Greatest Generation," offering critical job skills and training to a new generation of leaders. However, the IBVSOs are very concerned about the continued viability of the Post-9/11 GI Bill, should predatory practices continue or become more prevalent. This landmark benefit is too important to our veterans and our nation to allow any hint of impropriety.

The IBVSOs believe that it is imperative for the Veterans Benefits Administration and the Department of Education, in combination with the state approving agencies (SAAs), to refine metrics on student-veteran outcomes and also combine their resources to monitor postsecondary educational institutions that accept the Post-9/11 GI Bill in order to curb predatory practices.

The IBVSOs are also concerned that the Post-9/11 GI Bill may be vulnerable to budgetary attacks as the conflicts in Iraq and Afghanistan draw to a close. The benefits of the Post-9/11 GI Bill must continue to remain available to honor the sacrifice of our nation's veterans. To support this request, the Department of Veterans Affairs must develop the metrics to accurately measure the short-term and long-term impacts of these educational benefits. The IBVSOs believe that the Post-9/11 GI Bill is an investment not only in the future of our veterans but also our nation.

VETSUCCESS ON CAMPUS:

The Department of Veterans Affairs must develop outreach to veterans on college campuses by strategically selecting locations and working with veterans to determine the services that will help them succeed.

In June 2009, the Department of Veterans Affairs established the VetSuccess on Campus program, whose purpose is to help veterans succeed in completing their college educations. VetSuccess on Campus is part of VA's Vocational Rehabilitation and Employment (VR&E) program and is available to all veterans utilizing the Post-9/11 GI Bill, but only at a limited number of schools.

The VetSuccess on Campus program places VA vocational rehabilitation counselors and outreach coordinators on college campuses to provide vocational testing, career and academic counseling, and readjustment counseling services to veterans pursuing higher education opportunities. The program is currently limited to the following eight campuses: the University of South Florida, Cleveland State University, San Diego State University, Rhode Island College, Rhode Island Community College, Texas A&M Central Texas, Arizona State University, and Salt Lake Community College. VA has plans to expand the program to additional college campuses in the near future. The expansion would use a formula of campuses with veteran populations of 800–1,200 students.³

This program is positioned to provide a substantial level of assistance to student veterans at a pivotal time in their transition to a civilian lifestyle and occupation. Given the fact that during FY 2011 there were approximately 555,000 student veterans using the Post-9/11 GI Bill to attend school on more than 6,000 campuses, it would seem that, while the program has expanded, there is even greater opportunity for its further expansion to all campuses with 800–1,200 student veterans. Extending this base level program to any other campuses in FY 2012 or 2013 will, however, require additional resources.⁴

As VA actively seeks to increase the number of campuses included in the VetSuccess on Campus program, it must ensure that additional campuses are strategically selected. A comprehensive rubric for selecting campuses should include the number of veterans on campus, other resources available to veterans, and

geographical location relative to other educational institutions. *The Independent Budget* veterans service organizations believe that by selecting campuses that can benefit the greatest number of student veterans, the VetSuccess on Campus program will have a broad impact on veterans seeking higher education.

In addition, veterans use Post-9/11 GI Bill benefits and other VA educational opportunities at many types of educational institutions, including online campuses. VA must proactively reach out to these students to ensure that those attending nontraditional campuses benefit from the VetSuccess on Campus program as well. To reach these student veterans, VA should establish a virtual VetSuccess on Campus program that is available initially to veterans at nontraditional schools. If determined to be successful, the model may be expanded to campuses with lower veteran populations.

VA must continually assess the model, including the types of staff skill sets needed to effectively assist student veterans. Successfully completing a degree program is a measure of success, but this measure alone will not determine the extent to which the program assisted the veteran.

Regular evaluation of the program should occur throughout a student's academic career. Upon graduation, exit interviews with willing student veterans will help VA to build upon successes and make any needed changes.

Recommendations:

VA should seek to partner with other student services to act as a liaison between veterans and other assistance programs open to the nonveteran student population, particularly individuals with disabilities.

Congress must conduct appropriate oversight to ensure that VA is properly expanding and evaluating the VetSuccess on Campus program.

VA must expand the VetSuccess on Campus by strategically determining new campuses based on student veteran population standard of between 800 and 1,200 per campus, geographical location in comparison to VA medical care, and other resources available to veterans.

VA must continually evaluate the success of the VetSuccess on Campus program by measuring student veterans' use of the program and the role the program plays in their completion of educational programs.

VA should ensure that VetSuccess on Campus staff gain the essential knowledge and skill set necessary to meet the needs of the general student veteran population, including guidance in navigating through the Post-9/11 GI Bill.

³ House Veterans Affairs Committee, Subcommittee on Economic Opportunity, Prepared Statement of Thomas J. Pamperin, Deputy Under Secretary for Disability Assistance, Veterans Benefits Administration, U.S. Department of Veterans Affairs, 06/02/2011.

⁴ VA Reaching Out to Veterans on Campus Through VetSuccess: New Agreements Recently Reached to Ease Transition from Active-Duty Military, VA Press Release. <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2070>, March 11, 2011.



VA'S COORDINATION WITH STATE APPROVING AGENCIES IS INSUFFICIENT TO PREVENT FRAUD:

The Department of Veterans Affairs and state approving agencies must work together to ensure that only quality education programs can receive GI Bill funding.

Leaders in Congress and in the veterans' community have discovered instances of predatory practices among some proprietary schools receiving Post-9/11 GI Bill funds. In 2009, for-profit schools received more than a third of all GI Bill funds, while graduating less than 30 percent of all enrolled student veterans.⁵

As widespread allegations surfaced across the higher education industry, the Department of Education sanctioned five schools, including four for-profit institutions, for excessive default rates among students.⁶ The Department of Justice also filed a civil suit against one such institution for its predatory practices.⁷

Despite these troubling findings from the Departments of Education and Justice, all the schools in question have continued to receive Post-9/11 GI Bill dollars. To *The Independent Budget* veterans service organizations (IBVSOs), this represents a critical disconnect between the gatekeepers of veterans' education programs, the state approving agencies (SAAs), and the ultimate approving authority for GI Bill-eligible schools, the Secretary of Veterans Affairs.

A recent Government Accountability Office report highlighted the fraudulent and questionable practices exhibited by certain for-profit institutions,

particularly those receiving nearly 90 percent of their revenue from federal sources.⁸ To the IBVSOs, this report highlights the urgency of the issue and the need for improved oversight and coordination among state and federal agencies responsible for auditing and certifying schools.

Title 38, Code of Federal Regulations, clearly outlines the duties of SAAs, including their periodically inspecting schools receiving GI Bill funds. The authority of SAAs was established by Congress in 1947 to ensure that veterans and eligible dependents can use the GI Bill educational entitlement in an approved educational program. Under contract with VA, the key function of SAAs is to ensure that education and training programs meet VA standards through a range of approval entities and activities. Today, under contracts with VA, SAAs ensure that education and training programs meet federal VA standards through a variety of activities, such as evaluating course qualifications, assessing school financial statistics, and monitoring school progress.

Furthermore, Title 38, Code of Federal Regulations, clearly mandates that the Secretary of Veterans Affairs is the final approval authority for all schools to become eligible. Unfortunately, a major disconnect persists between the Secretary and the SAAs since the Secretary is expressly prohibited from exerting

any kind of control or oversight over the SAAs. This tenuous relationship demands scrutiny from both the IBVSOs and Congress to ensure that SAAs can competently assess GI Bill-eligible schools and that the Secretary asserts his authority to approve and disapprove schools.

Although the Secretary cannot oversee the SAAs, the Veterans Benefits Administration should have unlimited access to information already gathered and tracked by the Departments of Education, Justice, and Defense. This would allow the VBA to make fact-based and informed decisions on educational institutions serving veterans and receiving federal funding. Moreover, if another federal agency or department has sanctioned institutions of higher learning for predatory or other questionable practices, the Secretary must have the authority to sanction the same schools.

The IBVSOs must note that the SAAs are not solely responsible for the current situation. In the early 2000s, the SAAs faced losing their funding altogether. Thankfully, they succeeded in securing mandatory funding in 2006. When the Post-9/11 GI Bill took effect in August 2009, the scope of the SAAs' responsibilities changed dramatically. However, due to the mandatory funding model, resources have remained stagnant. The IBVSOs believe that SAAs cannot possibly be expected to carry out their duties without the proper resources.

Recommendations:

Congress should grant the Secretary of Veterans Affairs the authority to leverage all available information sources, including that of the state approving agencies and the Departments of Defense, Justice, and Education, to make an informed decision on program eligibility and institutions that will receive federal GI Bill funding.

Congress should grant the Secretary the authority to sanction schools when a federal agency or department cites an institution of higher learning for predatory or other questionable practices.

Congress must also revisit the funding mechanism for the state approving agencies to ensure that they have the resources necessary to properly carry out their mission of inspecting GI Bill-eligible programs.

⁵ Sen. Tom Harkin, *Benefitting Whom? For-Profit Education Companies and the Growth of Military Educational Benefit* (December 2010). <http://harkin.senate.gov/documents/pdf/4d01011f6076e.pdf>.

⁶ U.S. Department of Education, *Default Rates Rise for Federal Student Loans* (September 2011). <http://www.ed.gov/news/press-release/default-rates-rise-federal-student-loans>.

⁷ U.S. Department of Justice, *U.S. Files Complaint Against Education Management Corp. Alleging False Claims Act Violation* (August 2011). <http://www.justice.gov/opa/pr/2011/August/11-civ-1026.html>.

⁸ *For-Profit Colleges: Undercover Testing Finds Colleges Encouraged Fraud and Engaged in Deceptive and Questionable Marketing Practices*. <http://www.gao.gov/products/gao-10-948t>.



METRICS TO TRACK GI BILL AND EDUCATION BENEFITS SUCCESS ARE INSUFFICIENT:

The Department of Veterans Affairs must track metrics beyond simple enrollment and benefit usage to be able to gauge education program success.

The Veterans Benefits Administration (VBA) previously tracked individual enrollment and benefit usage by veterans utilizing GI Bill benefits; however, beginning with the 2011–12 academic year, the VBA has begun to track graduation rates. This limits VA's ability to measure the number of veterans using their education benefits at a given time and how much of that benefit has been used to date. Put simply, the Department of Veterans Affairs has no metrics to determine whether students who use their benefits achieve their academic goals.

Without proper metrics, VA, Congress, and *The Independent Budget* veterans service organizations (IBVSOs) cannot accurately assess the effectiveness of GI Bill programs or correct inefficiencies.

The Department of Education (DOE) surveys all schools receiving Title IV funding to track dozens of metrics and data points. Its oversight role allows the department to consistently monitor and analyze programs like Pell Grants and Stafford Loans. Using such metrics, the DOE can detect trends among

schools that may not be delivering the kinds of outcomes expected by the taxpayers; using this information it can take corrective action. However, the DOE does not track veterans' benefits on its surveys. Since VA has not yet developed the capability to collect and utilize this kind of data, the IBVSOs believe there may be loopholes that are opening education benefits to fraud and abuse.

Recommendation:

The Veterans Benefits Administration must quickly develop methods to monitor GI Bill usage similar to those being used by Department of Education to survey Title IV–funded schools. In this manner, VA will be able to detect trends among schools that may not be delivering the kinds of outcomes expected by taxpayers.



Training and Rehabilitation Services: Vocational Rehabilitation and Employment

Vocational rehabilitation for disabled veterans has been part of this nation's commitment to veterans since Congress first established a system of veterans' benefits upon entry of the United States into World War I in 1917. Today the Vocational Rehabilitation and Employment (VR&E) Service, through its VetSuccess Program, is charged with preparing service-disabled veterans for suitable employment or providing independent living services to those veterans with disabilities severe enough to render them unemployable.

Approximately 48,000 active duty, Reserve, and Guard personnel are discharged annually, with more than 25,000 of those on active duty found “not fit for duty” as a result of medical conditions that may qualify for VA disability ratings. With a disability rating the veteran would potentially be eligible for Vocational Rehabilitation and Employment services.⁹ According to the most recent report from the Government Accountability Office (GAO) on VR&E services, the ability of veterans to access VR&E services has remained problematic.

In 2003, the GAO designated federal disability programs, including those at VA, as high risk because they had difficulty managing their programs and were in need of transformation.¹⁰ In March of 2004, the VR&E task force, created by the Congressional Commission on Service members and Veterans Transition Assistance (Commission), released its report, with 110 recommendations for VR&E service improvements.¹¹ As a direct result of that report, the

VR&E Service implemented the Five-Track Employment Process, which strengthened the program's focus on employment. While important adjustments were made in numerous areas, VR&E's incentive structure for veterans remains primarily aligned with education and training programs, with no financial incentive for those seeking immediate employment.

In response to the 2004 VR&E Task Force report, VA implemented 100 out of the 110 VR&E Task Force recommendations. In the eight years since this task force report, VA has identified other significant opportunities in its continuing efforts to enhance service to veterans. VR&E's current transformation effort, for example, focuses on modernizing and streamlining services using a “veteran-centric approach.”¹²

While the Veterans Benefits Administration has implemented most of the 110 VR&E task force recommendations, *The Independent Budget* veterans service organizations continue to support its recommendations as well as those of the Commission¹³ to further enhance this important benefit by

- expanding access to all medically separated service members;
- making all disabled veterans eligible for vocational rehabilitation and counseling services;
- screening veterans rated as individually unemployable for other VR&E assistance;
- implementing satisfaction surveys of participants and employers;

- creating a monthly stipend for those participating in the employment track of VR&E's programs and creating incentives to encourage disabled veterans to complete their rehabilitation plans;
- increasing the ratio of VR&E counselors and case managers to handle a growing caseload;
- effectively tracking and reporting on participants to provide greater clarity on the utilization of the Five-Track Employment model;
- tracking employment outcomes that are measured longer than 60 days after hiring; and
- eliminating the current 12-year eligibility limit for veterans to take advantage of VR&E benefits.

In FY 2011 there were more than 107,000 participants in one or more of the five assistance tracks of VR&E's VetSuccess program. Of those who chose the vocational rehabilitation and employment track, approximately 9,900 were deemed fully rehabilitated. This decrease from FY 2010 when 10,038 veterans were successfully rehabilitated is likely the result of the variances in the subsistence allowance versus the housing allowance that were in effect before the passage of the "Post-9/11 Veterans Educational Assistance Improvements Act of 2010."¹⁴ As a result of this law, veterans with service-connected disabilities who participate in a program of vocational

rehabilitation under chapter 31 of Title 38, Code of Federal Regulations, who are also entitled to Post-9/11 GI Bill education benefits, are now allowed to choose whether to receive the monthly housing stipend payable under the Post-9/11 GI Bill or a monthly subsistence allowance.

It is readily apparent that VR&E is working to maximize its limited resources. Its work will continue as the number of veterans in the various phases of VR&E programs is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Even though the focus of the VR&E program has changed to career development and employment, it is not clear whether VA is able to meet the current and future demand for employment services without additional resources.

⁹ Congressional Research Service, Veterans' Benefits: The Vocational Rehabilitation and Employment Program, Order Code RL34627, August 21, 2008, p. CRS-12.

¹⁰ GAO-09-34, VA Vocational Rehabilitation and Employment: Better Incentives, Workforce Planning, and Performance Reporting Could Improve Program, 7.

¹¹ GAO-09-34, 1.

¹² Prepared Statement of Ruth A. Fanning, director, Vocational Rehabilitation and Employment Service, Veterans Benefits Administration, U.S. Department of Veterans Affairs, Committee on Veterans' Affairs Subcommittee on Economic Opportunity, United States House of Representatives, March 31, 2011.

¹³ Congressional Commission on Service members and Veterans Transition Assistance, January 14, 1999.

¹⁴ S.3447, "Post-9/11 Veterans Educational Assistance Improvements Act of 2010," PL 111-377.



VOCATIONAL REHABILITATION & EMPLOYMENT PRODUCTIVITY:

Productivity of the VA Vocational Rehabilitation and Employment Service is not sufficient to meet the needs of our nation's veterans in a timely manner.

The task before Vocational Rehabilitation and Employment's (VR&E) VetSuccess program is critical, and the need becomes clearer in the face of the statistics from the current conflicts. Since Sept. 11, 2001, there have been more than 2.2 million service members deployed. Of that group, more than 941,000 have been deployed two or more times.¹⁵ As a result, many of these service members are eligible for disability benefits and VR&E services if they are found to have an employment handicap. Specifically, 43 percent may actually file claims for disability.¹⁶ Due to the increasing number of service members returning from Iraq and Afghanistan with serious disabilities, VR&E must be provided the resources to further strengthen its program. There is no VA mission more important than that of enabling injured

military personnel to lead productive lives after serving their country.

In the face of these facts, of concern to *The Independent Budget* veterans service organizations (IBVSOs) are the current constraints placed on VR&E as a result of an average client to counselor ratio of 145:1 compared to the VA standard of 125:1. VR&E, working through outside contractors, continues to refine and refocus this important program so it can maximize its ability to deliver services within certain budgetary constraints. Given the anticipated caseload that future downsizing of the military will produce, a more concise way to determine staffing requirements and a more rigorous manpower formula must be developed.

Also, VR&E continues to have to rely on Corporate WINRS or CWINRS, a legacy case management system that provides support to schedule and track appointments, authorize, and track payments to facilities and contract service providers and maintains a history of events for each veteran. The acronym CWINRS was derived from the five VA regional office pilot test stations for the original program—Winston-Salem, Indianapolis, Newark, Roanoke, and Seattle—and is a case management enterprise national information system with the Veterans Benefit Administration.¹⁷ Given the VBA's efforts to upgrade its disability claims information technology (IT) systems, an upgrade of VR&E's Corporate WINRS system is, hopefully, also part of this endeavor. In addition, the IBVSOs believe that there should be additional study to determine whether VR&E's current tracking of a veteran participating in the program remains employed beyond the current 60-day period. We have long been concerned that this length of time is not sufficient as a measure of success since most employers have probationary employment periods in excess of 60 days. After the veteran has been placed, is the minimal follow-up by VR&E with the employer sufficient? We believe it is not at present.

Given the continued concern that the VR&E staffing ratio of 145:1 is not sufficient to provide the full range of services to a growing potentially eligible disabled veteran population, additional staff will be essential if VR&E is to also track veterans within the current 60-day early employment period or measure employment success beyond that period.

Inconsistent case management, with lack of accountability for poor decision making, has been an ongoing concern for the IBVSOs. In response, VR&E has expanded its quality assurance staff and increased the frequency of site visits from every five years to every two-and-one-half years. We look forward to the results of this program.

Recommendations:

VA needs to strengthen its Vocational Rehabilitation and Employment (VR&E) program to meet the demands of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq. It must provide a more timely and effective transition into the workforce and provide placement follow-up with employers for a minimum of six months.

Congress must provide the resources for VR&E to establish a maximum client to counselor standard of 125:1 and a new ratio of 100:1 to be the standard.

VR&E must place a higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

Congress should provide the resources to support the expansion of VR&E's quality assurance staff to increase the frequency of site visits.

Congress and the Administration must ensure that VR&E is provided the necessary resources to upgrade its legacy Corporate WINRS and the new VetSuccess information technology platform as part of the Veterans Benefits Administration's upgrade of its larger IT systems.

¹⁵ DOD "Contingency Tracking System," Number of Deployments for Those Ever Deployed for Operation Iraqi Freedom and Operation Enduring Freedom, as of Dec. 31, 2010.

¹⁶ VCS Releases Updated War Statistics, VCS Releases "Iraq and Afghanistan War Impact Report," VA Confirms Nearly 712,000 Iraq and Afghanistan War Veteran Patients," VA Benefits Activity: Veterans Deployed the Global War on Terror," through May 2011, Jul. 2011, Oct. 3, 2011. <http://www.veteranstoday.com/2011/10/03/vcs-releases-updated-war-statistics/>.

¹⁷ Department of Veterans Affairs Office of Inspector General Combined Assessment Program, Review of the VA Regional Office, Houston, Texas, Report No. 03-02725-93, p. 5, Feb. 27, 2004.

VOCATIONAL REHABILITATION AND EMPLOYMENT FUNDING ACCOUNTABILITY:

The VA Vocational Rehabilitation and Employment program needs to be accountable to ensure successful employment outcomes for veterans with disabilities.

Vocational rehabilitation and employment services are critical to helping eligible service members and veterans with service-connected disabilities obtain the skills necessary to help them reintegrate into the workforce. Participation in the workforce is particularly critical for veterans with the most significant disabilities since employment provides individuals with not only financial but also social benefits that contribute to an enhanced sense of purpose.

Ten years of war coupled with stagnant employment opportunities mean that the number of veterans with disabilities requesting and receiving vocational rehabilitation and employment programs will likely continue to increase. Compounded by high unemployment rates across all sectors, competition for many employment opportunities is harder than ever. VA's Vocational Rehabilitation and Employment (VR&E) services are critical to ensuring that veterans with disabilities have the competitive edge to win precious employment opportunities.

The ultimate accountability measure for VR&E funding is whether eligible veterans actually use the services to obtain long-term employment or live independently. Despite continued efforts to improve VR&E services, however, a significant number of veterans still do not successfully complete their rehabilitation plans. Although reasons for failing to complete rehabilitation are varied, VR&E must ensure that its programs and service delivery are not a common contributing factor. Furthermore, VR&E must take steps to develop mechanisms to provide the supports that

veterans need to address barriers to completing their rehabilitation plans.

For veterans who obtain employment, VR&E must provide increased follow-up to ensure that veterans have long-term employment success. Currently, veterans with disabilities who maintain a suitable job for 60 days are considered to be rehabilitated. Unfortunately, 60 days may not provide a sufficient period to determine whether a veteran will be successful in his or her new job.

Ultimately, the VR&E program must continue to streamline processes and implement metrics that will determine areas for improvement and allow for constrained resources to be used as efficiently as possible. Veterans who need VR&E services must be able to receive them through a delivery system that is veteran-centric and understands the needs of veterans with varying life experiences and responsibilities. These factors greatly impact vocational rehabilitation.

Recommendations:

Congress must conduct oversight to ensure that Vocational Rehabilitation and Employment (VR&E) program services are being delivered efficiently and effectively.

VR&E must develop and implement metrics that can identify problems and lead to solutions that effectively remove barriers to veteran completion of VR&E programs.

VOCATIONAL REHABILITATION AND EMPLOYMENT NATIONAL SURVEY AND PERFORMANCE DATA:

The Department of Veterans Affairs should improve the accuracy of its data on performance and veteran participation in the Vocational Rehabilitation and Employment program and conduct research to determine why veterans fail to complete the rehabilitation process.

The VA Vocational Rehabilitation and Employment (VR&E) program performance reports claim a rehabilitation rate of 70 percent; however, those results do not reflect the significant number of program participants who fail from the start as a result of veterans not keeping initial appointments with VR&E counselors.

According to the Government Accountability Office,¹⁸ VR&E began excluding from the total active cases veterans who discontinued from the program for reasons considered beyond VR&E's control. Specifically, VR&E excluded veterans from the calculation if they accepted positions deemed incompatible with their disabilities, were considered employable but were no longer seeking employment, and were unemployable as a result of medical or psychological reasons.

In its 2011 Performance Accountability Report, VA reported a 74 percent rehabilitation rate in 2009 and 76 percent in 2010.¹⁹ However, these calculations exclude 5,002 veterans in 2009 and 7,160 veterans in 2010 who discontinued participation without a rehabilitation plan. Had those excluded veterans been counted, the true VR&E success rate would have totaled 45 percent for 2009 and 43 percent for 2010, well below the numbers that were actually reported.

The number of veterans requiring VR&E services is expected to increase as service members leave the military at a higher rate following the wind-down of decade-long hostilities in Southwest Asia. Earlier this year, President Obama announced plans to withdraw 10,000 troops from Afghanistan by the end of this year and a total of 33,000 by September 2012,²⁰ meaning that the United States will need to see significant job creation to provide good jobs for returning service members. To add to the problem, there were roughly 200,000 more veterans in the labor force this June than there were a year earlier, according to the Bureau of Labor Statistics.

Until the data accurately reflect the number of active cases vis-à-vis the number of veterans successfully placed in employment, the true efficacy of this critical program will remain in question. Congress previously sought to address the problem by enacting P.L. 110-389, section 334.²¹ The law required VA to conduct a longitudinal study of the long-term outcomes of its vocational rehabilitation programs and the accuracy of reporting over a 20-year period for those veterans who began participating in the program during fiscal years 2010, 2012, and 2014. To date, funding has been provided internally by VA.

The Independent Budget veterans service organizations appreciate Congressional efforts to fully examine this critical program, given its potential to provide fresh insights on the complex issue of how best to deliver services to our nation's veterans. Nevertheless, the effort toward more accurate reporting as a basis for evaluating success must continue. As VA learns more about veteran nonparticipation from performance data gathered through this study, performance metrics should factor in the aforementioned group of veterans, which should result in the development of interventions that can be implemented and evaluated during the life of the study.

This study should include an acute focus on the reasons veterans discontinue participation in VR&E programs and provide a foundation for designing interventions that mitigate discontinuance at historically high rates.

Recommendation:

Congress must provide the necessary funding to carry out the longitudinal study over a period of at least 20 years as directed by P.L. 110-389, section 334.

¹⁸ <http://www.gao.gov/new.items/d0934.pdf>; 09-34 Report.

¹⁹ Department of Veterans Affairs 2011 Performance and Accountability Report, Part II, Part II—Performance Summaries by Integrated Strategy, p. II-55.

²⁰ <http://www.whitehouse.gov/the-press-office/2011/06/22/remarks-president-way-forward-afghanistan>.

²¹ P.L. 110-389, "Veterans' Benefits Improvement Act of 2008," Oct. 10, 2008, p. 28.

VOCATIONAL REHABILITATION AND EMPLOYMENT ELIGIBILITY:

Congress must change the eligibility requirements for the Department of Veterans Affairs Vocational Rehabilitation and Employment program to increase access to services.

Veterans must apply for Vocational Rehabilitation and Employment (VR&E) services within 12 years of the date of their military separation or upon notification by VA of a service-connected disability rating conferring eligibility. Services that seek to return veterans to the workforce and allow them to live independently should be greatly encouraged. Many veterans, however, are either not informed of their eligibility for VR&E services or do not fully understand the benefits of these services.

Although many veterans may not understand their eligibility or the value of VR&E services, other veterans who are initially eligible may not need the services until after the 12-year delimiting period has expired. Even though VR&E may assist eligible veterans who file applications for services outside of the 12-year delimiting period if the applicant has a serious employment handicap, veterans who would be entitled to services may believe that they will not be able to receive assistance. Furthermore, others who do apply after the 12-year delimiting period may not be able to receive assistance.

Because the mission of VR&E is to assist veterans with disabilities related to their service requiring rehabilitation to actively engage in the workforce and live independently, the arbitrary timeline for eligibility must be removed. Eliminating VR&E's delimiting date would allow veterans to access the VR&E

program on a needs basis for the duration of their employable lives. Veterans would still be subject to the applicable service caps.

Additionally, if a veteran has been deemed eligible for VR&E service, entitlement should be assumed. Currently, it can take several months for a veteran to begin a program of training. This occurs primarily because VR&E must validate entitlement to services. It is very rare, however, that a veteran is not found to be entitled for VR&E services. At the very least, this process must be streamlined to help veterans expeditiously begin receiving VR&E services.

Recommendations:

Congress must eliminate the 12-year delimiting period for Vocational Rehabilitation and Employment (VR&E) services to ensure that veterans with employment barriers or problems with independent living qualify for services for the entirety of their employable lives.

Congress should study changing the current program eligibility standards to determine if doing so would streamline the process for veterans to receive VR&E services by making all veterans eligible who have been assigned a service-connected disability rating regardless of the percentage.

INDEPENDENT LIVING: CRITICAL REHABILITATION COMPONENT LIMITS ENROLLMENT AND TARGETS MAXIMUM PARTICIPATION TO 30 MONTHS:

Congress should eliminate the 30-month maximum time frame for program participation for independent living services and the statutory cap of 2,700 new, per annum, Independent Living Program participants.

The Independent Living (IL) Program, established by Congress in 1980, focuses on providing services to veterans with severe disabilities. The program's goal is to provide the necessary services to veterans to enable them to achieve maximum independence in daily living. One unique benefit of this program is that funding needed to acquire necessary equipment or services can be readily obtained for the seriously disabled veteran. Using IL funds can save many months, perhaps a year of waiting if the veteran would pursue the needed accommodations through other VA grants. Waiting for needed accommodations can have a negative effect on the rehabilitation of the veteran.

Recently, Vocational Rehabilitation and Employment (VR&E) has made improvements to the program with the addition of a second national IL coordinator along with establishing standards of practice in the delivery of IL services.

P.L. 111-275 places a cap of 2,700 new veterans per year into the IL program. Congress originally placed a cap on enrollment 30 years ago when the program was introduced as a pilot. Through the years that cap was increased to the current level.

VR&E must monitor newly enrolled IL cases monthly to track total IL new participants with respect to the legislative cap. On average, 2,300 new veterans per year have enrolled in IL services in recent years. Monitoring this cap requires time and documentation throughout the local, regional, and national network of the VA rehabilitation specialists. This required monitoring consumes valuable time that should be used working with disabled veterans.

The current conflicts are producing severely injured veterans each month who could benefit from IL services. If the mandatory cap has been reached for a fiscal year, these veterans must wait until the next year to be admitted. This is not the response necessary to deal with severely injured veterans.

Independent living services were limited to a 30-month maximum for a veteran, but VR&E recently provided the means to extend the time period when necessary. Unfortunately, this 30-month time frame remains the standard for IL services unless otherwise requested by the veteran or VR&E counselor. Each veteran enrolled in IL services should be informed by VR&E of an option to request an extension of enrollment.

Recommendations:

Vocational Rehabilitation and Employment (VR&E) should be given additional professional full-time employment slots with specialist counselors who are fully trained in all program options offered by VR&E, including independent living.

Congress should eliminate the 30-month maximum program participation for IL services and the statutory cap of 2,700 new, per annum, VR&E Independent Living Program participants.

VA should require VR&E to inform each veteran enrolled in IL services of the option to request an enrollment extension.

VA should conduct additional training within the VR&E program so each VR&E counselor is knowledgeable of the Independent Living Program.

OUTREACH TO LOCAL AND NATIONAL EMPLOYERS:

Educating employers on how to connect with the veterans' community, on the local and national levels, is vital to ending rampant unemployment and increasing economic opportunities for veterans nationwide.

Despite the fact that a growing number of employers want to hire veterans, recent studies reveal that many potential employers find connecting with employable veterans difficult. Adding to this problem is the difficulty many veterans and employers alike face in translating military skills and experience into relevant civilian employment qualifications. To address this problem, recently Congress enacted the VOW to Hire Heroes Act of 2011,²² which will assist veterans in translating their military skills and training to civilian sector jobs. Additionally, Vocational Rehabilitation and Employment's VetSuccess Program implemented online search portals and résumé job boards designed to allow veterans and businesses to search for VA and non-VA resources that can connect employers with potential employees. Other VA programs include an on-the-job training program, the Special Employer Incentive Program, and the Non-Paid Work Experience Program.

These programs represent progress toward addressing unemployment in the veterans population. Several other federal programs offer employment services for veterans, but their effectiveness is questionable. In addition to the Department of Labor's Veterans' Employment and Training Service and the Small Business Administration's Veterans Business Outreach Program, state agencies offer One-Stop Career Centers that appear to replicate many of the services of these federal programs. Asking veterans to navigate the labyrinth of government programs and

services serves to diminish the reach and potential of otherwise effective government programs.

Establishing a centrally managed web portal to coordinate and customize both government and non-government vocational services for veterans and employers would have the potential to reduce the bureaucratic burden and provide a path toward employment. Such a system would be well served by a partnership between VA and non-VA employment resources, such as veterans service organizations and nonprofits that focus on under-served segments of the disabled veteran population. *The Independent Budget* veterans service organizations commend VA for entering into a number of cooperative agreements with private organizations. Nevertheless, we urge a more integrated, results-oriented approach to addressing the unique employment needs of disabled service members and veterans.

Recommendation:

VA must work in concert with the Department of Labor, the Small Business Administration, and applicable state agencies to develop and implement a single-source database and employer outreach interface geared toward facilitating contact between veterans seeking jobs and employers.

²² P.L. 112-56, Nov. 21, 2011.

VOCATIONAL REHABILITATION AND EMPLOYMENT COUNSELING PARTNERSHIPS:

Cooperative partnerships between the Department of Veterans Affairs and state agencies, via agreement with the Department of Education's Rehabilitation Services Administration, do not provide the full array of benefits and customized services to veterans in key demographics.

Despite the constellation of vocational rehabilitation services for veterans offered by the Departments of Education, the Department of Veterans Affairs, and state vocational rehabilitation agencies, unacceptable rates of unemployment persist in the disabled veteran community. Veterans in demographics that were not historically deployed to combat theaters in substantial numbers, such as women and members of reserve components, now factor into the problem, and at even higher rates of unemployment. Women veterans' unemployment reached 14.7 percent for 2011 compared to 9.2 percent for 2010.²³ Unemployment among National Guardsmen and Reservists peaked at 25 percent despite protections afforded under the "Uniformed Services Employment and Reemployment Rights Act," which were intended to prevent this very circumstance.

Cooperative agreements between federal and state agencies have led to progress in addressing unemployment across all demographics, for both service- and nonservice-connected veterans. Through memoranda of agreement, state agencies function as extensions of the Department of Education. However, as discussed earlier, far too many veterans are unaware of these services. Many unemployed veterans without severe physical or mental disabilities remain on waiting lists or are directed to other programs because their situation falls too low on the "Order of Selection" scale²⁴ to receive services from those state agencies.

Because of the Order of Selection option that states can exercise, it is possible for an unemployed veteran to meet the vocational rehabilitation agency's eligibility requirement and still never get served because other individuals, determined to have more significant disabilities, get served first. This is, in large part, due to competing priorities that prevent many states from meeting the state-federal 20/80 matching ratio they must satisfy in order to receive federal "maintenance of effort" funding necessary to maintain effective vocational assistance programs.²⁵ More service members will return from deployment as operations in the Middle East wind down, and many will turn to these state resources in pursuit of employment, which will further strain state resources.

For disabled veterans who need employment services, many must work with state counselors who are unfamiliar with the unique aspects of combat-acquired post traumatic stress disorder or traumatic brain injury. Such injuries make sustainable job placement a challenge, a similar problem that plagued Vietnam veterans. Research published in August 2010, indicated that in comparison to both nonveterans and veterans who never engaged in combat, Americans returning from combat face significant socioeconomic challenges, as evidenced by consistently higher rates of disability and unemployment. "Veterans who saw combat started their work lives at a relative disadvantage that they were unable to overcome," the research reported. "Soldiers exposed to combat were more likely than non-combat veterans to be disabled and unemployed in their mid-20s and to remain so throughout their worklife."²⁶ To exacerbate the problem, this challenge extends to women veterans and reservists who were exposed to combat, for which a solution has not been developed.

A number of non-VA, constituency-focused providers are better positioned to provide the targeted outreach and customized vocational assistance necessary to meet the needs of these uniquely challenged veterans, many of whom will exist among the wave of returning service members who may swell the job search pool next year. Yet those aforementioned cooperative agreements between VA and state agencies do not consider how potential nongovernmental partners could augment VA and state agencies in order to better address the needs of veterans who require more than conventional career assistance services.

VA can meet this need through cooperative agreements with nongovernmental agencies, nonprofit organizations, and veterans service organizations through structured referral processes intended to supplement services by state agencies that cannot serve lower priority veterans due to budget shortfalls and understaffing.

The importance of a new collaboration was acknowledged with the passage of the “VOW to Hire Heroes Act of 2011,” which now authorizes government agencies to forge partnerships with nonprofit organizations in the development of job mentoring programs.²⁷ These job mentoring relationships are inextricably linked with career search and development processes, thus should seamlessly bind the efforts of state and federal agencies with those of nongovernmental and nonprofit organizations that are more often committed to ensuring career sustainability long after initial placement.

The Independent Budget veterans service organizations believe state agency and VA Vocational Rehabilitation and Employment program staff would greatly benefit from training conducted by subject matter experts on the functional challenges of traumatic brain injury, post-traumatic stress disorder, spinal cord injury, and other disabilities to improve the delivery of vocational intervention services to those veterans.

Recommendation:

The Department of Veterans Affairs should improve its partnership with state agencies by incorporating the services of non-VA counselors and constituent-specific vocational assistance programs (those that cater to women, combat-exposed, paralyzed, blind, amputee, traumatic brain injured, etc.) to ensure that all veterans, regardless of demographic status, receive the full array of benefits and level of customization necessary for meaningful and effective vocational intervention.

²³ U.S. Bureau of Labor Statistics, Division of Labor Force Statistics, Economic News Release Last Modified Date: October 07, 2011. <http://www.bls.gov/news.release/empsit.t05.htm>.

²⁴ Order of Selection for Vocational Rehabilitation Services. http://www.ilr.cornell.edu/edi/publications/PPBriefs/PP_23.pdf.

²⁵ GAO-09-798. Vocational Rehabilitation Funding Formula, Options for Improving Equity in State Grants and Considerations for Performance Incentives. <http://www.gao.gov/new.items/d09798.pdf>.

²⁶ Sociologist Finds Combat Veterans Face More Lifelong Socioeconomic Challenges. American Sociological Association. http://www.asanet.org/press/combat_veteransfacemorelifongsocioeconomicchallenges.cfm.

²⁷ <http://veterans.house.gov/vow>.



VOCATIONAL REHABILITATION AND EMPLOYMENT STAFF TRAINING AND CONTINUING EDUCATION:

VA Vocational Rehabilitation and Employment counselors need to have appropriate training and participate in meaningful continuing education to ensure quality services for veterans.

The efficacy of vocational intervention relies on the competence and knowledge of the vocational rehabilitation counselor tasked to provide such services. Consequently, Vocational Rehabilitation and Employment (VR&E) counselors must have the proper training to be able to provide veterans with the vocational rehabilitation services that will allow them to work and live independently. Specifically, counselors should possess professional certification through the Commission on Rehabilitation Counselor Certification. VA should require counselors to be accredited to help ensure that only knowledgeable counselors are assisting veterans with vocational rehabilitation. Furthermore, to retain this certification, accredited counselors must complete continuing education or pass a re-examination.

Additionally, initial and continuing education must better address key segments within the veteran demographic who present complex education and job placement issues. These segments include veterans who are catastrophically disabled, homeless, single parents, and/or mentally ill. In order to provide effective vocational support services for these veterans, VR&E counselors need a more intimate understanding of the vocational barriers particular to each segment. Where traditional vocational rehabilitation methodologies chiefly focus on mere job placement, research supports that a holistic approach to vocational intervention is critical to sustainable post-rehabilitation success.²⁸ This can include improving access to education resources, ensuring quality health care, providing family/community support, and other support activities that address other concerns in the

veteran's life, thus allowing for a more acute focus on vocational recovery.

VA must ensure that vocational rehabilitation counselors have appropriate training and certification, whether through an outside accrediting body or through a VA-specific accreditation process. In lieu of requiring certification through an outside accrediting body, VA should develop a VA-specific certification for all VR&E counselors. If VA chooses to develop a VA certification, it must consult with outside stakeholders, including the Commission on Rehabilitation Counselor Certification, the Department of Education's Rehabilitation Services Administration, and veterans service organizations. The VA certification process must require rigorous continuing education elements and provide counselors with the resources needed to ensure that they are able to benefit from these opportunities, particularly for counselors with extremely high caseloads.

VA must implement a targeted training program that familiarizes VR&E staff with the special needs and vocational challenges inherent in key segments of the

veteran demographic. In order to ensure such training is timely and relevant, VA should regularly solicit the input of veterans service organizations, nonprofit organizations, and subject-matter experts that represent the interests of those special-needs constituencies.

Recommendations:

VA must ensure that vocational rehabilitation counselors have appropriate training and certification, whether through either an outside accrediting body or through a VA-specific accreditation process.

VA must implement a targeted training program that familiarizes Vocational Rehabilitation and Employment staff with the special needs and vocational challenges inherent to key segments of the veteran demographic.

²⁸ "A predictive model of employment identified 4 factors associated with employment: education, community mobility, functional independence, and decreased medical complications. Other variables significantly associated with employment included community integration, independent driving, independent living, higher income, and life satisfaction." Anderson C.J., and L.C. Vogel, "Employment outcomes of adults who sustained spinal cord injuries as children or adolescents," *Arch Phys Med Rehabil* 83(6): 791-801.



VR&E AND DEPENDENTS: EDUCATION TRACKS ARE INSUFFICIENT FOR A SIGNIFICANT NUMBER OF DISABLED VETERANS WITH FAMILIES:

VA stipends fall short of adequately assisting veterans undergoing vocational rehabilitation and employment while supporting dependents.

Veterans with families are the second-largest demographic that relies on vocational assistance as a means of enhancing economic opportunity and independence. They also present with the most pressing need for meaningful long-term employment. However, a great number of severely disabled veterans cannot complete vocational rehabilitation due to the lack of financial support necessary to engage in extensive vocational assistance programs while bearing the immediate and costly burden of supporting a family.

The intent behind vocational rehabilitation is well established: to provide veterans who are disabled as a result of their service with the resources necessary to achieve economic self-sufficiency through

gainful sustainable employment. The adequacy of these resources heavily depends on whether a veteran's life circumstances are conducive to successful completion of a program intended to result in enhanced economic opportunity in the future. Where that opportunity is deferred due to the length of time it takes to complete such programs, immediate demands, such as bills, family, and security, often rival a focus on vocational recovery. As veterans with spouses and/or children tend to utilize Vocational Rehabilitation and Employment program employment tracks at a rate higher than disabled veterans without dependents, these services must address the immediate concerns of veterans with dependents. Absent this, alternatives to vocational recovery that do provide supplemental payment for the cost of

caring for children and other dependents, such as Social Security Disability Insurance and Supplemental Security Income, become more attractive options than an uncertain, often-protracted investment in future economic viability.

Veterans seeking vocational intervention and assistance present with differing needs. For those with families who receive training, rehabilitation, and education services through VA, assistance with the cost of supporting a family, including cost-of-living increases, is imperative to successful completion. Increased living stipends and child care vouchers for veterans undergoing vocational rehabilitation would provide the foundational support necessary to

successfully complete such programs while maintaining some semblance of quality of life for the family. In doing so, the veteran is not forced to choose between remaining on government assistance in order to stay on the socioeconomic margin of security versus sinking below the poverty level in the short term in order to pursue a long-term educational and vocational rehabilitation track.

Recommendation:

Congress should provide child care vouchers, linked to cost-of-living increases, for veterans who have families and are undergoing vocational rehabilitation.



Employment and Entrepreneurship

Veterans have been hit disproportionately hard by our nation's economic downturn and, according to the Bureau of Labor Statistics, the job prospects for Iraq and Afghanistan-era veterans are particularly bleak. This is why *The Independent Budget* veterans service organizations (IBVSOs) have chosen to focus on fixing systemic shortfalls that keep veterans from securing meaningful employment and entrepreneurship opportunities upon leaving the military.

In June 2010, the Society for Human Resource Management conducted a survey on attitudes and practices related to employment of service members and veterans. Problems reported by private industry included the inability to find veterans, the lack of resources to address veteran-specific concerns, and, most important, the failure of private industry to correlate military job skills to civilian competencies.

The IBVSOs have long suspected that a military credentialing gap and the lack of understanding of military culture contributed to jarring unemployment statistics for veterans. In 2006 the Department of Labor sought to address this gap by commissioning a demonstration project on military credentialing, which to date has not been completed.

The IBVSOs believe that the path to a successful transition from military to civilian life begins with thorough Transition Assistance Program classes.

While leaders within the Department of Defense, VA, and the Department of Labor have acknowledged the need for additional resources to aid in this difficult transition, we still have serious concerns over what these changes have produced in the way of quality programs for a successful transition. The overall lack of measurable data makes it impossible for the IBVSOs, Congress, and federal agencies to adequately assess program successes and shortfalls, thus making it difficult to provide valid recommendations for improvement.

Many veterans are independent leaders who many times may choose to create their own business ventures. The IBVSOs wholly support veteran entrepreneurs, and advocate for improving programs designed to ensure veterans can succeed in the corporate world. Programs like the Center for Veterans Enterprise provide critical tools to aspiring veteran entrepreneurs, but more needs to be done to connect veterans to the available resources. We also believe that set-aside contracts must go to verifiable veteran-owned and service-disabled veteran-owned small businesses.

In these difficult economic times it is especially important that Congress focus on improving veterans' access to their earned employment benefits and programs.

TRANSITION ASSISTANCE PROGRAMS:

Successful transition from military service to civilian life hinges on veterans' ability to be competitive in the workforce; therefore, it is imperative that Congress ensure proper funding for transition assistance programs and that the programs are continually updated to meet increasing needs of those repatriating from overseas deployments.

The Transition Assistance Program (TAP) was developed to assist military families leaving active service. The Department of Labor (DOL) began providing TAP employment workshops in 1991, pursuant to section 502 of the "National Defense Authorization Act for Fiscal Year 1991" (P.L. 101-510). It is an interagency program delivered in partnership by DOL and the Departments of Veterans Affairs, Defense (DOD), and Homeland Security (DHS).

Returning to civilian life is a complex and exciting time for service members. TAP and the Disabled Transition Program (DTAP) will, generally, now be mandatory thanks to the "VOW to Hire Heroes Act" (P.L. 112-56) and will result in the program becoming an even greater benefit in meeting the needs of separating service members as they transition into civilian life. The VOW to Hire Heroes Act:

- Directs the DOD and DHS to, generally, require the participation of members of the armed forces being separated from active duty, and their spouses. Waivers of participation would be permitted for those whose participation is not, and would not be, of assistance since such members are unlikely to face major readjustment, health care, employment, or other challenges associated with transition to civilian life; and for those with specialized skills who are needed to support imminent deployment.
- Requires the DOL to conduct a study and provide a report to Congress to identify any equivalencies between the skills developed by members through various military occupational specialties and the qualifications required for various positions of civilian employment. These skills equivalencies will be published on the Internet and updated regularly.
- Directs the DOD to ensure that each member participating in TAP receives an individualized equivalencies assessment and to make each assessment available to VA and the DOL.
- Requires VA to contract, within two years, with appropriate contractors to provide members being separated from active duty, and their spouses, with appropriate TAP services.
- Authorizes the DOL, VA, the DHS, and the DOD, in carrying out TAP, to contract with private entities that have experience with instructing members on relevant topics on job training and job searching, including academic readiness and educational opportunities.
- Authorizes the DOD and DHS, as part of TAP, to permit an eligible member to participate in an apprenticeship or pre-apprenticeship program that provides them with the education, training, and services necessary to transition to meaningful employment.
- Directs the Comptroller General to conduct a review of TAP, and to submit review results and recommendations to Congress.
- Treats an individual as a veteran, a disabled veteran, or a preference eligible for purposes of appointments to federal competitive service positions if the individual meets all other qualifications except for the requirement of discharge or release from active duty under honorable conditions, as long as such individual submits to the federal officer making the appointment a certification that he or she is expected to be discharged or released under honorable conditions within 120 days after submission of the certification. Requires the director of the Office of Personnel Management to (1) designate agencies to establish a program to provide employment assistance to members being separated from active duty and (2) ensure that such programs are coordinated with TAP.
- Requires the inclusion of TAP performance measures in annual DOL reports on veterans' job counseling, training, and placement programs.²⁹

As noted above, as part of the new TAP, eligible members will be allowed to participate in an apprenticeship or pre-apprenticeship program that provides them

with education, training, and services necessary to transition to meaningful employment. These new TAP classes will also upgrade career counseling options and résumé writing skills, as well as ensuring the program is tailored for the 21st century job market.

Currently, TAP consists of the following five components:

- pre-separation counseling conducted by the respective military services,
- employment workshops presented by the Department of Labor,
- veterans benefits briefings conducted by VA,
- DTAP facilitated by VA, and
- personalized coaching and practicum.³⁰

TAP is also available for eligible demobilizing service members in the National Guard and reserves. It is organized to address the following four areas:

1. transition counseling—mandatory and conducted by the military services
2. “Uniformed Services Employment and Reemployment Rights Act” (USERRA) briefing (normally conducted by the DOL)
3. veterans benefits briefings—facilitated and sponsored by VA
4. DTAP facilitated and sponsored by VA

Efforts to improve both TAP and DTAP are under way. The scope of the changes was noted in DOL testimony before the House Veterans Affairs Committee of June 2, 2011:³¹

- redesign both TAP and DTAP to assess each individual’s readiness for employment, and their interests;
- updating the content of the employment workshop, to include workshops on employment readiness;
- providing skilled contract facilitators who are trained using newly developed program standards;
- providing an online, e-learning platform that will serve as a comprehensive resource for all service members, veterans, Reserve component members, wounded warriors, and spouses.
- providing customized coaching by phone or online for 60 days after participants attend the workshop; and

- performing metrics and satisfaction surveys after program completion, during the job search phase, and once employment has been obtained.

The Independent Budget veterans service organizations (IBVSOs) understand the plan is to begin piloting the redesigned workshops starting in January 2013 and to roll out the new workshops to all CONUS DVOP/LVER facilitated TAP sites by the end of FY 2012 and to the remainder of the overall sites by Dec. 31, 2012. We look forward to the fielding of the improved TAP and DTAP whose classes are often the only opportunity a service member, or qualifying family member, has to receive the critical information vital to sustaining their quality of life after the military.

The transition from a military career to a civilian and corporate sector career involves a major cultural shift. Veterans not only need employment but often need assistance in making this life-changing adjustment as well. This time of transition is one of the most stressful and challenging times experienced by many veterans. After spending years becoming part of a military culture, service members who leave the military face a new unknown culture when they step into a civilian role or corporate career. This transition is often complicated by injuries they received, both visible and invisible, while serving their country. As battlefield medicine continues to save more lives, VA and the DOD, DOL, and DHS must be ready to adapt and change their current transition and education programs to meet the needs of today’s veterans.

Service members leaving the military with service-connected disabilities are offered DTAP, a program that includes the normal three-day TAP workshop, plus additional hours of individual instruction and advice to determine employability and to address their unique needs related to disabilities. DTAP provides important information to wounded service members and their families at a critical nexus. Often these individuals are hospitalized or receiving medical rehabilitation away from their regular units during their military service discharge periods. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. In this respect, DTAP has not scored the level of success that TAP has achieved, and it is critical that coordination be closer between the DOD, VA, and Veterans Employment

and Training Service (VETS) to reduce this disparity for these severely disabled service members.

The IBVSOs believe Congress, the DOD, VA, and the DOL should provide increased funding for TAP and DTAP to support mandatory attendance for all personnel being discharged.

The IBVSOs have also been concerned with the large numbers of reserve and National Guard service members moving through the discharge system with only the benefit of the abbreviated TAP as opposed to the more comprehensive program attended by active component members. Neither the DOD nor VA seems prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life. If service members are uninjured, they may clear the demobilization station in a few days, and little if any of this time is dedicated to informing them about veterans' benefits and services. Additionally, the DOD personnel at these sites are most focused on processing service members through the sites. Lack of space and facilities often restricts contact between demobilizing service personnel and VA representatives. To ensure full participation in this important program, the IBVSOs have long recommended making participation in the more comprehensive TAP mandatory for all discharging service members. The VOW to Hire Heroes Act should finally bring closure to this issue.

The 2010 U.S. Department of Labor Office of Inspector General (OIG) audit of VETS found problems with contract compliance and tracking of service delivery.³² The OIG found that VETS did not have effective management controls to ensure TAP participants received the employment assistance needed to obtain meaningful employment:

- VETS could not substantiate the 124,700 participants that it reported as having attended TAP workshops with participant attendance documents and monitoring of 117 of 247 (47 percent) domestic and overseas TAP sites. The OIG found a lack of consistent evaluation criteria and resolution tracking in VETS monitoring.
- VETS also did not use measurable performance goals and outcomes to evaluate program effectiveness, and lacked adequate controls over contracting for TAP workshop services.

- These deficiencies resulted in undermining VETS' ability to ensure it was providing a high-quality program, as required, to provide the assistance needed to ensure veterans succeed in obtaining meaningful employment, and may impact critical program decisions by Congress, VETS, and other stakeholders. In addition, the OIG identified deficiencies that resulted in \$2.3 million in unsupported and other questioned costs and found that \$713,000 spent might have been put to better uses by VETS.

The OIG recommended the following actions by VETS:

- development and implementation of procedures to report and document participant attendance, a monitoring process, and controls for contract activities and administration;
- ensuring that VETS personnel adequately monitor TAP workshops;
- retention of participant information needed to measure and report outcome goals;
- establishment of new memoranda of understanding with its partner agencies;
- revision of methods for contractor cost justification cost comparisons; and
- recovery of unsupported and questioned contract costs.

The aforementioned revisions to TAP and DTAP for which the IBVSOs continue to advocate should provide the basis to properly address the concerns identified by the DOL OIG and minimize the likelihood of their recurrence.

The IBVSOs fully concur with these recommendations and urge VETS to move forward on implementation. The IBVSOs also recommend regular audits of TAP to ensure that these recommendations are correctly implemented.

Recommendations:

All Transition Assistance Program (TAP) classes should include in-depth VA benefits and health-care education sessions and time for question and answer sessions.

The Departments of Veterans Affairs, Defense, Labor, and Homeland Security should design and implement

a stronger Disabled Transition Assistance Program (DTAP) for wounded service members who have received serious injuries, and for their families.

Chartered veterans service organizations should be directly involved in TAP and DTAP or, at minimum, serve as an outside resource to TAP and DTAP.

The DOD, VA, DOL, and DHS must do a better job educating the families of service members on the availability of TAP classes, along with other VA and DOL programs regarding employment, financial stability, and health-care resources.

Congress and the Administration must provide adequate funding to support TAP and DTAP to ensure that active duty as well as National Guard and reserve service members receive proper services during their transition periods.

²⁹ P.L. 112–56, Sections 221–226, 235, and 238.

³⁰ DOD Transition Assistance Program and Disabled Transition Assistance Program Guide. http://www.turbotap.org/portal/transition/resources/PDF/AC_GUIDE_Introduction_to_Transition_Assistance_Information.pdf, p. 1.

³¹ Testimony of Assistant Secretary for Veterans' Employment and Training Raymond M. Jefferson, before the Subcommittee on Economic Opportunity Committee on Veterans Affairs, United States House of Representatives, June 2, 2011.

³² Veterans' Employment and Training Service, *Vets Needs To Strengthen Management Controls Over The Transition Assistance Program*, Report No. 06–10–002–02–001 (September 30, 2010).



VETERANS AND POST-SERVICE LICENSURE AND CREDENTIALS:

Federal, state, and local governments as well as businesses should increase focus on the translation of military experience to civilian occupations.

The Departments of Defense, Veterans Affairs, and Labor have devoted considerable resources to aid service members in their transitions to civilian life. However, while less than 1 percent of our nation's population chooses to serve in the military, unemployment rates continue to skyrocket among veterans and are disproportionately high if compared to their nonveteran counterparts. The veterans who served to protect our nation's safety and freedoms are then faced with the fight for employment when transitioning to civilian life. While there are numerous federal, state, and private sector programs designed to assist veterans during transition, the fact remains that the unemployment rate among veterans continues to rise.

The U.S. Bureau of Labor Statistics Economic News Release of October 7, 2011, noted the unemployment rate of veterans generally, 18 years and over, was 8.1 percent for 2011 compared to 8 percent for 2010. In addition, veterans of the Gulf War era II (September 2001–present), have an unemployment rate of 11.7 percent for 2011 compared to 10.2 for 2010. Women veterans' employment statistics are worse still, with an unemployment rate of 14.7 percent for 2011 compared to 9.2 percent for 2010.³³ In July 2010, veterans reporting a service-connected disability rated 60 percent or greater reported workforce participation of 27.9 percent.³⁴

Responding to the disproportionately high unemployment rates among veterans, in June 2010, the Society for Human Resource Management (SHRM) released the findings of its national survey, titled "Employing Military Personnel and Recruiting Veterans—Attitudes and Practices SHRM Poll."³⁵ The survey examined pay and benefits that organizations provide to employees who have been mobilized to serve on active duty service, either as a reservists or as members of the National Guard, as well as the challenges organizations face when an employee has been mobilized to serve on active duty. The benefits and challenges of hiring military veterans were examined, as were the programs that would assist organizations in recruiting and hiring veterans. Unfortunately, the survey results simply confirmed what many veterans service organizations already suspected. Employers reported that, while they wanted to actively hire veterans, they did not know what the appropriate channels were to do so and did not receive much assistance from local DOL or VA offices. The survey also found that only 13 percent of private sector companies offered any type of transition assistance to newly separated service members or active duty returning Guard and Reserve members.

The survey also examined the problems employers have experienced in the past after hiring veterans.

Sixty percent of employers found they were unable to translate a veteran's military experience into a job's requisite skills. This finding illustrates the problem veterans have effectively translating their military qualification and experiences to civilian employment. Due to the fact that the DOD establishes performance standards for every occupation within the armed forces, it is able to provide some of the best vocational training in the nation, yet transferability of military skills and training to civilian occupations is problematic and often dependent upon a service member's choice of state residency.

Several years ago, in a bid to address this issue, the "Veterans Benefits Health Care and Information Technology Act of 2006"³⁶ authorized the DOL Assistant Secretary for Veterans' Employment and Training to carry out a demonstration project on credentialing to facilitate the seamless transition of members of the military from service on active duty to civilian employment. It was to have used at least 10 military occupational specialties as part of the demonstration project, each required for civilian employment in an industry with high growth or high worker demand. Further, the Assistant Secretary was to have consulted with various federal, state, and industry officials to identify requirements for credentials, certifications, and licenses that require a set of skills that could be matched to a military occupational specialty, and to cooperate with the appropriate officials to reduce or eliminate barriers to providing a credential, certification, or license for the civilian equivalent occupations.³⁷ However, since this authority was discretionary and not mandatory, and since no funding was obligated for the task, the study was not carried out.

With the passage of the VOW to Hire Heroes Act of 2011, which was signed into law Nov. 21, 2011, such a study is now mandated. It requires the Assistant Secretary for Veterans' Employment and Training to carry out a two-year demonstration project on the credentialing and licensing of veterans. It requires the Assistant Secretary of Labor of Veterans' Employment and Training to (1) conduct a study comparing the costs incurred by the DOD in training members for military occupational specialties selected for the demonstration project with costs incurred by the VA and Department of Labor in providing employment-related assistance to veterans who previously held such military occupational specialties, and (2) report study results to Congress.³⁸

The Independent Budget veterans service organizations believe this demonstration project must include the development of a clear process so that wherever a veteran chooses to reside after military service, that state will grant an expedited licensure or certification for the civilian equivalent job he or she held while in the military. Additionally, we believe that the DOD and other federal agencies tasked with assisting transitioning service members should reach out to and educate private sector employers on the value of their employing veterans. This outreach must include engaging both large corporations and small businesses.

The Administration has also been working in this area, with a specific focus on enhancing employment opportunities for medics and corpsmen in its "Call for a Career-Ready Military."³⁹ Military medics as first responders on the front lines save lives, yet because their military training does not meet states' licensure and certification requirements, these same individuals, who may be interested in working as nurses, physician assistants, or in other health care jobs once they leave the military, are often not given credit or credentials for the very skills training they received or experience they gained while serving.

Veterans often enter the military fresh out of high school or college, and the first culture they learn is that of the military. But on leaving active duty, many veterans, often those with little experience working in the civilian world, must learn a new civilian business culture and how to navigate to a successful career. Often, medics, corpsmen, and individuals from many other military occupations return to school to take classes using the Post-9/11 GI Bill, classes conceivably they could have taught, in order to qualify for the same job at home that they had in the military.

To fast-track medics into jobs in community health centers and other parts of the health-care system, the Health Resources and Services Administration (HRSA)⁴⁰ is exploring opening up career paths beyond nursing and expanding opportunities for veterans to become physician assistants. Through this initiative, the HRSA will begin to give priority in physician assistant grant awards to universities and colleges that help train veterans for careers as physician assistants. Through the Patient Protection and Affordable Care Act, the American Recovery and Reinvestment Act, and appropriations acts in fiscal years 2010 and 2011, \$45 million was invested to

support accredited physician assistant training programs. Currently there are 57 active physician assistant training grants.⁴¹

To expand the number of training programs that accommodate veterans, models will be identified that offer expedited curricula for veterans and offer enhanced veteran recruiting, retention, and mentoring services. The initiative will engage all physician assistant programs in learning how to replicate these models so that schools across the country can create better training and career pathways. The HRSA started by providing technical assistance to more than 21 institutions in 2011. These institutions represent those with active veterans' programs that can share best practices and strategize for further outreach to the 159 accredited physician assistant programs across the country, extending the reach beyond those that receive HRSA funds.⁴²

The DOD and VA, working closely with others, are leading a new task force to develop reforms to ensure that every member of the military receives the training, education, and credentials they need to transition to the civilian workforce or to pursue higher education. These reforms are to include the design of a "Reverse Boot Camp," an option that will extend the transition period to give some service members more counseling and guidance to make them career-ready.⁴³

While parts of the federal government exerted effort to inform military personnel of the options available to them in the civilian world over a limited range of career paths, acceptance by the DOD and other federal agencies of this opportunity to develop more robust systems for this purpose has been muted. Although often discussed, no action has been taken other than providing information to military personnel about their future career options. No system is yet in place to build upon the military training currently being provided that would lead to academic credits and acceptance of military specialty education and training for civilian equivalent occupations.

Certain civilian organizations have developed programs to make the transition easier for those leaving the military. For example, *Troops2Truckers* provides transitioning service members with professional commercial trucking industry training, Commercial Driver's License or training certification, and a job offer with no out-of-pocket cost.⁴⁴ *Helmets to Hardhats* places veterans into promising building

and construction careers via apprenticeships where they learn trades through on-the-job training supplemented by classroom instruction.⁴⁵ Also, *Troops to Teachers*, formerly a U.S. Department of Education and DOD program, helps eligible military personnel begin new careers as teachers in public schools.⁴⁶ While the VOW to Hire Heroes Act of 2011 takes an important step in this direction, with its demonstration project, assessing the transferability of up to five military specialties, it is far from the comprehensive initiative that must be undertaken.

Recommendations:

Congress should monitor Department of Labor (DOL) implementation of the VOW to Hire Heroes Act provisions mandating the DOD, VA, and DOL to work together to identify equivalencies between military and civilian occupations and the credentialing, licensing, and certification so military training meets civilian certification and licensure requirements in each state.

Congress should engage in a national dialogue, working closely with the Administration generally, and the DOD, VA, and DOL specifically, as well as state governments, employers, trade unions, and licensure and credentialing entities at all levels, to establish a process so military training meets civilian certification and licensure requirements for states in which veterans choose to live once they leave the military.

³³ U.S. Bureau of Labor Statistics, Division of Labor Force Statistics, Economic News Release Last Modified Date: Oct. 07, 2011. <http://www.bls.gov/news.release/empst.r05.htm>.

³⁴ Ibid.

³⁵ Society for Human Resource Management, *Employing Military Personnel and Recruiting Veterans—Attitudes and Practices SHRM Poll*. <http://www.shrm.org/Research/SurveyFindings/Articles/Pages/EmployingMilitaryPersonnelRecruitingVeterans.aspx>, 6/24/2010.

³⁶ P.L. 109–461, Sec. 604, Demonstration project on credentialing and licensure of veterans, Dec. 22, 2006.

³⁷ Ibid.

³⁸ P.L. 111–56, Sec 237, "VOW to Hire Heroes Act of 2011."

³⁹ Presidential Call for a Career-Ready Military, White House FACTSHEET: We Can't Wait: Obama Administration's New Initiatives to Help Create Jobs for Veterans, October 25, 2011. <http://www.whitehouse.gov/the-press-office/2011/10/25/fact-sheet-we-cant-wait-obama-administrations-new-initiatives-help-creat>.

⁴⁰ U.S. Department of Health and Human Services Health Resources and Services Administration. <http://www.hrsa.gov/grants/index.html>.

⁴¹ Presidential Call for a Career-Ready Military, White House FACTSHEET: We Can't Wait: Obama Administration's New Initiatives to Help Create Jobs for Veterans, October 25, 2011. <http://www.whitehouse.gov/the-press-office/2011/10/25/fact-sheet-we-cant-wait-obama-administrations-new-initiatives-help-creat>.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Troops 2 Truckers. <http://www.troops2truckers.com/>.

⁴⁵ Helmets To Hardhats. <http://www.helmetstohardhats.org/>.

⁴⁶ Troops to Teachers. <http://www.proudtoserveagain.com/>.

DEPARTMENT OF LABOR VETERANS' EMPLOYMENT AND TRAINING SERVICE:

The Department of Labor Veterans' Employment and Training Service needs to be a leading voice of employment for veterans in the national labor market.

The Department of Labor Veterans' Employment and Training Service (DOL VETS) has a critical role to play in increasing employment opportunities for veterans. As stated on the DOL website, the mission of DOL VETS is to "provide resources and expertise to assist and prepare [veterans] to obtain meaningful careers, maximize their employment opportunities, and protect their employment rights."

One of the primary ways that DOL VETS assists veterans with finding meaningful employment is through the Jobs for Veterans State Grants Program, which provides noncompetitive grant funds to state workforce agencies. The Jobs for Veterans State Grants Program provides funding for the Disabled Veterans Outreach Program (DVOP) specialists and local veterans' employment representatives (LVERs) in each state. LVERs work to increase employment opportunities for veterans in the community primarily by conducting outreach with employers. DVOP provides intensive services to veterans with the most significant barriers to employment.

Although the grant program provides states the opportunity to use resources in a manner appropriate to each state, there is a critical disconnect between the funding provided through DOL VETS and the provision of services. Consequently, DOL VETS is limited in its influence over the provision of services to veterans on the ground. More accountability is needed to ensure that these funds are truly being used to best meet the needs of veterans faced with employment barriers. In the absence of greater accountability, *The Independent Budget* veterans service organizations are concerned that veterans are not receiving the full attention of employment specialists.

The voice of veterans in employment can also be strengthened by ensuring that DOL VETS is integrated into the broader labor agenda managed by the DOL. The alignment of the VETS program within the DOL should bring greater focus to veterans' unemployment and in particular for those who face significant barriers, such as physical injury or other disability.

Veterans with significant disabilities would greatly benefit from increased collaboration between employment programs designated for veterans and those designated for people with disabilities. For example, Congress should require DOL VETS to partner with the DOL Office of Disability Employment Policy on the development and implementation of labor programs and policies that impact veterans with significant disabilities to ensure that these veterans benefit from the collaboration of the disability and veterans' communities.

Recommendations:

Congress must give the Department of Labor Veterans' Employment and Training Service (DOL VETS) the tools and resources necessary to ensure that veterans are benefiting from labor programs targeted to addressing their particular employment needs.

DOL VETS must work collaboratively within the DOL to increase employment opportunities for veterans with the most significant barriers to employment.

THE DEPARTMENT OF LABOR NATIONAL VETERANS TRAINING INSTITUTE REMAINS INADEQUATELY FUNDED:

The National Veterans Training Institute lacks adequate funding for its important mission of preparing veterans' employment representatives.

The National Veterans Training Institute (NVTI) is a contracted program funded and administered by the Department of Labor Veterans' Employment and Training Service through the University of Colorado. Each state sends new veterans' representatives for intensive training. These positions include the Disabled Veterans' Outreach Program (DVOP) representatives and local veterans' employment representatives (LVERs).

The Department of Labor Veterans' Employment and Training Service (DOL VETS) also sends its staff members to the NVTI for training in the details of the Uniformed Services Employment and Reemployment Rights Act (USERRA) and for veterans' preference investigative training. These federal programs protect the employment rights of individuals while they are serving our nation.

Of the 2,557 DVOP/LVER positions nationwide, historically the turnover rate for these positions exceeds 20 percent annually. This turnover rate is primarily attributed to veterans who use the DVOP and LVER positions as an entry to a state's employment system. By being situated in these low-paying, full-time state government positions, these veterans use this situation to seek better paying government or private sector employment. This turnover consequently requires new candidates to receive the necessary training from the NVTI.

Each state employs DVOP representatives within its divisions of employment. DVOP representatives are trained to provide intensive services to assist disabled veterans, particularly those who may face barriers to employment. Often these state employment representatives will be the first support contacts newly discharged veterans will encounter as they begin to make the transition to civilian life. The LVER positions within a state's employment division assist

veterans who have no disabilities and are seeking employment. Both positions should have knowledge of employment opportunities in their communities and knowledge of educational or training opportunities that can enhance veterans' employability. The constant turnover in these positions means that some unemployed veterans are being assisted by new and poorly trained employment specialists.

As a result of inadequate funding, the NVTI has performed its responsibilities over the past three years with a shortage of at least two to three full-time staff members. The NVTI currently has a projection of 66 to 90 training sessions to be presented in FY 2012 as it create its work schedule for FY 2013. This workload is determined by the DOL VETS program. Current law requires DVOP and LVER positions to receive NVTI training within 18 months of employment. All classes are a minimum of five days of classroom and computer training. The training that NVTI provides for USERRA investigators takes two weeks. The NVTI will train a total of 1,704 veterans' employment personnel in FY 2012 with a budget of \$2.4 million.

As the DOL VETS program continually searches for new and creative avenues for assisting veterans with employment, having the option of requesting additional training support from the NVTI would be a valuable asset. The underfunded NVTI is unable to provide this option without additional resources.

Recommendation:

Congress must provide increased funding to the Department of Labor for the National Veterans Training Institute to ensure the professional training programs can be made available for state and federal employment representatives on a timely basis.

VETERAN-OWNED BUSINESSES AND THE FEDERAL GOVERNMENT:

Efforts within the federal government to meet the goals of contracting with veterans or service-disabled veteran-owned small businesses and to prevent fraud require additional action.

At present, vendors desiring to do business with the federal government, with one exception, must register in the Central Contractor Registration (CCR) database,⁴⁷ and those who indicate they are veterans or service-disabled veterans simply self-certify their status without verification. The exception is for those who wish to do business with the Department of Veterans Affairs. In their case, certification is a more formal undertaking managed by VA's Office of Small and Disadvantaged Business Utilization (OSDBU). Approximately \$10 billion in contracts were awarded in fiscal year 2010 to self-certified service-disabled veteran-owned small businesses (SDVOSBs) in the CCR.⁴⁸

P.L. 109-461 requires VA to establish a Vendor Information Page database to move beyond veterans or service-disabled veterans' business owners' simple self-certification and instead to accurately identify businesses that are 51 percent or more owned by veterans or service-disabled veterans.⁴⁹ The act also requires that VA only use its set-aside and sole-source award authority for SDVOSB firms listed in the database and debar for a reasonable period of time those businesses that seek to defraud the government.⁵⁰

This database was originally established to act as a single-source of certified veteran-owned small businesses (VOSBs) and SDVOSBs to supply all federal agencies and prime contractors information to assist the federal government with achieving the not less than 3 percent goal of set-aside contracts being awarded.

The government's support of VOSBs and SDVOSBs contributes significantly to restore veterans' quality of life while aiding in their transition from active duty. Yet, their ability to compete for contract awards remains problematic since many federal agencies have not reached the 3 percent goal of set-aside contracts. Federal agencies must be held accountable to meet the federal procurement goals outlined by Executive Order 13360 and sections 15(g) and 36 of the Small Business Act, which gives agency contracting officers the authority to reserve certain procurements for SDVOSBs.

As increasing numbers of service-disabled military members begin to transition into civilian life, many choose to start their new lives as entrepreneurs. One of the benefits of successful VOSBs and SDVOSBs is that veterans tend to hire fellow veterans.⁵¹ This has the potential to decrease veteran unemployment. With the recent changes in the verification system, VA must have the proper number of trained personnel working to certify and to recertify SDVOSBs and VOSBs in a timely manner. As of October 2011, VA's VetBiz Vendor Information Pages (VIP) database, managed by its Center for Veterans Enterprise (CVE) within OSDBU, shows that the agency has verified the eligibility of more than 5,000 SDVOSB firms.⁵² Currently there are more than 15,000 firms that have self-certified their SDVOSB eligibility in the CCR database.⁵³ Hundreds, perhaps thousands more SDVOSBs and VOSBs may be in the process of registering their businesses or verifying their status.

In audits of the SDVOSB program conducted in 2009 and 2010, the Government Accountability Office identified weaknesses in fraud prevention controls that may have allowed ineligible firms to receive about \$100 million in SDVOSB contracts.⁵⁴ These areas include the lack of government-wide controls that allow ineligible firms to receive contracts by self-certifying that they were legitimate SDVOSB firms. In addition, VA lacks the ability to continue the monitoring of firms' eligibility and lacks an effective process for investigating and prosecuting firms.

According to the recently released Interagency Task Force on Federal Contracting Opportunities for Small Businesses, veteran business owners could be better served if VA and the Small Business Administration (SBA) established a partnership to assist veterans who are interested in participating in federal procurement. The CVE would maintain the VIP database and verify accurate veteran/service-connected disabled veterans' status. The SBA would retain the responsibility for validating the business ownership, size standards, and structural integrity of the business. The SBA would have direct reporting and input authority to the VIP database through the Office of Veterans Business Development once this information

is collected. VA would maintain the veteran eligibility status. The SBA would be responsible for verifying all other socioeconomic categories for the purpose of federal procurement. The SBA already maintains the infrastructure, expertise, and established regulatory guidance to include the veteran population within its authority. VA would develop clearer and more comprehensive small business contracting policies.⁵⁵ *The Independent Budget* veterans service organizations support these task force recommendations for these important programs.

Recommendations:

Congress should take the necessary actions to require all federal agencies to use a single-source database in all verifications of veteran ownership status before awarding contracts to companies on the basis of a claim of service-disabled veteran-owned small business or veteran-owned small business preference.

The Departments of Labor and Veterans Affairs must improve oversight and outreach to all federal agencies, the Small Business Administration, and all other federal agencies tasked with protecting and promoting service-disabled veteran-owned small businesses, to assist in the development and implementation of stronger strategies/plans to reach the minimum 3 percent goal.

Congress must ensure that adequate resources are available to effectively monitor and recognize those agencies that are not meeting the 3 percent minimum goal and hold them accountable. The annual reports filed by all federal agencies, reporting fiscal year percentage of goal achieved, should serve as guidance on which agencies need the most assistance in the development and implementation of stronger contracting plans.

Congress must ensure that adequate resources are available in VA and other federal agencies to effectively monitor, identify, and prosecute those businesses that commit or attempt to commit fraud when contracting with the government.

VA must place increased effort on the certification process to ensure veteran-owned businesses that depend on, or are waiting for a government contract can be assured that excessive wait times on VA's administrative processes will not hinder the veterans' success in conducting their business.

⁴⁷ CCR is the primary contractor registrant database for the U.S. federal government. CCR collects, validates, stores, and disseminates data in support of agency acquisition missions.

⁴⁸ Government Accountability Office, *Service-Disabled Veteran-Owned Small Business Program: Additional Improvements to Fraud Prevention Controls Are Needed*, GAO-12-205T, Nov. 30, 2011, p. 1.

⁴⁹ P.L. 109-461, 502, 120 Stat. 3403, 3431-3435 (2006).

⁵⁰ *Ibid.*

⁵¹ Bureau of Labor Statistics, "Employment Situation of Veterans News Release" October 20, 2011. <http://stats.bls.gov/news.release/vet.htm>.

⁵² *Service-Disabled Veteran-Owned Small Business Program: Additional Improvements to Fraud Prevention Controls Are Needed*, GAO-12-152R *Service-Disabled Veteran-Owned Small Business Program*, Oct. 26, 2011, p. 3.

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ *Empowering Veterans Through Entrepreneurship, Interagency Task Force On Federal Contracting Opportunities For Small Businesses*, Nov. 1, 2011. http://www.sba.gov/sites/default/files/contracting_task_force_report_0.pdf.



REASONABLE TRANSITION FOR SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESSES:

There needs to be a reasonable transition period for all service-disabled veteran-owned small businesses to retain their federal protected status following the death of the disabled veteran.

For a veteran who suffers a disability while in military service, the federal government has deemed it appropriate to provide a range of benefits designed to ease the economic and other losses and disadvantages incurred as a consequence of such disabilities. These benefits include government assistance

for entering the federal procurement marketplace. Service-disabled veteran-owned small businesses (SDVOSBs) were first provided the opportunity to compete for procurement contracts on December 16, 2003, as a result of the Veterans Benefits Act.⁵⁶

Executive Order 13360, signed on October 20, 2004, directed all federal agencies to establish a goal of at least 3 percent of federal contracting for service-disabled veteran-owned businesses and gave agency contracting officers the authority to reserve certain procurements for SDVOSB set-asides.

P.L. 109–461, the “Veterans Benefits, Health Care, and Information Technology Act of 2006” established the Veterans First Contracting Program specifically for the Department of Veterans Affairs to increase business opportunities with the VA for SDVOSBs.⁵⁷

As a result of numerous public laws, many disabled veterans have been encouraged to take the personal risk of establishing small businesses, often only with the support of their families and their own personal financial resources. According to the Service Disabled Veteran Owned Small Business Council, “[t]here are roughly 5 million Veteran Owned Businesses (VOSBs) and approximately 500,000 Service Disabled Veteran Owned Businesses (SDVOSBs) in the United States.”⁵⁸ Their risk, when successful, creates new job opportunities and, in many cases, for other disabled veterans and veterans. The presence of SDVOBs is essential, particularly during our current challenging economic times.

While acquiring that first federal contract and meeting its many prerequisites may be a big challenge for SDVOSBs generally, a closer examination finds that the death of a service-disabled business owner currently presents a significant obstacle that can mean the dissolution of the business soon afterward. According to section 8127 (h)(2)(C), P.L. 109–461, the disabled veteran business owner’s surviving spouse is provided a 10-year transition period if the owner was a 100 percent disabled veteran at the time of his or her death, or if he or she died as a result of a service-connected disability in relation to contracts only with VA. Conversely, if the veteran business owner was rated less than 100 percent service connected or dies of a nonservice-connected condition, the surviving spouse has only one year to transition the business,

again for contracts only with VA. If the SDVOSB and service-disabled business owner hold contracts with any other federal government agency, the business immediately loses its SDVOSB status upon the death of the disabled veteran. Current law provides for no period of transition. Thus, the SDVOSB can no longer compete for federal procurement opportunities.

The loss of the veteran business owner can place SDVOSB employees and their families as well as the surviving spouse at severe risk due to either downsizing or closing the business because of loss of federal procurement opportunities and finally laying off their workers. Such events can result in severe financial hardship for all concerned. These circumstances could be averted, or, at the very least, the impact could be phased in over a longer time frame, if surviving spouses not protected by the limited provisions of P.L. 109–461 or heirs of disabled veterans were allowed to have a more reasonable transition period for the SDVOSB program than the current one-year VA-only provision. To do so would help maintain the jobs created by the SDVOSBs for disabled veterans, other veterans, and other employees and would not unduly put them at increased financial hardship due to job loss or downsizing or closing of the SDVOSB.

Recommendation:

Congress should provide for a reasonable transition period for all service-disabled veteran-owned small businesses (SDVOSBs), not covered by the limited provisions of P.L. 109–461, to retain their SDVOSB status with the federal government following the death of the disabled veteran via a surviving spouse, children, or heirs.

⁵⁶ P.L. 108–183, “Veterans Benefits Act of 2003,” § 308, Procurement program for small business concerns owned and controlled by service-disabled veterans. <http://www.acq.osd.mil/osbp/docs/pl108-183.pdf>.

⁵⁷ P.L. 109–461, “Veterans Benefits, Health Care, and Information Technology Act of 2006,” § 8127. Small business concerns owned and controlled by veterans: contracting goals and preferences. <http://www.gpo.gov/fdsys/pkg/PLAW-109publ461/pdf/PLAW-109publ461.pdf>.

⁵⁸ Service Disabled Veteran Owned Small Business Council. <https://www.sdvosb-council.org/>.

VA PENSION WORK DISINCENTIVES:

VA pension work disincentives should be removed.

Many veterans, who served honorably and were discharged in good health, later acquire significant disabilities. Eligible veterans will qualify for the Department of Veterans Affairs pension.⁵⁹ VA pension is often likened to Supplemental Security Income (SSI) under Social Security. However, unlike that program, VA pensioners face a “cash cliff” in which benefits are terminated once an individual crosses an established earnings limit. Because of a modest work record, many of these veterans or their surviving spouses may receive a small Social Security Disability Insurance (SSDI) benefit that supplements their VA pension. If these individuals attempt to return to the workforce, not only is their SSDI benefit terminated but their VA pension benefits are reduced dollar for dollar by their earnings.

More than 20 years ago, under P.L. 98–543, Congress authorized VA to undertake a four-year pilot program of vocational training for veterans awarded a VA pension. Modeled on the Social Security Administration’s trial work period, veterans in the pilot were allowed to retain eligibility for pension up to 12 months after obtaining employment. In addition, they remained eligible for VA health care up to three years after their pension terminated because of employment. Running from 1985 to 1989, this pilot program achieved some modest success. However, it was discontinued because prior to VA eligibility reform most catastrophically disabled veterans were reluctant to risk their access to VA health care by working.

The VA Office of Policy, Planning and Preparedness examined the VA pension program in 2002 and, though small in number, 7 percent of unemployed veterans on pension and 9 percent of veteran spouses on pension cited the dollar-for-dollar reduction in VA pension benefits as a disincentive to work.⁶⁰ Now that veterans with catastrophic nonservice-connected disabilities retain access to VA health care, work incentives for the VA pension program should be re-examined and policies toward earnings should be changed to parallel those in the SSI program.

Recommendation:

Work disincentives in the VA pension program should be re-examined and consideration given to changes that would parallel Social Security work incentives, such as a trial work period and reduction in benefits as earned income rises.

⁵⁹ Title 38 C.F.R. 3.3. Improved pension; P.L. 95–588 (92 Stat. 2497). A benefit payable by the Department of Veterans Affairs to veterans of a period or periods of war because of nonservice-connected disability or age. The qualifying periods of war for this benefit are the Mexican border period, World War I, World War II, the Korean conflict, the Vietnam era, and the Persian Gulf War. Basic entitlement exists if a veteran served in the active military, naval or air service for 90 days or more during a period of war (38 U.S.C. 1521(j)) and meets the net worth requirements under 3.274 and does not have an annual income in excess of the applicable maximum annual pension rate specified 3.23; and is age 65 or older; or is permanently and totally disabled from nonservice-connected disability not due to the veteran’s own willful misconduct.

⁶⁰ Evaluation of VA Pension and Parents’ DIC Programs, VA Pension Program Final Report, ORC Macro, Economic Systems Inc., Hay Group, Dec. 22, 2004. www1.va.gov/op3/docs/pension.pdf.

National Cemetery Administration

The Department of Veterans Affairs (VA) National Cemetery Administration (NCA) maintains 131 of the nation's 147 national cemeteries, as well as 33 soldiers' lots. The 131 NCA-operated cemeteries are composed of approximately 3.1 million gravesites¹ and are located in 39 states and Puerto Rico. As of late 2010, there were more than 20,021 acres within established installations in the NCA. Nearly 60 percent are yet to be developed and hold the potential to provide approximately 5.5 million more gravesites, composed of 4.9 million casket sites and 600,000 in-ground cremation sites. Of these 131 national cemeteries, 71 are open to all interments, 19 can accommodate cremated remains only, and 41 will perform only interments of family members in the same gravesite as a previously deceased family member.

VA estimates that approximately 22.4 million veterans are alive today, and with the transition of an additional 1 million service members into veteran status over the next 12 months, this number is expected to continue to rise until approximately 2017. These veterans have served in both World Wars, the Korean War, the Vietnam War, the Gulf War, Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn, and hostile conflicts around the world and during times of peace. On average, 14.4 percent of veterans choose to be laid to rest in a national or state veterans' cemetery. As new national and state cemeteries continue to open, as our aging veterans population continues to grow, and as we continue to be a nation at war on multiple fronts, the demand for burial at a veterans' cemetery will continue to increase.

The most important obligation of the NCA is to honor the memory of America's brave men and women who have selflessly served in the armed forces. Therefore, maintaining NCA cemeteries as a national shrine dedicated to the memory of these men and women is a top priority. In fact, many of the individual cemeteries within the NCA system are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of the United States.

The Independent Budget veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment demonstrated by NCA leadership and staff in their continued dedication to providing the highest quality of service to veterans and their families. It is in the opinion of the IBVSOs that the NCA continues to meet its goals and the goals set by others because of its true dedication and care for honoring the memories of the men and women who have so selflessly served our nation. We applaud the NCA for recognizing that it must continue to be responsive to the preferences and expectations of the veterans' community by adapting or adopting new burial options and ensuring access to burial options in the national, state, and tribal government-operated cemeteries. We also believe it is important to recognize the NCA's efforts in employing disabled and homeless veterans.

¹ Department of Veterans Affairs National Cemetery Administration Fact Sheet (Apr. 2012). <http://www.cem.va.gov/pdf/facts.pdf>.

NCA Accounts

In FY 2011 the National Cemetery Administration operated on an estimated budget of \$298.3 million associated with the operations and maintenance of its grounds. The NCA had no carryover for FY 2011. The NCA was also able to award 44 of its 48 minor construction projects and had four unobligated projects that will be moved to FY 2012. Unfortunately, due to continuing resolutions and the current budget situation, the NCA was not able to award the remaining four projects.

The NCA honors veterans and their families with final resting places in national shrines and lasting tributes that commemorate their service and sacrifice to our nation. *The Independent Budget* veterans service organizations (IBVSOs) support the operational standards and measures outlined in the National Shrine Commitment. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get to where they should be.

The NCA has worked tirelessly to improve the appearance of our national cemeteries, investing an estimated \$39 million into the National Shrine Initiative in FY 2011. According to NCA surveys, as of October 2011 the NCA has continued to make progress in reaching its performance measures. Since 2006, the NCA has improved headstone and marker height and alignment in national cemeteries from 67 percent to 70 percent and improved cleanliness of headstones, markers, and niches from 77 percent to 91 percent. Although the NCA is nearing its strategic goal of 90 percent and 95 percent, respectively, for height and alignment and cleanliness, more funding is needed. Therefore, the IBVSOs recommend the NCA's Operations and Maintenance budget be increased by \$20 million per year until the operational standards and measures goals are reached.

The IBVSOs recommend an Operational and Maintenance budget of \$280 million for the National Cemetery Administration for FY 2013 so it can meet the demands for interment, gravesite maintenance, and related essential elements of cemetery operations. This request includes the \$20 million for the National Shrine Initiative.

The IBVSOs call on the Administration and Congress to provide the resources needed to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.

Table 9. FY 2013 National Cemetery Administration (dollars in thousands)

FY 2012 Administration Request	\$251,000
FY 2012 <i>Independent Budget</i> Request	\$275,000
FY 2012 Enacted*	\$250,000
FY 2013 <i>Independent Budget</i> Recommendation	
Operations and Maintenance**	\$280,000
*Amount based on continuing resolutions	
** Total amount, including National Shrine Initiative	

THE STATE CEMETERY GRANTS PROGRAM:

The State Cemetery Grants Program is a cost-effective way for the National Cemetery Administration to achieve its mission.

The State Cemetery Grants Program (SCGP) complements the National Cemetery Administration's mission to establish gravesites for veterans in areas where it cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including establishing a new cemetery and expanding or improving an established state or tribal organization veterans' cemetery. New equipment, such as mowers and backhoes, can be provided for new cemeteries. In addition, the Department of Veterans Affairs may also provide operating grants to help cemeteries achieve national shrine standards.

In FY 2011 the SCGP operated on an estimated budget of \$46 million, funding 16 state cemeteries. These 16 state cemeteries included the establishment or ground breaking of five new state cemeteries, three of which are located on tribal lands, expansions and improvements at seven state cemeteries, and four projects aimed at assisting state cemeteries to meet the NCA national shrine standards.

Since 1978 the Department of Veterans Affairs has more than doubled the available acreage and accommodated more than a 100 percent increase in burial through this program. The SCGP faces the challenge of meeting a growing interest from states to provide burial services in areas not currently served. The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system

of national cemeteries. With the enactment of the "Veterans Benefits Improvement Act of 1998," the NCA has been able to strengthen its partnership with states and increase burial services to veterans, especially those living in less densely populated areas without access to a nearby national cemetery. Through FY 2010, the state grant program has established 75 state veterans' cemeteries in 40 states and U.S. territories. Furthermore, in FY 2011 VA awarded its first state cemetery grant to a tribal organization.

The Independent Budget recommends an appropriation of \$51 million for the SCGP for FY 2013. This funding level will allow the SCGP to establish new cemeteries, at their current rate, that will provide burial options for veterans who live in regions that currently have no reasonable accessible state or national cemetery.

Recommendation:

Congress should fund the State Cemetery Grants Program at a level of \$51 million for FY 2013. *The Independent Budget* veterans service organizations believe this small increase in funding will help the National Cemetery Administration meet the needs of the State Cemetery Grant program, as its expected demand will continue to rise through 2017. Furthermore, this funding level will allow the NCA to continue to expand in an effort of reaching its goal of serving 94 percent of the nation's veteran population by 2015.

VETERANS' BURIAL BENEFITS:*Burial benefits have lost their value.*

Since its inception, more than 3 million burials have occurred in national cemeteries under the National Cemetery Administration. Currently, the NCA oversees 131 existing cemeteries, with five new cemetery sites planned to open for burials within the next five years.

In 1973 the Department of Veterans Affairs established a burial allowance that provided partial reimbursement for eligible funeral and burial costs. The current payment is \$2,000 for burial expenses for service-connected deaths, \$300 for nonservice-connected, and a \$700 plot allowance. At its inception, the payout covered 72 percent of the funeral costs for a service-connected death, 22 percent for a nonservice-connected death, and 54 percent of the cost of a burial plot.

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potter's fields. In 1923 the allowance was modified. The benefit was determined by a means test until it was removed in 1936. In its early history the burial allowance was paid to all veterans, regardless of their service connectivity of death. In 1973 the allowance was modified to reflect the status of service connection.

The plot allowance was introduced in 1973 as an attempt to provide a plot benefit for veterans who did not have reasonable access to a national cemetery. Although neither the plot allowance nor the burial allowance was intended to cover the full cost of a civilian burial in a private cemetery, the recent increase in the benefit's value indicates the intent to provide a meaningful benefit. *The Independent Budget* veterans service organizations are pleased that the 111th Congress acted quickly and passed an increase in the plot allowance for certain veterans from \$300 to \$700 effective October 1, 2011.

However, we believe that there is still a serious deficit between the original value of the benefit and its current value. In order to bring the benefit back up to its original intended value, the payment for service-connected burial allowance should be increased to \$6,160, the nonservice-connected burial allowance should be increased to \$1,918, and the plot allowance should be increased to \$1,150.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that the Department of Veterans Affairs separate burial benefits into two categories: veterans who live inside the VA accessibility threshold model and those who live outside it. For veterans who live within reasonable accessibility of a state or national cemetery that would be able to accommodate their burial needs but who would rather be buried in a private cemetery, the burial benefit should be adjusted as well. These veterans' burial benefits should be based on the average cost for VA to conduct a funeral. The benefit for a service-connected burial should adjust to \$2,793; the amount for a nonservice-connected burial would increase to \$854; and the plot allowance would increase to \$1,150. This will provide a burial benefit at equal percentages, based on the average cost for a VA funeral and not on the private funeral cost that will be provided for veterans who do not have access to a state or national cemetery.

Recommendations:

Congress should divide the burial benefits into two categories: veterans within the accessibility model and veterans outside the accessibility model.

Congress should increase the plot allowance from \$700 to \$1,150 for all eligible veterans and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected burial benefits from \$2,000 to \$6,160 for veterans outside the radius threshold and to \$2,793 for veterans inside the radius threshold.

Congress should increase the nonservice-connected burial benefits from \$300 to \$1,918 for all veterans outside the radius threshold and to \$854 for all veterans inside the radius threshold.

The Administration and Congress should provide the resources required to meet the critical nature of the National Cemetery Administration's mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.



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