

THE INDEPENDENT BUDGET

Veterans Agenda for the 115th Congress

Policy Recommendations for Congress and the Administration



THE INDEPENDENT BUDGET
FOR THE 115TH CONGRESS



PREFACE



The contributions made by our veterans to the growth and development of the United States are part of the basic fabric of the nation. In fact, the very foundations of the American way of life were, in large part, hewn by individuals who at some point in their lives served in the United States Armed Forces. Unlike the environment in which today's voluntary force serves, during our nation's infancy military service was a highly accepted and even expected obligation of citizenship. Then and now, because of the leadership and determination of service members and veterans to set the example and serve as influential frontrunners in all areas of American society—economic, political, social, and moral—we are able to enjoy the stature as the leader of the global community of nations.

Our service members, on behalf of all our citizens, share a long history of shouldering the burden and bearing the sacrifice of defending this country. For this reason, our veterans and military service members have been the beneficiaries of the promises and support of a grateful nation after serving. Veterans' benefits have been purchased by an individual's sacrifice and therefore should not be diminished by politics or any dereliction of duty by Congress or the administration. The promises made to our service members, who stepped forward and selflessly raised their right hands as part of a solemn oath to "support and defend the Constitution of the United States against all enemies, foreign and domestic," must be faithfully upheld and fulfilled.

The coauthors of *The Independent Budget*—Disabled American Veterans (DAV), Paralyzed Veterans of America (Paralyzed Veterans), and the Veterans of Foreign Wars—have held the longstanding responsibility of highlighting for the administration, Congress, the Department of Veterans Affairs, the Department of Defense, and the American people the unique benefits, specialized health care, infrastructure, education, employment, training, and memorial concerns and challenges being faced by our service members, their families, and all veterans. More important, we offer real solutions through consensus recommendations to those problems we have identified. We remain ever vigilant to the cause of ensuring that veterans and their families get the benefits and health care services that they have earned and deserve.

INDEPENDENT BUDGET AUTHORS

INDEPENDENT BUDGET AUTHORS

Three coauthoring organizations have worked in collaboration for more than 30 years to produce 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.

DISABLED AMERICAN VETERANS

DAV empowers veterans to lead high-quality lives with respect and dignity. It is dedicated to a single purpose: fulfilling our promises to the men and women who served. DAV does this by ensuring that veterans and their families can access the full range of benefits available to them, fighting for the interests of America's injured heroes on Capitol Hill, linking veterans and their families to employment resources, and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV, a nonprofit organization with nearly 1.3 million members, was founded in 1920 and chartered by Congress in 1932. Learn more at dav.org.

PARALYZED VETERANS OF AMERICA

Paralyzed Veterans, founded in 1946, is the only congressionally chartered veterans service organization dedicated solely to the benefit and representation of veterans with spinal cord injury or disease. For 70 years, it has ensured that veterans received the benefits earned through their service to our nation, monitored their care in VA spinal cord injury centers, and funded research and education in the search for a cure and improved care for individuals with paralysis.

As a partner for life, Paralyzed Veterans also develops training and career services, works to ensure accessibility in public buildings and spaces, provides health and rehabilitation opportunities through sports and recreation, and advocates for veterans and all people with disabilities. With more than 70 offices and 34 chapters, Paralyzed Veterans serves veterans, their families, and their caregivers in all 50 states, the District of Columbia, and Puerto Rico. To learn more about Paralyzed Veterans and its programs, visit pva.org.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

The Veterans of Foreign Wars of the United States (VFW) is the nation's largest and oldest major war veterans' organization. Founded in 1899 and chartered by Congress in 1936, the VFW is comprised entirely of eligible veterans and military service members from the active, Guard, and reserve forces. With nearly 1.7 million VFW and Auxiliary members located in more than 6,600 posts worldwide, the nonprofit veterans' service organization is proud to proclaim "NO ONE DOES MORE FOR VETERANS" than the VFW, which is dedicated to veterans' service, legislative advocacy, and military and community service programs. For more information or to join, visit vfw.org.

Individually, each of the coauthoring organizations serves the veterans community in a distinct way. However, the three 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
American Federation of Government Employees
American Foundation for the Blind
American Military Retirees Association
American Psychological Association
American Society of Nephrology
American Veterans for Equal Rights
American WWII Orphans Network
Association of American Medical Colleges
Association of the United States Navy
Combined Korea-US Veterans Association
Easterseals
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National Alliance for Eye and Vision Research
National Alliance on Mental Illness
National Association of American Veterans, Inc.
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
Nurses Organization of Veterans Affairs
U.S. Coast Guard Chief Petty Officers Association
U.S. Federation of Korea Veterans Organization
Vietnam Veterans of America

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INTRODUCTION

We are pleased to present The Independent Budget (IB) Policy Agenda for the 115th Congress. This year marks the 30th edition of this important endeavor. Since the release of our last policy agenda at the start of the 114th Congress in January 2015, we have seen significant attention on reforming key elements of the delivery of veterans' health care and benefits. Our focus remains on informing and influencing key policy decisions directed by the administration and Congress that will have a direct impact on veterans and their families. Our priorities include:

- high-quality, accessible, comprehensive, and veterans-centric health care;
- timely and accurate delivery of all earned benefits to veterans and their eligible dependents and survivors, including disability compensation, pensions, education, housing assistance, and other necessary supports; and
- dignified memorial services to all eligible veterans and the preservation of our national cemeteries as shrines to those lost after serving our nation.

Continued discussion about the role of community care in the delivery of health care to veterans remained a complicated issue. In October 2015, the Department of Veterans Affairs (VA) released a comprehensive community care plan to improve access to and delivery of services. In November 2015, we presented our own framework to affirm the principles that govern the delivery of health care outlined previously. Our recommendations focused on four key tenets:

- restructuring the veterans' health care delivery system
- redesigning the systems and procedures that facilitate access to health care
- realigning the provision and allocation of VA's resources to reflect its mission
- reforming VA's culture with workforce innovations and real accountability

Subsequently, the Commission on Care released its report in July 2016, which offers important recommendations on larger reform of the entire VA health care system. The essential core of the commission's plan was similar to that of the IB and VA, and it will be up to the incoming 115th Congress to start moving forward with implementing this new integrated model of health care for our nation's veterans.

Meanwhile, the IB's coauthors were directly involved in discussion about reforming the benefits appeals process. Thoughtful consideration was given to the initial plan offered by VA and legislation that was offered to effect necessary changes. However, as with other key issues in the 114th Congress, policy, political, and partisan divisions stood in the way of that reform.

This policy document is meant not only to serve as a wide-ranging reference focused on all issues important to veterans, but also to be an educational tool for the use of VA and of all veteran's stakeholders, as well as the administration, Congress, and the American people. It is the hope and expectation of the IB coauthors that Congress and the administration will devote real attention to the broad recommendations we offer to address the issues facing veterans and move past political posturing that provides no benefit to veterans.

CRITICAL ISSUES



Strengthen, Reform, and Sustain the VA Health Care System

RECOMMENDATIONS:

Working closely with veterans service organization (VSO) stakeholders, Congress must enact legislation, and VA must issue regulations and define policies, procedures, requirements, and responsibilities, necessary to create veterans community integrated health care networks, with VA serving as the overall coordinator and primary provider of care and community partners providing sufficient capacity to eliminate access gaps in each market.

Congress must ensure VA has the clinical and business capabilities to create and maintain a high-performing health care system, which must include interoperable electronic health records and modern tools for scheduling, billing, claims payment, and patient-centered navigation to interrelated veterans' health care benefits and services.

VA's highest priority must be to sustain its specialized services, which are essential and irreplaceable for millions of veterans and which rely on the support of VA facilities providing a full continuum of care for the ill and injured veterans who rely on them.

Veterans' access to care, including to non-VA community providers in the networks, should be based on clinical need and veteran preference, not arbitrary time or distance standards. Existing access standards for the Choice Program (30 days / 40 miles) should be phased out as VA's local integrated networks eliminate access gaps.

In consultation with VSO stakeholders, Congress should enact legislation, and VA should implement regulations, necessary to create a veterans rural-community extended health care network to address the special challenges facing rural veterans.

To further close gaps in access to a full spectrum of health care services, Congress must work with VA to enact legislation to provide veterans access to urgent care services, provide sufficient funding and authority for emergency care, and continue to aggressively expand telehealth and web-based medical services.

Congress must ensure VA is appropriated the resources needed to meet the true and full demand by enrolled veterans for medical care provided through VA facilities as well as by community partners.

Congress must authorize VA to increase utilization of public-private partnerships to construct and operate VA medical facilities.

Congress must provide VA the authority to allocate and reallocate VA medical care appropriations throughout the fiscal year according to veterans' health care needs.

In order to ensure that VA's resources are properly utilized, Congress must enact legislation to require a VA Quadrennial Veterans Review (QVR) planning process and establish a biennial independent audit of VA's budgetary accounts and the Enrollee Health Care Projection Model.

To improve veterans' health care outcomes and experiences, VA must move its patient advocates program into the new Veterans Experience Office, which should also be responsible for ensuring that all patient health care protections afforded under title 38 are fully applied and complied with by all community network providers, public and private.

OVERVIEW:

In the 114th Congress, the question of how to strengthen and reform the VA health care system was the dominant issue for VA, the House and Senate Committees on Veterans' Affairs, and the veterans' community. Since the access crisis was uncovered by Congress and the national media in the spring of 2014, a vigorous national debate has taken place about how best to provide timely, high-quality, comprehensive, and veteran-centered health care to our nation's veterans.

There have been dozens of congressional hearings, multiple internal reviews, numerous media investigations, enactment of temporary programs and laws, expert stakeholder input, an independent assessment, and finally last fall a comprehensive report with recommendations from the congressionally mandated Commission on Care.

Despite multiple perspectives and organizations engaged in this debate, by the end of 2016 virtually all of the major stakeholders had coalesced around a common long-term solution: the best way to transform veterans' health care is by creating an integrated network of VA and community providers, with VA serving as the coordinator and primary provider of care.

This evolutionary approach, which builds upon existing strengths, has been endorsed by *The Independent Budget's* veterans service organizations (DAV, PVA, and VFW), most major VSOs, VA Secretary Robert A. McDonald, key congressional leaders from both parties, and the Commission on Care. While all do not agree on every detail of this new paradigm, there is a remarkable convergence of views about how, when, and where injured and ill veterans should be able to obtain health care in this new system.

With the current veterans' Choice Program scheduled to expire this year, and millions of America's veterans continuing to choose and rely on VA for their medical care, it is time for Congress and the new administration to act and create the future VA health care system that America's veterans deserve.

HISTORY OF UNDERFUNDING VA HEALTH CARE:

Since the catalyst that began this debate was lack of access, it is important to understand the true underlying causes of access problems facing veterans. While the problems today are significant, 14 years ago VA faced a much more serious crisis centered on access to VA health care, as hundreds of thousands of veterans—peaking at 310,000 in July 2002—were found to be waiting 6 months or longer just to receive an initial VA medical appointment. In May 2003, a bipartisan presidential task force (PTF) reported that in January 2003 “at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up—a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide required care.” The PTF concluded that there was a **“mismatch in VA between demand for access and available funding.”**

A dozen years later, these same access problems created news again as tens of thousands of veterans were reported to be waiting for VA health care and a number of VA employees were found to have been involved in significant scheduling and waiting list manipulations in Phoenix, Arizona, and some other VA facilities. In order to examine the reasons for this latest VA access crisis and to offer recommendations for improvement, Congress authorized an “independent assessment” to be conducted. The resulting report issued by the MITRE Corporation, the Rand Corporation, and others in September 2015 reached findings that were remarkably similar to the PTF report from a dozen years earlier.

The independent assessment's first finding was a **“disconnect in the alignment of demand, resources and authorities”** for VA health care. Its first recommendation was the need to “address the misalignment of demand with available resources both overall and locally.” In terms of access to care, it found that “increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care over the next five years,” with a core recommendation of “increasing physician hiring.” The report also identified the key barriers that limited provider productivity, including “a shortage of examination rooms and poor configuration

of space,” and “insufficient clinical and administrative support staff,” all of which would require additional funding for the VA health care system.

Furthermore, the assessment found that the “capital requirement for the Veterans Health Administration (VHA) to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, and the gap between capital need and resources could continue to widen.” It estimated this gap at between \$26 and \$36 billion over the next decade, although the report suggested several significant management strategies that could potentially lower the projected gap down to between \$7 billion and \$22 billion.

The findings of this assessment are fully consistent with the earlier PTF’s conclusions and confirm *The Independent Budget* veterans service organizations (IBVSOs) have reported for more than a decade: the resources provided to VA health care have been inadequate to meet the mission of care for veterans. While there are many factors that contributed to the access crisis, it is a simple fact that when there are not enough doctors, nurses, and other clinical professionals or enough usable treatment space to meet the rising demand for care by enrolled veterans, the result will be waiting lists and access problems.

To be clear, the IBVSOs are not suggesting that simply increasing funding by itself—without making significant reforms in VA—will lead to better health outcomes for veterans over the next 20 years. However, history shows that no VA reform plan has any chance of success unless sufficient resources are consistently provided to meet the true demand for services, when and where they need them. With more and more veterans seeking out VA as it improves access, Congress will have to continue investing resources to allow VA to keep up with rising demand.

RECORD OF HIGH-QUALITY CARE

Another critical but often overlooked finding of the independent assessment confirmed what the IBVSOs, other veterans’ service organizations, and most studies have shown: the quality of care provided by VA is high—equal to or better than the private sector. Specifically, the independent assessment found:

“In new analyses comparing VHA’s (Veterans Health Administration) quality with non-VA providers, VHA performed the same or significantly better on average than the non-VA provider organizations on 12 of 14 effectiveness measures (providing recommended care) in the inpatient setting, and worse on two measures. On average, VHA performed significantly better on 16 outpatient Healthcare Effectiveness Data and Information Set® (HEDIS) measures of effectiveness compared with commercial health maintenance organizations (HMOs); on the 15 outpatient HEDIS measures of effectiveness that were available for Medicaid HMOs; and on 14 of 16 outpatient effectiveness measures compared with Medicare HMOs.”

When it came to “patient-centeredness” measures, the independent assessment continued:

“Our analyses indicated that average VA performance at the facility level is significantly worse than non-VA performance, notably on many of the patient experience measures for care in the inpatient setting and the 30-day all-cause risk-standardized readmission measures for heart attack, heart failure, and pneumonia. . . .

We also observed substantial variation in quality measure performance across VA facilities, indicating that Veterans in some areas are not receiving the same high-quality care that other VA facilities are able to provide. A high-priority goal for VA leadership should be narrowing these gaps to ensure that quality of care is more uniform across VA facilities so that Veterans can count on high-quality care no matter which facility they access.”

The MyVA initiative is using its Diffusion of Excellence Initiative to combat variability of quality among VHA facilities. This is reflective of an issue we consistently hear from our members across the country about their frustration with a system that needs to be more responsive to veterans’ preferences, needs, and values. We

believe that implementation of the MyVA initiative has already made significant progress toward improving VA's patient-centeredness, the veteran's experience, and overall satisfaction with VA health care. The best path forward for a 21st century veterans' health care system must continue building upon the strengths of the VA, including its unparalleled expertise treating the unique conditions of injured veterans, while working to reform systemic problems hindering the timely delivery of care.

IMPLEMENTING AND FIXING THE CHOICE PROGRAM

Enacted in August 2014, the Veterans Access, Choice, and Accountability Act (P.L. 113-146; also known as the Choice Act) ordered the independent assessment, as well as the independent Commission on Care, to develop recommendations for long-term solutions. However, the primary focus of the Choice Act was to rapidly provide new access through the creation of the temporary Choice Program. As approved by Congress, the Choice Program would allow certain veterans to choose community care if they would otherwise be forced to wait more than 30 days for required care or to travel more than 40 miles to a VA facility to receive such care. The law required VA to stand up this nationwide program—which could potentially touch all 9 million enrolled veterans—in just 90 days.

Since its inception 2 years ago, the Choice Program has been beset with problems, some resulting from the flawed design of the law and others due to the unrealistic implementation schedule mandated by Congress. As the number of veterans using the Choice Program rose, so did the number of problems related to care coordination, appointment scheduling, and provider payments. Although the IBVSOs supported passage of the Choice Program as a necessary and temporary response to the access crisis, the law was neither intended to be nor supported as a permanent centerpiece of VA's future health care delivery model.

Within weeks of the Choice Program's commencement, both veterans and VA health care personnel reported confusion about how, when, and for what types of care the program was to be utilized. The law required VA to use third-party administrators (TPAs) to operate the program; however, this only added to the confusion and breakdown in communication between veterans, VA, and TPAs. Problems with scheduling, health record transfers, care coordination, doctor payments, and veterans' copayments all hindered usage of the Choice Program during its first several months. To address these and other technical and implementation challenges, Congress passed, and the president signed, two subsequent pieces of legislation (P.L.s 113-175 and 114-41) to address some of the major flaws in the Choice Program. Among the major changes were a redefinition of how to calculate the 40-mile distance criteria for Choice Program eligibility and removal of a requirement that medical records be returned to VA before provider payments were made. These adjustments, as well as additional training of VA personnel, slowly increased utilization of the program. From August 1, 2015, through July 31, 2016, VA and the TPAs created more than 3.2 million Choice Program authorizations for veterans to receive care in the community, an 11 percent increase compared to the prior one-year period.

At the same time, VA was also addressing its own capacity limitations by using funding in the Choice Act designed to hire thousands of new doctors, nurses, and other health care staff, as well as to expand treatment space through new leases and renovation of existing treatment space. As a result, according to VA, in August 2016, 96 percent of all requested appointments were within 30 days of the clinically indicated or veterans' preferred date; 85 percent were within 7 days; and 21 percent were same-day appointments. VA also reported that the average waiting time for primary care appointments was 4.7 days, 6.7 for specialty care, and 2.8 for mental health care. Although the number of veterans receiving care at VA and the total number of appointments have risen both inside VA and through non-VA community care programs, VA, VSOs, Congress, and independent experts are in agreement that it is time to reform the VA health system to ensure veterans receive high-quality, comprehensive, timely and veteran-focused health care.

VA'S HIGH PERFORMING NETWORK PLAN

As mandated by P.L. 114-41, VA developed and submitted a plan to Congress in September 2015 to consolidate non-VA community care programs, including the Choice Program. VA's plan called for creating a "high-performing network" comprising both VA and community providers to create seamless health care access for enrolled veterans. In building its network, VA proposed first relying on the most cost-effective, compatible, and highest-quality community partners (particularly the Department of Defense [DOD], the Indian Health Service [IHS], and other federal health systems), then university hospitals that have existing academic affiliations with VA, and then the best of private providers. Under its plan, VA would serve as the coordinator and guarantor of care for veterans to ensure that no veteran falls through the cracks. Most enrolled veterans would get most of their care directly from VA, with network partners filling in gaps in access to care whenever and wherever they may exist.

Throughout 2016, VA further developed its plan and began taking actions under its existing authority to move forward with its Community Care Consolidation Plan. Throughout this process, VA has consulted with the IBVSOs and other stakeholders, and that collaboration remains critical to the success of this and other VA reforms. Among the most challenging questions yet to be resolved are how to build and operate the networks, how to coordinate the provision of care, and how to manage all the financial and logistical elements of working with private-sector providers. VA has already begun processes necessary to develop a formal request for proposal from qualified health care systems capable of providing and managing health care networks to provide the supplementary capacity VA requires to meet veterans' demand for care. However, until Congress takes certain legislative actions, including enacting new provider agreement authority with flexible payment authority to meet local market demands, VA's plan cannot be brought to fruition.

IB FRAMEWORK FOR VETERANS HEALTH CARE REFORM

Around the same time VA was developing its consolidation plan, the IBVSOs developed our own Framework for Veterans Health Care Reform based on a few core principles. First, we affirmed that our nation has a sacred obligation to make whole the men and women injured or made ill as a result of their military service to the United States—to, as President Abraham Lincoln famously said, "care for him who shall have borne the battle, and for his widow, and his orphan." Second, though there is much the private sector can contribute to honor this commitment, it is ultimately the responsibility of the federal government to ensure that veterans have proper access to the full array of benefits, services, and supports promised to them for their service. Third, America's veterans have earned and deserve high-quality, accessible, comprehensive, and veteran-focused health care designed to meet their unique circumstances and needs. Any health care system that does not meet these standards is not capable of providing veterans the care they require.

The IB Framework is based on these principles and builds on VA's existing strengths. It has many similarities to VA's Community Care Consolidation Plan, but it takes a more holistic approach by addressing barriers that were outside of the VA plan's limited scope. The IB's coauthors have leveraged historical expertise, extensive conversations with veterans around the country, and survey data to develop a new model of care centered on veteran perspectives and focused on the positives and negatives of the current VA health care delivery system. The IB's four-pronged Framework looks beyond the current organization and division between VA care and community care to create a seamless system that is best for veterans.

Restructure the Veterans Health Care Delivery System

The IB Framework calls for optimizing the strengths and capabilities of the VA health care system and supplementing it with other public and private health care providers to create veterans community integrated health care networks. VA would be responsible for organizing the networks and coordinating care and would remain the principal provider of care for veterans. Similar to VA's Community Consolidation plan, the IB Framework would utilize network providers as an extension of VA care to fill access gaps whenever and wherever they may occur.

The design and development of integrated networks should be locally driven and nationally guided and must begin with and continue to have regular, open, and active engagement of veterans stakeholders to ensure that the networks are and remain focused on veterans' needs and preferences. Further, VA must continually monitor and optimize local integrated community networks—particularly the allocation of funding for VA and community providers and the determination of location, capabilities, and capacity of VA health care facilities—in order to meet changing demographic patterns and accommodate veterans' preferences. Implementation of these local networks should be carefully coordinated and phased to ensure that care provided to veterans through any existing community care programs and providers is not disrupted. VA should regularly report to Congress on negative impacts on veterans, how to mitigate those impacts, and suggest recommendations for the continuation of existing non-VA care programs.

Under the IB plan, most veterans would continue to receive most of their VA-provided care directly from VA doctors and clinical staff; network providers would be utilized to ensure timely access to convenient care when VA is unable to meet the demand or it is in the best interest of the veteran. In order to ensure that veterans who rely on VA for most or all of their care can continue to use VA as they desire—whether due to their highly specialized needs or personal preference—VA must have the ability to manage the work flow within the networks. VA must have a critical mass of veteran patients in its health care facilities to maintain both the quality of care and the cost-efficiency of delivering that care. Absent a critical mass, some number of VA facilities would be forced to eliminate some services or programs or might be forced to close or consolidate with other facilities, thereby reducing more convenient access for some veterans. In particular, VA's world-class specialty care programs—including its spinal cord injury/disease (SCI/D) system of care, visual impairment rehabilitation program, polytrauma system of care, as well as treatment for burn care, amputations, prosthetics services, and post-deployment mental health care, which are largely unavailable outside of the VA system—rely on robust, full-service VA health care facilities.

Furthermore, VA must maintain a critical mass to fulfill the other three missions of the VA health care system: to provide education and training of medical professionals, biomedical research to support clinical care, and backup support for the federal government during national emergencies. The loss of any of these missions would be significant not just for veterans, but also for the entire nation. The VA health care system must also have sufficient capacity and capabilities to continue fulfilling its obligations to the Veterans Benefits Administration (VBA), the National Cemetery Administration (NCA), and other federal agencies and programs that work collaboratively to serve veterans.

VA must continually monitor and optimize the utilization of local community networks so that changes in demand, capacity, and capabilities result in appropriate adjustment of network funding allocation between VA and community providers, as well as in determination of the location and capacity of VA health care facilities. VA must continually engage directly with veterans and VSOs to determine their preferences for receiving care because utilization data is artificially skewed by current capacity and access constraints.

The IB Framework also calls for establishing a Veterans Managed Community Care program to ensure that rural and remote veterans have an option to receive veteran-centric and coordinated care wherever they live. Veterans whose homes are far from VA health care facilities, and often far from any health care providers, have special access challenges that will require more focus and flexibility to account for local circumstances. To accomplish this will require strengthening the Office of Rural Health, establishing a higher-level care coordination program that includes case management, allowing greater flexibility in terms of contracting and payment for community providers and allowing community partners to practice across state lines using federal preemption. VA must also continue to expand its telehealth and web-based health care services that not only increase access for rural and remote veterans, but also for any veteran who does not always have timely or convenient access to health care.

Redesign the Systems and Procedures That Facilitate Access to Health Care

Under the IB Framework, access to care, including decisions about access to community network providers, would be based on clinical determinations and veteran preferences, rather than based on arbitrary time (30 days) or distance (40 miles) standards. All enrolled veterans would be designated a primary care provider after consideration of their needs and desires, with VA-employed providers designated whenever reasonable. When veterans require specialized care, their primary care providers—including non-VA primary care providers in the local network—would refer them to specialty care providers within the network, again utilizing VA providers first whenever reasonable.

Veterans must be able to request reconsideration of either their designated primary care provider or specialty provider and should be accommodated whenever reasonable, based on medical need, accessibility, availability, preference, or other appropriate factors. When veterans are unsatisfied with their providers or treatment options, there must be a review process providing rapid reconsideration, as well as a more formal clinical review process than what exists today.

Veterans should expect to have the same experience when accessing care through either a VA provider or a community network provider, including the same methods for scheduling appointments, making copayments, and submitting other health insurance information. The MyVA initiative will be critical to achieving this uniform experience in the future VA health care system.

The IB Framework also calls for adding urgent care services to the standard medical benefits package to help fill the gap between routine primary care and emergency care and reduce reliance on more costly emergency room care for non-life-threatening issues. The addition of urgent care services will also alleviate some of demand on VA's primary care providers. VA must increase its capacity to deliver urgent care at existing VA medical facilities and create additional capacity through private-sector urgent care clinics around the country to create new options between emergency care and primary care. In addition, to strengthen and clarify how VA offers emergency care services for enrolled veterans, Congress must provide sufficient funding and oversight, and VA must issue interim final rules for the VA emergency care benefit.

Realign the Provision and Allocation of VA's Resources to Reflect Its Mission

As noted above, unless there are sufficient resources provided to the VA health care system on a consistent basis, no reforms, including the IB Framework, will be successful in the long run. Next month, the IBVSOs will issue specific budgetary recommendations necessary to adequately support VA's for VA medical care programs and its capital and information technology (IT) infrastructure requirements. In addition to fully funding VA health care, Congress must ensure VA has the clinical and business capabilities to create and maintain a high-performing health care system, to include interoperable electronic health records and tools for effective and efficient scheduling, billing, and claims payment, and patient-centered navigational tools to help veterans access various health care benefits and services.

In order to make more efficient use of whatever resources are provided by Congress, the IB Framework calls for expanding public-private partnerships and considering shared-use facilities with other federal, state, local, and community resources. VA must be required to engage community leaders to develop broader sharing agreements so it can plan infrastructure in a way that allows communities to share resources and invest in services the community lacks.

The IB Framework also calls for reforming the congressional appropriations process to ensure VA has the resources it needs and the flexibility to allocate them to provide the health care and services veterans demand, without unnecessary appropriations restrictions. For example, VA is currently precluded from using Choice Program funds to reimburse community providers engaged under the Patient-Centered Community Care (PC3) program and vice versa, even though both programs are intended to meet the same need. VA is also prohibited

from moving funding from community care accounts to increase VA's internal capacity, even if veterans' health care utilization patterns show increasing demand for care in VA facilities. Congress should work with VA to develop and approve legislation to ensure that the undersecretary for health has the authority to allocate funding for the medical care of veterans wherever it is needed throughout the fiscal year.

Further, to ensure that VA's resources are sufficient and properly aligned to fulfill its mission, the IB Framework calls for the establishment of a QVR process, similar to the Quadrennial Defense Review (QDR) performed every four years by the Department of Defense (DOD). A QVR would help VA to align its strategic mission with its budgets and operational plans and help provide continuity of planning across future administrations. VA should also develop a Future-Years Veterans Program (FYVP) detailing five years' of projected spending, as well as fully implement its Planning, Programming, Budgeting and Execution (PPBE) system to better ensure that funding is effectively used for its designated purposes.

Reform VA's Culture with Transparency and Accountability

In order to help change and engrain a new culture of transparency and accountability, the IB Framework calls for establishing a biennial independent audit of VA's finances to identify accounts and programs that are susceptible to waste, fraud, and abuse. The audit would also examine the development of VA's budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and the subsequent appropriations, including advance appropriations, in meeting requirements based on veterans' needs.

In addition, the IB Framework calls for strengthening VA's Veterans Experience Office by combining its capabilities with VA's patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring that the health care protections afforded under title 38 of the United States Code (USC), a veteran's right to seek redress through clinical appeals, claims under title 38, USC, section 1151, and the Federal Tort Claims Act, and the right to free representation by accredited VSOs are fully applied and complied with by all providers participating in the VA-community networks, including both private and public health care entities.

The IB Framework was presented in testimony to both the House and Senate Committees on Veterans' Affairs during the 114th Congress and has received strong support from many other veterans and military service organizations.

COMMISSION ON CARE

In September 2016, the congressionally mandated and independent Commission on Care reported its recommendations to the Secretary of Veterans Affairs and to Congress. The commission had spent the prior year reviewing the findings of the independent assessment, engaging with stakeholders and other outside experts and developing its recommendations to improve the VA health care system for veterans. The commission examined a wide range of ideas and options, including the IB Framework and VA's Community Care Consolidation Plan. It also considered proposals to privatize or dismantle the VA health care system over the next two decades, but ultimately it rejected such radical ideas, instead reaching an overwhelming consensus on a series of recommendations to strengthen and reform the VA health care system.

The IBVSOs agreed with the majority of the commission's recommendations, including its primary one calling for establishment of "high-performing, integrated community-based health care networks." Similar to the VA and IB plans, the recommendation maintains VA as the coordinator and primary provider of care and views the use of community providers and choice as a limited means to expand access in circumstances in which VA is unable to meet local demand for care.

However, the IBVSOs do not support one aspect of the commission's recommendation—specifically, allowing veterans to choose any primary or specialty care provider in the network even when VA is able to provide the requested care in a timely fashion. This open-choice option would result in fragmented care, worsen health outcomes, lower the overall quality of care, and result in significantly higher costs that could ultimately endanger the overall VA system of care that millions of veterans rely on, particularly veterans who were injured or made ill during military service.

As the commission's report states, “veterans who receive health care exclusively through VHA generally receive well-coordinated care . . . [whereas] . . . fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.” While veterans' individual circumstances and personal preferences must be taken into consideration, decisions about access must first and foremost be based on clinical consideration, rather than on arbitrary distances or waiting times. However, in order to ensure consistently reliable access as well as high-quality care for enrolled veterans, VA must retain the ability to coordinate and manage the networks. As the commission's report states, “well-managed, narrow networks can maximize clinical quality,” while “achieving high quality and cost effectiveness may constrain consumer choice.”

Furthermore, the commission's recommended option to allow every individual veteran to determine which VA or non-VA providers in the network they would use could affect access for other veterans and would lead to increased costs. The commission itself recognized the likelihood of higher costs for networks under its recommended option, cautioning that VA “must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources.” In fact, the commission's economists estimate that the recommended option could increase VA spending by at least \$5 billion in the first full year and that it could be as high as \$35 billion per year without strong management control of the network. The commission also considered a more expanded choice option to allow veterans the ability to choose any VA or non-VA provider without requiring it to be part of a VA network. Economists estimated such a plan could cost up to \$2 trillion more than baseline projections over just the first 10 years.

While we agree that the VA health care system must evolve by integrating community providers into networks, VA must retain the ability to coordinate care and manage workload within the networks. In general, the networks must have the ability to expand to include community providers if veterans face access challenges or VA is unable to provide sufficiently high-quality care. However, the size, scope, and design of local networks, as well as clinical work flow, must be directed by VA based on a predictive demand-capacity analysis and veterans' preferences in each market to assure quality and adequate access to care. It is essential for VA to be able to maintain the critical mass of veteran patients necessary to sustain its specialized care programs, which in turn rely on VA health care systems offering a full continuum of care to its patients.

The IBVSOs also strongly disagreed with the commission's recommendation to eliminate the VA secretary's control of the VA health care system and give it to an unelected, independent board of directors that would be less accountable to the president, Congress, veterans, and the American people. Separating veterans' health care services from other veterans' benefits and services would result in less comprehensive and coordinated support for veterans, particularly those injured or ill from their service. Inserting another layer of bureaucracy between veterans and the VA health care system would create more problems than solutions. We appreciate the commission's interest in recommending greater stability and continuity of leadership; however, we believe better means are available to accomplish these goals without undercutting VA's uniquely integrated system of services and benefits.

As discussed above, the IBVSOs believe that the establishment of strategic planning mechanisms such as a QVR, an FYVP, and a PPBE system could provide VA stability and continuity in a more practical, effective, and feasible manner than trying to establish a semi-independent governance board.

In addition, the IBVSOs believe that consideration should be given to extending or overlapping the terms of the undersecretary for health and other senior VA leaders beyond presidential elections to provide additional stability and continuity and to further insulate them from political influence.

A NEW CONSENSUS ON VETERANS HEALTH CARE REFORM

After two years of spirited debate about the future of veterans' health care, the IBVSOs believe there is a new and growing consensus on how to strengthen, reform, and sustain the VA health care system. Despite beginning from vastly different perspectives, the IBVSOs, other veterans' leaders, the VA, bipartisan leaders in Congress, and most recently the independent Commission on Care are all in agreement on the key to fixing the access problem and ending long waiting times, while maintaining a high-quality, comprehensive, and veteran-focused health care system. All are proposing the same basic policy solution: create local integrated health care networks that combine the strength of the VA system with the best of community care, whenever and wherever gaps in coverage exist.

There is still more work to be done to flesh out all of the necessary details to move in this new policy direction, and there must be significant new investment to provide the IT systems and capital infrastructure necessary to build and operate the networks. But after more than two years of debate, there is finally agreement about how to best meet the health care needs of veterans today and over the next 20 years. It is imperative that the 115th Congress quickly move forward from debating to creating the future VA health care system veterans deserve.



Resolve Budget Constraints that Negatively Impact Veterans Programs

RECOMMENDATIONS:

Congress must end sequestration.

The congressional appropriations process must be reformed to ensure VA has the resources it needs to provide veterans timely access to high-quality health care.

VA must establish a QVR process.

Congress must establish a biennial independent audit of VA's budgetary accounts.

BACKGROUND AND JUSTIFICATION:

The Budget Control Act of 2011 set arbitrary budget caps to reduce the federal budget's discretionary spending by \$1.2 trillion over nine years—equally divided between defense and nondefense programs. The federal budget would be further reduced by 10 percent across-the-board cut, if federal agencies exceed these budget caps. Since the budget caps were established in 2010 and were not based on actual or projected needs for affected agencies, they no longer reflect the realities of demand on federal programs.

As a result, these arbitrary budget caps have significantly limited VA's ability to carry out programs that have seen spikes in demand, such as the program of comprehensive assistance for family caregivers, hepatitis C treatment, and overall outpatient care. Sequestration has a significant impact on our nation's ability to fulfill its promise to the brave men and women who have worn her uniform. Despite nearly universal congressional opposition to such haphazard budgeting, Congress has opted to simply renegotiate outdated budget caps instead of ending sequestration.

This leaves VA with a misalignment between the resources it is given and the demand on its programs. In fact, the CMS Alliance to Modernize Healthcare emphasized in its report *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* that VA's ability to meet its promise to veterans is limited by the resources it receives from Congress and that VA would need increases over the next five years to meet expected demand.

The potential impact of this misalignment was seen in fiscal year (FY) 2015 when VA's medical services appropriations account was funded at nearly \$2.0 billion short of the IB's FY 2015 recommendations. Less than six months after receiving its FY 2015 appropriations, VA reported a \$2.6 billion budget shortfall in its medical services accounts that would have forced the department to shutter VA medical facilities if Congress were unable to provide additional funds. Fortunately, VA was authorized to use the non-budgetary account to offset the shortfall. However, that account is set to expire by the end of FY 2017, and more budget shortfalls are likely in the future.

In fact, VA faces a potential funding crisis by the end of FY 2017 and into FY 2018. With the Choice Program set to expire in August 2017 and its funding possibly running out before then, VA will have to address the new community care demand it has fostered without necessary resources. Moreover, the FY 2018 advance appropriations levels recommended by the administration and approved by Congress are woefully inadequate to meet the ever-increasing demand for services both inside and outside the VA health care system. VA admitted to underestimating the advance appropriations request in February 2016, insisting that the next administration would have to adjust for that fact. And yet Congress knowingly provided insufficient funding—projected to be anywhere between \$5 billion and \$12 billion short. If this problem is not addressed immediately, VA faces an access and service delivery problem the likes of which it has never encountered.

That is why the IBVSOs agree with the independent assessment's finding that the congressional appropriations process does not provide VA the flexibility it requires to meet the demands on its health care system. While the IB was at the forefront of efforts to enact advance appropriations to relieve the pressures of a broken appropriations process on the VA health care system, we believe that consideration should be given to new proposals that might optimize the funding process.

To ensure VA's budget requests are accurate and properly aligned with the health care needs of the veterans population, the IBVSOs believe it is also important to reform VA's current planning methodology, budget forecasting, and resource allocation systems to align them with veterans' changing demographic and health care needs. Similar to DOD's QDR, VA would benefit from a QVR which would serve as the benchmark for the future-year veterans programs and take a long view of the prospective resource needs based on demand for health on the entire VA health care system.

While ensuring VA has the resources it needs to meet demand is important, it is also critical that VA continue to serve as a good steward of federal resources used to provide timely, quality care to veterans. To support this point, the IBVSOs believe an independent audit of VA's budgetary accounts could identify line items and programs that are susceptible to waste, fraud, and abuse. Such an audit could also examine the development of the budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and subsequent appropriations, including advance appropriations.

Reform the Claims and Appeals Process

RECOMENDATIONS:

Comprehensive legislation to modernize, streamline, and reform the benefit claims' appeals process that was developed and agreed to in 2016 by senior leaders of VA, the Board of Veterans' Appeals, VSOs, and other stakeholders must be enacted, fully funded, faithfully implemented, and aggressively monitored to ensure it achieves its intended purposes while fully protecting veterans rights.

Congress should enact legislation requiring VA to provide due deference to private medical evidence that is competent, credible, probative, and otherwise adequate for rating purposes. VA should be required to fully consider completed Disability Benefit Questionnaires (DBQs) from private health care professionals and to fully consider medical opinions from private health care professionals when those opinions are competent, credible, and probative to the issue at question.

Congress should enact legislation to effectively eliminate unnecessary evidentiary burdens, such as those contained within title 38, USC, section 5108, "new and material evidence," and reject similar proposals such as "new and relevant evidence."

Congress must carefully and continually oversee VA's IT initiatives to ensure that quality, accuracy, and timeliness of claims and appeals processing remain top priorities when considering workload management. VA's claims and appeals processing IT infrastructure must be planned, developed, resourced, implemented, and integrated properly to keep pace with current processing demands and those occurring when work processes and priorities change.

IT systems such as the Veterans Benefits Management System (VBMS), the National Work Queue (NWQ), and the Stakeholders Enterprise Portal (SEP) must have efficient interoperability. Seamless electronic transmission of compensation, pension examinations, DOD service treatment records DOD, other government agencies, and private businesses and organizations throughout all VA systems is vital to efficient claims and appeals processing.

"IT systems such as the Veterans Benefits Management System (VBMS), the National Work Queue (NWQ), and the Stakeholders Enterprise Portal (SEP) must have efficient interoperability. Compensation and pension examinations and records from the DOD, private businesses and other government agencies must flow seamlessly in this electronic environment."

VA must ensure these IT systems have features built in to capture information that can be used to improve quality, consistency, and accountability. Design, development, and implementation of these systems must provide stakeholders with adequate information, access, and functionality needed to properly serve those we represent.

Introduction

In July 2012, VBA was facing a significant backlog of claims for disability compensation. At that time there were 883,930 claims pending, and the inventory was growing. It seemed as if there was no solution. In response to this crisis, VBA set out to transform and modernize its systems and procedures for processing veterans' claims for benefits.

VBA created and implemented a new claims-processing organizational model for its VA regional offices (VAROs), developed and then rolled out a new Fully Developed Claims process to speed simpler claims, and collaborated with VSOs to create new standardized medical evidence forms, called DBQs, to streamline the

rating process. VBA also designed, tested, deployed, and now operates essential IT systems, including VBMS, SEP, and e-Benefits, which together have revolutionized the electronic filing and processing of claims. VBMS associated with veterans' new e-folders facilitates simultaneous review by all VBA offices, 168 VA medical centers (VAMCs), and VSOs who represent veterans. VBA now processes nearly all claims electronically and receives nearly half of their compensation claims as Fully Developed Claims (FDCs).

At the end of 2016, just over four years from VBA's peak disability claims inventory, it has managed to drive down the number of claims pending to 379,000; 74,500 pending claims (or roughly 20 percent) are considered backlogged, meaning they have been pending longer than 125 days. VBA continues to process claims in record numbers each year. It completed over one million claims in 2014 and 2015, and in 2016 processed more claims than the preceding two years. This is a significant achievement accomplished through a blend of people, technology, resource-specific allocation, and mandatory overtime.

These accomplishments are in fact deserving of praise, but much more work lies ahead for VBA, Congress, and stakeholders. The resources available to VBA today must be maintained and enhanced, and they must evolve to ensure veterans receive accurate, fair, and timely decisions without compromising the non-adversarial, pro-veteran, and due-process safeguards of the system that benefits veterans today.

Disability compensation claim processing is only one facet of VBA's responsibilities. While VBA was driving down claims in the ratings inventory, its appeals inventory and non-disability ratings inventory were steadily rising. At the end of 2016, there were over 460,000 appeals pending at various stages. Within VBA alone, there were close to 380,000 appeals pending action. The remaining 80,000 appeals are pending action by the Board of Veterans' Appeals (the Board).

The appeals backlog is of significant concern to the IBVSOs. These injured and ill veterans, their dependents, and their survivors are waiting upward of three years for decisions on their appeals. Without significant reform, proper resources, and planning in the 115th Congress, the time it takes to get a decision on an appeal will simply get longer and longer.

These delays are unacceptable. Congress must enact legislation and provide VBA with the resources needed to process all claims and appeals timely and accurately.

Legislation to Reform the Claims and Appeals Process

The current backlog, dysfunction, and resource needs for the appeals process the major impetuses for urgent fundamental reform. Much of the dysfunction within the appeals process relates directly to inadequate resources to efficiently process both claims and appeals simultaneously. VBA's overall demands simply outpaced their capacity.

Despite past failed attempts to modernize its claims-processing systems over the past two decades, VBA made a critical decision to transform its paper-based systems and replace it with modern IT systems and business processes. During this transformation and modernization initiative, then VA Secretary Eric Shinseki announced ambitious aspirational goals for transforming the claims system, promising that by 2015, VBA would decide all claims for disability compensation within 125 days and decisions would be completed with 98 percent accuracy. At the conclusion of FY 2016, VBA reported that disability claims processing averaged 123 days at 95 percent accuracy.

This production and quality goal has continued to guide VBA, but it may need to reexamine its goals and aspirations that focus more on timeliness of appeals and non-disability claims, accountability, the overall claimant experience, and continued emphasis on quality. To truly fix its claims and appeals processing systems, VBA must foster a work culture focused on these facets. Establishing arbitrary and artificial metrics such as the one in place currently can lead to unintended consequences such as backlogs in other critically important areas.

There must also be a partnership with stakeholders when considering goals and objectives. VSO stakeholders have intimate familiarity with VA's myriad benefits and services and have gained tremendous experience and knowledge through decades of providing representation to veterans, their dependents, and their survivors.

Much of VBA's efforts and energy over the years were keenly focused on driving down the disability claims backlog. To its credit, it has managed to drive down and manage the disability compensation claims inventory, also known as the ratings inventory. Its ability to bring down the claims backlog is attributable to increased staffing, enhancements to its IT systems, implementation of mandatory overtime, the FDC program, and reassignment of appeal processing personnel to work on claims.

But with its attention fixated on the claims backlog, appeals became a peripheral matter for VBA. Appeal-processing personnel were often tasked to work claims in an all-out effort to reduce the claims backlog. This included re-tasking staff to work claims during mandatory overtime.

This illustrates VBA's reliance on people to do the work. As a consequence of shifting its workforce around to address disability rating claims, the appeals inventory and non-rating claims inventory rose steadily and are nearing a crisis point.

For the past several years, VBA has issued over one million rating decisions. At the end of FY 2015, it completed 1.4 million claims; at the end of FY 2016, it completed 1.3 million claims. On average, VBA can expect to receive 10 percent of those decided claims as appeals. Therefore, VBA can expect to receive about 130,000 appeals, based on claims work decided for FY 2016.

The Appeals Backlog

At the end of 2016, there were over 460,000 appeals pending at various stages. Within VBA alone, there were close to 380,000 appeals pending action. The remaining 80,000 appeals are pending action by the Board.

Appellants face significant delays when they choose to appeal a decision made by VBA. For appellants seeking further review of their decisions before the Board, they can expect to wait upward of three years for a decision on their appeal. Of the 130,000 appeals expected to enter the system about 65,000, or half, will continue to the Board. This is 5 percent of the total number of claims filed.

Despite its best efforts, the Board has been unable to keep pace with incoming appeals. It has been decades since the Board has managed to achieve a zero-sum year where its output matched the number of appeals received, because many appeals require supplemental processing. Therefore, its work continues to mount.

In FY 2015, the Board managed to issue 55,713 decisions with roughly 647 full-time employees (FTEs). In order for the Board to address its current appeals inventory and what it expects to receive, the administration requested funding for an additional 242 FTEs, which Congress approved for FY 2017.

The 2017 FY budget submission also projected the appeals inventory could top one million if the status quo is maintained without fundamental reform legislation. The delay associated with resolving an appeal is unreasonable and unacceptable. If comprehensive claims and appeals reform is not accomplished soon, appellants will endure even longer wait times for resolution of their appeals.

Legislative Reform Efforts

It is critically important that, when VA begins to implement reforms and plans to address the current backlog of appeals, strong protections in place today (such as duty-to-assist requirements, due-process rights, and the non-adversarial construct of the system) are not compromised by being forced into the new system for the sake of simply reducing the overall number of unresolved appeals. Congress and stakeholders must ensure

that reforms to the claims and appeals process keep the veterans' best interests at the forefront of any decision, never compromising the veteran-centric spirit that is an integral component of VA's sacred mission.

In the 114th Congress, significant claims and appeals-reform legislation was introduced. The legislative language contained within H.R. 5083, H.R. 5620, and S. 3328 reflected significant efforts of a working group formed in March 2016 that consisted of the IBVSOs, other VSO stakeholders, and leaders within VBA and the Board.

The original task before the working group was to solve the appeals dilemma, but the working group quickly realized the intrinsic nature of the claims process and how it affects the appeals process; these two facets are in fact symbiotic. Therefore, the working group determined that an effective fix would also have to consider additional changes to the claims process. Of note, support for current reform efforts appears strongest among the IBVSOs and other VSO stakeholders that regularly provide substantial and direct services to claimants and appellants.

A New Framework for Veterans' Claims and Appeals

The working group agreed that decision notification letters must be clear, easy to understand, and easy to navigate. Notice letters must convey not only VA's rationale for reaching its determination, but also the options available to claimants after receipt of the decision. The legislation required that in addition to an explanation for how veterans can have the decision reviewed or appealed, all decision-notification letters must contain the following information to help them in determining whether, when, where, and how to appeal an adverse decision:

- a list of the issues adjudicated
- a summary of the evidence considered
- a summary of applicable laws and regulations
- identification of findings favorable to the claimant
- identification of elements that were not satisfied leading to the denial
- an explanation of how to obtain or access evidence used in making the decision
- if applicable, identification of the criteria that must be satisfied to grant service connection or the next higher level of compensation for the benefit sought

Understanding the benefits and weaknesses of the current system, the working group developed a new framework that would protect the due-process rights of veterans while creating multiple options to receive favorable decisions more quickly. A critical factor was developing a system that would allow veterans to protect their earliest effective dates while allowing them opportunities to introduce new evidence without having to be locked into the long and arduous formal appeals process at the Board. In general, the framework provided three main options for veterans who disagree with their claims decision and want to seek redress of VBA's determination. Veterans would have to elect one of these three options within one year of a claims decision.

First, there would be an option for readjudication and supplemental claims when there is new evidence submitted or a hearing requested. Second, there would be an option for a local, higher-level review of the original claims decision based on the same evidence at the time of the decision. Third, there would be an option to pursue a formal appeal to the Board—with or without new evidence or a hearing.

The central dynamic of this new system was that a veteran who received an unfavorable decision from one of these three main options could then pursue one of the other two appeals options. As long as the veteran continuously pursues a new appeals option within one year of the last decision, he or she would be able to preserve his or her earliest effective date, if the facts so warrant. Each of these options, or "lanes" as some call them, have different advantages that allow veterans to elect what they and their representatives believe will provide the quickest and most accurate decision on their appeal.

For the first option—readjudication and supplemental claims—veterans would be able to request a hearing and submit new evidence that would be considered in the first instance at the VARO. VA’s full “duty to assist” would apply during readjudication, to include development of both public and private evidence. The readjudication would be a *de novo* review of all the evidence submitted both prior to and subsequent to the claims decisions until the readjudication decision was issued. If the veteran was not satisfied with the new decision, he or she could then elect one of the other two options to continue pursuing his or her appeal.

For the second option—the higher-level review—the veteran could choose to have the review done at the same local VARO that made the claim decision or at another VARO, which would be facilitated by VBA’s electronic claims files and the NWQ’s ability to instantly distribute work to any VARO. The veteran would not have the option to introduce any new evidence or have a hearing with the higher-level reviewer, although VBA indicated it would allow veterans’ representatives to have informal conferences with the reviewer in order for them to point out errors of fact or law. The review and decision would be *de novo*, and a simple difference of opinion by the higher-level reviewer would be enough to overturn the original decision. If the veteran was not satisfied with the new decision, he or she could then elect one of the other two options to pursue resolution of his or her issue.

For the third option—Board review—there would be two separate dockets for veterans to choose from: an “expedited review” that would allow no hearings and no new evidence to be introduced and a more traditional appeal that would allow both new evidence and hearings. Both of these Board lanes would have no duty-to-assist obligation to develop any evidence submitted. For both of these dockets, the appeal would be routed directly to the Board. Statement of the Cases, Supplemental Statement of the Cases and VA Form 9’s would no longer be required.

The working group established a goal of having “expedited review” appeals resolved within one year, but there was no similar goal for the more traditional appeals docket. While eliminating introduction of evidence and hearings would naturally make the Board’s review quicker, it is important that sufficient resources be allocated to the traditional appeal lane at the Board to ensure a sense of equity between the two dockets. Legislative language should be added to ensure the Board does not inequitably allocate resources to the expedited review lane.

For the traditional Board appeal lane, veterans could choose either a video conference hearing or an in-person hearing at the Board’s offices in Washington, DC; there would no longer be travel hearing options offered to veterans. New evidence would be allowed but limited to specific time frames: if a hearing is elected, new evidence could be submitted at the hearing or for 90 days following the hearing; if no hearing is elected, new evidence could be submitted with the filing of the Notice of Disagreement (NOD) or for 90 days thereafter. If veterans are not satisfied with the Board’s decision, they could elect one of the other two VBA lane options, and if they file within one year of the Board’s decision, they would continue to preserve their earliest effective date. The new framework would impose no limits on the number of times veterans could choose one of these three options, and as long as they properly elected a new one within a year of the prior decision, they would continue to protect their earliest effective date.

If the Board discovered a duty-to-assist error occurred prior to the original claim decision, the Board would (unless the claim can be granted in full) remand the case back to VBA for it to correct the errors and readjudicate the claim. Again, if the veteran was not satisfied with the new VBA claim decision, he or she could choose from one of the three options available, and as long as the election is properly made within one year of the decision, the earliest effective date would continue to be preserved.

One additional option becomes available after a Board decision: the appellant would also have the opportunity to file a Notice of Appeal to the Court of Appeals for Veterans Claims (the Court) within 120 days of the Board’s decision, which is the current practice today. Decisions of the Court would be final. The legislation also included an amendment to title 38, USCUSC, section 5104A, to require that any finding made during the claims or appeals process that is favorable to the claimant would be binding on all subsequent

adjudicators within the department, unless clear and convincing evidence is shown to the contrary to rebut such favorable finding. In the new structure in which appeals can move back and forth from the Board to VBA, veterans must be reassured that favorable findings cannot be easily overturned by a different adjudicator or reviewer during this process. The IBVSOs also found this provision to be beneficial to claimants.

Overall, the new framework embodied within those bills could provide veterans with multiple options and paths to resolve their issues more quickly, while preserving their earliest effective dates to receive their full entitlement to benefits. The structure would allow veterans quicker “closed record” reviews at both VBA and the Board, but if they become aware that additional evidence was needed to satisfy their claim, they would retain the right to next seek introduction of new evidence or a hearing at either VBA or the Board. If implemented and administered as envisioned by the working group, the new claims- and appeals-processing system could be more flexible and responsive to the unique circumstances of each veteran’s claim and appeal, leading to better outcomes for many veterans.

Remaining Issues and Questions Related to Appeals-Reform Legislation

Notwithstanding broad support for the new claims- and appeals-processing system and accompanying legislation, there is a uniform concern regarding the current appeals inventory, appeal equitability, planning, and implementation. Due to the complexity of the system and the scope of the changes proposed, some stakeholders are naturally cautious about such sweeping claims and appeals reforms. Transition to a new processing system will require adjudicating new appeals differently than those filed before the change in law.

The IBVSOs continue to work with Congress, the Board, and VBA to resolve and clarify a number of issues, further improving the proposed new appeals structure. There are still some critical issues that need to be further explored to ensure there are no unintended negative consequences for veterans.

One of the most critical questions is how the introduction of new evidence will be treated by VBA and the Board and how duty-to-assist requirements will apply. For the higher-level review, no new evidence is allowed; however, there is an informal opportunity for the veteran’s representative to attend a conference with the reviewer to point out errors. If during this conference the representative identifies evidence not yet submitted as part of the discussion, how will the higher-level reviewer acknowledge or treat this information? Will the claim be referred back to the readjudication option as a supplemental claim, indicating there is evidence that needs to be developed? Will the reviewer inform the representative or the veteran directly that if there is new evidence that may affect the decision, the veteran should file a supplemental claim for readjudication to present that evidence directly or through a hearing?

Similarly, there are questions that need to be answered about how the Board will handle new evidence introduced outside the limited opportunities allowed at and 90 days after the filing of a NOD or a Board hearing. What happens if a veteran elects the Board option with a hearing and submits new evidence to the Board prior to the hearing date? Will the Board hold the evidence until the hearing and then consider it, or will the Board return or ignore the evidence?

In addition, since there is no duty-to-assist requirement after the NOD filing, what if evidence properly submitted indicates that additional evidence exists that could affect the decision? Will the Board ignore that evidence or inform the veteran that there was additional evidence that could have changed the decision but that it was not sought nor considered? Will or should the Board remand the appeal back to VBA for readjudication to allow for full development of all evidence? In each of these circumstances, and others that may arise, VA places the greatest weight on providing veterans the maximum opportunity to support their appeals in order to receive favorable decisions, rather than seeking to limit the workload of its employees.

There are also two critical operational concerns that will affect whether the new appeals structure can be properly implemented as envisioned. First, the Board and VBA must develop and implement a realistic plan to address the almost 460,000 appeals currently pending, most of which are still within VBA’s jurisdiction.

Until these pending appeals are properly resolved, no new appeals structure or system can be expected to be successful. While we have been in discussion with VBA and the Board about how best to address these legacy appeals, we have yet to agree on formal plans to deal with its current backlog of appeals. We need Congress to perform aggressive oversight of this process to ensure a proper outcome.

Furthermore, since appeals that are filed today can take years to complete, some will last more than a decade. How will VBA and the Board operate two different appeals systems simultaneously, each with separate rules for treating evidence and the duty to assist? How will new employees be trained under both the old and new systems so that there is efficient administration of these two parallel appeals systems? How will the CAVCCAVC view the existence of two different standards for critical matters such as the duty to assist veterans? In order to address these and other concerns about implementation, VA must have the resources and time necessary to address the existing backlog of appeals and ensure a smooth transition to the new system.

Finally, as mentioned above, the most critical factor in the rise of the current backlog of pending appeals was the lack of sufficient resources to meet the workload. Similarly, unless VBA and the Board request and are provided adequate resources to meet staffing, infrastructure, and IT requirements, no new appeals reform will be successful in the long run. As VBA's productivity continues to increase, the volume of processed claims will also continue to rise, which has historically been steady at a rate of 10 to 11 percent of claims decisions. In addition, the new claims and appeals framework will likely increase the number of supplemental claims filed significantly. VA has indicated a need for greater resources for both VBA and the Board to make this new appeals system successful; however, too often in the past funding for new initiatives has waned over time.

The IBVSOs will not compromise any aspect the system's pro-veteran nature for the sake of simply achieving reform. The due-process protection and duty-to-assist rights currently afforded to veterans cannot be diminished. In order to protect these critical due-process rights, any uncertainties should be resolved through clear statutory language.

The close working relationship between VA, VSOs, and other stakeholders must continue throughout all stages of the planning and implementation process. It would be a fatal error if VA does not fully engage with its VSO stakeholder partners in the design and execution of any new or existing transformation initiatives. VSOs have tremendous experience and expertise in claims processing, and through our service programs the IBVSOs are active partners inside the VAROs.

Private Medical Evidence

VBA must have increased authority and flexibility to use and accept claimant-supplied DBQs and private medical evidence for rating purposes.

Currently, title 38, USC USC, section 5125, states in part that VA "may" accept medical examinations from private physicians provided by claimants for rating purposes without requiring further confirmation by a Compensation and Pension (C&P) medical examination if that evidence is sufficiently complete and adequate for rating purposes. But as the statute is written today, it simply gives VA the "option" to accept such evidence for rating purposes, rather than requiring it to issue rating decisions based on that information.

Providing VBA with expanded authority to issue rating decisions based on private medical evidence will improve overall decision timeliness and reduce demand on VBA resources when C&P examinations are requested unnecessarily.

Veterans typically submit three types of evidence from their private treating physician or other health care provider:

- treatment records detailing the initial complaints of a health issue, as well as testing, diagnosis, and treatment constitute valuable information that can be used to allow VA to grant service connection or increased evaluations for established service-connected disabilities
- DBQs are forms central to VA's disability evaluation process. DBQs capture very specific medical information that enables adjudicators to make benefit determinations regarding entitlement to service connection and disability ratings. Nearly all DBQs have been available to the public and can be completed by a veteran's private health care provider
- private nexus medical opinions can be used to support a diagnosis, establish etiology of a condition, or connect a present disability to an event in service. Many medical opinions are written by a veteran's treating physician (someone who can provide a long and detailed history of treatment) or by a specialist in the field of medicine encompassing the disability in question. These health care professionals often have specialized knowledge of the veteran's condition and a treatment history that is not available to a VA examiner conducting a onetime C&P examination. Further, many are experts in their field, offering decades of study and experience to support their opinions

Often VAROs and employees are reluctant to issue rating decisions based on private medical evidence supplied by veterans because VA C&P examinations tend to capture very specific information needed for reconciliation and application of VA's schedule for rating disabilities. However, VA should issue interim ratings based on private medical evidence and only request the appropriate C&P examination to close any evidentiary gaps when claimant-supplied medical evidence is not adequate for a complete and comprehensive rating.

Second, VA compensation, pension, and survivor benefit claims are eligible to be filed as FDCs. Use of private medical evidence for rating purposes is a major facet of VBA's FDC program, but enhancements can be made to improve this program. Today, over 50 percent of all claims are submitted as FDCs.

This program provides claimants with a sense of personal ownership as they gather and supply the evidence needed to support their claims. The FDC program continues to play a vital role in helping to keep down the claims inventory and backlog and is integral to providing timely and accurate benefit determinations. FDCs alleviate some aspects of VBA's duty-to-assist requirements that it would otherwise have to perform in conjunction with the adjudication of a claim.

Claim timeliness can be improved and resources can be saved when ratings based on private medical evidence are used, instead of C&P examinations. In order for the FDC program to grow and remain a viable claims-filing option, adjudicators must be encouraged and have broader discretion to make rating decisions based on claimant-supplied evidence. VBA must encourage its adjudicators to use competent and credible private medical evidence for rating purposes and only order VA C&P exams when necessary to close unresolved evidentiary gaps.

Third, over the past several years, the IBVSOs and VBA have collaborated to develop and deploy DBQs. These forms are used by private physicians, VAMCs, and DOD when performing exit exams. DBQs are designed to capture essential and specific information that correlates directly to VA's rating schedule disabilities. Rather than waiting for VBA to complete the C&P examination process, veterans can take these DBQs to their treating physicians for completion, then submit their claim as an FDC to expedite the claims-adjudication process. Veterans currently have access to 71 different DBQs.

The largest area of rework for claims processors tends to be a lack of data provided within a DBQ. Some claims in the FDC program with DBQs still require C&P examinations because some DBQs are deemed

inadequate for rating purposes if they are not filled out correctly or completely. VBA would then be required to order a C&P examination to obtain all the relevant information needed for rating purposes.

Supplemental requests for C&P examinations increase claims-processing times. Although some information may be missing from these DBQs, there may be enough information to issue an interim rating decision while VBA waits on the results from the C&P examination.

Many service-connected veterans rely solely on the Veterans Health Administration (VHA) for their care. When they file claims for disability compensation, it is only natural for them to seek assistance with a DBQ from their VA treating physician. This should be a simple process: either their VA treating physician can complete the DBQ, or veterans would be referred to VHA's C&P examination division to have the form completed.

Veterans in some states are simply unable to get DBQs completed by VHA personnel. Consequently, they are placed at a disadvantage if they want to file a claim under the FDC program. They cannot fully utilize the FDC program by supplying completed DBQs and are forced to go through the entire VBA C&P examination process. VA must facilitate DBQ completion within VHA when requested by veterans.

Providing a useful mechanism to give due consideration to claimant-supplied private medical evidence and DBQs for rating purposes would reduce VA's reliance on C&P examinations. Eliminating steps during the claims process would lead to more timely decisions and reduce the time VBA would have to spend performing evidentiary development functions. Greater acceptance of private medical evidence would also increase FDC fillings among claimants.

Finally, to encourage the submission of private medical evidence and DBQs from claimants, Congress should amend title 38, USC USC, 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 require a duplicative and redundant VA medical examination.

Unnecessary Evidentiary Burdens

Claimants are required to supply new and material evidence to reopen claims that have been finally decided. These finally decided claims tend to be those for initial benefit entitlement, such as claims to establish service connection. This evidentiary threshold exists to prevent VBA from reopening and readjudicating claims based on evidence considered in prior decisions but does not preclude claimants from filing claims.

This standard creates an unnecessary evidentiary burden that serves no practical effect other than to delay a claim from ultimately being reopened, because VBA must review all the evidence of record to determine whether the recent evidence is new *and* material. VBA is simply performing this two-part evidentiary test to determine whether to reopen a claim in light of all the evidence of record.

Second, title 38, USC USC, section 5108, provides no actual benefit since VA must review all the evidence of record in addition to the newly submitted evidence to determine whether it is both "new and material." This evidentiary requirement provides no practical benefit to VA or veterans. It simply generates unnecessary work for VBA and the Board and delays a final determination.

VA should simply be required to determine whether evidence received in conjunction with a claim changes a previous determination. VBA and the Board are still required to expend resources for these claims. They are required to review the evidence of record, issue decisions, conduct hearings upon a claimant's request, and perform other administrative functions if a claimant decides to appeal a finding that new and material evidence has not been submitted to reopen a claim. If the Board does find such evidence, the claim is reopened after a delay that could be up to three years and the expenditure of valuable resources.

The VBA will then have to perform another adjudication based on the evidence of record and the evidence deemed new and material by the Board. Rather than reducing VBA's workload by dissuading additional claims filings, the current statute has resulted in additional work for both VBA and the Board.

Finally, the evidentiary test should simply be to determine whether "new evidence" changes a previous decision. Congress attempted to address this very issue in the 114th Congress within H.R. 5083 and S. 3328 by changing the "new and material evidence" to a "new and relevant evidence" standard. This is essentially the same evidentiary test as adjudicators would then have to determine if evidence was relevant.

VA would expend the same amount of resources when claimants challenge a finding that evidence submitted was not "relevant." The IBVSOs believe that it is better for claimants and VA to simply perform a "new evidence" test and determine if that evidence is sufficient to change a previous decision.

While the current standard may have been intended to prevent the submission of redundant or irrelevant evidence, it does not effectively serve that purpose and should be repealed or amended.

Information Technologies

VBA has undergone significant IT transformation that enabled it to transition away from being an organization that completed most of its work in a paper-based environment to one where today most work is completed almost entirely electronically. VBA's initial focus was the creation and deployment of VBMS, an IT platform that would facilitate electronic processing of claims for disability compensation.

Appeal processing was not developed concurrently with VBMS. As it stands today, VBMS does not provide the full continuum of functionality from claim to appeals resolution. When a decision is appealed, the VBMS platform is not conducive to efficient appeals processing within VBA or the Board.

Much of VBA's focus, resources, and energy have been directed toward disability claims processing to reduce the backlog, and VBMS has helped achieve results. Undoubtedly, VBA's ability to process over one million claims consecutively over the past few years can be attributed in some part to VBMS, but its workforce also played an integral role in helping to achieve such a claims-processing milestone.

VBA relies heavily on this system to automate much of the adjudication process and improve work flow. Automation has also helped to improve the disability rating quality by mitigating some of the errors and inconsistencies intrinsic to the human element associated with claims processing.

VBMS also provides stakeholders with the ability to perform myriad functions related to claims submission, tracking, and rating reviews. This system does provide a greater level of access and functionality but is also constantly evolving, which requires updates and occasional fixes.

For the IBVSOs and other stakeholders, SEP is the pipeline that plugs directly into VBMS. This conduit enables stakeholders to submit claims and upload evidence directly into VBA's system, yet another feature to improve timeliness by further streamlining the adjudication of claims.

VBA has also migrated to a centralized mail-processing system. Paper documentation submitted by claimants is routed through VBA's claims intake center in Janesville, Wisconsin. These documents are sorted, labeled, and uploaded into a veteran's e-folder within VBMS. However, sometimes this evidence can be uploaded and labeled incorrectly. When this happens, stakeholders and VA adjudicators can overlook key evidence needed to perform proper and complete claims adjudications.

Inefficiencies within this process also require people to spend time sifting through electronically uploaded documents. Evidence labeling within VBMS must become more user friendly and improved to provide a greater level of clarity of all documents contained within the system.

The evidence-upload process must be improved to ensure that when paper documentation is sent in to VA, it is uploaded quickly and the documents being uploaded must be separate and distinguishable from one another.

Congress has provided VA with substantial resources over the past few years to develop, implement, and maintain its IT infrastructure. Since the inception of VBMS back in 2009, this program alone has received close to \$1 billion in funding. These resources were needed to create and maintain this electronic claims-processing system that made claims adjudication more efficient through automation, but additional resources will be required to keep pace with current and future workload demands.

Automated Decision Letters

Some aspects of automation must be used cautiously, such as the Automated Decision Letter (ADL) notification process. While ADLs can substantially reduce a VBA adjudicator's production time, ADLs also can significantly reduce an adjudicator's ability to thoroughly discuss elements of a claims decision that are needed for claimants to have a comprehensive understanding of the elements VBA used to arrive at a decision.

The format and content of ADLs can influence the number of appeals filed. As *The Independent Budget* has noted in recent years, current notification letters often insufficient information to enable claimants and/or their representatives to fully understand the rationale for the rating decisions or the evidence that was considered.

The IBSVOs believe that efficiencies gained through ADLs cannot override the requirement to provide claimants with a full and detailed account of the facts and evidence used to decide their claim. Without sufficient confidence in rating decisions, veterans and their advocates are more likely to pursue appeals options. VBA must continue to work with VSOs to improve claims-decision letters.

The Board and Appeals Processing

The Board in particular is trying to use the VBMS e-folder component to perform its work, but it processes appeals in an entirely different manner from VBA. The Board requires a greater level of functionality to properly adjudicate a record within VBMS that will enable it to sort, tab, and annotate evidence. This has led to appeals-processing inefficiencies that, in the end, simply lead to unnecessary delays for appellants seeking resolution of their appeals.

Congress recognized the significance of this issue and provided VA with \$19.1 million in FY 2016 funds to develop systems that can provide cross-sectional functionality. Fortunately, IT modernization efforts within VBA and the Board are currently under way.

The Board is planning to replace its current legacy appeals workload management system, the Veterans Appeals Control and Locator System (VACOLS). It is currently evaluating new technologies to determine the best platform that will enable veterans' law judges and attorney to break a VBMS record into different pieces for more efficient evidentiary review and appeals processing. However, any platform the Board finds best suited to its needs must facilitate the needs of VBA personnel and stakeholders involved in the claims and appeals process.

National Work Queue

During FY 2016, VBA deployed its NWQ system, another paperless workload-management initiative designed to improve the VBA claims-processing productive capacity. It builds on the work-flow and management capabilities provided through VBMS, allowing veterans' e-folders to be instantly accessible to any VARO and incorporated into the work queue of any VBA employee.

These e-folders contain personal information, data, and records required to perform claims adjudication. NWQ is intended to provide VBA with the ability to leverage all its resources by redistributing its workload to

all ROs based on various parameters such as the total pending workload and the number, experience, and type of employees working at each RO.

NWQ can also separate and allocate workload based on any parameters or priorities established by VBA. In effect, it acts as the nexus between VBA business processes and IT systems, playing the role of “traffic cop” for claims processing.

During the first phase of the NWQ deployment, the primary filter for determining where a veteran’s claim will be processed will be the veteran’s place of residence, as is the case under the current organizational model. However, if the veteran’s local VARO is under resourced or overburdened with work, NWQ will assign that claim to another RO, brokering it in a much more efficient, timely, and accountable manner. .

NWQ can provide VBA with significant technological capabilities to reorder and redistribute workload. It will also have the functionality to assign development of a claim to one RO but the rating work to a different RO if that referral results in a timelier decision. It could potentially divide claims by issue, assigning some of the development and rating work to multiple ROs, but the IBVSOs would have concerns about this practice. However, VBA has indicated it does not have plans to divide or separate claims in this manner.

VA’s IT infrastructure must be planned, developed, resourced, implemented, and integrated properly to keep pace with current processing demands and those occurring when work processes and priorities change. IT systems such as VBMS, NWQ, and SEP must have efficient interoperability with other government systems to facilitate seamless electronic transmission of information.

These systems must have the capability to capture information that can be used to enhance quality, consistency, and accountability. Stakeholders must be included in the design, development, and implementation of these systems to ensure there is adequate access and functionality to facilitate adequate client representation.

Summary

Sweeping claims and appeals-reform efforts would fail to achieve their intent if not planned, implemented, monitored, and resourced correctly.

For instance, relaxing evidentiary standards would simplify the process for veterans and VA adjudicators, but without adequate IT systems in place to properly manage the workload, the benefits gained from simplification would be minimized by continued deficiencies within the IT infrastructure. These critical issues are essential components to truly reform VA’s claims and appeals processes. They are all very much interrelated and have an impact on one another in some way.

But with a partnership between Congress, VA, and stakeholders all working together, from start to finish, we can ensure the reengineering of a system that adequately meets the needs of our ill and injured veterans, their dependents, and their survivors seeking timely, accurate, and fair decisions for benefits based on their service to our country.

Realign and Modernize Capital Infrastructure

RECOMMENDATIONS:

VA must begin requesting funding that will close all safety, condition, access, and utilization gaps and at the same time present a five- and 10-year plan that will systematically describe when and how VA plans to close each gap.

VA must submit a plant replacement value (PRV) for all VA-owned property and calculate its baseline and each facility's nonrecurring maintenance (NRM) funding request from that value.

Congress must fund a 10-year comprehensive facility master plan.

Congress must pass legislation to allow VA to enter into public-private partnerships when proposing major construction projects and alternative means to closing access and utilization gaps.

NRM funding calculations should be removed from the VERA model.

VA must submit an annual report to Congress on the results of the SCIP process, subsequent capital planning efforts, and details on the costs of future projects.

BACKGROUND AND JUSTIFICATION:

The VA health care system goes back more than 150 years to when it opened its first national home on November 1, 1866. When World War I veterans returned from Europe with complications from shell shock and mustard gas exposure, the United States was ill prepared to care for these unique conditions. In 1918, the need to care for veterans had grown so quickly that Congress authorized rapid expansion of veterans' hospitals. But due to a lack of planning, the Bureau of War Risk Insurance and Public Health Service had to rent space in existing hospitals and hotels to ensure care was provided to our returning veterans. By 1930, 54 veterans' hospitals had been built to provide direct care for the unique needs of veterans.

Today, VA operates the largest integrated health care system in the United States, including 152 hospitals, more than 900 community-based outpatient clinics, and 161 extended-care and domiciliary facilities. Unfortunately, many of these facilities are aging and struggling to meet the needs of today's veterans. In 2004, VA's facilities were utilized at about 80 percent of their planned capacity. Today they are utilized at 109 percent of capacity, even though based on the actual conditions of the facilities they should be operating at just under 80 percent. Over the past few years, the VA budget request and the Congress's VA construction appropriation has fallen far short of the actual need. VA facilities are where enrolled veterans receive health care, and the facilities are just as important as the physicians and staff who deliver that care. A VA budget that does not adequately fund facility maintenance and construction will continue to negatively impact the quality and timeliness of veterans' health care.

In its FY 2015 budget submission, VA introduced the Strategic Capital Investment Planning (SCIP) process. SCIP provides an in-depth analysis of VA infrastructure, identifying gaps in access, utilization, and safety and details the cost to close these gaps.

The vastness of the VA capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 6,000 buildings and almost 34,000 acres of land with a PRV of approximately \$45 billion. Although VA has reduced the number of critical infrastructure gaps, more than 4,000 gaps remain that will cost between \$52 billion and \$63 billion to close, including \$11 billion in activation costs.¹

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

¹VA, *FY 2017 Budget Submission Construction and 10 Year Capital Plan*, vol. 4 of 4, February 2016, 1–4, 9.3–8.

The IBVSOs understand that some projects move through the planning and contracting stages quicker than others, but to allow safety gaps to sit for years, like the one in West Los Angeles, with no clear strategy to correct them, not only impedes access for veterans but also potentially puts them in harm's way.

Without a comprehensive understanding of the health care resources that exist within and outside of VA, the department would have difficulty making sound decisions on capital investments and right-size its inventory of facilities for the near, mid, and long term. Funding to close infrastructure gaps continues to be insufficient. VA must begin requesting funding that will close all safety, condition, access, and utilization gaps and at the same time present five- and 10-year plans that will systematically describe when and how VA plans to close each gap. In developing these plans, VA must work from a budget proposal that is designed to maintain VA facilities for the buildings' expected life-cycle, as well as to eliminate existing gaps in safety, access, and utilization.

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

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

VA increasingly lags in closing current NRM safety, condition, utilization, and access gaps and continues to fall behind on preventing future gaps from occurring. Just to maintain what VA has in its infrastructure portfolio, the VA NRM account must be funded at \$1.3 billion per year, based on IBVSOs' estimate of PRV. NRM is currently being funded at \$462 million per year. Along with PRV-calculated funding baseline, additional funding needs to be invested to prevent the \$22 billion NRM backlog from growing even larger.²

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

To close all major and minor construction safety, condition, access, and utilization gaps, VA will need to invest approximately \$23 billion. Nearly \$5 billion is needed to rectify seismic deficiencies. Studies have identified 12 major construction seismic-correction projects, nine of which are partially funded. These projects cannot wait any longer. As VA develops its five- and 10-year plans, it must make closing these gaps a priority, with the goal to have seismic deficiencies rectified within five years.

²VA, *FY 2017 Budget Submission Construction and 10 Year Capital Plan*, vol. 4 of 4, February 2016, 9.3–8.

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

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

Over the life cycle of a medical facility, utilization and services often change because of shifting patient demographics and new technologies that change the way health care is delivered. VA must invest in medical-center architectural master planning so these changes can be better anticipated and funding can be made available as the need arises, not years later. Congress must fully fund a 10-year comprehensive facility master plans.

VA must do a better job of engaging local community partners to increase access and better utilize resources. Each facility master plan should have an analysis of services provided and services needed, and, when it makes sense, VA must leverage those partnerships to improve care and better allocate resources through expanded use of public-private partnerships.

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

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



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

RECOMMENDATIONS:

Congress must pass legislation to correct the inequity in access to VA's PCAFC.

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

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

Congress must pass legislation to allow primary caregivers to earn income credits for caring for disabled veterans, to safeguard their own income security.

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

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

VA must issue a publicly available document to establish the department's authority, policy, requirements, and lines of responsibility for implementation and delivery of caregiver supports and services.

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

VA must better integrate supports and services to caregivers of veterans not eligible for the program.

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

BACKGROUND AND JUSTIFICATION:

Family caregivers supporting severely disabled veterans require real strength to tend to the needs of family and home, assist their veteran with everyday activities, take their veteran to appointments, or just be there in their time of need. Caregiving takes endurance, commitment, and patience.

There are many benefits to veterans residing at home in their community with proper support as opposed to institutionalization. Support from family caregivers plays a crucial role in helping to reduce health care costs and improves the veteran's psychosocial well-being. There is however, a cost that caregivers bear.

Studies also show sustaining caregivers work requires a multifaceted approach—including training, health care coverage, and support services—to reduce the burdens of caregiving and to bolster their ability to serve long term.

Title I of P.L. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010 (Caregivers Act), requires VA to create caregiver-support programs to serve three types of family caregivers:

- primary caregivers who are the main source of support for veterans severely injured on or after September 11, 2001
- secondary caregivers who generally serve as a backup to the primary caregiver
- general caregivers who are the main source of support for all other severely ill and injured veterans enrolled in the VA health care system

The law has a multifaceted approach of support from VA:

- general caregiver supports are those such as caregiver education and training, use of telehealth technologies, restricted counseling and mental health services, and respite care.
- secondary family caregivers supports includes all general caregiver supports, monitoring their veteran's quality of life, instruction and training specific to their veteran's needs, paid travel expenses while accompanying veterans to appointments, information and assistance to address the routine, emergency, and specialized caregiving needs, individual and group therapy, counseling, and peer support groups

Primary family caregivers support includes all general caregivers and secondary family caregiver supports, a monthly caregiver stipend, at least 30 days a year of respite care, and Civilian Health and Medical Program of the VA (CHAMPVA) health care coverage if they have none.

Most recent data indicates 22,850 primary caregivers were receiving needed supports and services through this program at the end of 2016. Also available is an evidence-based six-week online workshop designed to reduce caregiver stress and increase family caregiver well-being. VA's family caregiver web site (caregiver.va.gov) averages 1,400 hits a day. The Caregiver Support Line (1-855-260-3274) averages 200 calls a day.

The Law's Inequity for Caregivers and Veterans

Family caregivers of veterans suffering from a severe service-connected illness, such as amyotrophic lateral sclerosis (ALS), or multiple sclerosis, provide enormous amounts of care and support. However, they are excluded from primary caregiver supports no matter what era they served in.

While title I of P.L. 111-163 created a program to address the adverse impact of caregiving, the law turned a blind eye to those caring for ill veterans and veterans ill or injured before September 11, 2001. The IBVSOs recognize this law authorizes similar yet limited services and supports to general caregivers but failed to recognize the need to integrate these with existing supports and services such as those discussed below. VA must integrate existing caregiver supports for general caregivers to ensure broad access and seamless delivery.

Program Leadership and Operations

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

Currently only one person acts as both the director and deputy director of the Caregiver Support Program. The program and the caregivers of severely injured veterans this individual serves are therefore not being effectively represented in higher organizational policy discussions. Moreover, the IBVSOs appreciate VHA leadership support toward hiring of a program analyst; however, unlike other clinical programs under VHA's current organizational structure, its Caregiver Support Program Office has no corresponding clinical operations office to work collaboratively with its policy office and support field operations.

In addition, the VHA directive needed to establish the authority, policy, requirements, and lines of responsibility for implementation and delivery of caregiver supports and services has yet to be issued. Program integrity and success may continue to be compromised without a public policy outlining uniform and consistent national procedures for providing caregiver supports and services. Such a directive should correspond with existing policy, such as VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics.

Having a program director, deputy director, and Caregiver Support Clinical Operations office would better facilitate developing and deploying a more robust and integrated IT system for the caregiver program a high priority to capture comprehensive workload data to support effective oversight and management. In September 2014, GAO recommended VA expedite short- and long-term solutions for an IT system that fully supports the program and enables program officials to comprehensively monitor the program.

Without reasonable support and reliable data, the IBVSOs are concerned about VA's ability to properly analyze and project the amount of resources needed to address the backlog of pending applications, while supporting the growing caregiver. The administration's FY 2015 budget request appeared reasonable. A, flat-lined FY 2016 advance appropriations request for the Caregiver Support Program is not.

Enhancements Needed in Caregiver Services and Supports

The IBVSOs have heard consistent criticism from primary caregivers on certain aspects of this program. Many primary caregivers comment on differences between this program and DOD's Special Compensation for Assistance with Activities of Daily Living (SCAADL) in terms of eligibility and caregiver training. For example, while both SCAADL and PCAFC provide monetary benefits, SCAADL provides monetary compensation to eligible service members, whereas VA provides a stipend to primary family caregivers. Moreover, SCAADL does not distinguish between illness and injury when determining eligibility, compared to PCAFC, which limits eligibility to veterans and service members who incurred or aggravated a "serious injury."

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

In addition, family caregivers applying for comprehensive supports under this program voiced frustration over the lack of transparency of the applications process and details about the program. Creating and implementing policy to better serve caregivers of severely injured veterans should depend on representative data that can be used to determine validity, reliability, and statistical significance. We note that in an earlier version of the Caregivers Act, Congress would have authorized VA and DOD to contract for a national survey of family caregivers of seriously disabled veterans and service members, with a report to Congress. The final bill failed to include this language. VA estimates the survey would cost approximately \$2 million over a four-year period.

We applaud VA's initiative and efforts to evaluate the short-term impacts of the PCAFC on health and well-being of veterans and their primary family caregivers, as well as how caregivers use and value components of both the PCAFC and the Caregiver Support Services Program. The results from this comprehensive evaluation should help inform the VA about the value and benefits of caregiver supports and services and identify best practices for improving and better targeting its programs.

To date, the evaluation indicates increased use of health care services by veterans participating in PCAFC, but the cause of the increase has not yet been determined, nor is it known if this increase in health care use is improving health status, health outcomes, and quality of life for veterans. Equally important, the evaluation is suggesting caregivers in PCAFC are more confident and better prepared in their role and that the stipend is reducing the financial strain of caregiving; however, the caregiver sample size is small and limits the applicability of these preliminary findings. The IBVSOs urge VA continue this evaluation while addressing existing limitations to better guide the current program and policy and to inform policymakers oversight of the program.

Future Income Security for Primary Caregivers

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

Under PCAFC, predominantly spouses—but also some parents, relatives, and friends—receive a tax-free stipend based on the amount of hourly assistance the veteran requires. Over 6,000 of these caregivers are assigned to Tier 3 (the highest level, for providing a maximum of 40 hours of care per week) for their stipend payments.

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

Because of the relative youth of these seriously injured veterans, many primary caregivers are facing a long horizon of supporting their veteran. Due to stipend payments' tax-free nature, primary caregivers cannot claim them as income, and stipends are not considered wages or earnings creditable for the purposes of Social Security, which places the caregivers' future income security at risk.

Home and Community-Based Services for Supporting Caregivers

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

VA OIG and GAO reports from early 2000 to as recently as late 2013 document the same issue time and again: that some VA medical facilities employed local restrictions to limit access to these services. In September 2013, OIG reported some VA medical facilities depressed waiting time data and used various methods and strategies to restrict access to homemaker/home aides, respite, and skilled care services—in-home services often employed to support family caregivers.

Veteran-Directed Home and Community-Based Services

Many veterans are finding themselves requiring more assistance to continue living at home in their community. To help them, VA, in partnership with the Administration on Aging (now the US Administration on Community Living [ACL]), established the Veteran Directed-Home and Community Based Services (VD-HCBS) program in 2008.

Veterans participating in this program are authorized a monthly flexible-spending budget to buy goods and services based on a needs assessment, to allow a severely disabled veteran to live safely at home. That is, veterans participating in this program are able to hire family and friends to provide for their personal care needs—or to provide support to their family caregivers.

Through local partnerships between VA facilities and Aging and Disability Network officials, the VD-HCBS program has served over 3,600 veterans across 34 states, the District of Columbia, and Puerto Rico. At the same time, 61 VAMCs have partnered with Aging and Disability Network agencies, including State Units on Aging, Aging and Disability Resource Centers, Area Agencies on Aging, and Centers for Independent Living, to offer the program.

VD-HCBS provides another option to veterans who would otherwise need to be placed in a nursing home due to, among other things, the burden placed on their caregiver.



Ensure that VA Provides High-Quality, Effective Programs and Services to Meet the Unique Needs of Women Veterans

RECOMMENDATIONS:

VA and DOD should aggressively pursue cultural and organizational changes to ensure that women are respected.

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

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

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

VA needs to ensure timely access to gender-specific health care for women veterans by requiring every VAMC to hire or contract with a part-time or full-time gynecologist.

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

DOD must allocate the resources needed to fully implement its Sexual Assault Prevention and Response Office's strategic plan. It should conduct program evaluations and prospective scientific studies to monitor the success of its plan to prevent military sexual trauma (MST), change the military culture, and assess program progress and outcomes.

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

DOD should transfer contact information and data on all TAP participants to VA and the Department of Labor (DOL), which should be responsible for providing gender-specific follow-up with all service members six to 12 months after separation to offer additional support and services.

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

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

Congress should reauthorize and fully fund the Supportive Services for Veteran Families (SSVF) program to promote positive transitions for women veterans during the anticipated downsizing of the armed forces. VA and the Department of Housing and Urban Development (HUD) should invest in additional safe transitional and supportive beds designated for women veterans, especially those with children.

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

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

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

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

VA should address the needs of women veterans in education by piloting programs such as education and career counseling, virtual peer support for women students, and child-care services. VA should establish comprehensive guidelines that schools can use to assess and improve their services and programs for student veterans.

BACKGROUND AND JUSTIFICATION:

Women continue to be a rapidly increasing and important component of the US military service branches. Today women constitute approximately 20 percent of new recruits, 15 percent of the 1.3 million active-duty component, and 20 percent of the 1.1 million reservists. DOD's 2014 Demographics Report indicates a continuous increase not only in the number of women serving, but also the number of women officers. Of the 300,000 women veterans who served in Afghanistan and Iraq, 166 have made the ultimate sacrifice, and over a thousand have been wounded in action.

In January 2016, the secretary of defense removed the ban on women serving in combat, making all roles in each branch of the US military open to women. As women begin to serve in the newly acquired combat positions, a new set of challenges will arise as a result of battlefield injuries. In addition, as these servicewomen transition from the military, VA will also be faced with a unique set of challenges, to include the need for increased specialized care and care for a larger population of women in their childbearing years. According to VA, the number of women veteran patients under 35 years old has increased by 120 percent between FY 2003 and FY 2013. The impact of wartime deployments for women will also continue to contribute to a number of new transitional and reintegration challenges for women in the years to come, requiring VA and other federal agencies to ensure they evaluate and adjust programs and services to meet the unique needs of women veterans, instead of solely focusing on the traditional programs and services that were tailored to the needs of male veterans.

Deployment to theaters of combat pose a unique challenge for servicewomen and their health care providers. It is important for clinicians treating women to understand the reproductive risks associated with military service, especially when deployed to a theater of combat or other deployments where proper handwashing is inaccessible. The inability to properly perform daily hygiene increases the difficulty of managing menstruation, therefore increasing the likelihood of urinary tract infections or other gender-specific conditions. Deployment to combat theaters can also disrupt basic preventive care and ongoing treatment for conditions such as endometriosis. According to a committee opinion issued by the American College of Obstetricians and Gynecologists, women who are deployed to theaters of combat may have higher rates of abnormal Pap smears. All military service branches have the responsibility to ensure these unique challenges for women are addressed and that they are responding to the care needs of women service members during deployment.

As servicemen and -women transition from military service, they attend the Transition Assistance Program (TAP), which is designed to inform them of the many benefits and services available to them as veterans once they are discharged from the military. TAP is conducted during the final days of active-duty service and is designed to assist service members as they prepare to separate from the military, with the goal of helping them transition successfully back into the community as civilians. TAP courses are designed to assist former service members to reenter the job market able to compete for positions for which they are qualified. Unfortunately,

individuals seek out and absorb information when they perceive they need it, not necessarily when it is made available. Some service members may be more receptive to this information six to 12 months after discharge, while they are more actively engaged in seeking help and assistance.

Additionally, there have been no comprehensive studies completed to evaluate the effectiveness of TAP for women. TAP partners should assess the unique needs of women veterans when developing course curriculum to ensure their issues are addressed. Like their male counterparts, women transitioning from the military seek to establish satisfying, gainful employment. Many women are able to transition successfully; however, according to DOL, higher rates of unemployment are present among post-9/11 veterans. For women veterans, this trend was even more pronounced. According to a March 2014 GAO report (No. 14-144), with the drawdown from the wars in Iraq and Afghanistan and planned force structure reductions, many service members are projected to leave the military through 2017. It is important that federal employment programs be prepared to equally and efficiently provide guidance and assistance to transitioning women veterans.

Employment and housing are also essential components to the overall well-being of women veterans. According to VA, women veterans' homelessness rates have increased. Compounding this issue, within this population you also find increased rates of MST, and more servicewomen are likely to be single parents. According to the National Center on Homelessness among Veterans, 8.5 percent of all female veterans using homeless programs served in Operations Enduring and Iraqi Freedom (OEF/OIF), of which 82 percent were age 39 or younger. Given these factors, it is imperative that resources are provided to adequately take care of this relatively small population and that it is not overlooked.

Following military service, as women reintegrate into society, they are faced with overcoming many different challenges, including difficulty accessing services that are specific to their unique needs and feeling invisible. This gap helps to feed a feeling of not belonging or lack of identifying. There is a perception within VA that when a woman veteran comes to VA, she is not there to receive services but on behalf of a male family member. Likewise, women also feel as though society does not view their service as valuable or as important as that of men and often end up fighting just to be recognized as veterans. According to the May 2015 report from the Advisory Committee on Women Veterans, many women themselves still do not identify as veterans. For these reasons, VA has launched several campaigns such as "I'm One," yet this problem is slow to be resolved and requires continuous effort from all who work within VA. It is necessary for VA to continue to educate employees at all levels on the importance or recognizing the contributions from women veterans and their honorable service as equal to the service of their male counterparts. VA should also continue its culture change campaigns to ensure women are treated with the same dignity and respect as that of men.

As women transition from the military and attempt to access services and benefits as veterans, they often encounter several barriers. The 2015 VA report *Barriers for Women Veterans to VA Health Care* discussed nine barriers: comprehension of eligibility requirement and scope of services, effect of outreach specifically addressing women's health services, effect of driving distance on access to care, location and hours, child care, acceptability of integrated care, gender sensitivity (VA users only), mental health stigma, and safety and comfort (VA users only). Women veterans continuously indicate child care as barrier to obtaining services from VA. Forty-two percent of women surveyed indicate it is difficult to find child care so they can seek VA health care services and would find on-site child care to be useful. The IBVSOs urge Congress to make this program permanent to enhance access for women veterans who wish to receive their care through VA.

Where Do Gaps Exist

Health Care Services

According to VA researchers, unlike their male counterparts, who are able to achieve a basic level of care in one visit, women veterans are more likely to receive the same basic level of care from an assortment of VA and non-VA providers in multiple visits. The VA has taken steps to transform the care for all veterans with the implementation of Patient Aligned Care Teams (PACTs). A PACT is a partnership between the veteran and his or her health care team that has the goal of treating the whole person, with emphasis on prevention and

promotion through coordinated care whereby each member of the team has a clearly defined role, with the veteran at the center. The team members include family members and caregivers, primary care provider, nurse, clinical associate, and administrative clerk. When additional services are required, another team may be added for support, such as mental health care providers, other specialists, and other non-VA health care professionals. All the members work with the veteran and together to ensure the whole person is taken care of. However, researchers note that it is not fully understood how the PACT model will meet the needs of women veterans and other special populations or how to include specific accommodations for gender-specific care and improve gender sensitivity. The IBVSOs recommend that VA find ways to ensure the PACTs are adapted to meet the needs of women veterans.

According to VA, women's mental health has seen a 154 percent increase in the number of women veterans accessing VHA mental health services since 2005, and in FY 2015, 182,107 women veterans received care. VA offers many mental health programs specifically tailored for women veterans; however, many women are unaware of these programs and services. Ensuring women are aware of the services provided by VHA has continued to be a challenge. To better represent women and ensure women have a place to turn to for assistance, VA has employed Women Veterans Program Managers (WVPMs) at every VAMC. WVPMs are able to assist women veterans in navigating the VA health care system, informing them about specialized services, state and federal benefits, and resources where they reside.

The impact of wartime service affects male and female service members differently, but both servicemen and -women may develop posttraumatic stress disorder (PTSD). Research has found that men are more likely to display anger and divert to substance abuse, whereas women are more likely to develop depression. Due to these differences in responses, it is necessary for the unique needs of women to be acknowledged to ensure proper treatment and services are provided. VA is the largest integrated mental health system in the United States that provides specialized treatment for PTSD, while also offering a comprehensive array of mental health and specialized post-deployment mental health services. These services include the Mental Health Residential Rehabilitation Treatment Program. The MH RRTP addresses the goals of rehabilitation, recovery, health maintenance, quality of life, and community integration. VA also offers inpatient mental health programs, programs for substance-use disorder (SUD), and suicide prevention.

Although VA has excellent evidence-based mental health treatment programs, there is still a need for increased access to gender-specific group counseling, residential treatment, and specialty inpatient programs to serve women. According to VA researchers, mental health providers need to be aware of physiological and hormonal changes that occur during a woman's life span and the possible impact of those changes on mental health. This is especially important since 40 percent of women veterans seen in VHA are in their childbearing years (ages 18–44) and over 25 percent are aged consistent with pre-menopause (ages 45–55). The IBVSOs recommend that VA continue its research on women veterans and mini-residency training programs to ensure VA providers have expertise in women's health. DOD and VA should also work cohesively on new approaches for transition from DOD to VA care for veterans with mental health issues

Education

The Post-9/11 Veterans Educational Assistance Act of 2008 (known as the Post-9/11 GI Bill) represents the largest expansion of educational support to military and veterans in our post-World War II experience, and this congressional authority provides excellent educational benefits. However, there is a paucity of information available on the education subsidies and support received by women veterans and on the outcomes of the use of the Post-9/11 GI Bill benefits and services by women. We do know that women veterans are more likely than nonveterans of either gender to have a college degree. According to statistics from DOL, 42 percent of females who served our country are college graduates, just as they are more likely to be enrolled in school.

A survey conducted by Student Veterans of America shows that 46 percent of veterans using their education benefits have children and 14 percent are single parents. Many times, the mother in single-parent situations has sole custody of the child/children. Where institutions of higher education close or lose their accreditation,

veterans may lose the housing allowance they receive while attending school. This may cause special hardship for single parents responsible for supporting their families while pursuing academic or vocational degrees or certificates. VA must take steps to ensure this does not happen to any veteran, let alone single parents.

VA must gather data on the needs of women veterans currently using the Post-9/11 GI Bill to ensure their successful completion of academic goals. As research shows, individuals with degrees as well as those currently enrolled in higher education have lower rates of unemployment.

Employment

The need for assistance will become even more pressing if DOD executes its downsizing plans. Those who expected a full military career may be suddenly thrust, with little warning, into ill-prepared civilian communities and job markets as new veterans. DOL has provided women veterans with many customized programs, communications, and supports. Despite these efforts, the unemployment and underemployment rates for women veterans are not only higher than those of their male veteran counterparts, but they are also higher than for nonveteran women. Yet women veterans have higher rates of degrees from institutions of higher education.

Women veterans who successfully transition not only help the economy, but are also personally successful in doing so. Data from VA reflects that the gender wage gap is significantly closer to nonexistent between female and male veterans. Women veterans use less public assistance programs such as the Supplemental Nutrition Assistance Program, are significantly less likely to live in poverty, and are almost three times more likely to have health insurance.

Women veterans can serve as a successful example for women in the civilian professional job market. Downsizing the military is likely to exacerbate this problem. Additional efforts from Congress are needed to reverse these trends and assist women veterans in successfully joining the civilian workforce.

The IBVSOs recognize all of the work being done by VA to enhance the care provided to women veterans; however, more should be done to ensure the needs of women veterans are met at the same level of their male counterparts. The growing portion of women in the veterans' population compels VA and other federal partners to prepare for increased demand for treatment, benefits, and services.

BENEFIT PROGRAMS



Expedite Specially Adapted Housing (SAH) Grant Processing for Eligible Terminally Ill Veterans

RECOMMENDATION:

Congress should pass appropriate legislation to provide VA with the authority to implement emergency procedures to bypass existing regulations when life-threatening situations are involved. VA should be required to expedite the approval of the Specially Adapted Housing process and be authorized to exercise judgment at the local level in cases where the failure to act poses a significant risk to the life or health of a veteran.

BACKGROUND AND JUSTIFICATION:

Veterans who suffer from ALS and other terminal illnesses often do not survive to benefit from the improvements that an SAH grant could have afforded them. The root of this problem is the complex network of myriad regulatory requirements that guide the SAH program. Staffing shortages compound the problem by limiting the amount of time and effort employees are able to dedicate to navigating through the red tape in order to fully address these unique situations.

While the required SAH renovations must be as compliant as possible, there must be a balanced focus on the immediate needs of the veteran. It is not uncommon for unneeded adaptations to be forced on veterans as a condition of project approval, only to be removed by them after the work is completed. These extra adaptations are a needless waste of time and money. Safety issues must be weighed to ensure that concerns, such as potential evacuation in case of fire, do not prevent immediate modifications that would be critical in preventing more imminent dangers, such as falling. VA must encourage employees at the local level to request waivers when appropriate and to streamline the overall waiver process.

Veterans with ALS and other terminal illnesses who satisfy eligibility requirements dealing with medical feasibility, property suitability, and financial feasibility can be granted conditional approval that would authorize them to incur certain preconstruction costs for home adaptation. While a procedural framework exists today for this to happen, there are risks involved for the clients who seek to invoke these provisions.

Also, in some cases, VA can provide direct reimbursement for work that has been completed, but nuances in the law can too easily thwart these options. Every veteran and every situation is unique, and these variances require legislation to be crafted in such a way as to facilitate favorable outcomes for the most severely disabled veterans who may face life-threatening emergencies in the absence of prompt modifications to their living environment.

Numerous administrative hurdles must be overcome in the application of the SAH decision process. The minimum property requirements (MPRs) focus on safety and sanitation. Some MPRs address how these two items can best be achieved. More progress, however, is needed when dealing with unique situations, such as veterans with terminal illness.

Provide a Supplemental Automobile Grant to Eligible Veterans

RECOMMENDATION:

Congress should authorize a supplementary automobile grant to eligible veterans in amounts equaling the difference between the amount previously spent and the current grant maximum in effect at the time of vehicle replacement and maintain the efficacy of this vital benefit.

BACKGROUND AND JUSTIFICATION:

Congress authorizes VA to provide financial assistance to eligible veterans through a grant in the amount of \$20,235. This grant is used towardward the purchase of a new or used automobile to accommodate a veteran or service member with certain disabilities that resulted from a condition incurred or aggravated during active military service.

Unfortunately, the cost of replacing modified vehicles purchased through the VA automobile grant program presents a financial hardship for veterans who must bear the full replacement cost once the adapted vehicle has exceeded its useful life. The divergence of a vehicle's depreciating value and the increasing cost of living only compounds this hardship.

Congress and VA have already acknowledged the adverse impact that higher cost of living has on veterans who utilize the SAH grant. The law now authorizes up to three usages of the SAH grant and provides for annual increases in the maximum grant amount to keep pace with the residential cost-of-construction index. When the maximum grant amounts are increased, veterans or service members who have not used the assistance available to them up to the allowable amount may be entitled to a grant equal to the increase in the grant maximum amount in effect at that time. This increase also means a veteran who previously used the grant is entitled to additional SAH benefits—the current rate of maximum entitlement minus what was previously used. The intent of this onetime 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 calculus should be applied to the automobile grant.

The Department of Transportation reports the average useful life of a vehicle is 12 years, or about 128,500 miles. On average, the cost to replace modified vehicles ranges from \$40,000 to \$65,000 when the vehicle is new and \$21,000 to \$35,000 when the vehicle is used. These substantial costs, coupled with inflation, present a financial hardship for many disabled veterans who need to replace their primary mode of transportation once it reaches the end of its usefulness.

Congress must resist, and the IBSVOs will strongly oppose, any effort or proposal to eliminate reimbursement for certain adaptive equipment now standard on most new vehicles. VA proposed such a recommendation in its 2017 budget proposal as a cost-saving measure, but in reality it only further erodes the value of the automobile grant by removing the veteran's purchasing power to a level inconsistent with Congress's original intent. It is a surreptitious reduction in benefits for veterans with serious service-connected disabilities. Under current law, VA reimburses eligible veterans for necessary adaptive equipment required to operate a vehicle safely and effectively. VA is not looking to "modernize the law" to reflect the fact that certain equipment on automobiles that used to be optional is now standard.

The true intent behind this proposal is to give VA broader discretion to determine "necessary equipment" for veterans to safely operate vehicles. It would create a scenario where VA could determine that features such as air-conditioning, now standard on nearly all vehicles, are no longer "necessary" for veterans to operate vehicles, because they are now considered a standard vehicle features. But if the air-conditioning in the vehicle breaks, a veteran with a spinal cord injury that has lost the ability to effectively regulate his or her

body temperature would now have to pay out-of-pocket to repair this piece of equipment, because VA would consider this a standard vehicle feature.

Take leather seats as another example. They ease the transfer in and out of a vehicle for veterans with loss of use of lower extremities. Leather seats are currently considered a reimbursable item, but under the VA's new authority it would not be considered adaptive equipment subject to reimbursement.

For those less nuanced with the adaptive equipment needs of seriously disabled veterans, something like leather seats and air-conditioning would seem like nothing more than luxury items. However, these vehicle features, although standard on most vehicles today, are in fact critical components to facilitate safe, efficient, and comfortable vehicle operation.

Ultimately, measures such as this must be opposed, as they would dilute the value of this essential benefit to veterans with serious service-connected disabilities.

Provide a Supplemental Home Adaption Grant for a New Home

RECOMMENDATION:

Congress should establish a supplementary housing grant that covers the cost of new home adaptations for eligible veterans who have already used their initial grants.

BACKGROUND AND JUSTIFICATION:

Grants should be established for special adaptation 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. 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 facilitate freedom of movement.

VA adapted-housing grants currently given to eligible veterans are provided on a onetime basis. Homeowners, however, sell their homes for any number of reasons both foreseeable and unforeseeable (e.g., change in the size of families, relocation for career or health reasons). Once the housing grant is used, veterans with service-incurred disabilities who own specially adapted homes must bear the full cost of continued accessible living should they move or modify a 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.

Relax Standards to Establish Service Connection Based on Military Sexual Trauma

RECOMMENDATION:

Revise Section 3.304(f)(3) to allow that a veterans lay testimony alone may establish MST (the stressor) when a mental health professional confirms the claimed stressor is adequate to support a diagnosis of post-traumatic stress disorder related to that stressor.

BACKGROUND AND JUSTIFICATION:

Evidentiary standards for establishing a service connected disability resulting from MST should be relaxed. Twenty in 100 female veterans and one in 100 male veterans have reported to VA they experienced MST while on active duty. A recent study examined MST in men and women deployed in the wars in Iraq and Afghanistan. Forty two (42) percent of women and twelve and a half (12.5) percent of men reported experiencing MST.

According to the Department of Defense Sexual Assault Prevention and Response Office, 86.5 percent of sexual assaults go unreported, meaning that official documentation of most assaults may not exist. Sexual assault is one of the most devastating crimes against a person. Long after physical injuries heal, psychological wounds can persist.

For decades VA treated claims for service connection for mental health problems resulting from MST in the same way it treated all claimed conditions—the burden was on the claimant to prove the condition was related to service. Without validation from medical or police records, claims were routinely denied. More than a decade ago VA relaxed its policy of requiring medical or police reports to show that MST occurred.

Nevertheless, thousands of claims for service connection for post-traumatic stress disorder (PTSD) resulting from MST have been denied since 2002 because claimants were unable to produce evidence that assaults occurred. From 2008 to 2012 grant rates for PTSD resulting from MST were 17 to 30 points lower than grant rates for PTSD resulting from other causes. Incidents occurring during service tend to be reported years after the event(s), making it exceedingly difficult to obtain evidence to support service connection for PTSD and other mental health challenges.

The IBVSO's conclude that current VA regulations and policies with regard to MST lead to high denial rates of claims for PTSD and other mental health conditions. Given the high incidence of veterans experiencing sexual trauma while on active duty, the IBVSOs believe it reasonable for VA to grant veterans the same reduced evidentiary burden as provided title 38, United States Code, § 3.304(f)(3).

Reform Survivor Benefit Programs (SBP)

RECOMMENDATION:

Congress should authorize Dependency and Indemnity Compensation (DIC) eligibility increases for all survivors, equal to that of other federal programs. The amount of increase should be 55 percent of VA disability compensation for a 100 percent disabled veteran.

Congress should repeal the inequitable offset between DIC and SBP because no duplication occurs between these two separate and distinct benefit programs.

Congress should enact legislation to enable eligible surviving spouses to retain DIC upon remarriage at age 55.

BACKGROUND AND JUSTIFICATION:

Increase DIC Rates

The current rate of compensation paid to the survivors of deceased members is inadequate and inequitable when measured against other federal programs. Under current law, DIC is paid to an eligible surviving spouse if the military service member died while on active duty or when a veteran's death resulted from a service-related injury or illness.

DIC payments were intended to provide surviving spouses with the means to maintain some semblance of economic stability after the loss of their loved ones. Survivors relying solely on DIC face significant financial hardships at the time of their spouse's death.

Therefore, IBVSOs believe the rate of DIC should be increased from 43 percent to 55 percent of a 100 percent disabled veteran's compensation for all eligible surviving spouses.

Eliminate DIC and SBP Offsets

Current law requires DOD SBP annuity payments be reduced by an amount equal to VA DIC payments. Service-connected disability compensation benefits are provided to veterans by VA for the effects of injuries and illnesses sustained while on active duty. Payments authorized under the SBP program by DOD for surviving spouses are governed by separate and distinct eligibility criteria. Congress must act to repeal this inequitable offset because there is no duplication of benefits.

When a veteran's death is the result of service-connected injury or illness, or following specific periods of total disability due to service-connected causes, eligible survivors or dependents can receive DIC from VA. 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 DOD SBP program, deductions are made from an active duty members military pay to purchase this survivor annuity.

The SBP is not a gratuitous benefit because it is actually purchased by the military retiree. Upon a retiree's death, the SBP annuity is paid monthly to eligible beneficiaries. If the veteran's death was unrelated to any service-connected injury or illness, or if the veteran was not totally disabled due service-connected disability for the requisite period of time preceding death, beneficiaries receive their full SBP payments.

If a veteran's death was due to service-connected causes or if the requisite period of time was attained while a veteran was rated totally disabled due to service-connected causes, 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 payments, beneficiaries lose SBP annuity payments in its entirety. Therefore, payments made by the retiree towards the purchase of the SBP plan were essentially made in vein

Remarriage

No eligible surviving spouse should be penalized because of remarriage. Congress should lower the remarriage age requirement from 57 to 55 to continue DIC payments for survivors of veterans who have died on active duty or from service-connected disabilities. Equity with beneficiaries of other federal programs should govern

Congressional action for this deserving group.

Current law allows a surviving spouse to reestablish entitlement to DIC benefits if they remarry at age 57 or older. *The Independent Budget VSOs* appreciates Congressional action that was taken to allow certain survivors to reestablish entitlement to this rightful benefit; however the current age threshold of 57 years remains arbitrary and imposes an unnecessary burden upon those seeking to remarry.

Remarried survivors of retirees of the Civil Service Retirement System, for example, obtain a similar benefit at age 55. This change in eligibility would also bring DIC in line with SBP rules that permit continued entitlement when remarriage occurs at the age of 55.



Repeal the Tax Imposed on Military Retirees Rated Less Than 50 Percent Disabled

RECOMMENDATION:

Congress should enact legislation to repeal the inequitable tax imposed on military longevity retirees that requires their retirement pay be offset by an amount equal to their disability compensation when they are rated less than 50 percent disabled.

BACKGROUND AND JUSTIFICATION:

All military longevity retirees should be permitted to receive military retirement pay and VA disability compensation concurrently through the Concurrent Retirement Disability Pay (CRDP) program. The IBVSOs believe the current prohibition imposed upon military longevity retirees rated less than 50 percent disabled has persisted for far too long. An honorably discharged veteran retired after 20 or more years who sustained service-connected disabilities should not be penalized for becoming injured or ill while in service to our country.

Many veterans retired from the armed forces based on length of service must forfeit a portion of their retired pay, earned through faithful performance of military duties, as a condition of receiving VA compensation for service-connected disabilities when they are rated less than 50 percent disabled. This policy is inequitable. Military M retired pay is earned by a veteran's career, usually more than 20 years of honorable and faithful service performed on behalf of our nation.

VA compensation is paid solely because of disability resulting from military service, regardless of the length of service. Most nondisabled military retirees pursue second careers after military service to supplement their incomes, thereby enjoying a full reward for completion of a military career with the added reward of full civilian 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.

A longevity-retired injured or ill 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 financial rewards. In order to place all injured and ill longevity military retirees on equal footing with nondisabled military retirees, no offset should occur between full military retired pay and VA disability compensation.

To the extent that military retired pay is offset by VA disability compensation, the disabled military retiree is treated less fairly than a nondisabled military retiree. Moreover, an injured or ill 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.

Congress has recognized this tax to be, in fact, inequitable. In recent years the law was changed to correct this injustice by allowing certain military retirees—those with VA disability ratings of 50 percent or greater—to receive their full retirement and their full service-connected disability compensation benefits through the CRDP program. This is evidence that Congress does not consider DOD and VA compensation payments as duplicative.

One way for Congress can approach balancing cost and equitability would be to phase in CRDP for the less than 50 percent service-connected veterans. The only reason this group of deserving retired veterans rated less than 50 percent disabled are precluded from receiving both benefits is to simply to save the government money.



Protect Standards for Service Connection

RECOMMENDATION:

Congress should reject proposals that would change the definition of service connection for veterans' disabilities and death. Standards for determining service connection should remain grounded in the existing law, which recognizes the 24-hour nature of military service.

BACKGROUND AND JUSTIFICATION:

Disability compensation is paid to a veteran who is disabled as the result of an 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. Compensation may also be paid to National Guard and reserve service members who suffer disabilities resulting from injuries while undergoing training.

Periodically a committee, commission, government agency, or member of Congress proposes that military service should be treated as if it were a civilian job. That is to say, they propose that if a service member happens to get sick or injured while working a shift, he or she might be eligible, after discharge, for medical treatment and, perhaps, compensation from the federal government. Conversely, if a service member is injured before or after “work” or becomes ill from a disease that is not obviously related to military service, he or she would not be eligible for service connection. Furthermore, medical care after service would be the responsibility of the veteran alone.

Unlike a civilian job, where most people work set hours and can spend the rest of their day (and off days) doing anything they want to do, 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 essentially on call 24 hours a day, 365 days a year. A soldier on leave can be ordered back to base to be deployed that same day. 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 additional weeks or months. The ground crews that prepared planes in support of missions in Iraq, Afghanistan, and Libya worked anytime they were needed, day or night. Service members are there when needed, every day, often at risk of injury, disease, or death in defense of all Americans. Congress created the Veterans' Disability Benefits Commission (VDBC) to carry out a study of “the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service.” After more than 30 months of hearings, study, analysis,

and debate, the VDBC unanimously endorsed the current standard for determining service connection. Current law requires only that an injury or disease be incurred or aggravated coincident with active military service. This remains sound public policy; any change would only impose additional hardship on the men and women who have already given so much.

Eliminate Rounding Down Veterans' and Survivors' Benefit Payments

RECOMMENDATION:

Congress should no longer round down veterans' and survivors' cost-of-living adjustments (COLAs).

BACKGROUND AND JUSTIFICATION:

In 1990, Congress, in an omnibus reconciliation act, mandated 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 has continued to extend it every few years. 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.

The effect of rounding down monthly COLA increases has eroded approximately \$10 per month for every veteran or survivor. For example, a veteran totally disabled from service-connected disabilities would have received \$2,994.033 per month in 2016. With the reinstatement of the round-down, a 3 percent COLA in 2017 would produce a monthly payment of \$2,994, just 3 cents per month less than he or she would receive without the round-down.

Thirty-six cents per year seems insignificant at first. The next year a 3 percent COLA is based on \$2,994, not \$2,994.03, and produces a loss to the veteran of \$1.03 for the year. However, this is where the impact of rounding down becomes realized. In the third year, the difference is \$1.37 per month, or \$16.44 per year. If this continues in the tenth year, the veteran is losing \$42.48 per year and in a 10-year period the veteran has lost \$210.

The cumulative effect of this provision of law levies a tax on disabled veterans and their survivors, costing them money each year. When multiplied by the number of disabled veterans and DICIC recipients, millions of dollars are siphoned from these deserving individuals annually. All told, the government estimates that it would cost beneficiaries \$1.6 billion over 10 years.

Veterans and their survivors rely on their compensation for essential purchases such as food, transportation, rent, and utilities. It also enables them to maintain a marginally higher quality of life. This is money, after helping veterans that circulates through their communities, helping raise the standard of living for other Americans as well.

The IBVSOs note and greatly appreciate the passage of P.L. 114-197, the Veterans' Compensation COLA Act of 2016, which became law on July 22, 2016. This legislation did not contain a round-down provision. Congress must act to permanently eliminate the practice of rounding down.

Exclude the Value of Life Insurance Policies as Countable Income

RECOMMENDATION:

Congress should enact legislation that exempts the cash value of VA life insurance policies and all directly resulting dividends and proceeds from consideration in determining a veteran's entitlement to health care under Medicaid.

BACKGROUND AND JUSTIFICATION:

Life insurance provides the surviving spouses and dependents of veterans with a means of maintaining financial stability after a sponsor's death. In some cases, however, veterans are forced to surrender their VA life insurance policies and apply the cash value of the surrendered policy toward the cost of nursing home care as a precondition of Medicaid coverage.

When this occurs, these policies become nothing more than a funding vehicle for the veteran's care prior to death, masquerading as a form of protection for survivors. As a result, the government is paying for a veteran's care in lieu of paying proceeds to survivors, instead of fulfilling both obligations.

Reduce Premiums for Service-Disabled Veterans Insurance

RECOMMENDATION:

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

BACKGROUND AND JUSTIFICATION:

Improved life expectancy and new mortality tables should be used to reduce premiums for SDVI. Congress created the SDVI program for veterans who faced difficulty obtaining commercial life insurance due to their service-connected disabilities. At the program's onset in 1951, rates were based on contemporaneous mortality tables and remained competitive with commercial insurance.

Since that time, reductions in commercial mortality rates reflected improved life expectancy as illustrated by updated mortality tables. VA remains bound to outdated mortality tables, the use of which results in rates and premiums that are no longer competitive with commercial insurance offerings. This deviates from the intent of this benefit to provide SDVI to veterans with service-incurred disabilities who cannot obtain commercial life insurance due to their disability. 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 the IBVSOs recognize the efforts of Congress in authorizing an increase from \$20,000 to \$30,000 in the supplemental amount available with the passage of P.L. 111-275, the Veterans Benefits Act of 2010, we believe congressional intent will not be met under the current rate schedule because many service-disabled veterans cannot afford VA premiums.

Establish Presumptive Service Connection for Hearing Loss and Tinnitus

RECOMMENDATION:

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

BACKGROUND AND JUSTIFICATION:

Many veterans are exposed to acoustic trauma and increased noise exposure due to the nature of job requirements while on active duty. In some cases these veterans acquire hearing loss or tinnitus but are unable to prove service connection because of inadequate in-service testing procedures, lax examination practices, or poor record keeping.

Establishing a presumption would resolve this long-standing injustice and streamline the process to when evaluating entitlement to service connection. The Institute of Medicine issued a report in September 2005 titled *Noise and Military Service: Implications for Hearing Loss and Tinnitus*. This report found patterns of hearing loss consistent with noise exposure seen in cross-sectional studies of military personnel and a relation between combat, combat arms, combat support, and combat service support veterans.

Combat veterans are typically exposed to prolonged, frequent, and exceptionally loud noises from such sources as gunfire, tanks, artillery, explosive devices, aircraft, and other equipment used in the performance of their military occupations. Exposure to acoustic trauma is a well-known cause of hearing loss and tinnitus. Many combat veterans are unable to document their in-service acoustic trauma needed to prove the relation between hearing loss or tinnitus.

World War II veterans are at a particular disadvantage. In the 1940s, military audiometric tests were done by spoken and whispered voice. These tests were universally insufficient to detect all but the most severe hearing loss and testing records fell short for a variety of reasons. Today's hearing-test baseline for active-duty service-members has been "renormed." This renorming skews test findings by reflecting better hearing results than may actually be present.

Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to adjudicate because of extenuating circumstances. Congress should do the same for this group of veterans and require VA to develop a list of military occupations known to expose service members to noise.

VA should also be required to presume noise exposure for any veteran who worked in certain military occupations and grant service connection for those who now experience documented hearing loss or tinnitus after separation from service. Furthermore, combat veterans should be afforded the benefits of this presumption.



Establish More Equitable Rules for Hearing Aid Compensation

RECOMMENDATION:

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

BACKGROUND AND JUSTIFICATION:

Currently, the VA's VASRD does not provide a compensable rating for hearing loss at the established levels severe enough to require hearing aids. 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, similarly 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 title 38, CFR section 1(4), of the VASRD shows that all disabilities whose treatment warrants an appliance, device, implant, or prosthesis receives a compensable rating, with the exception of a hearing loss with hearing aids.

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

Expand the Definition of Wartime Service for Non-Service-Connected Disability Pension

RECOMMENDATION:

Veterans who receive hostile-fire pay, served in a combat environment, or were awarded the Armed Forces Expeditionary Medal, the Purple Heart medal, the Combat Infantryman Badge, or similar decoration for participation in military operations should be eligible to receive VA non-service-connected disability pension benefits regardless of whether they served during an officially recognized "wartime period."

BACKGROUND AND JUSTIFICATION:

A 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 non-service-connected disabilities, who served at least one day of active duty during a period of war, and who has a qualifying low income.

Although Congress has the sole authority to declare war, the President, as commander in chief, may send US forces into hostile situations at any time. While some of these incidents occur during defined periods of war (e.g., Somalia, 1992–95), many other military actions take place during periods of "peace" (e.g., Grenada, 1983; Lebanon, 1982–87; Panama, 1989) including the the Mayaguez Incident (May 12–15, 1975).

The sole service criterion for eligibility for a 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 amend the law so that the receipt of hostile-fire pay or award of an expeditionary medal, campaign medal, combat-action ribbon, or similar military decoration would qualify an individual for VA pension benefits. This action would ensure that veterans who were placed in hostile situations would become eligible for a pension should they become totally disabled due to non-service-connected disabilities.

Establish More Equitable Rules for Veterans Exposed to Agent Orange on the Korean Demilitarized Zone (DMZ)

RECOMMENDATION:

Extend the presumptive service-connection end-date to May 7, 1975, for Korean War veterans who served on the Demilitarized Zone to mirror the end date for Vietnam War veterans. The extension of the delimiting date to May 7, 1975, would afford veterans with qualifying Korean service the same assumption of exposure as is afforded veterans with Vietnam service.

BACKGROUND AND JUSTIFICATION:

Currently, the Korean DMZ presumptive service-connection end date is August 1971. The delineating dates for presumptive service connection because of exposure to the herbicide Agent Orange in Korea should be established in the same manner as they are for Vietnam War veterans: if a veteran served in Korea north of the Imjim River at any time after Agent Orange was applied there, then presumptive service connection should be granted for the conditions identified in title 38, CFR, section 3.309(e).

For Vietnam veterans, the current law states that if service in Vietnam is verified as defined in title 38, CFR, section 3.307(a)(6), service connection for any of the presumptive conditions contained in title 38, CFR, section 3.309(e), will be granted.

For Korean DMZ veterans, presumptive service connection is granted if a veteran served on the Korean DMZ between April 1968 and August 1971 (title 38, CFR, section 3.307[[a]][6][iv]). This is verified by assignment to one of the units that rotated to the Korean DMZ. Hostile-fire pay was granted for these period(s) of DMZ assignment.

Usage:

- Vietnam: Agent Orange was used in Vietnam from January 1961 to October 1971
- Korean DMZ: Agent Orange was used on the Korean DMZ from April 1968 through July 1969

Presumptive Periods:

- Vietnam: January 9, 1962, and ending on May 7, 1975—four years after last application
- Korean DMZ: April 1968 and ending on August 31, 1971—two years after last application

DOD records confirm that Agent Orange was used extensively in sections of the Korean DMZ. 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 five parts per trillion (or one ounce in six million tons). Dioxin's toxic properties are enhanced by the fact that it can enter the body through the skin, the lungs, or through the mouth.

The dioxin on the Korean DMZ did not lose its efficacy on August 31, 1971. It continued to be absorbed into the bodies of the troops who were operating north of the Imjim River and affected the health of those veterans, just as it did to Vietnam veterans.

JUDICIAL REVIEW



Enhancements Needed for the Court of Appeals for Veterans Claims (CAVC)

RECOMMENDATION:

Congress should enact legislation that would permanently increase the number of judge appointments to the CAVC from seven to nine.

Congress should enact legislation as described herein to preserve the limited resources of the CAVC and reduce the CAVC's backlog.

Congress should provide all necessary funding to construct a courthouse and justice center in a location of honor and dignity—a location befitting the authority and prestige of the CAVC.

BACKGROUND AND JUSTIFICATION:

Permanently Increase the Number of Judges to Nine

The CAVC's caseload regularly averages roughly 4,600 cases per year. As a result, the CAVC has had one of the highest, if not the highest, caseloads per active judge of any federal appellate court in the country. In response, the CAVC was authorized in 2008, as part of the Veterans Benefits Improvement Act to expand, at least temporarily, to nine judges, as of January 2010.

The last temporary authorization to increase the number of CAVC judges expired at the end of 2012. Subsequent to that authority's expiration, two judges have retired, leaving the CAVC with only seven judges.

Congress must enact legislation to permit a permanent increase in judge appointments to keep pace with an increasing caseload. If these two temporarily authorized appointments become vacant, the CAVC is not authorized to replace them. The statute mandates no more than seven judges, which would adversely impact the CAVC's ability to make timely decisions because the remaining judges would be left to absorb the current and incoming workload.

The CAVC's Backlog

Congress is aware that the number of cases appealed to the CAVC has increased significantly over the past several years. To capitalize on current efforts to reform the claims and appeals process, collateral issues must also be addressed. Nearly half of those cases are consistently remanded to the Board.

The CAVC has attempted to increase its efficiency and preserve judicial resources through a mediation process, under ruler 33 of the CAVC's Rules of Practice and Procedure, to encourage parties to resolve issues before a court briefing is required. Despite this change to CAVC 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 CAVC's resources and defeating the purpose of the practice. In this instance, VA usually commits to defend the Board's decision at the early stage in the process.

Subsequently, when VA general counsel reviews the appellant's brief, general counsel often changes its position, admits to error, and agrees to or requests a remand. Likewise, VA agrees to settle many cases in which the CAVC requests oral argument, suggesting acknowledgment of an indefensible VA error through the CAVC's proceedings. VA failure to admit error, to agree to remand, or to settle cases at an earlier stage of the CAVC's proceedings does not assist the CAVC or the veteran.

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

state that under title 38, USC USC, section 7264(a), the CAVC shall prescribe amendments to ruler 33 of the CAVC's Rules of Practice and Procedure. These amendments would also contain language stipulating that 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 CAVC and the appellant describing the bases upon which VA remains opposed to remand. If VA later determined that a remand was necessary, it may only seek remand by joint agreement with the appellant. No time would be counted against the appellant where stays or extensions are necessary when VA seeks a remand after the end of seven days after the ruler 33 conference.

Furthermore, if VA sought a remand after the end of seven days after the ruler 33 conference, VA would waive any objection to and may not oppose any subsequent filing by the appellant for Equal Access to Justice Act fees and costs under title 28, USC USC, section 2412. The CAVC would have the authority to impose appropriate sanctions, including financial sanctions, against VA for failure to comply with these prescribed rules.

A Dedicated CAVC Building

Finally, the CAVC 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 26 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only article I court that does not reside in its own courthouse. The CAVC should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Congress allocated \$7 million in FY 2008 for preliminary work on site acquisition, site evaluation, planning for construction, architectural work, and associated other studies and evaluations; no further funding has been provided. The issue of providing a fitting and proper court facility must move forward.

MEDICAL CARE



TVHA has been under serious scrutiny in recent years. Issues surrounding patient waiting times, accountability, and care in the community have highlighted the public conversation around veterans' health care. These problems validate concerns that IBVSOs have raised for many years. We have long known that access and lack of capacity presented a serious and chronic problem in VHA, and yet most of those concerns were never properly addressed.

Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. Despite considerable existing challenges, VA has led the way in various areas of biomedical research, specialized services, and health care technology. Unique among the nation's health care systems, VA provides developed expertise across a broad continuum of care. Currently, VHA provides specialized health care services that include program specific centers for care in the areas of spinal cord injury/disease, blindness 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 and in many cases simply does not exist.

The policy proposals we present and the funding recommendations we make are intended to enhance and strengthen the VA health care system. It is our responsibility, along with Congress's and the administration's, to defend and improve a system that, while deeply flawed, is critical to maintaining the lives and well-being of millions of veterans. For all of the criticism that the VA health care system receives (and much of it deserved), VA continues to outperform, in quality of care, safety, and patient satisfaction, every other health care system in America. For this reason the coauthors of *The Independent Budget* believe VA to be a vital national asset for veterans, to be protected and enhanced—not dismantled.

HEALTH CARE PROGRAMS AND ACCESS

VA Must Provide Timely Access to Mental Health Services and Sustain a Comprehensive Mental Health Program for All Veterans

RECOMMENDATIONS:

The IBVSOs urge Congress to ensure that ample resources are provided for VA mental health programs, including comprehensive treatment for serious mental illness and sexual trauma, Veterans Readjustment Services peer-to-peer programs, promotion of evidence-based treatments for PTSD, and specialty SUD services to provide effective mental health care for all veterans needing such services.

VA should improve timely access for veterans in crisis and those seeking VA primary mental health care and specialized programs while concentrating on targeted outreach, anti-stigma, early intervention, and routine screening for all post-deployed veterans as a critical building block to an effective mental health and suicide-prevention effort.

VA should ensure that veterans with war-related mental health issues have access to VA specialized mental health services from providers who have the cultural competency and expertise to understand and treat the unique needs of the veterans population.

The IBVSOs support continued mental health research to close gaps in care and develop best practices in screening, diagnosis, and treatment for veterans' post-deployment readjustment challenges.

BACKGROUND AND JUSTIFICATION:

Over the past decade, the VA Office of Mental Health Services has evolved a comprehensive set of mental health services while seeing a significant increase in the number of veterans receiving services. VA provided specialty mental health services to 1.6 million veterans in FY 2015. In 2007, VA began to co-locate mental health services into primary care settings to improve access and quality. From FY 2008 to March 2014, VA provided more than 3.6 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 942,000 veterans—over one million were provided in FY 2015 alone. In 2016, the MyVA Access initiative was announced to address urgent health needs of veterans, with a plan to make same-day primary care and mental health services available at all 166 VAMCs by the end of the year.

GAO has identified key barriers that deter veterans from seeking mental health care, including stigma, lack of understanding or awareness of the potential for improvement, lack of child care or transportation, and work or family commitments. Early intervention and timely access to mental health care can greatly improve quality of life, promote recovery, prevent suicide, obviate long-term health consequences, and minimize the disabling effects of mental illness.

VA has increased staffing of new mental health providers following a 2012 OIG report on VHA, *Review of Veterans' Access to Mental Health Care* (<http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf>), and made efforts to improve waiting times for access to mental health services and address numerous known barriers to care. However, based on two GAO reports in 2015 and 2016, *Clearer Guidance on Access Policies and Wait-Time Data Needed and Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care, as well as investigations by the US Office of Special Counsel* (<https://osc.gov/News/pr16-05.pdf>), it is still unclear to IBVSOs if veterans are receiving the types of services they need and prefer—and when they need them. Veterans indicate they desire a variety of new services, such as web-based life-coach and skill-building tools, comprehensive and intensive evidence-based therapies, and nonmedical/nontraditional therapies, such as complementary and alternative medicine options (e.g., yoga, meditation, acupuncture, tai chi, and other therapies).

While veterans who served in Iraq and Afghanistan make up only a small percentage of the VA patient population, they are requiring a significant proportion of VA specialized mental health services. Since 2001, over 2.7 million service members have deployed, and some multiple times. Of this group, almost 2 million are now fully eligible veterans. Of those who have become eligible for VA health care, almost 1.2 million have obtained care. Nearly 58 percent of them have been given a mental health diagnosis, prominently including PTSD, depressive disorders, and alcohol dependence syndrome.³

Experts estimate that about 11–20 percent of Iraq and Afghanistan veterans,⁴ as many as 12 percent of Gulf War veterans, and about 30 percent of Vietnam veterans have experienced PTSD at one time or another in their lives. PTSD is associated with other mental health conditions, substance-use disorders, unemployment, and homelessness.

³<http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2015-qtr2.pdf>.

⁴<http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp>.

Post-Traumatic Stress Disorder/Substance-Use Disorders (SUD)

RECOMMENDATIONS:

VA must continue to screen veterans for PTSD and refer those who screen positive into treatment as soon as possible.

VA must continue to train and hire mental health care professionals to meet the increasing demand for specialized care. VA should collaborate and work to train private-sector mental health professionals who agree to contract with VA to alleviate waiting times.

VA's National Center for PTSD must continue to identify innovative interim measures for veterans awaiting evidence-based care, including pharmacologic treatment, group interventions, and use of properly trained peer mentors. Ongoing treatment alternatives for those who decline more traditional evidence-based care or who have dropped out of care must also be considered.

Treatment of women and minorities with PTSD and SUD (or both) must receive special attention to ensure that their particular gender or cultural needs are addressed in policy, program services, and treatment models.

VA must continue to investigate the most effective treatment for the high portion of veterans who experience comorbid PTSD and SUD, as well as develop treatment options for veterans who are newly diagnosed with PTSD or other mental health conditions. VA providers must take steps to prevent at-risk veterans with PTSD from becoming dependent on drugs or alcohol used to "self-medicate."

VA must continue to ensure that its prescribing practices for chronic pain are as safe as possible. It should reassess patients with long-term use of prescribed opioids to assure alternative treatment options such as surgery, physical therapy, or meditative practices are readily available.

BACKGROUND AND JUSTIFICATION:

Along with traumatic-brain injury (TBI), PTSD is another condition that is closely associated with service in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND). PTSD is the psychological impact of witnessing one or more traumatic events. Like TBI, the effects of PTSD can be of an acute nature where veterans spontaneously recover, or they can be chronic, resulting in symptoms that veterans without effective treatment experience for the rest of their lives. Unfortunately, multiple deployments with intense exposure to warfare have put many veterans of recent deployments at high risk for developing chronic PTSD. VA has a well-established treatment program for PTSD and is meeting the needs of veterans from past wartime service eras in addition to addressing the more recent needs of the newer generations of combat veterans.

Lessons learned from Vietnam better informed VA's deployment of resources to address PTSD in the wake of OEF, OIF, and OND. Early on, VA was able to screen for veterans' exposure to events associated with the development of chronic PTSD and use existing protocols to assess symptoms associated with the disorder. VA and DOD developed post-deployment screens that indicate appropriate candidates for more comprehensive assessment. VA has also integrated behavioral health into the primary care setting, which allows individuals who screen positive for PTSD, SUD, or other mental health issues to be assessed almost immediately. VA has also developed a number of self-help tools which have been used by veterans from countries all over the world. Web-based curriculum and mobile apps such as PTSD Coach, Concussion Coach, Cognitive Processing Therapy, and Prolonged Exposure coach have been popular, alone or in conjunction with therapy, among younger generations of tech-savvy veterans. These tools offer awareness and help to active-duty service members or others concerned about the impact of seeking treatment on their military or post-military careers

or the stigma associated with seeking mental health care. Vet Centers are another access point for readjustment counseling services that more discreetly meets the needs of veterans and service members who prefer a nonmedical model of care or want their mental health treatment kept private.

VA has trained more than 6,000 clinicians in the evidence-based protocols shown to be most effective in addressing PTSD—cognitive processing therapy and prolonged exposure therapy. Each of these treatment protocols involve multiple sessions of individualized treatment. Unfortunately, demand for these services has grown by approximately 14 percent in the last four years of reported data (from 500,000 in FY 2011 to 568,000 in FY 2015). In FY 2015, vet centers provided readjustment counseling to about 226,000 veterans, service members, or family members. While VHA continues to hire clinicians to meet the specialized mental health treatment needs of veterans, waiting times for appointments are growing. VA's National Center for PTSD offers support to specialized PTSD treatment facilities and mentoring to train providers in evidence-based therapies, but demand continues to outpace capacity. From 2013 to 2015, veterans' satisfaction with the ability to schedule timely appointments or see providers as often as necessary also declined.

Symptoms of PTSD can resemble those of TBI, with affected individuals experiencing high levels of anxiety or depression and exhibiting difficulty with self-regulation, judgment, and concentration due to preoccupation with the memories of traumatic event(s). Diagnosis is further complicated by the fact that often the veteran may have coexisting conditions of TBI and PTSD. Symptoms of PTSD may significantly impair veterans' ability to reengage with their community and put them at higher risk for developing SUD or committing suicide.

Unfortunately, VA sees many veterans with more than one mental health disorder. Patients with more than one diagnosis are often among the most difficult to treat. While estimates of prevalence of coexisting PTSD and SUD vary, most findings suggest that significant portions of populations with PTSD also have SUD. Researchers from the VA National Center on PTSD cite a large epidemiologic study finding almost half of those in the general population with lifetime PTSD also suffer from SUD. A study done in the 1980s with Vietnam veterans found almost three quarters of those with PTSD also had SUD, but VA researchers found in 2012 that 32 percent of those veterans who received care for PTSD also screened positive for SUD. From FY 2011 to FY 2015, VA treated 15.7 percent more veterans for SUD, which mirrored VA's increase in veterans treated for PTSD (14 percent). While there may be no relationship between the similar growth in numbers, it is clear that there is increased need for both types of treatment in the population. VA is one of the few behavioral health systems to offer specialized treatment addressing more than one diagnosis simultaneously. It offers specialized treatment for PTSD and SUD concurrently in both integrated and stand-alone treatment programs. Clinical guidance developed by VA and DOD in 2010 recommends concurrent treatment of these two disorders.

VA is also taking steps to ensure it uses pharmaceutical treatment options appropriately. Under the Opioid Safety Initiative (OSI), VA reduced the number of veterans for whom it prescribes opioids by 22 percent. Prescribed use of opioids for chronic pain management has unfortunately led to addiction to these drugs for many veterans and other Americans. VA uses evidence-based clinical guidelines to manage pharmacological treatment of PTSD and SUD to ensure better health outcomes.



Traumatic Brain Injury and Polytrauma Rehabilitation

RECOMMENDATIONS:

VA must continue outreach to veterans of recent deployments as well as identifying veterans of past service eras who may benefit from screening and treatment of mild to moderate TBI.

VA must ensure ongoing therapy for veterans who require it as explicitly authorized in law, by eliminating arbitrary limitations on the number and/or frequency of physical, occupational, and speech therapy visits for veterans with moderate and severe TBI and allowing clinicians to use their discretion in prescribing. This will better ensure consistency of delivery throughout the system.

VA and DOD must continue to improve the VA-DOD clinical practice guidelines for TBI as research identifies more refined screening and testing in addition to more effective treatment and rehabilitation protocols.

VA must continue to improve the case-management system and ensure that discharge plans are effectuated.

VA and DOD must continue to research interventions to improve the care and treatment of TBI and polytrauma. Assistive technology is one promising way of improving the ability of veterans with moderate to severe TBI to manage tasks of daily living.

VA must conduct a comprehensive analysis of the Assisted Living–TBI pilot program to determine its effectiveness in enhancing rehabilitation, quality of life, and community integration of participating veterans and sustaining positive gains.

VA must report to Congress its findings and recommendation based on its analysis. Concurrently, because of the positive gains veterans experience in the Assisted Living–TBI pilot, Congress and VA must ensure that community-based brain injury residential rehabilitative care remains available to veterans in the pilot until a future direction has been determined.

BACKGROUND AND JUSTIFICATION:

TBI and PTSD have been called the “signature” injuries of OIF, OEF, and OND. Returning service members and veterans have high rates of exposure to events such as blasts from improvised explosive devices (IEDs) and land mines, car crashes, falls, physical assaults, and sports injuries. Many had multiple exposures to such events.

TBIs fall on a spectrum categorized from mild to severe. Some brain trauma is the secondary effect of stroke or other acute disease or injury such as from motor vehicle accidents. According to the Institute of Medicine (IOM) report *Gulf War and Health, Volume 7: Long-Term Consequences of Traumatic Brain Injury*, individuals with TBI are at increased risk of developing epilepsy and neurodegenerative diseases such as Alzheimer’s disease, Parkinson’s disease, or Lewy body dementia. In addition, repetitive blows to the head can result in chronic traumatic encephalopathy, a condition that may start with loss of certain executive functions such as memory, concentration, or attention and may eventually progress to problems with tremors, slurred speech, coordination, and gait. Other associated disorders with TBI include posttraumatic hypopituitarism, which may also lead to other neuroendocrine conditions. Over time, individuals with TBI may also develop other conditions, such as sleep disturbances, obstructive sleep apnea, incontinence, sexual dysfunction, metabolic dysfunction, or musculoskeletal dysfunction.

Most traumatic injuries are mild, and veterans often spontaneously recover; however, even mild injuries may have sustained effects that impact veterans’ ability to function optimally. These sustaining injuries can affect mood, behavior, attention, judgment, initiative, focus, and self-regulation among other executive functions, impacting veterans and their loved ones’ lives in significant ways. People with such injuries may have difficulty maintaining personal relationships, engaging in productive activity, including work or education, and managing their daily lives.

Many mild to moderate brain injuries can be difficult to detect. VA has screened most of the veterans of recent deployments under its care and diagnosed 94,000 cases of mild TBI. However, older generations of veterans who might potentially benefit from treatment may have never been screened for TBI. Providers of those eras

lacked the awareness of the long-term effects of concussive injuries or the clinical practice guidance that exists for treatment today.

About 3,100 TBIs treated in VA are characterized as severe. Another 4,600 veterans with brain trauma associated with stroke or other cardiovascular events are treated in the system.

VA and DOD have established new standards of care for meeting the needs of veterans from recent deployments. The Defense and Veterans Brain Injury Consortium (DVBIC) began in 1992, and VA began developing TBI centers. DVBIC has developed clinical practice guidelines for the screening and treatment of mild TBI in VA and DOD. It developed a caregivers' guide and improved standards for coding to enable better tracking of individuals' care outcomes. The system continues to set standards for providing care and measuring care quality and outcomes.

To meet the emerging need of veterans returning from deployments in Iraq and Afghanistan, VA's lead TBI centers evolved into polytrauma rehabilitation centers (PRCs). PRCs serve as the hubs of the nationwide system VA has in place at 148 medical facilities today, which include five PRCs, in addition to network sites, polytrauma clinics, and polytrauma care teams (embedded in some primary ambulatory care teams).

VA developed the polytrauma system to address TBI and other frequently co-occurring injuries (including wounds requiring amputation, sight or hearing impairment, spinal cord injury, pain, and mental illnesses such as depression and PTSD), using a highly integrated and coordinated approach to address the complex needs for medical, rehabilitation, and supportive services. The system integrates VA and DOD care delivery and works closely with the grantees from the National Institute of Disability Rehabilitation and Research TBI Model Systems to share data and best practices. Much more research, including research into assistive technologies that may assist veterans with reintegration into the community, is necessary.

Veterans with the most chronic and severe brain injuries and their families often require a lifetime of care and support. VA has a case-management system in place that is designed to follow these patients into the first two years of recovery in the community—more if significant issues persist. An individualized rehabilitation and community reintegration plan is developed with an interdisciplinary care team (including the veteran or his or her family caregiver) prior to the veteran's discharge from a PRC. The successful implementation of the plan is highly dependent upon the family's ability to adequately support the veteran at home, the patient's distance from needed care, and the PRC case managers' inability to control the resources necessary to execute the discharge plan. For example, the PRC may have prescribed speech therapy for the discharged veteran, but the VAMC nearest the veteran's home charged with delivering the care may not deem the veteran an appropriate candidate for treatment. VAMCs also significantly vary the amount of care (such as physical, speech, and occupational therapy) they are willing to reimburse or provide, often halting such services once it deems a maximal level of benefit has been reached. Unfortunately, without these services, veterans may regress and even develop secondary conditions that require more intensive medical treatment.

Waiting times for such services as the Independent Living Program through VBA's Vocational Rehabilitation Program may affect execution of the plan. In addition, these very complex neurobehavioral conditions often require services such as cognitive rehabilitation and neurobehavioral care that are not widely available in VA and may need to be addressed through contracts with community providers. The case manager may not be as familiar with the available resources in the veteran's community. These problems with discharge planning and case management must be addressed as the program evolves.

Recognizing the need to fill the neurobehavioral care gap, VHA established an ongoing pilot project examining provision of neurobehavioral residential care (termed by Congress as assisted living) for veterans of recent deployments with moderate to severe TBI. The pilot has been extended until October 2017. Some of the private-sector facilities selected as providers have embraced the challenge adapting their programs, establishing important relationships with VA and military providers and even creating new space to meet the specific needs

of veterans and service members. Quarterly feasibility reports of the pilot show generally positive gains in veteran patient health outcomes, as well as high levels of satisfaction from both patients and family members. However, comprehensive analysis has yet to be performed to determine the value and effectiveness of this type of community-based brain-injury residential rehabilitative care in light of the long-term consequences of moderate and severe TBI. While this analysis is being performed, services being provided should remain available to veterans under the authority of the pilot program or title 38, USC, section 1720(g), which authorizes VA to provide assisted living to certain veterans with TBI.

Military Sexual Trauma (MST)

RECOMMENDATIONS:

Congress should continue MST-related oversight and hearings with the goal of improving VA-DOD collaboration and improving policies and practices for MST-related care and disability compensation.

VBA should employ the clinical and counseling expertise of sexual trauma experts within VHA, or other specialized providers, during the disability compensation examination phase.

VBA should continue to train staff and review MST-related claims to ensure that established directives for claim adjudication are being followed.

VBA should establish a designated point of contact on all claim-related documents sent to veterans and ensure veterans are provided with the appropriate MST coordinator where their claim is being worked. VA should ensure the website hosting MST coordinator information is current.

VBA should conduct an anonymous survey of all veterans who have filed an MST-related disability compensation claim or undergone a compensation examination to determine how the process can be improved or made less traumatic for sexual assault survivors.

VBA should identify and map all personal trauma claims, with a focus on MST, by gender to determine the number of claims submitted annually, award and denial rates, and conditions most frequently diagnosed. This information should be available to the public and reported annually to key stakeholders.

DOD and VA need to improve collaboration efforts to develop an appropriate resolution for requesting and sharing MST-related records when authorized by the service member or veteran.

DOD and VA must continue to improve their Integrated Mental Health Strategy (IMHS) to ensure members and veterans receive proper screening, treatment, and compensation for conditions resulting from military sexual trauma.

VHA should adjust its authorization policy for beneficiary travel for veterans referred for MST-related mental health treatment at specialized inpatient/residential programs outside of facilities where they are enrolled.

BACKGROUND AND JUSTIFICATION:

MST continues to be a problem within DOD among all branches, including both active and reserve components. MST affects service members and veterans of all backgrounds without regard to age or race. The definition of MST under federal law (title 38, USC, section 1720D), is defined as psychological trauma, which in the judgment of a VA mental health professional resulted from a physical assault of a sexual nature, battery

of a sexual nature, or sexual harassment that occurred while the veteran was serving on active duty, active duty for training, or inactive-duty training.

The DOD office responsible for matters related to sexual assault is the Sexual Assault Prevention and Response Office (SAPRO). SAPRO serves as the single point of oversight for sexual trauma policies, provides guidance to all service branches, and facilitates resolution of common issues that arise within the joint commands of the military services. SAPRO's primary objective is to promote prevention of sexual assault through training and education programs, encourage increased reporting of incidents, improve response capabilities, enhance system accountability, and ensure treatment and support for survivors of sexual assault.

Sexual assault is a crime that affects both servicemen and -women; however, women tend to report the crime more often than males. According to DOD, in FY 2014, an estimated 10,600 men and 9,600 women experienced sexual assault. Of the 20,200 assaults, it is estimated that only 23 percent reported the crime. These numbers are especially alarming, illustrating that servicemen are experiencing sexual assault in higher numbers than thought. This is of significant concern and also reveals a gap in reporting. Men only report sexual assault at 10 percent, whereas females report assault at 38 percent. Research has found that men do not easily identify as having experienced sexual assault and will often refer to an event as hazing. Forty-nine percent of servicemen experiencing sexual assault report the assault as having involved multiple alleged offenders.

While DOD continues to increase its efforts to reduce or eliminate sexual trauma within the military service, the number of servicemen affected by MST is slow to decline, with a less than 1 percent decrease from the DOD report in FY 2014. In FY 2015, the military services received 6,083 reports of sexual assault, 4,584 of the reports were unrestricted, and 1,499 remained restricted at the end of FY 2015. (There are two reporting options recognized by DOD when reporting MST-related crimes. An unrestricted report prompts command notification and investigation, whereas a restricted report prompts sexual assault prevention and response services.) DOD estimates that on average, a staggering 77 percent of sexual assaults go unreported.

Congress must ensure DOD and VA improve their collaborative effort in awareness, reporting, prevention, and response among both service members and veterans. The identification of service members transitioning from military service having been affected by MST is a vital step in ensuring the veteran receives all of the appropriate care he or she needs, and has earned. VA's national screening program screens all patients enrolled in VA's health care system for MST. National data from this program reveals that about one in four women and one in 100 men respond affirmative to having experienced MST. All veterans who screen positive are offered a referral for free MST-related treatment, which notably does not trigger the VBA disability claims process. According to VA, in FY 2015, 99,060 women and 63,440 men were seen in VHA affirming a history of MST. MST-related care was provided to 115,566 veterans, which is up from 102,836 in FY 2014.

VA has identified transitioning service members and newly discharged veterans as high-priority groups for outreach and is collaborating with SAPRO and other national VA program offices to ensure that veterans are aware of MST-related services available through VHA and that MST-specific content is part of mandatory out-processing completed by all service members. In August 2014, section 401 of the Veterans Choice Act amended the current authority to extend eligibility to veterans who experienced MST while serving on inactive-duty training, therefore closing the gap between treatment for those on active duty and those inactive for training. According to VA, veterans are being treated for physical and psychological conditions relating to MST. This treatment is free to MST survivors and independent of service-connected status.

Although VHA is providing excellent care to veterans with assault histories, in December 2012, OIG released a health care inspection report concluding that women veterans are often admitted to specialized MST programs outside their Veterans Integrated Service Network (VISN) and that obtaining authorization for reimbursement of travel expenses is a frequent problem for both patients and staff. OIG noted the current beneficiary travel directive is not aligned with VA's MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

Another challenge for veterans with MST-related conditions occurs during the VBA disability compensation process. It can take many years for survivors to even acknowledge that a trauma occurred, and sharing details with advocates and care providers can be extremely difficult. Survivors of sexual assault often report they feel re-traumatized when they have to recount their experiences to disability compensation examiners. Therefore, we encourage VBA to employ the clinical and counseling expertise of sexual trauma experts within VHA or other specialized providers during the compensation examination phase.

MST coordinators are available at every VAMC to assist veterans in accessing MST services, which include outpatient mental health assessments and evaluations, group and individual therapy, and specialty services to target problems such as PTSD, substance use, depression, and homelessness. Many community-based vet centers also have trained sexual trauma counselors. Additionally, there are residential rehabilitation and treatment programs to help veterans who need more intensive treatment, some of which have specialized MST tracks.

Despite increased awareness thorough military reports, congressional hearings, documentaries, and media stories, many service members, male and female, experiencing sexual trauma still do not disclose this information at all, and when they do it can be many years after the assault. IBVSOs strongly believe that survivors of military MST deserve proper recognition, treatment, assistance in developing their claims, and compensation for any residual conditions related to the assault. Due to the unique circumstances surrounding MST, these cases need and deserve special attention. If we are to fully support service members and veterans in their recovery, the development of systems that take into account the unique circumstances that surround sexual assault in the military are essential. Most important, DOD must make the necessary changes to prevent sexual assault in the military services and properly manage care coordination for the survivor when an assault does occur.

DOD and VA must fully commit to improving their IMHS to ensure service members and veterans get the proper screening, treatment, and compensation for conditions resulting from MST. There is still much work to be done by the DOD in its prevention and elimination. There must be a streamlined and integrated approach to ensure service members and veterans receive every opportunity to recover their good health and mental well-being following this type of trauma.



DOD and VA Must Intensify Their Suicide Prevention Efforts

RECOMMENDATIONS:

Congress should provide the resources, and VA must ensure existing programs are effective and accessible, deploying new initiatives designed to address the changing needs of veterans at risk for suicide.

VA and DOD must improve their collaboration and focus on implementation of their IMHS to address suicide risk and prevention and improve mental health outreach efforts to service members and veterans. DOD should continue anti-stigma campaigns such as #BeThere and identify and deploy the best evidence-based treatment strategies for suicide prevention in this population. These strategies should include easy access to mental health services in primary care, which is essential to addressing and overcoming the stigma frequently associated with seeking mental health care within DOD and VA programs.

Continued support for VA's Make the Connection campaign and Coaching into Care tips for family members, as well as the Veterans Crisis Line (VCL), which includes chat and text services—all a part of VA's comprehensive suicide prevention strategy.

VA must increase options for veteran- and family-centered mental health care programs, including family therapy and marriage counseling.

BACKGROUND AND JUSTIFICATION:

Suicide among the nation's veterans continues to be a top priority among DOD active-duty and reserve components, as well as within VA, with special emphasis on war veterans. Both departments remain focused on enhancing outreach initiatives, targeting suicide prevention efforts, and reducing stigma associated with suicide.

Though VA has made many improvements in prevention efforts, there has only been a small decrease in the number of veterans dying by suicide. According to the Suicide Data Report released by VA in 2012, it was estimated that 22 veterans died by suicide daily in 2010. The most recent report, released in August 2016, indicates this number has slowly declined, with an average of 20 veterans having died per day by suicide in 2014 (7,240 in all). In 2010, Veterans accounted for 18 percent of all deaths by suicide among American adults, constituting 8.5 percent of the adult population (ages 18+). Of all veteran suicides in 2014, about 65 percent of all Veterans who died by suicide were age 50 years or older. Notably, 14 of the 20 suicides per day in 2014 were veterans not receiving VA care. In 2014, female VHA users with the highest rates of suicide were at the age of 40 to 59, which has been a consistent pattern each year from 2001 to 2014. . Female veterans commit suicide at a rate 2.4 times higher than women who have not served in the military. These are staggering statistics, and more must be done to understand this group of veterans.

One death by suicide is one too many. Congress must ensure that sufficient resources are made available for suicide prevention efforts, to identify those at higher risk of dying by suicide, to deploy new interventions, and to effectively treat those with previous suicide attempts. Programs such as the Veterans Crisis Line (VCL), Make the Connection, and Coaching into Care; the placement of suicide prevention coordinators at all VAMCs and large outpatient facilities; and joint campaigns between DOD and VA such as #BeThere should be continued to aid in anti-stigma efforts and the promotion of suicide prevention awareness.

The VCL provides immediate access to mental health crisis intervention and support. According to VA, since its inception, the VCL has answered over 2.3 million calls, made over 289,000 chat connections, and completed over 55,000 texts, resulting in the dispatch of emergency services to callers in imminent suicidal crisis over 61,000 times.

Because suicide often involves psychological and societal factors, it is important for VA and DOD to have the ability to target at-risk groups by identifying markers related to these factors as early as possible. One way VA has accomplished the task of being proactive rather than reactive in the prevention of suicide is by using predictive analytics to identify and act before a crisis. Screenings and assessment processes are set up throughout the VA system to assist in the identification of patients at risk for suicide.

DOD and VA IMHS must continue to advance and integrate a coordinated health model to improve access, quality, effectiveness, and efficiency of mental health services. Suicide-prevention efforts are no small task and will require continued efforts in understanding more about increasingly at-risk groups and prevention aimed at identifying these individuals before there is ever a crisis. Individuals suffering from relationship problems have also been identified as an at-risk group for whom suicide has often been seen as the solution. Programs such as Coaching into Care that assist family members and friends by providing them with ways to help motivate the veteran to seek services should continue to be available at all VA health care facilities. VA's Make the Connection is an online resource designed to connect not only veterans and family members, but also friends and other supporters with information about, resources for, and solutions to issues affecting their lives.

It is imperative for Congress to ensure VA has all of the resources it needs to not only ensure programs in existence are effective and accessible, but also to deploy new initiatives designed to address the changing needs of veterans at risk for suicide. VA should continue its proactive approach to suicide prevention by building on

its early identification program and ensuring variables for all known high-risk groups for suicide are added and effectively used. While VA and DOD have made improvements in suicide prevention, a continued focus must remain on lowering and eliminating suicide in the veteran population.

Rural Veterans' Health Care

RECOMMENDATIONS:

VA must expand innovative approaches to ensure better transportation for rural veterans, including deployment of social workers to primary care sites to identify and address transportation needs and establish more internal transportation programs, especially for older or disabled veterans.

VA should evaluate its beneficiary travel program to ensure it is adequately and cost-effectively meeting veterans' needs for safe and accessible transportation. It may consider alternatives to its current program such as establishing coordinated transportation networks or providing travel vouchers for eligible veterans.

Congress and VA must conduct rigorous oversight of VA's new contract care program to ensure the needs of rural veterans are met and take steps to reinstate contractual relationships with sole-source providers in underserved communities as necessary, notwithstanding their participation in the Choice Program.

VA's Office of Rural Health must receive funding commensurate with its mission of expanding access to a large portion (one third) of VA's enrolled users.

VA's Office of Rural Health should continue to collaborate with its intra-agency partners, such as its Office on Sharing, to ensure that all available opportunities to meet rural health care needs are explored. It should also coordinate with the Health Research Service Administration's Federal Office of Rural Health Policy to explore opportunities and address barriers to greater sharing of federal health resources in rural America.

BACKGROUND AND JUSTIFICATION:

Rural populations, in general, have difficulty accessing high-quality health care, but for veterans requiring specialized treatment for service-incurred disabilities or conditions, receiving needed care may be even more challenging. Rural populations, including veterans, are generally poorer, older, less likely to have health insurance, and more likely to describe their health status as worse than urban peers. Most older rural veterans require ongoing care for chronic health conditions, many of which are service-connected. More of these veterans (56 percent versus 36 percent of urban veterans) are enrolled in the VA health care system. Veterans from rural areas are overrepresented in VHA enrollment relative to urban peers; only a quarter of all veterans live in rural America, but rural veterans constitute a third of all VA enrollees.

Health care providers cannot sustain operations in many rural areas of the country where the individual's need may be great but the combined population does not have enough need for services to fully engage a health care clinic or provider. Rural populations often rely upon safety net providers—federally qualified health centers (FQHCs), rural health clinics, critical access hospitals, or other community resources—to address the needs of all community members. Indian Health Service and military treatment facilities also help fill rural health needs but follow stricter eligibility guidelines.

VA has 21 hospitals or medical centers located in rural areas. VA's Community Based Outpatient Centers add another 350 points of access in rural settings. Still, access to health care for rural veterans is a problem,

particularly as veterans age, become more disabled, or lose family caregivers who have served transportation and supportive-care needs.

Transportation is one of the most pressing issues for rural veterans. Beneficiary travel funds reimburse eligible veterans for part of their travel expenses, but the reimbursement depends upon the veteran finding an able and available driver and vehicle. Some veterans are able to tap into VSO community resources for the aged and disabled to meet transportation needs but may require assistance in coordinating these services.

The White River Junction VA Medical Center in Vermont may offer a model for meeting transportation needs. It has a transportation program that allows veterans to schedule van rides for medical appointments at VA facilities or care paid for by VA in the community. It uses five vans with wheelchair lifts and employs drivers living in different parts of its catchment area to improve coverage. The program takes calls from about 200 veterans daily, demonstrating the tremendous need for such a program. Other VAMCs have embedded social workers in patient-aligned care teams to assist veterans with identifying support services such as transportation.

Congress authorized VA's Choice Program to improve veterans' access to health care through contracted care networks. VA then decided to consolidate many of its contract care programs, including those specifically aimed at rural populations, under Choice. Ironically, administrative hurdles and underdeveloped provider networks have actually compromised access to care for many veterans, including those in rural America. Choice had the unintended consequence of upending many veterans' established relationships with trusted providers who were not able or willing to participate in the Choice networks. These effects may be most profound in rural communities. Community providers in rural America who see just one or a few veterans may not be willing or able to support VA's requirements for participation. Unfortunately, these providers are often the sole source of health care available in the area. VA may need to determine if Choice can adequately meet needs in these rural and other underserved areas and identify other initiatives to fulfill these needs if necessary.

Broad sharing authority must also address rural Americans' health care needs. VA has many sharing agreements with the Indian Health Service and military treatment facilities, but there are additional opportunities that would likely increase access and decrease costs for all federal providers. FQHCs and rural health clinics might offer additional sharing opportunities. If enough demand from veterans exists, VA could consider offering telehealth or employing staff in some sites under other government programs' jurisdiction. Unfortunately, restrictions upon funding and eligibility rules limit opportunities and effectively deter government programs from working together to develop shared health care resources or use existing resources more efficiently, especially in medically underserved areas.

VA has a well-developed telemedicine and connected health portfolio, with programs that expand its reach into many areas, including some underserved areas. VA has used telehealth initiatives to reach rural populations, particularly for providing specialty care. Unfortunately, more than a third (36 percent) of rural veterans lack access to the Internet at home, which further constrains VA's ability to meet their needs. The web-based technologies that VA routinely uses to monitor and educate so many veterans cannot be used for them in their homes.

Despite these significant challenges, VHA's Office of Rural Health continues to develop innovative approaches to addressing veterans' needs. Its small and stagnant earmark (\$250 million) needs to increase to better reflect the large portion of veterans it represents and its workload. The Office of Rural Health produces a national rural needs assessment. It develops and funds rural promising practices to offer new models of rural care and provides training to rural health providers. It also collaborates with other VA programs and federal agencies to develop options for expanding veterans' access to high-quality health care in rural communities.

American Indian and Alaska Native Veterans

RECOMMENDATIONS:

VA must fully enable the Office of Tribal Government Relations to undertake targeted outreach to tribal governments to increase awareness of VA services.

VA must improve efforts to ensure culturally competent care is provided to AI/AN veterans.

VA must and IHS must efficiently and quickly implement reimbursement agreements to ensure veterans' access to care.

More research is needed to assess the gaps in health care for veterans in Indian country.

BACKGROUND AND JUSTIFICATION:

American Indians and Alaska Natives (AI/AN) serve in the US military at higher rates than any other race. While only making up 1 percent of the overall US population, Native peoples make up 2 percent of the active-duty personnel and 1.5 percent of the total veteran population. Native veterans are more likely to have a service-connected disability and the highest unmet health care needs.⁵ Yet they are the most underrepresented among veterans who access their earned benefits and services through VA. Despite the trust responsibility of the federal government to provide recognized tribal members with health care,⁶ American Indians experience the greatest health disparities in the United States.⁷

For veterans living in Indian country—on reservations or in tribal communities—they often face barriers to care that are unlike those experienced by most others. Native veterans are more likely to have on average a household income of less than \$10,000. Nearly 60 percent are unemployed.⁸ Of the 27,500 miles of reservation road owned and maintained by the Bureau of Indian Affairs, only 7,100 are paved. These are some of the most unsafe road networks in the nation.⁹ Only 25 percent of households on reservations have a vehicle. In many communities, there is limited, if any, access to the Internet.¹⁰ Without reliable means to travel to health care appointments or even access telehealth, AI/AN veterans continue to go without care.

For AI/AN veterans who are dually eligible for IHS and VA health benefits, confusion at the facility level of both systems regarding payment is a barrier. According to congressional testimony and media reports, AI/AN veterans have trouble accessing either health care system and are often turned away by both.¹¹ For those who have accessed or received VA care but do not continue, a negative experience—a culturally insensitive provider or lack of appropriate services—is often the cause.¹²

⁵US Census Bureau, American Community Survey, Public Use Microdata Sample, 2010, prepared by the National Center for Veterans Analysis and Statistics.

⁶The federal Indian trust responsibility is a legally enforceable fiduciary obligation on the part of the United States to protect tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to American Indian and Alaska Native tribes and villages. <http://www.bia.gov/FAQs/>

⁷Indian Health Service Fact Sheet, <https://www.ihs.gov/newsroom/factsheets/disparities/>.

⁸National Congress of American Indians, November 2013, <http://files.ncai.org/broadcasts/2013/November/bb%20-%20Veterans.pdf>.

⁹National Congress of American Indians, November 2013, <http://files.ncai.org/broadcasts/2013/November/bb%20-%20Veterans.pdf>. <AU: Suggest "ibid." not be used, because footnotes could end up on different pages.>

¹⁰US Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, (September 2004), 77–80, and VHA Office of Rural Health, "Frequently Asked Questions about the Native Domain," <http://www.ruralhealth.va.gov/native/faqs.asp>.

In 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU) to improve Native American veterans' access to VA. Since 2010, VA has worked to build trusting relationships with tribes, expand telehealth services, and provide cultural competence training at VA. The VA Office of Tribal Government Relations (OTGR), established in 2011, is charged with overseeing tribal consultations and ensuring that VA respect the government-to-government relationships with tribes. The implementation of the MOU has been led by the OTGR, the VA Office of Rural Health, and the IHS chief medical officer. As of 2015, AI/AN veterans have seen an increase in outreach from VA, improved quality and coordination between the two federal health systems, and increased cultural competency trainings for staff.

In 2012, VHA and IHS signed a reimbursement agreement allowing VA to reimburse for direct care services provided to eligible Native veterans at all IHS sites across the country. Tribal health programs enter into local reimbursement agreements with nearby VAMCs. As of 2015, there are 89 signed local reimbursement agreements with tribal health programs. VA has reimbursed IHS a total of \$33 million for direct services provided to eligible AI/AN veterans.¹³

VA is expanding its Veterans Transportation Services (VTS) program to more than 80 rural communities nationwide. Only three have extended services with tribal nations. The VTS program must build partnerships with tribal governments and extend VTS into communities where transportation is a barrier to care.

A difficult history between tribes and the federal government impacts VA's legitimacy in tribal communities. VA must continue to build trust in these communities that have long been ignored.



Inappropriate Billing

RECOMMENDATIONS:

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

Congress should continue oversight of the Choice program to ensure veterans are not inappropriately billed by community providers.

VHA should establish policies and monitor compliance to prevent veterans from being billed for service-connected conditions and secondary conditions that are related to the service-connected conditions.

VHA should establish and enforce a national policy describing the required action(s) a VA facility must take when a veteran identifies an inappropriate billing episode. Resolution(s) must then be reported to a central database for oversight purposes.

VHA and VBA must improve the eligibility data interface to ensure that information available to the VHA is accurate, up to date, and accessible to staff responsible for billing and revenue.

¹¹VA and IHS: *Further Action Needed to Collaborate on Providing Health Care to Native American Veterans*, GAO-13-354 (Washington, DC: April 26, 2013); *Health Care Access: Improved Oversight, Accountability, and Prioritization Can Improve Access for Native American Veterans*, GAO-14-489 (Washington, DC: June 2014).

¹²Twenty percent of AI/AN people speak English as a second language. As AI/AN veterans age, they often lose their English. VA providers are unlikely to have Native language translators.

¹³VA, Office of Tribal Government Relations, *2015 Executive Summary Report*.

VHA must measure copayment accuracy rates and periodically assess the accuracy and completeness of its copayment charges.

BACKGROUND AND JUSTIFICATION:

VA was granted the authority to collect payments from health insurers of veterans who receive VA care for non-service-connected conditions, as well as other revenues such as veterans' copayments and deductibles, and manage these collections through the Medical Care Collections Fund. 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. In recent years, as IBVSOs have seen significant increases in both medical care collections estimates and the actual funds collected, we have received an increasing number of reports from veterans who are being inappropriately billed by the 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 of veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers, two of the most common secondary conditions associated with spinal cord injury. Inappropriate billing for such secondary conditions forces service-connected veterans to seek readjudication of claims for original service-connected ratings. This process is an unnecessary burden to both veterans and an already backlogged claims system.

Moreover, inappropriate billing is not a problem being experienced only by service-connected disabled veterans, but by non-service-connected disabled veterans as well. The IBVSOs continue to receive reports of non-service-connected disabled veterans receiving inappropriate bills, most commonly being billed multiple times for the same treatment episode or having difficulty getting their insurance companies to reimburse for treatment provided by VA. In addition, non-service-connected veterans experience inappropriate charges for copayments.

The Veterans Choice Act of 2014 requires VA to operate a temporary program allowing veterans to use certain community providers outside the VA health care system. Due to the complexity of the program and its departure from VA's usual practice of directly coordinating, authorizing, and paying for care in the community, veterans are being inappropriately billed by community providers.¹⁴

Improving VA-Academic Affiliations to Train the Next Generation of Physicians Who Will Care for Veterans

RECOMMENDATIONS:

Congress must enact legislation to exempt VACAA Graduate Medical Education residency positions from the 1997 Medicare cap. Legislation to lift the Medicare GME cap must prioritize teaching hospitals affiliated with VAMCs.

VA must improve community care and construction partnerships with its academic affiliates to ensure veterans have timely access to high-quality health care.

¹⁴VACAA (e)(3) VA as secondary payer to Other Health Insurance for non-service-connected care under the Choice Program. VACAA (c)(1)(B) and (h) authorization of care for a period of time specified by VA or through the completion of the episode of care may not cover follow-up care or for additional services recommended by community provider. VACAA (l) requires the return of medical records from community provider to VA as a condition of payment but is not customary. Lengthy delays in payments lead community providers to bill veterans for care provided.

Congress must authorize VA to recruit health care professionals who are trained at VA by offering residents employment opportunities that are contingent on completion of required training programs.

BACKGROUND AND JUSTIFICATION:

As the largest integrated health care system in the country, VA is the proverbial “canary in the coal mine” for identifying physician shortages in America’s health care workforce. While the exact need has yet to be determined, the Association of American Medical Colleges estimates that the United States is facing a shortage of 61,700 to 94,700 physicians by 2025, with specialty shortages particularly acute. The most vulnerable patient populations are in underserved areas, many of which have large veteran populations. With more than 60 percent of US-trained physicians receiving VA training prior to employment, the VA health care system plays an important role in training the next generation of physicians and filling such shortages. Congress took an important first step toward addressing these shortages and expanding VA’s training mission by increasing VA GME slots up to 1,500 residency positions with the passage of VACAA. However, VA is the only federal agency that has expanded support for residencies to help address physician workforce shortages. Thus, this synergy between a VA hospital and its affiliated academic medical center is an important relationship to maintain and foster.

Academic partnerships facilitate the joint recruitment of faculty to provide care at both VA and academic medical facilities. VA GME programs also educate new physicians on cultural competencies for treating veteran patients (inside and outside the VA) and help recruit residents physicians to the VA after they complete their residency training. According to results from the VA’s Learners’ Perception Survey, residents who rotate through the VA are nearly twice as likely to consider employment at VA institutions. While VA has statutory authority to directly hire physicians, it is not authorized to offer them employment until after they complete their residency program. Since private health care systems often offer residents employment a year or two before they complete their residency programs, VA is at a disadvantage when hiring health care professional who complete their residency at VA medical facilities. This statutory limitation hinders VA’s ability to hire and retain physicians who complete their residency program at VA and would like to continue to work at VA. VA residency programs are sponsored by an affiliated medical school or teaching hospital. While programs and specialties at VAMCs vary considerably, on average medical residents rotating through VA spend approximately three months of a residency year at VA. To successfully expand VA GME, VA estimates that affiliated teaching hospitals need two to three positions for every VA position to meet all program requirements.

The primary barrier to increasing residency training at medical schools and teaching hospitals is the cap on Medicare GME financial support, which was established in 1997. Legislation was introduced in the 114th Congress that exempts medical residents partially funded under VACAA from the Medicare GME cap. Two other bills were introduced expanding the number of Medicare GME–supported training slots and incentivizing VA partnerships by including a preference for teaching hospitals affiliated with VAMCs.

VA and academic medicine have enjoyed a 70-year history of affiliations to help care for those who have served this nation. However, this shared mission can be strengthened through joint ventures in research, education, and patient care. Already institutions and medical faculty collaborate in these areas, but often VA lacks the administrative mechanisms to cooperatively increase medical personnel, services, equipment, infrastructure, and research capacity to meet growing demand for veterans health care. Through joint ventures with academic affiliates, VA would ensure veterans have access to clinical services at teaching hospitals that are scarcely available elsewhere.

VA sole-source contracting allows academic affiliates to plan, staff, and sustain infrastructure for certain complex clinical care services for veterans that are scarcely available elsewhere. VA Directive 1663 states: “Sole-source awards with affiliates must be considered the preferred option whenever education and supervision of graduate medical trainees is required (in the area of the service contracted). The contract cost cannot be the sole consideration in the decision on whether to sole source or to compete.”

However, by VA's own estimation, once the decision has been made to contract care in the community, VA sole-source contracting with trusted academic affiliates takes longer than the formal competitive solicitation process. In 2016, GAO found it takes multiple years on average to develop and award high-value, long-term sole-source affiliate contracts, partially as a result of a process that is not designed for clinical service agreements.

Non-VA Emergency Care

RECOMMENDATIONS:

VA must immediately issue an interim final rule to remedy the inconsistency between current non-VA emergency care reimbursement regulations and statute, and Congress must provide VA the necessary resources to timely adjudicate and pay claims under the new rule.

Congress must enact legislation to make non-VA emergency care benefits less burdensome to veterans and VA.

Congress must conduct oversight on the VA emergency care program to ensure VA is complying with current law.

Because of the complexity of current law governing non-VA emergency care benefit, VA must survey veterans' knowledge of non-VA emergency care benefits to tailor its education efforts.

BACKGROUND AND JUSTIFICATION:

In order for VA to pay for emergency services provided to veterans by non-VA providers, VA must apply three disparate statutory authorities with varying eligibility requirements. This difference in criteria has led to some non-VA emergency care claims being inaccurately and improperly processed.

According to VA, approximately 30 percent of the 2.9 million non-VA emergency claims for payment or reimbursement filed with the VA in FY 2014 were denied. Between the start of FY 2014 and August 2015, approximately 89,000 claims were denied because they did not meet the timely filing requirement, 140,000 claims were denied because a VA facility was determined to have been available, 320,000 claims were denied because the veteran was determined to have other health insurance that should have paid for the care, and 98,000 claims were denied because the condition was determined not to be an emergency.

Additionally, the CAVC ruled unanimously in April 2016 that VA wrongly denied claims for reimbursement when the department ignored a 2010 statute meant to protect certain veterans from out-of-pocket costs when forced to use non-VA emergency care. From this ruling, it is estimated more than two million claims submitted since 2010 could be eligible for reimbursement and that over the next decade nearly 69 million claims could be submitted, which could cost as much as \$10 billion.

Because delays in processing non-VA emergency claims place substantial financial responsibilities on veterans and emergency care providers, VA must issue interim final rule regulations with all deliberate speed. In addition, Congress must provide VA the necessary resources to timely adjudicate and pay claims.

Erroneous denials of non-VA emergency care claims make veterans financially liable for care that VA should have covered. Because the financial liability is often large and credit ratings are negatively affected, veterans choose to delay or avoid going to non-VA emergency rooms or go to a VA facility instead.

Research suggests that patients’ concerns about costs can keep them from going to the emergency room. A 2010 study in the *Journal of the American Medical Association* found that insured patients without financial concerns were more likely to seek emergency care within two hours, but almost half of uninsured patients or patients with financial concerns waited six hours or more to seek care.

The laws prescribing non-VA emergency care benefits continue to place extraordinary burden on veterans requiring that they be educated on convoluted and burdensome administrative criteria not typically found in private health-insurance plans. Current law governing health insurance plans prohibits higher copayments or coinsurance for emergency care from out-of-network hospitals. Also, health insurance plans should not require prior approval before getting emergency room services from out-of-network hospitals.

SPECIALIZED SERVICES

Continuation of Centralized Prosthetic Funding

RECOMMENDATIONS:

VA must continue to nationally centralize and protect all funding for prosthetics and for sensory aids. Congress must ensure that appropriations are sufficient to meet the prosthetic needs of all enrolled veterans, including the latest advances in technology, so that funding shortfalls do not compromise other programs. The VHA senior leadership should continue to hold field managers accountable for ensuring that data is properly entered into the National Prosthetics Patient Database (NPPD) and any other relevant database.

BACKGROUND AND JUSTIFICATION:

The protection of Prosthetic and Sensory Aids Service (PSAS) funding by a centralized budget has had a major positive impact on meeting the specialized needs of disabled veterans. Prior to the implementation of centralized funding, many VAMCs reduced overall budgets by reducing spending for prosthetics. Such actions delayed provision of wheelchairs, artificial limbs, and other prosthetic devices. Once centralized funding was enacted, the VA Central Office (VACO) could better account for the national prosthetics budget and medical equipment funding related to specialized services, including needs of veterans with spinal cord injury/disease (SCI/D), TBI, or amputations. The IBVSOs strongly encourage VA to maintain a dedicated, centrally funded prosthetic budget to ensure the continuation of timely delivery of quality prosthetic services to the thousands of veterans who rely on artificial devices to recover and maintain a reasonable quality of life.

Table 1: Prosthetics Expenditures

PROSTHETIC ITEM	TOTAL COST SPENT IN FY16	PROJECTED EXPENDITURE IN FY17
Surgical Implants	\$638,505,521	\$720,240,382
Medical Equipment	\$386,616,335	\$439,145,590
Sensory/Neuro Aids	\$441,317,554	\$488,462,005
Oxygen & Respiratory	\$211,472,977	\$242,650,434
Wheelchairs	\$239,070,971	\$266,229,298

PROSTHETIC ITEM (CONT.)	TOTAL COST SPENT IN FY16	PROJECTED EXPENDITURE IN FY17
Orthoses/Orthotics/Shoes	\$181,127,719	\$205,339,283
Limbs	\$89,257,511	\$95,782,619
Bionic Implants	\$114,143,359	\$131,633,689
HISA	\$35,677,649	\$42,633,020
Restorations	\$7,164,195	\$8,276,846
Home Dialysis	\$3,273,781	\$3,566,712
Others	\$66,347,526	\$75,647,263
Repairs	\$463,025,651	\$489,335,315
GRAND TOTAL	\$2,877,000,750	\$3,208,942,456

In FY 2016, PSAS expenditures were approximately \$2,877,000,750. The FY 2017 proposed budget allocation for prosthetics is estimated at \$3,208,942,456. The proposed increased funding allocations for FY 2017 are based primarily on FY 2016 NPPD expenditure data, which also included Denver Acquisition and Logistics Center billing, 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 national, network, and local management levels. Therefore, the VHA senior leadership must ensure that field managers regularly update the NPPD for accuracy. Table 1 shows NPPD costs in FY 2016 with projected new equipment and repair costs for FY 2017.

Inclusion of Stakeholders in the Development of Rules, Policies, and Directives

RECOMMENDATIONS:

VA should continue to include VSO stakeholders in the development of rules, policies, and directives to ensure veterans gain input to the issues that affect them.

VA should continue to promote more open communication between the VSOs and VA offices on routine matters. The VHA-VSO liaison office should be copied to ensure the executive staff of the undersecretary for health is kept informed.

BACKGROUND AND JUSTIFICATION:

Within the past year, there has been a marked improvement over the previous five years when VHA excluded the VSOs from the development of rules, policies, directives, and other issues that affect the veterans community they represent. Consequently, the VHA offices operated in a vacuum without veteran input, which

caused numerous problems. As a result, the published documents during that period lacked the necessary information to adequately serve the veteran. The VSOs were not only excluded from the process of providing input—they received no communication from VHA that a document had been written, nor were they informed when a document had been sent to the field. This blindsided the VSOs, who were unable to provide answers to the veterans who were affected by the changes in the new document. The leadership of PSAS, the Field Advisory Committee for the Automobile Adaptive Equipment program, and the undersecretary for health's office began to include VSOs in the rewriting of a handbook through a VSO forum, which received our recommendations on how to improve the processes and procedures outlined in the handbook. The IBVSOs encourage VHA to continue this practice of inclusion.

There has also been within the last year an improvement in communication between PSAS and VSOs. In the previous five years, the VHA excluded the VSOs from participating in prosthetics meetings with the VISN prosthetics representatives and required that all VSO communications with the VHA offices go through the VHA-VSO liaison offices on all issues, no matter how routine. This “stonewalling” caused an atmosphere of mistrust between the VSOs and VHA. This past year, PSAS has opened up communication with the VSOs, who have welcomed the opportunity to bring issues and problems directly to the VHA office involved so that solutions could be worked out. PSAS has provided briefings to the VSOs to keep them informed and to receive feedback. The result has been an improvement for the disabled veterans who depend on VA to provide top-quality care. The IBVSOs consider themselves to be advocates for veterans and for VHA, and the open communication has begun to rebuild a relationship of trust and mutual respect.



Timely Delivery of Prosthetic Devices

RECOMMENDATIONS:

Congress must conduct rigorous oversight of VA's new procurement and contracting practices in prosthetics and sensory aids.

VHA must continue to address delays that prolong the prosthetics ordering process. PSAS and the VHA Procurement and Logistics Office must continue to work together to ensure prosthetic orders that are placed are tracked from prescription to delivery along process flows that show the actions and timelines required at each step.

The VHA Procurement and Logistics Office and the PSAS must continue development of the VHA Acquisitions Prosthetics Dashboard, which measures the timeliness of the purchasing process. These and other reports should be published on a monthly basis and provided to the VSOs.

BACKGROUND AND JUSTIFICATION:

As PSAS further develops a prosthetic and surgical products contracting center within the Office of Acquisition and Logistics, the VA leadership must maintain the quality and accuracy of prostheses delivered to veterans. At the end of FY 2013, VA completed the procurement transition of prosthetic purchases costing over \$3,500, from PSAS to the VHA Procurement and Logistics Office. This action essentially divided the responsibility for conducting prosthetic purchases between two separate services, creating a complicated, bureaucratic process that, at all levels within VA for the first couple of years, adversely affected the quality and accuracy of prostheses delivered to veterans.

While the VHA leadership had reassured stakeholders that the transition of warrant authority would not impact the timely delivery of prostheses to veterans, the IBVSOs remained concerned over the reported number of delayed or dropped orders, the diminution of quality service delivery for disabled veterans, and standardized purchasing of some prosthetic items and devices that were intended to be specialized and designed for unique applications. The effort to increasingly standardize products and capture savings through bulk purchasing reflected the disconnect between the veteran and clinician, who together understand the nuances of specialized care, and the contracting specialist, who procures an item such as a standard hospital bed for a veteran who actually needs a specialized one with automatic pressure relief features. Under the former system, these oversights were prevented through close communication between clinical professionals and veterans, both of whom could convey individualized needs directly to purchasing agents.

VHA has recognized the importance of meeting the unique needs of veterans requiring specialized care. Relevant purchasing authorities regarding requirements and exemptions from standardized purchasing can be found in several of its publications, including *VHA Directive 1081: Procurement Process for Individual Prosthetic Appliances and Sensory Aids Devices above the Micro-Purchase Threshold* and *VHA Directive and Handbook 1761.1: Standardization of Supplies and Equipment*.

The IBVSOs recognize that the transition to a prosthetic purchasing process shared by the PSAS and the VHA Procurement and Logistics Office was born from a series of OIG and congressional hearings that identified systemic deficiencies involving questions of waste and poor accountability of prosthetic inventories. Following these investigations, VA removed warrant authority from prosthetic purchasing agents. Under this change and in accordance with the Federal Acquisition Regulation 8123, statute authority and the ability to conduct transactions above the micro-purchase threshold would be reserved only for GS-1102 series contracting specialists who would be located in network contracting offices within each VISN. This change, in essence, returned the PSAS to its pre-8123 status, characterized by inflexible adherence to contract regulations and generating lengthy work-flow processes. After a phased trial-and-error rollout of this “warrant transition” across the VISNs, full implementation was completed at the end of FY 2013.

Alongside the warrant transition, a convoluted PSAS-funding model evolved, in which centralized funding occurred at the VISN level in some networks while others delegated prosthetic funding and management authority down to the facility level, with VACO retaining very little, if any, control over the prosthetic budget. This new funding model not only obscured accountability, but it also allowed for localized standards and budget priorities to trump longstanding interpretations of VHA policies, particularly those that favored veterans receiving individualized services.

As a result of these changes, veterans with unique medical needs (paralysis, amputation, etc.), whose quality of life relies on prosthetic devices, reported undue delays across the VA system. Although there was an overall improvement in FY 2014, FY 2015, and FY 2016, delays continued to be a problem. These were attributed to a range of factors, including staffing shortages, poor communication between prosthetic and contracting staff who make up the process, unclear expectations, inconsistently applied work-flow metrics, and a lack of a coherent set of policies, all of which have obscured lines of authority and accountability in the process. While several VISNs have been able to work through the challenges, the majority still face resource, communication, and performance barriers that have hindered successful implementation and resulted in continued delays and inefficiencies.

The IBVSOs are concerned about the increased amount of time it takes VA to execute procurements above the micro-purchase threshold since warrant transition and about the increased burden upon clinicians to procure what is medically needed for these special populations. Although these highly customized procurements represent a small percentage of the total workload for the VHA, they represent the most life-critical equipment, such as artificial limbs, mobility aids, and surgical implants. Delays in these procurements prove costly to both the government, in terms of the cost of unnecessarily extended hospital stays while veterans await delivery, and to veterans, who lose independence and quality of life.

To address these issues, VHA, PSAS, and the VHA Office of Procurement and Logistics developed a VHA Acquisitions Prosthetics Dashboard to track timeliness from prescription to delivery to veteran. The dashboard enables the VHA to determine how long the consult stays in prosthetics and acquisitions each step of the way. It measures performance at the facility and VISN levels. This change is a positive, proactive effort, which the IBVSOs fully support. We also support the publication of ordering and timeliness metrics to be provided to the VSOs on a monthly basis.

Effective communication between PSAS and procurement staff is paramount to serving veterans who rely on prosthetic devices and services. Also, the IBVSOs strongly encourage VA to work closely with stakeholders in the veterans' community, particularly during periods of major change and transition. PSAS uses subject matter experts from multiple program offices for their expertise with the use of the particular contracted items to establish Integrated Product Teams (IPTs). Additionally, a member from the National Center for Patient Safety is always a part of the IPT. The needs of the medical providers are met, first and foremost, when working with an IPT for a contract. We strongly encourage congressional oversight of the VHA new procurement and contracting practices to ensure that purchasing decisions are made to optimize the health and independence of veterans and are not solely to cut costs or adhere to federal and VA acquisition regulations that place cost or procedure over meeting the specialized needs of veterans with disabilities.



Consistent Administration of the Prosthetic Program

RECOMMENDATIONS:

VACO's Prosthetics and Procurement leadership must communicate a clear set of standards for procurement activities, both over and under the micro-purchase threshold, and establish model work-flow processes against which prosthetic orders can be measured.

In order to reduce variability in the delivery of prosthetic services across the country, VA must make certain that VISN prosthetic representatives perform their job of oversight to all prosthetic and orthotic personnel within their VISNs.

The VISN prosthetic representatives must be held accountable to ensure that the prosthetic services in VAMCs are following the directives and policies in a consistent manner. The medical center director and network director are dependent on their oversight and reports on the quality of prosthetic services.

BACKGROUND AND JUSTIFICATION:

In times of sweeping change in an organization with longstanding institutional practices, the importance of effective communication at all levels cannot be overemphasized. VHA maintains the responsibility for ensuring that all VISNs adopt consistent operational standards in accordance with national prosthetic policies. However, the failure to enact and enforce a national standard has resulted in the VHA national prosthetic staff and procurement staff having to navigate through a maze of varying local interpretations of VA policy. This lack of a national standard has led to the inconsistent administration of prosthetic services throughout VHA. With the implementation of the prosthetic procurement procedures, the opportunity for inconsistencies increased with more complex procurement. VISN directors and VHA Central Office staff should be accountable for implementing a standardized prosthetic program throughout the health care system, one that ensures consistent clinical care that meets veterans' individualized rehabilitative needs.

To improve communication and consistency, VA provides every VISN with a qualified prosthetic representative to be the technical expert responsible for ensuring implementation and compliance with national goals. The

VISN prosthetic representative maintains and disseminates objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetic policies, including administration and oversight of VHA prosthetic and orthotic laboratories. However, as new policies and procedures have evolved, VACO must continue to work with the VSOs and provide clear and effective guidance and communication to the field on how the changes impact the role and responsibilities of VISN prosthetic representatives and continue to measure metrics to govern and measure performance. The National Prosthetics Team has also invited VSOs to provide input and feedback through various forums. As a result, these efforts have helped reduce variability of practice in how VISNs execute the prosthetic ordering process and its resulting timelines.

Ensuring Quality and Accuracy of Prosthetic Prescriptions

RECOMMENDATIONS:

VHA should continue the Prosthetic Clinical Management Program (PCMP), provided the goals are to improve the quality and accuracy of VA prosthetic prescriptions and the quality of the devices issued. VHA must develop national standards for prioritizing and monitoring the expedited handling of orders involving veterans facing health-related hardships. VA's Office of Acquisition and Logistics should remain available to address and resolve any concerns involving uneven interpretation of policies.

VA must implement safeguards to make certain that the issuance and delivery of prosthetic devices and equipment will 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. 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 the quality of life of disabled veterans.

VHA should ensure that clinicians are allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical conditions and, in doing so, consider emerging technologies. VHA is investing in multimillion dollar contracts to standardize and improve procurement procedures to reduce barriers and variability in pricing.

BACKGROUND AND JUSTIFICATION:

VA must work to ensure that the prosthetic procurement process does not degrade the quality or accuracy of services provided to disabled veterans or to veterans with health-related hardships. The IBVSOs continue to cautiously support VHA efforts to assess and develop best practices to improve the quality and accuracy of prosthetic prescriptions and the quality of the devices issued through the VHA's PCMP. This caution is based on our concern that those best practices could spur inappropriate standardization or systematic limits on the types of prosthetic devices that the VHA would approve for veterans.

To address the issue of delayed prostheses for veterans facing hardships, particularly those with terminal illnesses, delayed hospital discharge, and housebound circumstances because of mobility barriers, VHA needs to develop and implement a clear policy on expedited handling of these procurements. Currently, PSAS can flag purchase requests as emergencies when it sends the requests to the network contracting office. Contracting can then act on these flagged requests immediately, assuming the office is adequately staffed and the purchase request is complete. However, the system does not distinguish among types of emergencies, creating circumstances, for example, where delayed payment to a vendor competes with a delayed hospital discharge because both cases are flagged as emergencies. The warrant transition has widened the gap between the VA desire to meet the needs of veterans and its ability to provide greater oversight and adherence to regulations.

Developing Future Prosthetic Staff

RECOMMENDATIONS:

VA must fully fund and support its National Prosthetics Technical Career Field (TCF) program to meet current shortages and future personnel projections.

VHA and its VISN directors must ensure that prosthetic departments are staffed by certified professional personnel or contracted staff who can maintain and repair the latest technological prosthetic devices.

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

BACKGROUND AND JUSTIFICATION:

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. Similarly, VHA must revise qualification standards for both prosthetic representatives and orthotic/prosthetic personnel to most efficiently meet the complexities of programs throughout VHA and to attract and retain qualified individuals.

In 2003, VHA developed and requested 12 training positions for the National Prosthetics TCF program, formerly referred to as the Prosthetics Representative Training Program. Initiated to ensure that prosthetic personnel receive appropriate training and experience to carry out their duties, it is a two-year training program for prosthetic representatives responsible for management of all prosthetic services within their assigned networks. In 2011, this allotment was increased to 18 training positions because of the number of vacancies of critical staff. Currently, approximately eight to 10 training positions are available annually. VISNs have also developed their own local prosthetic representative training programs. While the IBVSOs support local VISNs conducting such training to enhance the quality of health care services within the VHA system and to increase the number of qualified applicants, we believe local VISNs must also support and strongly encourage participation in the TCF program to develop future PSAS leaders. VHA must also revise qualification standards for prosthetic representatives and orthotic/prosthetic personnel to most efficiently meet the complexities of programs throughout VHA and to attract and retain qualified individuals.

As VA continues to improve the TCF program, leadership must make certain that veterans are made aware of employment opportunities throughout the PSAS, as well as opportunities to apply for admittance in the TCF program. 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 implemented the medical home-care delivery model using patient-aligned care teams, the IBVSOs believe additional prosthetic representatives will be needed. Adding representatives is particularly important as new programs in polytrauma, TBI, and amputation systems of care are implemented and expanded in VHA.

PSAS leadership must consist of a well-rounded team, including trained and experienced prosthetic representatives, appropriate clinicians and managers, and position-qualified disabled veterans with significant mobility or other impairments requiring the use of prosthetic devices. The IBVSOs believe the future strength

and viability of the VA prosthetic program depends on the selection of high-caliber leaders in the PSAS who appreciate the lived experiences of the veterans they support. Therefore, the PSAS must continue to improve and fund succession programs such as TCF to identify, train, and retain these professionals.

Meeting the Prosthetic Needs of Women Veterans

RECOMMENDATIONS:

VHA must provide training funds to educate PSAS and VHA procurement staff on the special prosthetic needs of women.

VHA must maintain support for a dedicated committee and special working groups that evaluate whether the needs of women veterans are being met and provide recommendations directly to the VA secretary for consideration.

VHA must explore contracting and procurement actions that provide devices made specifically for women.

VHA must identify emerging technology for women and propose ideas for research and development.

BACKGROUND AND JUSTIFICATION:

Over the past 15 years, women have joined the military in record numbers to contribute to the increasing role of America's military presence in the world. While women have always been a part of the military, the number of women serving and their roles were largely limited. Because more women have joined the military and serve in expanded roles, including inherently dangerous occupational specialties, more women veterans have been killed or wounded than in times past. According to the Defense Casualty Analysis System, 383 female service members have been wounded in action in Afghanistan, and 50 killed. In Iraq, 627 have been wounded in action, and 110 killed.

This new reality requires a focus on meeting the unique needs of an increasing number of women veterans in a health care system historically devoted to the treatment of men. Learning how to care for wounded women veterans, half of whom are of childbearing age, and their particular health issues and needs includes learning how to best meet their needs for prosthetic and assisted devices. The IBVSOs recognize and commend the VA efforts to enhance the care of female veterans in regard to technology, research, training, repair, and replacement of prosthetic appliances through the establishment of a women's prosthetic working group. The working group's mission was to eliminate barriers to prosthetic care experienced by women veterans and change the culture and perception of women veterans through education and information dissemination. The IBVSOs believe that VA must continue to support efforts to train VACO and field staff on the special prosthetic needs of women.

Prosthetic and Sensory Aids and Research

RECOMMENDATIONS:

VA must maintain its role as a world leader in prosthetic research and ensure that the VA Office of Research and Development and the PSAS work collaboratively to expeditiously apply new technological developments and transfer to maximally restore veterans' quality of life.

VA must ensure that institutional barriers to accessing new technologies are eliminated and that veterans whose lives would benefit from innovative, properly prescribed prosthetic items are given the opportunity to explore novel approaches to restoring function.

BACKGROUND AND JUSTIFICATION:

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 data from the DOD-VA Extremity Trauma and Amputation Center of Excellence, approximately 3 percent of wounded veterans returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetic and sensory aids continues to rise. Advances are still being made in prosthetic technology that will continue to dramatically enhance the lives of disabled veterans. VHA 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 widespread use, VHA 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.



Spinal Cord Injury/Disease Service

RECOMMENDATIONS:

VHA must ensure that the SCI/D continuum of care model is available to all SCI/D veterans nationwide.

VA must continue mandatory national training for the SCI/D “spoke” facilities.

VHA must centralize policies and funding for system-wide recruitment and retention bonuses for nursing staff.

Congress must appropriate the funding necessary to provide competitive salaries for SCI/D nurses.

Congress must establish a specialty pay provision for nurses working in spinal cord injury/disease centers.

VHA must implement updated SCI/D staffing methodology to improve access to care within VHA for SCI/D veterans.

VA and Congress must work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing long-term care centers, as well as increase the number of centers throughout VA.

VA must design an SCI/D long-term care strategic plan that addresses the need for increased access and make certain that VA SCI/D long-term care services “help SCI/D Veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability.”¹⁵

BACKGROUND AND JUSTIFICATION:

SCI/D System of Care

VA SCI/D care is provided using 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. This is ever so disheartening in the aftermath of the Phoenix waiting list scandal. In December 2009, VA developed and published the *Veterans Health Administration (VHA) Handbook 1011.06: Multiple Sclerosis System of Care Procedures*, which identifies a model of care and health care protocols for meeting the individual treatment needs of SCI/D veterans. Additionally, the *VHA ALS Handbook 1101.07 (2014)* speaks to the importance of coordinating care with SCI/D services (e.g., bowel and bladder care), encouraging ALS clinics to be located within SCI/D centers and incorporating SCI/D staff into the ALS interdisciplinary care team. Therefore, more of a national effort must be taken to integrate the MS System of Care with SCI/D, instead of deferring to the local level. In the meantime, MS clinics should be encouraged to engage in efforts to have SCI/D centers provide certain services on a consultative basis necessary for MS veterans.

Nursing Staff

Historical data has shown that SCI/D units are the most difficult places to recruit and retain nursing staff. Caring for a 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. Also, veterans with SCI/D often have psychosocial issues as a result of their injury/disease. 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 throughout the nation, resulting in an improvement in quality of care and access to care for veterans, as well as in the morale of the nursing staff. Unfortunately, facilities are faced with the local budget challenges when considering a recruitment or retention bonus or incentive specialty pay in the area of SCI/D. The funding necessary to support this effort is taken from local facility budgets, thus detracting from other needed medical programs. A consistent national policy of salary enhancement for specialty services should be implemented across the country to ensure qualified staff are recruited and retained. Funding to support this initiative should be made available to the medical facilities from the VISN or VACO to supplement their operating budgets.

While VA recognized that IBVSOs requested 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. The 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 non-bedside-specialty 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.

¹⁵VA, VHA, *Spinal Cord Injury and Disease System of Care*, VHA Handbook 1176.01, February 2011, 36, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2365.

The SCI/D System of Care is the only specialty service line with its own staffing mandate implemented in 2000 as a standardized method of determining the number of nursing staff needed to fulfill all points of patient care. Unfortunately, the VHA Directive 2008-085 staffing model lags behind patient care needs by 16 years, creating a system that fails to meet current patient demand and inaccurately reflects true staffing needs. VHA Directive 2008-085 sorely needs revision to reflect appropriate level of staffing to ensure SCI/D capacity is being met.

Unfortunately, the significant nurse shortage has resulted 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 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 severely compromise patient safety and serve as evidence for the need to enhance the nurse recruitment and retention programs.

Patient Classification

In 2015, SCI/D nurses performed more than 105,000 hours of overtime due to staff turnover and understaffing because the staffing model lagged behind patient health care needs by 16 years. VA has a system of classifying patients according to the hours of bedside nursing care needed. Five levels 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 level III has been used to define the national average acuity/patient classification for the SCI/D patient. These levels are converted into the number of full-time equivalent employees (FTEEs) needed for continuous coverage.

The emphasis of this classification system is based on bedside nursing care. It does not include administrative nurses, non-bedside-specialty nurses, or light-duty nursing personnel, as these individuals do not (and are not able) to provide full-time, hands-on bedside care for the patient with SCI/D.

Statutory Requirement for Maintenance of Capacity in VA SCI/D Centers

IBVSOs are concerned about continuing trends toward reduced capacity in VA's Spinal Cord Injury/Diseases Program. Reductions in beds and staff in both the VA's acute and extended-care settings continue to be reported. With the recent passage of H.R. 5091, VA once again is required to report its capacity to provide specialized services. This requirement will ensure that catastrophically disabled veterans' access to care is not diminished due to VA's lack of transparency with regard to its mandated capacity requirements and ensure that VA is held accountable for having the requisite number of available inpatient beds for veterans, as well as required staff levels to deliver quality care.

SCI/D Long-Term Care

As the veteran population ages, VA must assess and prepare for veterans' long-term care (LTC) / extended-care needs. Of particular concern is the availability of VA LTC services for the vastly growing aging SCI/D veteran population. As the onset of secondary illnesses and complications associated with aging and SCI/D occurs more frequently, VA is not devoting sufficient resources to meet this demand.

Nationwide, VA operates only six designated extended-care facilities for SCI/D veterans, with a total of 160 staffed beds. However, only three of these extended-care SCI/D centers accept ventilator patients. These facilities manage long waiting lists for admission, and veterans remain underserved, bearing long-term costs that remain invisible to decision makers who focus on the short-term gains.

Unfortunately, the existing centers are not optimally located to meet the needs of a nationally dispersed SCI/D veteran population. Often, the existing centers cannot accommodate new veterans needing long-term-care services, due to lack of beds, so these facilities manage long waiting lists for admission, and veterans remain unserved, which creates long-term costs that remain invisible to decision makers who focus on the short-term gains.

Although the majority of SCI/D veterans in LTC reside in community living centers (CLCs), these facilities do not have the same rigorous staffing requirements as extended-care SCI/D units. Additionally, their staff is likely not trained in caring for SCI/D LTC patients. In a Paralyzed Veterans survey conducted in FY 2014, 131 of the 135 VA CLCs responded and revealed that in the whole CLC system, there are only 13 CLCs with beds dedicated for SCI/D. Additionally, only 8 percent of the CLCs accept ventilator patients.

Paralyzed Veterans also surveyed 343 state veterans homes and skilled nursing facilities within a 50-mile catchment area of all SCI/D centers. The data that was most disconcerting concerned ventilator patients. Of the 343 skilled nursing facilities surveyed, only 49 accepted ventilator patients (14 percent). Only nine of the 49 facilities were on the East Coast, 28 were in the central United States, and 12 were located on the West Coast. State veterans homes cannot ease the ventilator case load immediately, as none surveyed could accept ventilator patients.

While VA has identified a need to provide additional SCI/D extended-care centers and has included these additional centers in ongoing facility renovation plans, many of these plans have been languishing for years. Therefore, the IBVSOs strongly recommend that VA and Congress work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing LTC centers, as well as to increase the number of centers throughout the VA system.

Access to Specialty Care

RECOMMENDATIONS:

VA must make certain that veterans who have sustained an SCI/D are appropriately referred by VA SCI/D clinics to VA SCI/D Centers to receive proper care when needed.

VA must enforce its policies that require 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.

Expanding VA's beneficiary travel benefit to catastrophically disabled, non-service-connected veterans will lead to an increasing number of disabled veterans receiving quality comprehensive care, as well as result in long-term cost savings for VA.

BACKGROUND AND JUSTIFICATION:

Veterans who have incurred an SCI/D are entitled to health care through VA's Spinal Cord Injury/Disease System of Care. This model is often referred to as the "hub and spoke" system of SCI/D care. Veterans with SCI/D 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, preventive services, sustaining health care, SCI/D home care, and long-term care. The SCI/D clinic provides basic primary and preventive health care. When veterans with a SCI/D are in need of care for recurrent problems, have complex issues, must undergo major surgeries or procedures that require specialized knowledge, 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 by transportation barriers.

Unfortunately, IBVSOs 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 physicians, nurses, administrative staff, or patient beds. The VHA's *Handbook 1176.01: Spinal Cord Injury and Disease System of Care* specifically states that "all acute rehabilitation and complex specialty care must take place at SCI/D centers (hubs)." 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. In order to avoid such adverse 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 preventive 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 SCI/D 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. Currently, the VA does not provide travel reimbursement for catastrophically disabled non-service-connected veterans who are seeking VA medical care. 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. Rather, the system was created to provide veterans with a full continuum of SCI/D care. For this particular population of veterans, their routine comprehensive annual evaluations often require inpatient stays, and as a result significant travel costs are incurred by these veterans.

When veterans do not meet the eligibility requirements for travel reimbursement and they do not have the financial means to travel, their chances of receiving the proper medical attention are significantly decreased. For veterans who have sustained a catastrophic injury, such as SCI/D, blindness, or limb amputation, 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 are quickly manifested 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. Therefore, 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. Specifically, the IBVSOs recommend that VA expand its beneficiary travel benefit to all catastrophically disabled, non-service-connected veterans.

Eliminating the burden of transportation costs as a barrier to care for this population will improve veterans' overall health and well-being, as well as decrease, if not prevent, future costs associated with both primary and long-term chronic acute care. 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.

Amyotrophic Lateral Sclerosis

RECOMMENDATIONS:

VA should develop a veterans' ALS registry to collect and assess the quality of care that is being provided, as well as evaluate ALS patient satisfaction within VA.

The VA ALS System of Care should be further integrated with the VA SCI/D System of Care.

BACKGROUND AND JUSTIFICATION:

ALS is a degenerative neurological disease that destroys nerve cells in the body that allow for voluntary muscle control. It leads to the gradual loss of brain and spinal cord cells that facilitate motor skills such as walking or running, eventually eliminating one's ability to move voluntarily.¹⁶ ALS is fatal and usually progresses at a fast rate after diagnosis. Therefore, it is of great importance for veterans to receive timely care and for the VA to be able to provide the clinical expertise that is needed to meet veterans' medical needs.

VA issued *VHA Handbook 1101.07: ALS System of Care Procedures* in July 2014. It describes the essential components and procedures to ensure that all enrolled veterans have access to ALS care and that the veteran and the veteran's family and caregivers are given necessary clinical care and support provided by a comprehensive, professional ALS interdisciplinary care team. The major focus of clinical care is to provide the highest quality of life through management of symptoms and emotional and physical suffering.

The ALS handbook highlights that, given the limited life expectancy for veterans with ALS, there is a need to expedite provision of assistive technology (AT) and durable medical equipment (DME). Procurement and delivery of all prescribed devices must be expedited to facilitate provision to the veteran prior to further decline in function. Additionally, AT services must be coordinated by a skilled AT professional at a VA ALS clinic, a related clinical service, or by using equivalent fee-based support.

Though there is no cure for ALS, certain actions can be taken to optimize remaining function, maintain functional mobility, and maximize the veteran's quality of life. Exercise programs may be physiologically and psychologically beneficial for veterans with ALS, particularly before there is a great deal of muscle atrophy.

Care integration is also an essential aspect in the ALS System of Care. It is vital that VA utilize the established programs within other systems of care to help inform veterans of treatment modalities and support services that are available. The ALS handbook encourages having ALS clinics within SCI/D centers and states that on SCI/D units the social worker, the advanced practice registered nurse, or the registered nurse case manager

¹⁶VA, *Agent Orange Review* 25, no. 1 (July 2010), www.publichealth.va.gov/exposures/agentorange.

would be the best points of contact for veterans and their caregivers. However, more must be done to integrate the two services. For example, once the veteran has been diagnosed with ALS, he or she must receive an evaluation by a clinician at a SCI/D center as soon as possible, since ALS is defined as spinal cord disease.



Improving VA's National System of Care for Multiple Sclerosis

RECOMMENDATIONS:

VA must provide mandated direction to make certain that all VISNs are in compliance with the *Multiple Sclerosis System of Care Procedures: VHA Handbook 1011.06*.

VA must take further national efforts to integrate the MS System of Care with the Spinal Cord Injury System of Care.

VA must comply with the MS care delivery model that requires an appointed MS care coordinator to partner with veterans and their caregivers and family members to help coordinate and manage all medical care provided by VA and non-VA providers.

VA must provide adequate funding to properly staff and support MS regional programs and MS support programs that provide the full continuum of MS specialty care.

Congress and VA must ensure that medical facilities are adequately funded to provide funding for cognitive rehabilitation, respite care, long-term care, and home care services for veterans with MS.

BACKGROUND AND JUSTIFICATION:

VA reports that for the period of FY 1998 through FY 2013, roughly 37,000 veterans with MS have sought care within VHA. Additionally, over the past five years, VHA has averaged about 17,500 unique MS patients per year. MS is an extremely complex and chronic neurological disease that results in cognitive deficits such as short-term memory loss and physical impairment; afflicted veterans often lose employment and their independence. VA must increase access to quality care for veterans with multiple sclerosis by ensuring adequate staffing, coordinating care across disciplines, and enforcing *VHA Handbook 1011.06*.

Despite the establishment of the Multiple Sclerosis Centers of Excellence (MSCoEs) and the *VHA Handbook 1011.06* in 2009, veterans still do not have consistent access to timely care for MS within VA. Issues such as the shortage of appropriate medical staff or the lack of care coordination are still precluding veterans from receiving care when it is needed.

VHA Handbook 1011.06 states that VA must have “at least two MSCoE, and at least one MS Regional Program in each Veteran Integrated Service Network (VISN). . . . Any VA medical center caring for Veterans with MS and not designated as an MS Regional Program must have a MS Support Program, spoke sites for MS care.” It also speaks to the importance of coordinating care with SCI/D services (e.g., bowel and bladder care). *VHA Handbook 1011.07* encourages ALS clinics to be located within SCI/D centers and incorporating SCI/D staff into the ALS interdisciplinary care team. Therefore, more of a national effort should be taken to integrate the MS System of Care with the SCI/D System of Care instead of leaving it up to the local level. For example, once the veteran has been diagnosed with MS, he or she must receive an evaluation by a clinician at a SCI/D center as soon as possible, since MS is defined as spinal cord disease.

The IBVSOs are concerned that *VHA Handbook 1011.06* is not being enforced and as a result veterans do not have adequate access to MS care due to the lack of resources in local and regional facilities. Local facilities are not adequately funded and therefore are not able to recruit and retain medical professionals with this specific experience to meet the staffing requirement. VA must provide local facilities with the necessary resources and funding to provide the appropriate health care services and cognitive rehabilitation that veterans with MS need. Equally as important is the need for adequate funding for respite care, long-term care, and home care services for this population. Quality care can only be provided if all the medical needs of veterans are being addressed and all individuals involved are informed.

Increase Veteran-Centric Medical and Prosthetic Research and Development

RECOMMENDATIONS:

The administration and Congress should provide at least \$713.2 million for the VA Medical and Prosthetic Research and Development program for FY 2017 to support current research on chronic conditions of aging veterans and for emerging research on conditions prevalent among younger veterans of OEF, OIF, and OND.

The VA research program is uniquely positioned to advance genomic medicine through the Million Veteran Program (MVP), an effort that seeks to collect genetic samples and general health information from one million veterans over the next five years. When completed, MVP will constitute one of the largest genetic repositories in existence, offering tremendous potential to study the health of veterans. To date, more than 500,000 veterans have enrolled in MVP. The IBVSOs recommend \$65 million to support this transformative and innovative program.

The administration and Congress should provide funding for up to five major construction projects in VA research facilities in the amount of at least \$50 million and appropriate \$175 million in NRM and for minor construction projects to address deficiencies identified in the independent VA research facilities review provided to Congress.

The administration and Congress should preserve the integrity of the VA research program as an exclusively intramural program, firmly grounded in scientific peer review, and should oppose designated funding for specific areas of research outside of the VA national management of the entire VA research portfolio.

BACKGROUND AND JUSTIFICATION:

The VA Medical and Prosthetic Research and Development program is widely acknowledged as a success on many levels, all directly leading to improved care for veterans and an elevated standard of care for all Americans:

- VA research has made critical contributions to advance standards of care for veterans in areas ranging from tuberculosis treatment in the 1940s to immunoassay in the 1950s to today's ongoing projects dealing with Alzheimer's disease, developing and perfecting the DEKA advanced prosthetic arm and other inventions to help the recovery of veterans grievously injured in war, and studies in genomics, chronic pain, cardiology, diabetes, and improved treatments for PTSD and other mental health challenges. These studies and their findings ultimately aid the health of all American

- VA research is a completely intramural program that recruits clinicians to care for veterans while conducting biomedical research. More than 70 percent of these clinicians are VA-funded researchers. VA also awards over 500 career development grants each year designed to help retain its best and brightest researchers for long and productive careers in VA health care
- VA researchers are well published (between 8,000 and 10,000 refereed articles annually) and boast three Nobel laureates and seven awardees of the Lasker Award (the “American Nobel Prize”); this level of success translates effectively from the bench to the veteran’s bedside
- through a nationwide array of synergistic relationships with other federal agencies, academic affiliates, nonprofit organizations, and for-profit industries, the program leverages a current annual appropriation of \$589 million into a \$1.88 billion overall research enterprise

Despite documented success, appropriated funding for VA research and development has lagged far behind biomedical research inflation since FY 2010, resulting in a net loss of VA purchasing power. As estimated by the Department of Commerce Bureau of Economic Analysis and the National Institutes of Health, to maintain VA research at current service levels the VA Medical and Prosthetic Research appropriation would require \$17 million in FY 2017 (a 2.7 percent increase over the 2016 pending appropriation). Should availability of research awards decline as a function of budgetary policy, VA risks terminating ongoing research projects and losing these clinician researchers who are integral to providing direct care for our nation’s veterans. Numerous meritorious proposals for new VA research cannot be awarded without a significant infusion of additional funding for this vital program.

The IBVSOs believe an additional \$17 million in FY 2017, beyond uncontrollable inflation, is necessary for expanding research on conditions prevalent among O IF/O EF/OND veterans, as well as continuing inquiries in chronic conditions of aging veterans from previous wartime periods. Additional funding will also help VA support emerging areas that remain critically underfunded, including

- post-deployment mental health concerns such as PTSD, depression, anxiety, and suicide;
- the gender-specific health care needs of the growing VA population of women veterans;
- engineering and technology to improve the lives of veterans with prosthetic systems that replace lost limbs or activate paralyzed nerves, muscles, and limbs;
- studies dedicated to understanding chronic multi-symptom illnesses among Gulf War veterans and the long-term health effects of potentially hazardous substances to which they may have been exposed; and
- innovative health services strategies, such as telehealth and self-directed care, relatively new concepts that lead to accessible, high-quality, cost-effective care for all veterans, as VA works to address chronic patient backlogs and reduce waiting times

State-of-the-art research also requires an investment in state-of-the-art technology, equipment, and facilities. For decades, VA construction and maintenance appropriations have failed to provide the resources VA needs to replace, maintain, or upgrade its aging research facilities. The impact of this funding shortage was observed in a congressionally mandated report that found a clear need for research infrastructure improvements system-wide. Nearly 40 percent of the deficiencies found were designated “ Priority 1: Immediate needs, including corrective action to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and/or correct life safety hazards.”

Long-Term Services and Supports

RECOMMENDATIONS:

VA must broaden its strategic planning focus from facility-based care toward greater home- and community-based services (HCBS) to achieve a more balanced offering of long-term services and supports (LTSS) to veterans.

Congress should enact legislation to facilitate expanding the VA HCBS program.

Congress should conduct oversight of the VA LTSS balancing efforts to meet the needs of veterans, including the effects on access to and availability of LTSS because of current statutory authority.

VA should design an SCI/D long-term care strategic plan that addresses the need for increased access and makes certain that VA SCI/D long-term care services “help SCI/D veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability.”

BACKGROUND AND JUSTIFICATION:

LTSS include many types of health and health-related services for individuals of any age who have limited ability to care for themselves because of physical, cognitive, or mental conditions. They are provided in institutional settings, such as nursing homes, and home- and community-based settings, such as adult foster care, homemaker / home health aide care, respite, skilled home care, veteran-directed home care, purchased home hospice and palliative care, and family caregiver assistance.

With the increasing number of veterans most likely to require VA LTSS—those ages 85 and older and those of any age with significant disabilities because of chronic diseases or severe injuries—the projected need and potential cost for VA LTSS in the coming decade will continue to increase.

Long-term services and supports are expensive, with institutional care costs exceeding costs for HCBS. Studies have shown that expanding HCBS entails a short-term increase in spending followed by a slower rate of institutional spending and overall LTSS cost containment. Reductions in cost can be achieved by transitioning and diverting veterans from nursing home care to HCBS if they prefer and are able.

VA spending for institutional nursing homes grew from \$3.5 billion to \$5.3 billion between 2007 and 2015; however, the number of veterans being cared for in this setting has remained relatively stable—partially attributed to expanding HCBS—indicating the cost of institutional care is rising.

Despite doubling HCBS spending between 2007 and 2015, VA currently spends just over 30 percent of its LTSS budget on HCBS, which remains far less than Medicaid’s HCBS national spending average for these services among the states.

Senior VA leaders continue to focus on a hospital-based medical model of inpatient and outpatient care with seemingly little appreciation of the menu of home- and community-based services and supports VA furnishes and buys for the most vulnerable of veteran patients. VA must continue its efforts to ensure veterans integrate into and are able to participate in their community with reasonable accommodations. For example, with VA’s recent creation of the Office of Community Care to lead the provision of community care services for veterans through the Choice Program, there remain serious concerns the office could result in a new silo with significant potential to interfere with long-established, efficient, and coordinated services for veterans in need of LTSS.

The need for VA LTSS for veterans with an SCI/D is vastly growing. While the life expectancy for SCI/D veterans has increased significantly over the years, so too have the secondary illnesses and complications

associated with both aging and SCI/D. The number of SCI/D veterans needing long-term-care services is rising, and VA does not have sufficient resources to meet the demand.

Ending Veterans Homelessness

RECOMMENDATIONS:

To continue the trend in reducing the number of homeless veterans, Congress must provide sustained funding to VA for supportive services and housing, continue research to identify the risks of homelessness, maintain effective prevention strategies, and enhance collaboration with community partners.

Congress should ensure that DOD assesses all separating service members to determine their risk of homelessness and help them avoid homelessness by providing life skills training if needed.

Congress should ensure that correctional, residential health care, other custodial, and VA facilities receiving federal funds (including Medicare and Medicaid reimbursements) have policies and procedures in place to ensure all service members being discharged have stable transitional or permanent housing arrangements with supportive services. For those who apply for income security and health security benefits (e.g., Supplemental Security Income, Social Security Disability Insurance, VA disability compensation, or Medicaid) prior to discharge, information about available VA resources and assistance should be provided to them.

VA should continue to work with community partners to meet the needs of homeless veterans and those at risk of homelessness and continue its outreach efforts to help homeless veterans gain access to VA programs.

Congress should ensure there is always an overseer to keep track of the population of homeless veterans, the causes for homelessness, and the best practices for ending veterans' homelessness and make permanent the establishment of the National Coalition for Homeless Veterans.

BACKGROUND AND JUSTIFICATION:

Since 2009, when the White House and VA announced the goal of ending veterans' homelessness, there has been a sizeable decrease in the amount of homeless veterans across the United States. In 2014, Mayors Challenge was launched as an initiative among mayors to end homelessness in their cities. This ambitious movement galvanized momentum and has spurred cities into action. According to a HUD report released on August 1, 2016, the number of veterans experiencing homelessness in the United States has been cut nearly in half since 2010. The data revealed a 17 percent decrease in veterans' homelessness between January 2015 and January 2016. This statistic is quadruple the previous year's annual decline and represents a 47 percent decrease since 2010. In January 2016, HUD estimated that just over 13,000 unsheltered veterans were living on the streets, a 56 percent decrease since 2010.

VA has made a strong commitment to ending veterans' homelessness, and it has done so with a three-pronged approach:

- conducting coordinated outreach to proactively seek out veterans in need of assistance
- connecting those identified as homeless or at risk for homelessness with housing solutions and health care
- community employment services and other supports through collaboration with federal, state, and local agencies to provide the needed services

Combined these steps seek to address the veteran as a whole person by addressing all needs, rather than focusing solely on housing status, an approach that will hopefully lead to better long-term outcomes. To maintain this downward trajectory, Congress must provide sustained funding for VA's homeless veterans programs and prevention efforts.

VA offers three essential programs aimed at ending veterans' homelessness. The Grant Per Diem (GPD) program funds community agencies providing services to homeless veterans. The Housing and Urban Development Veterans Affairs Supportive Housing (HUD-VASH), program is a collaborative program whereby HUD provides rental assistance through public housing authorities in the form of vouchers for privately owned housing to veterans who are eligible for VA health care services and are experiencing homelessness. During FY 2015, VA had over 33,000 veterans enter case management under the HUD-VASH program, and as of September 30, 2015, there were over 63,000 veterans housed with a HUD-VASH voucher. Supportive Services for Veteran Families (SSVF) is a VA program that provides community based grants to provide supportive services to very low-income veterans' families in or transitioning to permanent housing.

According to VA, the SSVF program served a cumulative total of 138,538 veterans between FY 2012 and FY 2014. VA data indicates 61 percent of veterans received rapid rehousing assistance over a three-year period, and 40 percent of veterans received homelessness prevention assistance. Rapid rehousing is focused on the immediate goal of obtaining permanent housing as quickly as possible. According to the US Census Bureau, veterans constitute 9 percent of the US adult population and made up 11 percent of the US adult homeless population. Not all homeless veterans or veterans with families are alike; therefore, it is important to have a variety of service types to fit the array of client needs.

When service members are separating from the military and returning to civilian life, this transition can pose numerous challenges. This transition can be even more challenging for members who may have experienced combat, sustained severe injury or illness, and or who may be a survivor of military sexual trauma. It is important for DOD to identify veterans who may need additional assistance to ensure their unique needs are met. DOD and VA should establish a program to ensure the information from DOD is provided to VA on at-risk separating service members and that prevention services are made available when the service member is discharged.

In FY 2013, VA served more than 365,000 veterans who were homeless or at risk and their families. Nearly 107,500 veterans and their families were either placed in permanent housing or prevented from becoming homeless. Additionally, 111,549 calls were made to VA's National Call Center for Homeless Veterans, a 38 percent increase from the prior fiscal year. Since 2010,

The National Coalition for Homeless Veterans (NCHV) was established in 2009 as part of VA's five-year program to end homelessness among veterans. The NCHV works to promote recovery-oriented care for veterans who are homeless or at risk for homelessness. Through a series of studies, the NCHV is producing a more accurate and reliable estimate of veterans homelessness, investigating the demographic makeup of this population, and determining where it resides. In addition, the coalition is uncovering the factors that predict homelessness among veterans; developing and implementing evidence-based interventions in housing, health care, and supportive services; formulating policy recommendations; and disseminating findings and training opportunities. The NCHV has not been permanently authorized and currently exists at the discretion of the secretary of VA.

Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) was launched in 1994 with a guiding principle that VA must work closely with the local community to identify needed services and deliver the full spectrum of services required to help homeless veterans reach their potential. Project CHALENG data identifies "met" needs as services that VHA can provide directly and "unmet" needs as services that require community partnership to meet. Nine of the top 10 *unmet* needs were the same for male and female veterans: housing for registered sex offenders, child care, legal assistance

in four separate areas (eviction/foreclosure prevention, child support issues, driver's license restoration, and outstanding warrants and fines), family reconciliation assistance, credit counseling, and discharge upgrade. Nine of the top 10 *met* needs were also the same for male and female veterans: medical services, testing and treatment in three separate areas (tuberculosis, hepatitis C, and HIV/AIDS), case management, services for emotional or psychiatric problems, medication management, substance-abuse treatment, and food.

According to VA, during 2013 nearly 50,000 Iraq and Afghanistan veterans were either homeless or in a federal program aimed at keeping them off the streets, almost triple the number in 2011. VA notes that the number of these veterans struggling with homeless issues has grown because the department has expanded efforts to identify and assist them. The department has programs throughout all 50 states, working with community groups to target homeless veterans, and as a consequence a more accurate picture of the number of these veterans is emerging. That said, a lack of affordable housing has contributed to veterans homelessness as a whole.

As the picture of veterans' homelessness begins to shrink, a new challenge is arising in the form of prevention. Congress must ensure VA has the resources and flexibility necessary to adjust to a higher demand for prevention while maintaining the ability to continue to house homeless veterans. Transitioning from a model of crisis to a model of support and maintenance will require proper funding and strategic placement of resources. VA and its partners will have to work closely to ensure areas and resources available are commensurate with the need. Before prevention can become a crisis, Congress, VA, and all stakeholders must plan ahead to ensure VA programs are flexible and complimentary when combined together or with public or private programming. Just as not all homeless veterans or veterans with families are alike; the picture from state to state, city to city will also be different. An ounce of prevention is worth a pound of cure.



Persian Gulf War Veterans

RECOMMENDATIONS:

Congress should conduct oversight on the direction of research for Gulf War illnesses and provide sufficient funding to resume robust research to identify effective treatments for veterans suffering from them.

Congress should conduct oversight on VA efforts to achieve the goals and implement actions outlined in the VA's Gulf War Veterans' Illnesses Task Force (GWVI-TF) reports.

VA should provide lines of responsibility for implementing lines of effort outlined in its annual GWVI-TF report as well as measurable outcomes and report reliable and valid data to achieve the goal of meeting the needs of veterans suffering from Gulf War illnesses.

VA should provide a public response to the recommendations of the Research Advisory Committee on Gulf War Veterans' Illnesses.

BACKGROUND AND JUSTIFICATION:

Congress and VA must aggressively pursue answers to the health consequences of veterans' Persian Gulf War service in 1990 and 1991. Longitudinal studies of veterans who fought in the war confirm that today, many years after it ended, at least 175,000 veterans who served in theater remain seriously ill.

An IOM committee noted individualized health care management plans are necessary and recommended that VA implement a system-wide, integrated, multimodal, long-term management approach for veterans who have

chronic multi-symptom illness. Veterans suffering from Gulf War illnesses require a holistic approach to the care they receive to combat their continuing decline in health status, function, or quality of life.

VA's GWVI-TF has issued three annual reports highlighting the department's efforts to address the unique needs of ill Gulf War veterans in several areas, including clinical care, clinical education and training, and targeted research efforts. However, the report lacks meaningful outcomes, measures, and accountability to properly evaluate performance, improvements, and achievement of goals to improve the health and quality of life of ill Gulf War veterans.

For nearly a decade, ill Gulf War veterans have been marginalized, and their chronic and often debilitating symptoms were decidedly cast aside as trivial—until the landmark report by the IOM was published in 2010 that suggested a path forward to speed development of effective treatments, cures, and prevention.

Established under P.L. 105-368 as amended, the Research Advisory Committee on Gulf War Veterans has achieved much to bring positive sweeping and lasting change to the research and treatment of Gulf War illnesses. The committee was reconstituted in 2015 following changes made by VA to the committee's charter and has since issued an annual report.

While progress has been made in assisting Gulf War veterans, research programs at VA often run counter to the advice of scientific experts. Estimates state that 60 percent or more of the millions of dollars identified for Gulf War research has been used for research with no appreciable link to veterans of that war.

Reproductive and Sexual Health

RECOMMENDATIONS:

Congress must make in-vitro fertilization (IVF) a part of the Medical Benefits Package.

Congress must address the needs of women veterans whose injuries prevent a full-term pregnancy.

Congress must address the needs of veterans whose injuries destroyed their ability to provide genetic material for IVF.

BACKGROUND AND JUSTIFICATION:

Reproductive Health

As a result of the recent conflicts in Afghanistan and Iraq, many service members have incurred injuries that have made them unable to conceive a child naturally. Since 2010, DOD has provided in-vitro fertilization to active-duty and retired service members. In late 2016, Congress enabled VA to offer the same services to veterans with a service-connected reproductive injury.¹⁷ As of this publication, it is unclear when this provision of the law will be implemented. An estimated 3,000 veterans with spinal cord injuries and urogenital injuries are likely to avail themselves of this service. Dozens of fertility clinics across the country will continue to provide discounted services in the meantime.

For more than two decades, advancements in medical treatments have made it possible to overcome infertility and reproductive challenges. Over those same 20 years, veterans have not had access to these advances

¹⁷P.L. 114-223, section 260, www.congress.gov/bill/114th-congress/house-bill/5325/text.

because of an act of Congress in 1992 prohibiting VA from providing IVF.¹⁸ Despite the recent authorization to provide IVF services, the ban at VA will go back into effect at the end of the two-year appropriation. This ban adversely impacts the well-being of veterans and their families. Availability of procreative services through VA will ensure veterans are able to have a full quality of life, one that would otherwise be denied to them as a result of their service.

For those veterans for whom IVF is not possible or desired, VA will temporarily assist in the costs associated with the adoption of a child. This, too, will provide veterans with an option they could not otherwise afford and a quality of life that would otherwise not be possible because of service.

Some women veterans with a catastrophic injury may be able to conceive through IVF but be unable to carry a pregnancy to term due to their injury. In such an instance, implantation of a surrogate may be their only option. VA is not authorized to provide IVF services with a veteran's surrogate. As such, the needs of women veterans with a catastrophic reproductive injury go unmet.

For veterans who have sustained a blast injury or a toxic exposure that has destroyed their genetic material, a third-party donation may be the only option. VA is not authorized to use any genetic material in IVF service that does not belong to the veteran and the veteran's spouse. Again, the needs of these veterans, who have an injury due to their service, are not able to receive the corresponding medical treatment to address it.

Issues regarding ownership, embryo use, donation, and/or destruction will be governed by the applicable state law and will be the responsibility of the veteran and his or her lawful spouse and the facility storing the cryopreserved embryos. Identical to DOD, VA will not have ownership or custody of cryopreserved embryos and will not be involved in the ultimate disposition of excess embryos.¹⁹ VA's role is and must remain limited to paying for this benefit when requested by the consenting veteran.

Sexual Health

There is growing body of evidence linking post-deployment problems such as depression or PTSD to sexual health problems. One study found almost 18 percent of veterans screened positive for sexual dysfunction.²⁰ Healthy sexual functioning and satisfaction with one's sex life are predictors of general well-being and overall health. VA providers must work to navigate sometimes awkward questioning to ensure veterans are able to voice concerns or problems about their sexual health that undoubtedly will impact their overall health.



Management of Chronic Pain

RECOMMENDATIONS:

Discontinue the Pain as the 5th Vital Sign Initiative, as pain or pain scales alone have been proven to be an insufficient reason for an opioid trial.

¹⁸Title 38, CFR, 17.38(c)(2), <https://www.law.cornell.edu/cfr/text/38/17.38>.

¹⁹1074(c)(4)(A), title 10, USC, "Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members," April 3, 2012.

²⁰G. R. Beaulieu, D. M. Latini, D. A. Helmer, C. Powers-James, C. Houlette, and M. R. Kauth, "An Exploration of Returning Veterans' Sexual Health Issues Using a Brief Self-Report Measure," *Sexual Medicine* 3, no. 4 (2015): 287–94, doi:10.1002/sm2.92.

Train physicians to utilize functional outcomes (e.g., walking distance, number of repetitions or specific exercises, and return to work) as objective evidence to determine inadequate/adequate pain control.

Fund the utilization of wearable technology, allowing physicians to gain objective data on quality of life, including but not limited to heart-rate variability and number of steps taken, which would allow physicians to monitor effectiveness of treatment plans.

Fund interventional studies in the OIF/OEF veterans' populations utilizing both traditional and nontraditional treatment modalities with functional outcomes rather than "pain score" or "VAS score" as primary endpoints. There is a lack of studies in this population.

Increase access to nonpharmacological treatments that can be accessed within the VA system itself, including but not limited to acupuncture, massage therapy, yoga, cognitive behavioral group therapies, and adaptive sports programs.

VA should create more multidisciplinary chronic pain clinics that would include a variety of physician specialties to create individualized treatment plans for each patient seen in the clinic.

Fund the utilization of telemedicine to increase access to multidisciplinary pain clinics.

Increase the amount of time primary care providers are able to spend with patients dealing with chronic pain to gain a better understanding of their pain issues.

Assign each chronic pain patient to a health coach to increase contact time with a provider. This health coach can be a physician, nurse, or social worker trained in educating patients in pain management. Fund studies to determine if increased provider contact improves functional pain outcomes.

Create a tool to monitor pain assessment, treatment plans, and pain reassessment.

BACKGROUND AND JUSTIFICATION:

VA has a long history of making positive changes in how chronic pain is managed. The details are well documented in VA's document *Implementation of the VA Health Administration Pain Management Strategy*. VA has adopted the Stepped Care Model for Pain Management (SCM-PM), emphasizing an individualized, stepwise approach. A VA update dated July 8, 2016, discussed the effectiveness of the OSI, which was implemented nationwide in August 2013 to decrease the number of patients on opioids and increase the number of patients receiving routine drug screens who are using chronic opioids. VA notes that as of March 2016, there are 112,846 fewer patients on long-term opioid therapy, 151,982 fewer veterans receiving opioids, and 94,045 more patients on opioids who received a drug screen. While these numbers do show that the OSI has been effective in reaching its goal to decrease the number of patients on opioids, it does not show whether or not veterans have received high-quality pain management for combat-related pain disorders.

Many professional medical societies have published guidelines to address opioid usage, with recent reviews finding widely varying quality of those guidelines. Most guidelines advise health care providers to exercise caution when prescribing opioids and encourage them to assess circumstances and suitability on an individual basis. As opioids continue to be utilized for the treatment of chronic noncancerous pain, the medical community as a whole has questioned their effectiveness and has well documented the potential for adverse events, abuse, and addiction.

Chronic pain affects over 100 million Americans, with an even higher prevalence in the veterans population. The prevalence of pain occurs in as many as 50 percent of veterans of OEF, OIF, and OND, with 59 percent of those with pain reporting pain severe enough to cause physical limitations. The prevalence of pain can be as high as 75 percent in female veterans who participated in these conflicts. Pain was also the most common

symptom reported in veterans of the Persian Gulf War. Musculoskeletal pain conditions have eclipsed all mental health conditions combined, becoming the most highly prevalent diagnoses among veterans returning from OEF and OIF. Additionally, the prevalence of pain complaints is growing each year.

Chronic pain and chronic opioid therapy are often accompanied by increased use of community health resources and other health comorbidities, especially substance abuse and mental health disorders. American opioid sales and opioid deaths have risen together with both, quadrupling from 1999 to 2010. Opioid-related deaths increased from 4,000 to 16,000, now surpassing motor vehicle crashes as a major cause of death in several states. Sixty percent of chronic-noncancerous-pain opioid deaths occurred in patients using medication as prescribed.

Chronic pain treatment has been estimated to cost the United States \$635 billion each year in medical treatment and lost productivity and is the most common cause of disability. It is among one of the costliest disorders treated in the VA setting, with health care utilization incrementally increasing with the duration of prescription opioids. For example, emergency department visits for nonmedical use of opioids increased 111 percent from 2004 to 2008. It is estimated that one million people treated for chronic noncancerous pain may use some form of opioid.

In addition to the physical and financial havoc chronic pain wrecks on patients and health care systems, it causes an emotional toll, both in those providing care such as physicians and family members and in patients themselves. Nearly three quarters of VA primary care providers describe chronic pain as “a major source of frustration,” while many feel burdened by treating patients with chronic pain. Patients often state that they are treated as drug seekers or “parolees” or have been “thrown aside,” while also believing they are often overprescribed pain medications by clinicians.

As the physical, emotional, and financial expense of pain and opioid usage continues to increase in soldiers returning from war, VA must improve how it treats chronic pain. Chronic pain management is complex because chronic pain is caused by many physiological, psychological, and emotional factors not yet fully understood. What is understood and well documented is that many patients require a multimodal multidisciplinary treatment approach involving both pharmacologic and nonpharmacological interventions. Despite the documented improvement in pain outcome utilizing multimodal multidisciplinary pain treatment, few clinics exist, due to poor funding and fiscal returns. Thus, most patients are treated by primary care providers confronted with hurdles including administrative barriers, limited pain-management training (causing low confidence in the treatment of pain), and limited time with patients.

VA should create more multidisciplinary chronic pain clinics that would include a variety of physician specialties, such as physiatrists, anesthesiologists, psychiatrists, nutritionists, therapists (physical, occupational, and speech), complementary and alternative medicine practitioners, neurologists, and surgeons. Providers should collaborate and create an individualized treatment plan for each patient seen in the clinic.

Despite the growing evidence in support of the SCM-PM, no method currently exists for evaluating this model. Clinicians have proposed the creation of an extraction tool that will evaluate three key dimensions, including pain assessment, treatment (including pain education), and reassessment. As the prevalence of chronic pain increases, it is concerning that multiple sources report the lack of interventional studies in veterans of the more recent conflicts. Finally, one study found better pain outcomes by gaining a deeper understanding of their pain through education and increased provider contact.

In summary, while VA has made many positive changes on how pain is managed, it has fallen short in many instances. The focus of its pain programs must be on improving functional outcomes rather than pain scores. It must continue to utilize physician education while increasing access to technologies, including telemedicine and wearable technology. Each pain patient should be given a health coach, while primary care providers should be given longer appointment times, allowing them to educate patients on pain as studies have shown an increased understanding of pain can increase pain outcomes. Increased funding should

be provided for interventional studies comparing and assessing traditional and nontraditional treatments in OIF and OEF veterans, as relatively few studies exist in this patient population. There is a need for increased access to nonpharmacological treatments for pain within the VA system. Finally, access must be increased to multidisciplinary pain clinics staffed by physicians from varying specialties. Increased access can be accomplished through the formation of more dedicated clinics and telemedicine. The recommended interventions should improve chronic pain management and decrease the number of opioids taken within the veterans population, improving the overall physical and emotional health of our veterans, those who take care of our veterans, and the health care system as a whole.

Information Technology: A Key to the VA Mission

RECOMMENDATIONS:

VA must choose its next health IT platform. Continued indecision is hampering its modernization.

VA must request, and Congress must provide, full funding to properly develop, modernize, and enhance VA's electronic health system and to upgrade its health IT infrastructure.

VA should continue to modernize and enhance its electronic health record system to meet national health IT standards, address cybersecurity vulnerabilities, and empower veterans, providers, and researchers.

VA should improve participation rates of the nine million veterans enrolled in its Blue Button initiative in personal electronic health records, with the goal of participation by a majority of the currently VA-enrolled veterans and 100 percent of new veteran enrollees.

VA should continue to seek a national leadership role in developing crucial health IT efforts.

BACKGROUND AND JUSTIFICATION:

The history of VA IT has been characterized by both enormous successes and catastrophic failures. Some of these programs were mismanaged, delayed, or internally flawed so that in the end they could not be saved, resulting in the waste of hundreds of millions of dollars.

In contrast to significant department-level failures, VHA, over more than three decades, successfully developed, tested, and implemented a world-class, comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on 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.

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 IBVSOs are acutely aware of the critical importance of effective IT management to veterans' health care and to their very lives.

Despite its superiority and historic success, several years ago VHA officials recognized that VistA was aging and needed to be modernized. The VistA Evolution program is a joint effort between VA's Office of Information and Technology and VHA to enhance VistA. A major component of this program is the replacement for the Computerized Patient Record System, the primary computer application that VA clinicians'

use when treating veteran patients, but it is lagging in certain areas of health care delivery available in commercially available products.

Empowering VA clinicians and researchers should also be a focus of the future VistA system and its successor. With the veteran patient population receiving care from other health care systems such as DOD, the Indian Health Service, and the private sector, and with the constant drive to achieve more cost-effective, high-quality care, meaningful interoperability to facilitate care coordination and population health management must remain a high priority for VA and Congress. After over 30 years of strong and consistent congressional oversight and mandates, VA and DOD are finally delivering interoperability with the Joint Legacy Viewer for users in both VHA and VBA. VA and community providers sharing information through Virtual Lifetime Electronic Records in conjunction with MyHealtheVet, Blue Button, and direct messaging.

As VA looks to the future, the VistA system and its successor need to be harnessed seamlessly to laptops, desktops, and a wide variety of mobile devices used both by VHA employees and by veterans. VA must continue the extraordinary growth of telehealth to include greater use of telemedicine, MyHealtheVet, health care mobile applications, and Veteran Appointment Scheduling. VA's next-generation health IT system should promote outreach, information sharing, and access empowerment, so that veterans of all generations can receive better treatment and care.

While these innovations develop, Congress continues to place restrictions on funds to modernize VA's electronic health records until the department is able to provide clarity on whether it wants to update VistA or choose a commercial off-the-shelf solution, as DOD has done. To this end, VA must move with measured speed toward a decision to mitigate current VA health IT modernization efforts from lagging behind ever-changing technology and veterans' needs. Delays and indecision today will unnecessarily incur greater risk against success in the future.



Oversight of VA's IT Modernization Efforts to Include Compliance with Sections 508 and 504 of the Rehabilitation Act

RECOMMENDATIONS:

We urge Congress to conduct robust oversight of the VA's compliance with sections 508 and 504 of the Workforce Innovation and Opportunity Act (WIOA) and to hold VA accountable for ensuring that its program of IT modernization provides VA with the capacity to communicate effectively and meaningfully with both veterans and VA employees who have disabilities.

BACKGROUND AND JUSTIFICATION:

There are more than a million veterans in the United States who have diagnosed visual disabilities. Additionally, hundreds of the VA employees and contractors who deliver programs and services to our nation's veterans on a daily basis also have visual disabilities. Both groups must rely upon VA's IT infrastructure to make it possible for them to communicate with VA. Section 508 of the Rehabilitation Act of 1973, which was recently incorporated into the WIOA, directs federal agencies to ensure that all electronic and information technologies developed, procured, maintained, or used in the federal environment provide equal access for federal employees and members of the public who have disabilities.

During the past year, VA has made significant strides toward ensuring that its web content complies with section 508 accessibility guidelines. However, VA employees and contractors, as well as veterans who have

visual and other print-reading disabilities, continue to face daunting challenges when attempting to utilize VA information technologies. The following compliance issues are areas of specific and ongoing concern:

- inaccessible kiosks at VAMCs, the use of which is required to check in for scheduled appointments
- inaccessible telehealth tools, namely the Health Buddy home monitoring station
- VBA web pages containing eBenefits information that is presented in a manner not compatible with assistive technologies, such as screen readers, used by people with visual disabilities
- continuing accessibility barriers faced by VA employees with visual disabilities who are forced to use legacy systems that are largely incompatible with adaptive software in order to do their jobs
- inadequate staffing of the VA Office of Section 508 Compliance, limiting VA's capacity to address internal and external accessibility issues in a timely manner

The items listed above are representative of the barriers encountered by both internal and public users of VA's information technologies. We believe that as VA's effort to modernize its IT infrastructure moves forward, accessibility must be addressed from the beginning. Both financial and human capital resources are in short supply these days, and VA can no longer afford to squander its resources by continuing the traditional agency practice of implementing inaccessible systems or equipment, only to find that it must be retrofitted in order to make it usable by its intended beneficiaries. We urge the House and Senate Committees on Veterans' Affairs to conduct robust oversight of VA's compliance with section 508 of the WIOA as a key element of any assessment of the sustainability of VA's IT infrastructure.

Further, we urge the members of the Veterans' Affairs Committees to hold VA accountable for adequately staffing its accessibility efforts. We urge VA to dedicate sufficient fulltime employees to the Office of Section 508 Compliance to ensure its ability to provide timely responses to the department's accessibility requirements. Finally, we urge Congress to ensure that for FY 2018 no less than \$18 million be dedicated to this effort. The same statute that addressed accessibility issues related to IT utilized by federal agencies also contains a directive (in section 504) that federal agencies make such modifications to their activities, programs, and services as may be necessary to make them accessible to persons with disabilities. VA currently provides a vast amount of information to veterans and its employees in non-electronic, hard-copy print format. In many cases, this print material is intended for and distributed to individuals VA knows cannot read it as presented because the recipient has a VA-documented visual disability. To date, the VA has made virtually no progress to establish effective means of communication with individuals who have visual and other print-reading disabilities. This failure can be life threatening to a veteran who is given unreadable discharge instructions by VA medical personnel. Likewise, VA employees provided with memorandums in a format they cannot read may face consequences that seriously impact not only their own job performance, but also the lives of the veterans the employee is supposed to serve.

As efforts get under way to redesign VA's databases and other information-collection and -sharing technologies, we urge VA to build into these upgrades the capability to provide information to visually impaired veterans, as well as employees who have visual disabilities, in alternative formats such as large print, audio recording, e-mail, or braille, so that the information can be accessed independently by the individual who receives it. Although VA leadership and its staff express a great deal of empathy for the needs of veterans and VA employees with visual impairments each time the issue of effective communication is brought to their attention, virtually no progress has been made to establish best practices that would enable implementation of policies to ensure the availability of such accessible communications. As VA undertakes a system-wide effort to modernize its infrastructure, the IBVSOs believe there is no better time to establish policies and practices that would increase VA's capacity to engage in effective, accessible communications with individuals who have print-reading disabilities. We urge Congress to conduct robust oversight of the VA's efforts to address this vital issue and hold VA accountable for the effectiveness of its communications with veterans, as well as the members of the VA workforce who have visual disabilities.

VA Leadership and Human Capital Management System

RECOMMENDATIONS:

Congress and VA should implement the recommendations of the Commission on Care for improving VHA's workforce planning, diversity, culture, and leadership succession and for assessing and awarding employee performance.

Congress, OPM, VA, and employee representatives must collaborate to develop policy allowing VHA to develop and reward its health care workforce in the current fast-paced, ultracompetitive health care environment.

Congress and VA should reevaluate current restrictions and policies on scientific and professional conferences and training activities in light of current reform and partnership efforts to continue to improve the VHA system of care.

Congress must support improvements to the VA's leadership and human capital management systems by providing the necessary funding and authorities to implement system reform and for VA to utilize the broad-based recruitment, retention, and employment incentives available in order to attract workforce talent and to remain competitive in various workforce markets.

VA and VHA leadership must make a top priority fixing the standard operating procedures in human capital management. Human capital management executives should be involved in developing high-level policy for cultural transformation, workforce planning and strategic vision for the department.

VA should apply Lean Six Sigma training methodology or similar techniques to human capital management procedures to eliminate duplication and waste and should consider use of commercially available tools to expedite hiring when possible.

VHA should continue to transform its organizational structure and reengineer business processes to better align its mission, eliminate unclear, duplicative functions, clarify roles and responsibilities, and establish performance measures and accountability that connect organizational goals to outcomes in delivering direct services provided to veterans from VACO down to field offices and medical facilities.

VHA must create an integrated and sustainable cultural transformation, promoting a positive organizational environment where leaders at all levels of the organization are responsible and accountable for this change.

Congress should conduct oversight and determine VA's ability to implement the original intent of P.L. 108-445, the Department of Veterans Affairs Personnel Enhancement Act of 2004, to ensure competitive compensation for recruiting and retaining full-time physicians, especially in rare subspecialty fields where the number of physicians is very limited.

VA should create career pathways for leaders, focusing on developing more diversity in leadership and employing veterans whenever practicable.

VA should continue its path to becoming a learning organization that rewards initiative and values employees' contributions.

VA should identify best practices from within and outside the organization and determine if they are applicable to its standard operating procedures. The MyVA initiative for hiring medical support assistants could inform other hiring processes for health care personnel if successful, for example.

Congress should amend any law to ensure veterans' preference appeal rights are applicable to all qualified federal employees.

BACKGROUND AND JUSTIFICATION:

After reports of secret waiting lists at the VAMC in Phoenix, President Barack Obama established the independent Commission on Care to make immediate and long-range systemic changes necessary to provide the best-quality care and support services to our nation's service members, veterans, and their families.

In response, Secretary McDonald's MyVA Initiative advocates improvements of both employee experience and internal support services. In his words, "I learned in the private sector that it is absolutely not a coincidence that the very best customer-service organizations are almost always among the best places to work." MyVA emphasizes the need for sound strategies, robust systems, high-performing culture, and passionate leadership resting upon a foundation of principles and technical competence. Human resources management systems and strategies are integral to fulfilling the MyVA vision, in addition to creating the environment in which not only VA employees, but ultimately, VA's consumers—veterans—thrive.

The Commission on Care issued its final report on June 30, 2016. The IBVSOs were pleased to see many of the VA's and VSOs' recommendations were incorporated in the final report. Several of the 17 recommendations it made to improve VHA. Specifically it addressed

- promotion of diversity in the workplace,
- culture,
- staff engagement,
- recruitment, promotion and leadership succession based on performance-based assessments,
- performance measurement reflecting top system-wide priorities, and
- integral involvement from VA/VHA leadership to build an effective human capital management system

While much has been done, Congress and VA has more to do to address the systemic and long-standing issues, particularly in reforming VA leadership and human capital management system as outlined above

The IBVSOs' Framework for Veterans Health Care Reform corroborates many of the leadership and human capital modernization recommendations outlined in the commission's report and the September 2015 report of the CMS Alliance to Modernize Healthcare, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*. In fact, regardless of how well VA reforms staffing and capital infrastructure processes, it will not be able to close the access gap if it does not receive the resources it needs to meet demand—that is, VA's ability to meet its promise to veterans is limited by resources it receives from Congress, and VA would need increases over the next five years to meet expected demand.

The access issue plaguing VA has been exacerbated by staff shortages within the VA health care system that impact VA's ability to provide direct care. Evaluating VA's capacity to care for veterans requires a comprehensive analysis of VA's staffing, funding, and infrastructure measured against veterans' health care demand and utilization.

Any plan to reform the culture of VA must also take into consideration the need to modernize VA's workforce and ensure VA employees serve the interests of the veterans' community. While there has been much focus by Congress on firing underperforming employees, the IB partners believe the issue and system are far more complicated and demand a holistic approach to workforce development that allows VA to recruit, train, and retain a high-quality workforce of talented and compassionate professionals capable of caring for our veterans, while simultaneously ensuring that VA has the authority to properly reward and hold employees accountable. This must include acknowledging that employee experience is equally vital to its transformation efforts. If Congress is intent on helping VA transform its culture and workforce, then Congress must give VA the leverage to hire employees quickly and offer compensation commensurate with their skill levels. Thus, we

urge Congress to conduct oversight and determine the adequacy of VA's implementation of P.L. 108-445, the Department of Veterans Affairs Personnel Enhancement Act of 2004, to ensure VA is exercising its full range of authorities to recruit and retain full-time physicians and critical health care professionals.

Moreover, VA must review every step in its standard operating procedures for human capital management with an eye toward improving efficiency and eliminating waste. VHA must determine whether processes in the recruitment and hiring cycle, from the identification of need to the onboarding process, add value, could be done concurrently with other tasks, or could be streamlined or improved with existing technology. VA has critical staff vacancies that must be filled as soon as possible to ensure veterans are served. Use of a systematic method such as Lean Six Sigma and participation from all levels of the human capital resources team and the Veterans Engineering Resources Center (VA's reengineering team) could greatly assist VA with this painstaking analysis.

To be sure, VHA human capital management is complicated. VHA now hires under several authorities, including title 5, title 38, "hybrid" title 5/ title 38 authority, the Senior Executive Service, and less commonly used authorities. The Office of Personnel Management (OPM) creates the rules and guidance for title 5 positions—mostly positions it considers "non-medical." VHA often finds that title 5 position descriptions inadequately describe and reward the functional tasks and technical competencies required to perform jobs. Rather than listing a fair market price for an individual who is highly skilled, OPM pay scales are largely determined by supervisory duties and tenure. Promotion is not connected to performance. In today's "flattened" organizational structures, supervisory duties are not necessarily indicative of the level of responsibility assigned to a position.

Pay scales for VA employees are often not competitive with those of individuals with similar jobs in the private sector and are not properly applicable to the health care environment where even custodial duties may require certain certifications or training that make these individuals more competitive in the job market. Certainly health care administrators' and managers' salaries are not competitive with those in the private sector. VA's "new" clinical managers, for example, top out of their average private-sector salary ranges in many areas almost as soon as they are hired.

While VHA has more control over title 38 positions (mostly doctors, nurses, dentists, and other highly trained medical staff) and "hybrid" positions (psychologists, pharmacists, physical, speech and occupational therapists, social workers, schedulers, et al.), it struggles with offering competitive salaries and benefits in a highly competitive market for scarce clinical personnel. It has created policies that are inefficient, unnecessarily complicated, and lengthy, causing them to lose interested job candidates who receive offers from competitors much more quickly. This is particularly challenging for positions in which there is a great deal of turnover such as medical support assistants.

Some of the decisions about pay scales and competition for scarce clinical personnel are not within VA's direct control. If there is good news, it is that with the right vision and leadership, VHA can extricate itself from the policy morass. Many of the hiring procedures VHA uses under title 38 and hybrid authority are guided by internal policy—VA does not need authority from Congress to change them and should take the initiative to do so.

VA must also establish a work environment that equally respects the rights and benefits of all employees. IBVSOs still hear of instances where employees are denied certain rights that are reserved for their counterparts who were hired under different hiring status. For instance, a federal appeals court ruled that VA health care employees appointed under title 38, section 7401 (primarily direct-care clinicians), lack the right to appeal violations of their veterans' preference rights because title 38 appointees are not covered by the Veterans Employment Opportunities Act of 1998 (*Scarnati v. Department of Veterans Affairs*, 344 F.3d 1246 [Fed. Cir. 2003]). Congress should amend any law to ensure veterans' preference appeal rights are applicable to all qualified federal employees to ensure VA has the ability to provide to the maximum extent possible opportunities for veterans to secure employment in the department.

Most of VHA's Office of Human Resources Management staff are involved in transactional activities rather than in establishing policy or other high-level activities that ought to occur in a corporate office. It is also diffused throughout the system with a human resources activity center in VACO, one in VBA, one each in VHA, NCA, and BVA. This makes it difficult to share responsibilities that may apply to all agencies, such as classification, coding, and training, and also confuses staff about whom to contact when guidance is needed. VA must reexamine the administrative structure of its human resources activities and determine if another organizational structure would address duplication and allow some efficiencies to occur.

In addition to onboarding, improving pay and benefit packages, creating career tracks, and enhancing culture to support an environment where risk is rewarded and all employees' views and opinions matter, will help retain VA's brightest stars. VA's leadership should also more closely embrace VA's human capital management executive team to ensure it is integrally involved in making organizational policy and defining the workforce needed to execute VA's strategic vision.

According to the Commission on Care, VHA has among the lowest scores in organizational health in the US government. This is a result of VHA executives not being focused on the importance of leadership's attention to the cultural health of the organization and not integrating the requisite training, assessments, and performance accountability into the system, including an organizational structure and management processes that facilitate decision making at the lowest level and foster the spread of best practices. If VA is to effectively transform and engage employees, it needs the financial incentives and hiring authorities to attract outside leaders and experts who want to serve in VHA, to include temporary and/or direct hiring of health care management graduates and senior government and private-sector health system leaders and experts.

Eye Injuries Among OIF/OEF/OND Veterans

RECOMMENDATIONS:

The IBVSOs recommend oversight hearings on the implementation of two sensory centers of excellence (COEs) for vision and hearing.

Congress must conduct oversight of the Defense and Veterans Eye Injury Vision Registry (DVEIVR), which is responsible for the electronic coordination of the eye-injured.

We recommend that defense appropriations committees include \$15 million for the -peer-reviewed Vision Research Program (VRP) in FY 2018.

The IBVSOs recommend DOD's Office of Defense Health Affairs (DHA) establish central management of the vision and hearing COEs.

BACKGROUND AND JUSTIFICATION:

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 ranks fourth behind TBI, PTSD, and hearing loss as one of the most common injuries among active-duty military service members, currently affecting 16 percent of all evacuated wounded in OIF, OEF, or OND, an increase from 13 percent in 2009. VHA reports that a total of 201,980 OEF/OIF/OND

veterans have been enrolled with variety mild, moderate, or severe eye diagnostic conditions.²¹ In May 2011, the DOD Armed Forces Surveillance Center MSMR report *Eye Injuries, Active Component, U.S. Armed Forces, 2000–2010* stated that during 11-year surveillance period review it found 186,555 eye injuries worldwide in military medical facilities within its data.²² VA peer-reviewed research also notes that among the 41,469 OEF/OIF/OND veterans diagnosed with eye conditions, upward of 75 percent of all TBI patients experienced short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems.²³

The director of DOD’s Office Vision Research Program at Fort Detrick, Maryland, has studied the diagnosis, treatment, and mitigation of visual dysfunction associated with TBI in defense-related vision research and has identified gaps in the ability to diagnose and treat visual impairments from blasts, along with inadequate treatments for eye-penetrating 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. The DOD MSMR reported that of the total of 186,555 injuries identified, 133,274 were mild, superficial ones that were treated on an outpatient basis. The MSMR report also identified 4,154 severe, penetrating eye injuries with high risk of blindness, 7,539 retinal and choroidal hemorrhage injuries, 798 optic nerve injuries, and 4,843 chemical and thermal eye-burn injuries between 2003 and the end of 2010. This report of active-duty service members with eye injuries demonstrated a sharp increase in eye injuries that occurred starting in 2004 in OIF and then continued into OEF with 9,571 orbital injuries, 82 percent from IED blasts.

TBI vision researchers found that veterans screened positive for TBI-related visual system dysfunction an average of 66 percent of the time, and with widespread screening more VA sites are diagnosing these vision impairments. 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.

The IBVSOs believe that VRP must be funded at higher rates than in the previous four years, where it has been lower than other congressionally directed medical research programs for deployment-related combat research. Funding new translational deployment treatments for severe eye damage from blasts must be increased in FY 2018 to \$15 million. We point out that such injuries can have not only long-term implications for the veteran’s vision health, productivity, and quality of life (as well as that of his or her family), but also a high financial impact on society.

In 2012, the National Alliance for Eye and Vision Research released its first-ever *Cost of Military Eye Injury and Blindness* study, prepared by Kevin Frick, PhD (of Johns Hopkins University’s Bloomberg School of Public Health). Based on published data from 2000–10 and recognizing a range of injuries from superficial to bilateral blindness, as well as visual dysfunction from TBI, it stated that the annual incident cost has been \$2.3 billion, yielding a total cost to the economy over this time frame of \$25.1 billion—a large portion of which is the present value of future costs such as VA and Social Security benefits, lost wages, and family care.

²¹Office of Public Health Epidemiologic Report, *Cumulative Frequencies of the Eye and Adnexa Enrollment OIF/OEF/OND* (FY October 2002 to second quarter, FY 2015).

²²DOD Armed Forces Health Surveillance Center, Medical Surveillance Monthly Report (MSMR), vol. 18, no. 5, “Eye Injuries, Active Component, U.S. Armed Forces 2000–2010,” May 2011, 2–7.

²³DOD Armed Forces Health Surveillance Center, Medical Surveillance Monthly Report (MSMR), vol. 18, no. 5, “Eye Injuries, Active Component, U.S. Armed Forces 2000–2010,” May 2011, 2–7.

²⁴Greg L. Goodrich, Karen D. Brahm, Palo Alto VAMC, “Visual Impairment and Dysfunction in Combat-Injured Service Members with Traumatic Brain Injury,” *Optometry and Vision Science* 86, no. 7 (July 2009).

²⁵Alliance for Eye Vision Research, “The Value of Defense-Related Vision Research: Peer-Reviewed Vision Trauma Research Program in Defense Appropriations,” *Decade of Vision 2010–2020* (Fall 2012).

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 and Limb Extremity Center of Excellence were established in the FY 2009 NDAA (P.L. 110–417). Congress established these three 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 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. The DOD’s *Recovering Warrior Task Force 2012-2013 Annual Report* recommends that changes also be made in regard to management of the vision and hearing COEs and that the Office of the Assistant Secretary of Defense for Health Affairs develop and implement measures of effectiveness that ensure consistency, completeness, and implementation of the clinical recommendations of these COEs. As of 2013, these changes had not been implemented.²⁶

The IBVSOs were encouraged initially by the Vision COE efforts with the DVEIVR, which began development in October 2010 and has been the first DOD-VA clinical registry with the ability to exchange integrated health records. It was initially the model for all other COE registries, but today it has only 27,000 eye-injured veterans’ records in its data system and less than this number of the veterans’ eye injury records from VHA’s electronic health record system. DVEIR was to be the first registry to combine DOD and VA clinical information into a single data repository for tracking patients and assessing longitudinal outcomes, which improved coordination of care, allowed development of new strategies for training, and enabled translation of peer-reviewed research into clinical practices and policy.

Congress must request more briefings and oversight of VHA and DOD on the implementation, funding, and senior governance of the DOD-VA vision and hearing COEs, as well as direct greater participation of the Health Executive Council in their operations. The IBVSOs are concerned that these COEs could also suffer setbacks as the defense health budget battles for FY 2018 and FY 2019 continue.

Hearing Loss and Tinnitus: The Forgotten Invisible Wounds

RECOMMENDATIONS:

VA must expand programs for research and treatment of tinnitus.

Congress must continue providing funding for VA and DOD to prevent, treat, and cure tinnitus.

DOD and VA must provide better education to service members and veterans on the importance of hearing protection and preventive actions.

BACKGROUND AND JUSTIFICATION:

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:

²⁶Department of Defense Recovering Warrior Task Force 2012-2013 Annual Report, page 9, Sept 2013.

- tinnitus is currently the most frequent service-connected disability of veterans from all periods of service and is particularly prevalent in Iraq and Afghanistan veterans
- 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 16.5 percent each year
- according to the *VA Fiscal Year 2015 Annual Benefits Report*, the total number of veterans awarded disability compensation for tinnitus is 1,450,462

Tinnitus is a growing problem for America's veterans. Tinnitus threatens veterans' futures with potentially 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 veterans' overall quality of life.

Acoustic trauma has been part of military life since muskets and cannons were part of the military arsenal, and the experience of post-9/11 combat veterans is no exception. America's newest generation of veterans continue to be exposed to some of the noisiest battlegrounds our military has ever experienced. IEDs remain the signature weapon used by America's post-9/11 enemies and regularly hit patrols, causing a wealth of health problems, including hearing loss and tinnitus.

A 2010 DOD study on hearing loss and tinnitus in Iraq War veterans found that 70 percent of those exposed to a blast reported tinnitus within the first 72 hours after the incident, and 43 percent of those seen a month after exposure to a blast continued to report chronic tinnitus. While the rate decreases over time, tinnitus rates exceeded hearing loss rates at all time points. These findings also demonstrate the need for more comprehensive diagnostics and a broader range of therapeutic approaches for tinnitus, particularly when it is not accompanied by hearing loss, which can only be achieved by continued and additional research on the condition.

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.²⁷ Thus, coping with tinnitus and PTSD or other mental health conditions makes recovery much more difficult.

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 Veterans' Affairs 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 is now a national management protocol for VAMCs.

The model is designed to address the needs of all patients who suffer from tinnitus, while efficiently utilizing clinical resources. There are five hierarchical levels of management: triage, audiology evaluation, group education, interdisciplinary evaluation, and individualized support. Throughout the process, patients work with a team of clinicians to create a personalized action plan to adequately mitigate problems associated with tinnitus.²⁸

While newer options for treatment of tinnitus such as PTM are emerging, the IBVSOs believe a cure to alleviate the phantom sounds plaguing the veterans' community is still needed. The best way to avoid tinnitus is prevention, thus DOD must continue to educate service members on the importance of wearing hearing protection in high-noise environments whenever possible. The focus of tinnitus research on the brain has also led to new research techniques and is attracting new disciplines to the field, which in turn is expediting progress in the way tinnitus is researched and ultimately treated.

²⁸J. A. Henry, T. L. Zaugg, P. J. Myers, C. Schmidt, C. Ribbe, K. Edmonds, S. Forbs, and E. Thielman, "Adult Tinnitus Management Clinical Practice Recommendation" *Progressive Tinnitus Management* (2015), .

This progress clearly illustrates the importance of continued research and funding in order to find a way to help the millions of veterans suffering from tinnitus.

Improve Oversight and Quality of Care at Community-Based Outpatient Clinics

RECOMMENDATIONS:

VA must improve oversight of all community-based outpatient clinics (CBOCs) at the national, regional, and local levels.

All CBOCs must consistently deliver the highest standard of care, with no disparities of quality between them and other VA facilities.

VA must continue to improve access to specialty care at CBOCs, particularly women's health services.

BACKGROUND AND JUSTIFICATION:

VA currently operates more than 1,000 CBOCs nationwide. These clinics, whether staffed by VA employees or contracted staff, make VA outpatient care more accessible to veterans who live in rural or remote areas. They also reduce the risk of readmission into a VA inpatient setting by properly utilizing outpatient preventive care. CBOCs play an immensely important role, and many veterans rely on CBOCs for the majority of their health care.

CBOCs are required to deliver the same quality of care as other VA facilities. The VA's OIG, however, continues to provide evidence that this is not always the case. The most recent annual evaluation data highlights specific areas of inadequacy over the entire CBOCs network, particularly in the area of care coordination for the approximately one third of VA patients who use more than one system of care, which includes CBOCs, VAMCs, and community care providers.²⁹ OIG also continues to find a large degree of variance in quality among CBOCs. The IBVSOs believe that this variance is largely because of the decentralized structure of the department, making it difficult for VA to ensure that individual VAMCs are exercising proper oversight over the CBOCs under their control.

VA Purchased Care

RECOMMENDATIONS:

VA must fully integrate purchased community care into its health care delivery model by using care coordination to realize the best health outcomes and achieve veterans' health goals.

²⁹P. Vandenberg, G. Uppal, A. Barker, and D. Flemming, "The Impact of the Affordable Care Act on VA's Dual Eligible Population," <http://www.hsrp.research.va.gov/publications/forum/apr13/apr13-1.cfm>..

VA must improve administrative functions and business practices and employ data analytics, including predictive data analytics, to ensure the purchase is cost-effective, preserves agency interests, and enhances the level of care VA furnishes veterans.

VA must ensure the new organizational structure of managing purchased care is properly resourced and supported to integrate purchased care activities and address system inefficiencies, as well as meet the need for clear guidance, supportive IT, and meaningful data reporting.

VA's OIG and GAO should conduct a follow-up review to audit the progress of actions VA has taken to improve purchasing care from non-VA providers.

External audits of VA and third-party administrators of the Choice Program should be performed and made public.

Congress must enact legislation to authorize VA to use provider agreements under terms and oversight similar to those used by Medicare to obtain extended-care services from private providers.

Congress must conduct oversight hearings and provide the necessary resources to facilitate full integration of statutory authority and practice of purchased community care into the VA health care system.

Congress must ensure VA has the clinical and business capabilities and interoperable electronic health record and tools for effective and efficient scheduling, billing, claims payment, and patient-centered navigational tools to help navigate various veterans' health care benefits and services.

BACKGROUND AND JUSTIFICATION:

Under specific authorities, VA purchases a broad spectrum of health services and supports from community providers for veterans, their families, and their survivors. From FY 2006 to FY 2013, the number of veterans who received VA-purchased care doubled to over one million, while spending increased nearly 170 percent to \$4.8 billion. Since then and prior to the enactment of VACAA and the implementation of the Choice Program, VA's purchased community care programs spent about \$7 billion per year.

In 2015, legal questions have been raised regarding VA's authority to purchase care under existing authorities that do not comply with federal acquisition regulations. As a result, VA has proposed language allowing the department to purchase care in those circumstances where it is not feasibly available from VA or through contracts or sharing agreements similar to the temporary provider agreement authority provided under VACAA.

The GAO and OIG reports describe a lack of integration of non-VA medical care programs across all levels of VHA. Integrated health care refers to the delivery of comprehensive health care services that are well coordinated, with good communication and health information sharing among providers. Patients are informed and involved in their treatment, and when properly integrated, the care is timely, of high quality, and cost-effective.

Until the enactment of VACAA and implementation of the Choice Program, support and resources for non-VA medical care programs did not match the demand of veterans enrolled in VA's health care system. While there are improvements in timely payments and reducing improper payments, recent OIG audit reports show a lack of coordination of purchased care where VAMC officials limited the use of purchased home care services for ill and injured veterans with limited physical functions. To date, we are waiting for external audits of VA and third-party administrators of the Choice Program.

VA has the obligation to lift the burden from veteran patients— especially critical for chronically ill and complex patients—who are trying to bridge the fragmented and disconnected care VA buys from the private sector. Absent care coordination and improved business practice, VA is not fully optimizing its resources, and value is lost to both the patient and VA.

Homeland Security and Funding for the Fourth Mission

RECOMMENDATIONS:

Congress should provide the funds necessary in the VHA FY 2016 appropriation to fund the VA fourth mission.

VA must request appropriate funding for its fourth mission, separately from the medical services appropriation.

BACKGROUND AND JUSTIFICATION:

VA has four critical health care missions, the first of which is to provide health care to veterans. Its second mission is to educate and train health care professionals. The VA's third mission is to conduct medical research, and its fourth is to serve civilians—both domestic and foreign—in times of national emergency. Whether the emergency is precipitated by a natural disaster, a terrorist act, or a public health contagion, the federal preparedness plan for such events, known as the National Response Framework, involves multiple agencies. As the largest integrated health care system in the country, with medical facilities in cities and communities all across the nation, VA is uniquely situated to provide emergency medical assistance and plays an indispensable role in our national emergency preparedness strategy.

Multiple laws authorize VA's fourth mission. VA's role in homeland security and response to domestic emergencies was established by P.L. 107-188, the Public Health Security and Bioterrorism Preparedness Response Act of 2002. It requires VA to coordinate with the Department of Health and Human Services (DHHS) to maintain a stockpile of drugs, vaccines, medical devices, and other biological products and emergency supplies. Subsequently, the National Disaster Medical System was created to combine federal and nonfederal resources into a unified response and as an interagency partnership between DHHS, the Department of Homeland Security, DOD, and VA. To accomplish its fourth mission, VA has created 143 internal pharmaceutical caches at VAMCs. 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. Additionally, VA serves as the principal medical care backup for DOD during and immediately following a period of war or a period of national emergency.

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 intended to be responsible for research toward developing methods of detection, diagnosis, prevention, and treatment regarding the use of chemical, biological, or radiological threats to public health and safety. Although authorized by law at a funding level of \$100 million, these centers did not receive funding and were never established.

The IBVSOs believe the administration must request, and Congress must appropriate, sufficient funds to ensure VA can meet these responsibilities in FY 2018 and FY 2019. Additionally, we continue to believe these funds must be provided outside the medical services appropriation. VA has invested considerable resources to ensure it can support other government agencies when disasters occur. However, VA has not received any designated funding for the fourth mission. Homeland security funding within VA is taken from medical services funds. VA

will make every effort to perform the duties assigned as part of the fourth mission, but if dedicated funding is not provided, VA will be required to divert from the already strained resources it needs for direct health care programs.



Lesbian, Gay, Bisexual, and Transgender (LGBT) Veterans

RECOMMENDATIONS:

VA must continue working to ensure providers are able to meet the health care needs of LGBT veterans.

BACKGROUND AND JUSTIFICATION:

According to VHA's Office of Patient Care Services and Office of Health Equity, an estimated one million LGBT veterans face unique challenges to accessing quality health care. As a result, LGBT veterans experience lower overall health status. LGBT persons experience mental health problems at a higher rate than heterosexuals. And as veterans experience mental health problems at a higher rate than nonveterans. Other high-risk conditions for LGBT veterans include certain cancers, heart disease for gay and bisexual men, and intimate partner violence and MST for lesbian and bisexual veterans. Older LGBT veterans are less likely to receive care from adult children and may experience discrimination in nursing homes or community living centers or live in fear of it if their sexual orientation or gender identity is not publicly known. Just as post-9/11 veterans face different health care challenges than those who served in Korea, and just as women veterans face different health care challenges than their male counterparts, LGBT veterans have specific needs that VA, until recently, has not met.

In recent years, VA has worked to reduce health disparities for LGBT veterans by providing education to VHA providers about LGBT health issues and updating nondiscrimination policies to include sexual orientation and gender identity. VHA Directive 2013-003 ensures the appropriate provision of care for transgender and intersex veterans.

VHA has LGBT veteran care coordinators at VACO to develop and deliver training to clinical staff in VHA on LGBT health care and maintain staff resource websites. At the facility level, VA is hiring LGBT veteran care coordinators to ensure veterans receive culturally competent care. There are now nine postdoctoral psychology fellowship training positions with an emphasis on LGBT veteran health care. The goal for these fellowships is to train psychologists who have specialized expertise in LGBT veterans' health care for employment in VA. Other trainings developed for staff on sexual health now include LGBT-inclusive language.

EDUCATION, EMPLOYMENT, AND TRAINING



Since the Revolutionary War, the question of what service members do when they are no longer in the service has been a problem not only for themselves and their families, but also for society as a whole. From the late nineteenth century to the early twentieth century, the national solution to this “veteran problem” was, to some extent, isolation and segregation from civil society. This brought about the former existence of soldiers’ homes, federal vocational schools, and veterans farm colonies. With the emergence of expanding social mores following World War I, it became increasingly obvious this policy was severely flawed, and we began to see development toward current veterans’ policies.

In light of the extraordinary service and sacrifice required of our all-volunteer military, the IBVSOs believe our nation not only has a moral obligation to assist our transitioning service members, but a practical one as well. This is perhaps more true than ever, as our transitioning service members continue returning to a slow-recovering economy offering limited employment opportunities for making living wages.

From a purely economic perspective, it is clear that assisting veterans transitioning out of the military in reaching their employment potential is truly a win-win-win situation—it is good for the economy, their employers, and the veterans themselves. This is especially important since the majority of working-age veterans want to remain as productive in the civilian workplace as they were while in the military, and it is the nation’s solemn obligation to ensure them every opportunity to be successful in that endeavor. The most critical time for these actions is immediately after a service member exits the military, yet it is also important to provide support and resources to veterans of all eras.

According to a recent VA National Center for Veterans Analysis and Statistics report,

- there will be an overall decline in the population of Caucasian male veterans through 2043,
- there will be a simultaneous increase in the population of female veterans through 2043, and
- the minority veteran population is expected to increase by over 13 percent by 2030

As of May 2016, much of the projected decrease in the male veteran population cohort is due to the aging of the last draft-era veterans from World War II (1.7 million), the Korean War (2.3 million), and the Vietnam War (7.4 million). It is hard to believe that at the end of the Vietnam War, the veteran population stood at nearly 60 million, compared to the 21.9 million current veterans, which means over the last 40 years America has lost more than two-thirds of its veterans. As the population of veterans continues to decrease, in part thanks to new technology that reduces force sizes, the IBVSOs do not want to see priority of their education, employment, and training needs decrease as well. It needs to remain a priority to continue to meet the economic and educational needs of those who served.

A 2012 survey done by Prudential Financial, Inc., titled *Veteran Employment Challenges* addresses both the specific employment roadblocks, as well as the numbers, of our newest veterans. The report indicates that as of the first quarter of 2013, there were approximately 783,000 unemployed veterans, of whom 207,000 were post-9/11 veterans. It must be remembered that in light of the continuing drawdown over the course of the next few years, close to one million service members will be transitioning out of the military.

Fortunately, the Bureau of Labor Statistics tracks veteran employment rates on a quarterly basis along with those of the rest of the American population. As of October 2015, the national average for unemployment was 5.0 percent, while the veteran unemployment rate was 4.3 percent.

The IBVSOs gratefully acknowledge the continued support of both the administration and Congress for their efforts in not only recognizing but also prioritizing the specific employment challenges being faced by transitioning service members. We also believe our veterans and those still serving need, and deserve,

- ongoing access to relevant career development and employment resources throughout their military service geared toward their current and future employment needs,
- the opportunity to continue or pursue higher education,

- support in earning any required licenses and/or credentials to ensure they are able to equitably compete with their civilian counterparts for living-wage jobs, and
- the opportunity to continue serving their country in a meaningful career once they return to civilian life

There are many reasons why our nation needs to support our veterans as they transition from military to civilian life, and this section will outline some of the ongoing problems facing veterans, as well as many of the resources available to assist them and specific recommendations for improvement. The question answered by this section is: what tools are available to veterans to assist them in this important transition? The simple answer is: education, training and employment.

According to a 2012 survey by Prudential and Iraq and Afghanistan Veterans of America, 60 percent of respondents said they struggled translating their military skills into a civilian job experience, which created a significant barrier to employment. Many high-demand, good-paying jobs such as paramedic, truck driver, nurse, and welder require either a national certification or state occupational license. Currently our national and state systems make it very difficult for service members and veterans to obtain these civilian certifications and licenses that directly translate to their military training. Service members and veterans are often required to repeat education or training in order to receive these occupational credentials, even though much—and in some cases, all—of their military training and experience overlaps with credential training requirements. And employers, many with significant needs for skilled workers, are left waiting for these military members to complete these often lengthy programs—programs many veterans could have taught themselves.

Ensure Veterans' Success in Higher Education

RECOMMENDATIONS:

Congress, VA, DOD, and the Department of Education (ED) must work together to ensure college-bound veterans have access to quality pre-enrollment consumer information and post-enrollment consumer protections when utilizing their earned education benefits at the college or university of their choice.

VA must develop quality metrics with which to evaluate student veteran success in higher education, identify potential problems, and develop quantifiable solutions.

Congress needs to continue investing in campus-based support resources for student veterans, such the VetSuccess on Campus program (which should be expanded), and additional programs that support peer-to-peer support or offer resources to develop veteran COEs.

Congress must also work with ED and VA to ensure veterans attending schools that are at risk of closing are given ample notice beforehand, as well as make sure veterans enrolled in schools that do close are not immediately cut off from their living stipend and do not lose their educational benefits.

BACKGROUND AND JUSTIFICATION:

In 2009, Congress made a significant investment in the future of our nation's veterans by commissioning the Post-9/11 GI Bill. This landmark benefit would provide veterans who served in support of the Global War on Terror with the financial means to pursue higher education.

Six years into the program, more than one million veterans have already chosen to tap into this lucrative benefit program, seeking to become our country's next generation of leaders. However, with the expected

drawdown of our military's active-duty force, VA officials believe we have not yet seen the largest influx of post-9/11 veterans into America's classrooms.

With such a significant investment in the future success of today's warfighters, Congress, as well as VA and its partner agencies, have an obligation to ensure veterans not only enroll in college, but they also succeed when they get there. As a nation, we also have the responsibility to ensure veterans do not become victims of fraud, waste, and abuse when they seek to use their benefits. As some bad actors in higher education lose their accreditation, close, or go out of business, it is necessary that Congress not turn its back on veterans enrolled in those schools.

By education industry standards, student veterans are often considered nontraditional students. Veterans often bring significant transfer credits and life experience to the classroom, and they must often balance significant life obligations that many of their college peers do not have. As a result of these unique characteristics, the education industry is many times not equipped to serve the unique needs of veterans or track their progress. Particularly if these schools lose accreditation or close, veterans who have families are put in even worse situations. They are forced into a predicament in which they may not be able to feed their families, pay their bills, or finish their educational goals.

By implementing the Independent Budget's recommendations, we can work to ensure that college-bound veterans and those already enrolled in higher education make informed decisions on how to best utilize their benefits, that campuses are prepared to best serve the unique needs of student veterans, and that student veterans are able to successfully obtain their academic goals, thus demonstrating a return on our investment in our nation's heroes.



Veterans Licensing and Credentialing

RECOMMENDATIONS:

DOD, VA, DOL, and other federal, state, and local government agencies tasked with assisting transitioning service members should continue reaching out to educate private-sector employers on the value of employing veterans. These efforts in outreach must include engaging all employers, including federal agencies, for-profit and nonprofit corporations, and as small businesses.

Congress must also continue engaging in a national dialogue of working closely on with the administration, DOD, VA, DOL, state governors, adjutant generals, employers, trade and professional associations, and licensing and credentialing entities at all levels to identify equivalencies between military and civilian occupations. This will develop the process to bridge the gap between state credentialing, licensing, certification requirements, and military training. Such processes should ensure veterans are able to seamlessly transfer their military training into meaningful civilian employment in all states, regardless of the state where veterans received their training.

Congress should ensure all the military also covers the costs of credentialing exams/fees for all enlisted service members and their spouses, particularly for spouses who require credentialing for fields such as mental health or law in a new state after moving due to military orders. States should also be encouraged to grant expedited licensure and certification to transitioning service members for the civilian equivalent of the job they held while in the military, as well as for their family members who require licensing and certifications upon moving to a new state for a permanent change of duty station.

BACKGROUND AND JUSTIFICATION:

Every year, between 240,000 and 360,000 military members transition from military to civilian life. As the drawdown continues, in the next few years the military expects to transition another million service members. As a nation, we need to be prepared to do our part in assisting our transitioning service members with living-wage employment opportunities so they become valued additions to our society and economy while being able to adequately support their families. We should continue to see strong demand for skilled labor in the areas of IT, health care, renewable energy, and advanced manufacturing—all ideal options for our highly trained and disciplined veterans. If trends continue, the expectation is that openings for jobs requiring basic and/or advanced degrees, as well as occupational certificates, will exceed the growth in overall employment in coming years.

The unemployment rate among our nation’s veterans continues to be an area of intense focus, not only for veterans, but also for the administration, VSOs, and employers, all of whom continue to devote substantial resources, financial, information and personnel to assist service members as they transition out of the military. As an integral part of the overall veteran transition process, licensing and credentialing for securing appropriate, living-wage employment cannot be overemphasized in importance. While progress has been made, members of the military and veteran communities continue to be concerned.

In recognition of the fact that problems related to the licensing and credentialing of veterans cannot be resolved solely by the federal government and its agencies, the Obama administration worked with stakeholders at all levels, including employers, to develop best practices and workable solutions. They also worked to forge a government-wide collaboration between all agencies.

Making it easier for service members, veterans, and their spouses to obtain civilian certification and licensure is of utmost importance and value for our nation’s economy. That is why, under President Obama’s direction, DOD established the Military Credentialing and Licensing Task Force in 2014, tasked with identifying and creating opportunities for service members to earn civilian occupational credentials and licenses through partnerships with national certifying bodies. His administration also prioritized the launching of credentialing and licensing efforts, partnering with the states to streamline state occupational licensing for veterans.

Strengthen Veteran-Owned Small Business Programs

RECOMMENDATIONS:

Congress must take the necessary steps to prevent excessive delays in awarding contracts to Service-Disabled Veteran-Owned Small Businesses (SDVOSBs) and Veteran-Owned Small Businesses (VOSBs) by requiring all federal agencies to use a single-source verification database.

All federal agencies must meet the set-aside goal of not less than 3 percent of the total value of all prime and subcontract awards to businesses controlled by service-disabled veterans each fiscal year.

DOL and VA must improve oversight and assist in development and implementation of stronger strategies to reach the federally mandated minimum 3 percent procurement goal.

Congress should revise the enforcement penalties for misrepresentation of a business as a VOSB or SDVOSB from a reasonable period of time as determined by the VA secretary to a period of not less than five years. Congress must establish a reasonable transition period for SDVOSBs to retain federal protected status following the death of the disabled veteran owner.

BACKGROUND AND JUSTIFICATION:

The federal government's support of VOSBs and SDVOSBs contributes significantly in restoring veterans' quality of life while aiding in their transitions from active duty.

Section 502, of the Veterans Entrepreneurship and Small Business Development Act of 1999 (P.L. 106-50) codified "the Government-wide goal for participation by small business concerns owned and controlled by service-disabled veterans shall be established at not less than three percent of the total value of all prime contract and subcontract awards for each fiscal year." Many federal agencies have not reached the three percent goal of set-aside contracts, therefore a veteran's ability to compete for contract awards remains problematic. Federal agencies must be held accountable to meet the federal procurement goals outlined by Executive Order No. 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.

Congress should enact legislation requiring the federal government make set-aside goals of not less than 3 percent mandatory objectives rather than goals. Congress should require underperforming federal agencies to make up shortfalls in achieving these objectives in the subsequent fiscal year.

Because of changes in the verification system, timely verification continues to be an issue for SDVOSBs and VOSBs. According to reports from both GAO and VA's OIG, "despite VA's Verification Program, fraud still exists in the Veterans First Contracting Program. VA must hire and train a sufficient number of employees to quickly and effectively certify and recertify veterans' small businesses."

Finally, while acquiring an initial federal contract and meeting its many prerequisites may be a big challenge for SDVOSBs, the death of service-disabled business owners presents an even greater obstacle for their survivors. Surviving spouses or children may lose the SDVOSB or VOSB status in its entirety when the veteran dies.

Currently, surviving spouses of 100-percent-disabled veteran business owners have a 10-year period to re-categorize the business after the date of the veteran's death if the death is related to their service-connected disability. All other surviving spouses have one year to transition if the contract is through VA, and loss of status is immediate if the contract is held by any other federal agency.

Accommodations must be made so businesses built and operated by ill and injured veterans can continue to thrive and support not only the owner's family, but also the families of those who are employed through these SDVOSBs.



Ensure Proper Oversight and Support for Non-VA Workforce Development Programs

RECOMMENDATIONS:

Congress must monitor the implementation of WIOA to ensure the law's promised improvements in state workforce programs for veterans and their families come to fruition.

Congress should support the new Vietnam Era Veterans Readjustment and Assistance Act (VEVRAA) regulations governing federal contractor obligations to recruit, hire, and advance the interests of veterans.

Congress should permanently authorize the Work Opportunity Tax Credit (WOTC) because of its importance to companies in hiring veterans.

BACKGROUND AND JUSTIFICATION:

Several programs outside of VA have an impact on the employment prospects of veterans. WIOA includes the Jobs for Veterans State Grants (JVSG) program, federal contracting rules under VEVRAA, and veteran hiring incentives provided by the WOTC program.

WIOA was signed into law by the president on July 22, 2014, reauthorizing the nation's workforce development system. The law, which became effective July 1, 2015, contains several major provisions of interest to the veterans' community, including

- requirements that state workforce plans specify how they will implement priority of service for veterans,
- funding to help veterans and people with disabilities navigate multiple service programs and activities,
- more liberal Job Corps eligibility rules for veterans within six months of discharge, and
- assurances that veterans with disabilities will be better served by state vocational rehabilitation programs

DOL is analyzing how WIOA provisions affect the JVSG program and plans to issue further guidance as needed. However, in April 2014, DOL issued a directive that could have an impact on the effectiveness of the WIOA in serving certain veterans with disabilities. However, at this time, the impact of that directive still cannot be clearly defined.

In a training and employment guidance letter, TEGL 19-13, the agency narrowed the scope of services provided by local veterans' employment representatives (LVERs) and Disabled Veterans' Outreach Program (DVOP) specialists. LVERs are no longer allowed to perform any casework for individual veterans, and DVOP specialists are no longer allowed to serve veterans with non-service-connected disabilities. Estimates state that 70 percent of veterans, including veterans with disabilities, will be denied access to these veteran employment specialists. Under those circumstances, veterans' priority of service under other DOL-funded job training and placement programs becomes increasingly important.

WIOA was hailed as important bipartisan legislation that would streamline and focus the nation's workforce development system on the most effective tools for improving employment prospects for those most in need of assistance. Strong congressional oversight will be required to ensure that veterans receive the attention they deserve as implementation of WIOA moves forward.

On September 24, 2013, DOL's Office of Federal Contract Compliance Programs (OFCCP) published a final rule that makes changes to the regulations implementing VEVRAA, at 41 CFR, part 60-300. These new regulations became effective on March 24, 2014.

To address ongoing employment disparities affecting veterans, OFCCP strengthened the regulations implementing VEVRAA by making affirmative action requirements more specific and by requiring contractors to establish benchmarks to measure their progress toward achieving equal opportunity for protected veterans. New VEVRAA regulations also make it easier for veterans to find and apply for the jobs that federal contractors list with job agencies. OFCCP has been using the additional documentation requirements called for by the regulations to conduct more effective compliance evaluations of federal contractors. Unfortunately, some in Congress have sought to exempt many companies with federal contracts from compliance with OFCCP regulations. Rather than undermining these protections, Congress should support proper implementation of VEVRAA to promise these companies are abiding by their obligations to recruit, hire, and advance covered veterans.

WOTC has offered employers tax incentives to hire certain targeted populations, including veterans, since 1996. In 2011, the Veterans Opportunity to Work (VOW) to Hire Heroes Act expanded provisions in the WOTC program to cover additional veterans with employment barriers. Unfortunately, Congress often allows this tax credit to lapse, leading to uncertainty among employers wishing to claim and job seekers wishing to benefit from the credit.

DOL statistics indicate that, in FY 2014 alone, over 80,000 veterans were certified by state workforce agencies, allowing employers to claim the tax credit on their tax returns.³⁰ The WOTC program expanded coverage of long-term unemployed workers, including VOW to Hire Heroes Act veterans, and was extended retroactively through 2019 by the Protecting Americans from Tax Hikes Act of 2015.

As Congress enters into discussions of tax reform, the WOTC authority should be made permanent so employers will be incentivized by this hiring tax benefit.

Enhance Vocational Rehabilitation Productivity and Partnerships

RECOMMENDATIONS:

VA must provide veterans a more timely and effective transition into the workforce and provide placement follow-up with employers for a minimum of 12 months.

VA should improve its partnership with state agencies by incorporating the services of non-VA counselors and constituent-specific vocational-assistance programs (those able to accommodate the needs of women, the combat exposed, the paralyzed, the blind, amputees, the traumatically brain injured, et al.) to ensure all eligible veterans receive the full array of benefits and level of customization necessary for meaningful and effective vocational intervention.

The Technical Assistance Guide (TAG) was revised and released in July 2016. The TAG must be updated regularly to ensure both DOL and VA are consistently providing appropriate step-by-step services to ill and injured veterans for their successful “job ready” reintegration.

Congress must provide the necessary funding to carry out a longitudinal study over a period of at least 20 years, as directed by the Veterans Benefits Improvement Act of 2008 (P.L. 110-389, section 334).

BACKGROUND AND JUSTIFICATION:

Current VA Vocational Rehabilitation and Employment (VR&E) program resources are insufficient to meet the needs of our nation’s veterans in a timely manner. Cooperative partnerships between VA, DOL, and other federal and state agencies must be enhanced to provide the full array of benefits and customized services to veterans in key demographics. VA needs to strengthen the VR&E program to meet the demands of ill and injured veterans. The importance of this type of collaboration was woven into the VOW to Hire Heroes Act, which authorizes government agencies to forge partnerships with nonprofit organizations in the development of job-mentoring programs.

The task before the VR&E program is critical, and the need becomes clearer in the face of the statistics from the current conflicts. Since September 11, 2001, more than 2.7 million service members have been deployed. Of that group, nearly one million have been deployed two or more times. As a result, many military service veterans will become eligible for VA disability benefits due to a service-connected disability. An employment handicap due to a service-connected disability is the catalyst for VR&E services. Unfortunately, many veterans are unaware of the VA ancillary services available to them. VA can close these informational gaps through cooperative agreements with nongovernmental agencies, nonprofit organizations, and VSOs via structured referral processes intended to supplement services by state agencies that cannot serve lower-priority veterans because of budget shortfalls and understaffing.

³⁰https://www.doleta.gov/business/Incentives/opptax/pdf/WOTC_NationalCertifications_TargetGroup_FY20132014.pdf.

VR&E must be provided the resources to further strengthen the program and its partnerships with local and federal entities. This is especially true due to the increasing number of service members returning from tours in Southwest Asia with serious disabilities. No mission is more important than that of enabling injured military personnel to lead productive lives after serving their country. For ill and injured veterans who need employment services, many must work with state counselors who often are unfamiliar with the unique aspects of combat-acquired PTSD or TBI. Sustainable job placement is challenging for veterans with PTSD and TBI, a lesson learned as an under-recognized problem that plagued veterans of Vietnam.

The IBVSOs believe state agencies and VR&E program staff would greatly benefit from training conducted by subject-matter experts on the functional challenges of TBI and PTSD, SCI/D, and other severe or catastrophic disabilities. This training would improve the delivery of vocational intervention services to those veterans. The IBVSOs believe there should be a study to determine if VR&E's current standard of 60 days for tracking whether a veteran in the program remains employed is adequate. This is because many employment probationary periods are in excess of 60 days. We believe a longer period—such as one year—would be more appropriate for VR&E to follow up with an employer.

To further the understanding of a joint services approach toward getting disabled veterans into suitable employment, a TAG was created in 2008 as a joint venture between the DOL's Veterans' Employment and Training Service (DOLVETS) and VA's VR&E.

The VOW to Hire Heroes Act influences changes within the TAG. Additionally, lessons learned among the respective departments since the TAG was established will improve future versions. Revisions of the TAG should incorporate best practices from its inception to the present.

The IBVSOs support a requirement in the Veterans Benefits Improvement Act of 2008 that VA conduct a 20-year longitudinal study of the long-term outcomes of individuals participating in VA vocational rehabilitation programs, beginning with the group that entered vocational rehabilitation in 2010. However, this study was conditioned on the availability of discretionary appropriations; thus, funds to support it were taken from VR&E's existing resources. Over the course of this study, the IBVSOs would expect VA to develop new interventions based on it. Also, the IBVSOs believe Congress should continue to support this study with sufficient appropriated funding.

We believe the existence of better data, including success rates and evaluation of VA's ongoing approaches, are essential to promote an effective vocational rehabilitation effort. This study should include a critical focus on the reasons veterans discontinue or do not participate in the VR&E program. This data will provide a foundation for designing interventions that may ease the lack of VR&E participation or discontinuance.

Enhance Vocational Rehabilitation and Employment Services

RECOMMENDATIONS:

Congress must eliminate the 12-year delimiting period for VA VR&E services to ensure disabled veterans with employment handicaps, including those who qualify for independent living services, qualify for VR&E 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 by expanding eligibility to all veterans who have been awarded service-connected disability ratings, regardless of the degree of disability.

Congress should authorize VA to make available child-care vouchers, linked to cost-of-living increases, for veterans who have families and are participating in a VR&E program.

Congress must provide sufficient resources for VR&E to establish a maximum client-to-counselor standard of 125:1 or better and explore new methodologies to formulate a proper client-to-counselor ratio based on the challenges associated with more severely disabled veterans.

Congress should authorize VA to create a monthly stipend for those participating in the employment track of VR&E's programs, creating incentives to encourage disabled veterans to complete their rehabilitation plans.

BACKGROUND AND JUSTIFICATION:

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 VR&E is charged with providing wounded, ill, and injured veterans with an array of services. These services are meant enable veterans to obtain and maintain suitable and gainful employment. In the case of those veterans with more serious service-related disabilities, VR&E is authorized to provide independent living services.

In 2003, GAO designated the VA disability program as "high risk" because of program management difficulties; transformation was needed. In March 2004, the VR&E task force, created by the Congressional Commission on Service Members and Veterans Transition Assistance, released a report with 110 recommendations for VR&E improvements. As a direct result of that report, VR&E implemented a five-track process strengthening the program's focus on employment. Also in response to the report, VA implemented 100 out of the 110 VR&E task force recommendations.

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. Considering the basic costs of living, veterans may be unable to wait until the completion of their program to begin working simply to generate some sort of income. They may be forced to leave the program prematurely simply to provide for themselves or their families. Child-care vouchers, linked to cost-of-living increases, for veterans who have families and are undergoing a VR&E program are recommended by the IBVSOs.

The IBVSOs continue to support the task force's recommendations, as well as those of the commission, to further enhance this important benefit by expanding VR&E access to all medically separated service members, making all disabled veterans eligible for VR&E counseling services.

Veterans are eligible for VR&E services and programs if their military discharge is other than dishonorable and have a VA service-connected-disability rating of at least 10 percent or a memorandum rating of 20 percent or more from VA. The VR&E program is also accessible to active-duty military personnel expecting to be medically discharged with the requisite discharge and anticipated disability rating of at least 20 percent or more from DOD and VA.

The period of eligibility to apply for VR&E services cannot currently exceed 12 years from either the date of separation from active duty or the date veterans are notified by VA of a service-connected disability rating. This 12-year application eligibility period can only be extended if a vocational rehabilitation counselor (VRC) determines a veteran has a serious employment handicap. Participants in VR&E cannot exceed 48 months of entitlement. The 48-month period of entitlement may also be extended in unique circumstances.

Congress must change the eligibility requirements for the VR&E program to increase access to services while increasing subsistence allowances for veterans with dependents. A veteran's service-connected illnesses and injuries are life-long consequences of service to our nation and so too must be the ability to utilize benefits resulting from such service remain life-long. Service-disabled veterans must be authorized to receive access to

VR&E services at any point during their employable lives when service-connected disabilities interfere with their employment.

As more service members return from the conflicts in Southwest Asia and as VBA continues to process more claims at an accelerated rate because of gains achieved through transformation and automation, the number of veterans in the various tracks of VR&E programs is expected to continue rising.

As a consequence of increased workload demand placed upon VR&E's counselors (such as collateral responsibilities in the VetSuccess on Campus program), the IBVSOs are concerned about the current constraints placed on VR&E because of an average client-to-counselor ratio of 135:1 (compared to the VA standard ratio of 125:1) and the disparity among caseloads within some VAROs.

VR&E will not be able to provide adequate service, especially one-on-one counseling, at the 135:1 ratio. Given an anticipated increase in VR&E that caseload downsizing of the military will produce, and the complexities associated with rendering appropriate services for severely disabled veterans, accurately determining staffing requirements based upon a comprehensive manpower formula is imperative. New methodologies must be developed to formulate a proper client-to-counselor ratio based on the challenges associated with severely disabled veterans.

The IBVSOs also appreciate Congress's intent outlined in P.L. 114-223, section 254, as it recognized the need to establish more reasonable client-to-counselor ratios within VR&E. This section permits VA to use funds to ensure the ratio of veterans to full-time employment equivalents within any rehabilitation program does not exceed 125 veterans to one full-time employment equivalent. It also requires VA to report to Congress on rehabilitation programs, including an assessment of the veteran-to-staff ratio for each program and recommendations to reduce the veteran-to-staff ratio for each program.

The IBVSOs are concerned this creates an underfunded mandate, as VA would have to reprogram already appropriated dollars designated for other critical programs to achieve this client-to-counselor ratio. The appropriation to achieve this ideal caseload must be included in VA's overall budget authority, not redirected from other vital programs to fill one gap while creating others.

VA Pension Work Disincentives

RECOMMENDATIONS:

Work disincentives in the VA pension program should be reexamined, and policies toward earnings should be changed to parallel those in the Supplemental Security Income (SSI) program.

BACKGROUND AND JUSTIFICATION:

Many veterans who served honorably and were discharged in good health later acquire significant disabilities. As a consequence, eligible veterans will qualify for a VA non-service-connected pension. Such a pension is often likened to SSI under Social Security. However, SSI recipients have access to a work-incentive program whereby their public benefit is gradually reduced as their earned income rises. Unlike SSI recipients, 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 also 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 also 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, the pilot program allowed veterans to retain eligibility for a 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.

VA’s Office of Policy, Planning, and Preparedness examined the VA pension program in 2002 and, though small in number, 7 percent of unemployed veterans and 9 percent of veteran spouses on pension cited the dollar-for-dollar reduction as a disincentive to work. Now that veterans with catastrophic non-service-connected disabilities retain access to VA health care, loss of access to medical care is no longer an impediment to work, but the VA pension cash cliff remains a barrier.

Enhance the Independent Living Program (ILP)

RECOMMENDATIONS:

Congress must remove the cap on the ILP within the VR&E program. All rehabilitation options, including independent living, must be available for veterans who require such services.

VR&E management must ensure continued proficiency of the vocational rehabilitation counselors (VRCs) in understanding eligibility requirement of, and the benefits available through, the ILP.

VR&E must continue to improve coordination within VA for needed benefits and services and receive sufficient resources and technologies to ensure proper administration of the ILP

BACKGROUND AND JUSTIFICATION:

The ILP was created by Congress in 1980 as a pilot program with a cap of 500 participants. It is now a permanent program through which VA is allowed to serve a cap of 2,700 participants. For veterans with significant disabilities who may not be ready to pursue employment goals, the ILP provides further rehabilitation assistance.

The IBVSOs are firmly opposed to any cap on this uniquely individualized rehabilitation assistance for veterans with significant disabilities. Congress’s decision to place a mandatory cap on this program has resulted in adverse consequences. The ILP assistance afforded to wounded, ill, and injured veterans with specific barriers to employment should be allocated according to need rather than governed by arbitrary program caps. For its part, VR&E must ensure VRCs are proficient in the purpose and benefits of this program. Informed VRCs will ensure the ILP is offered to, and available for, all who may benefit. Without continued proficiency and consistent oversight, the administration of the ILP will continue to vary between regional offices and even among VRCs.

Finally, improved coordination within VA, along with adequate administrative systems and technologies, are crucial for proper execution of the ILP. VR&E must conduct oversight to ensure referrals within VA for services and benefits are timely addressed. In addition, VR&E must have sufficient resources and technologies to collect and analyze relevant information for the ILP, including the number of individual applicants and the specific types of benefits and services provided.

The National Cemetery Administration



The National Cemetery Administration (NCA) maintains 134 national cemeteries, as well as one rural national veterans' burial ground and 33 soldiers' lots. In 1862, Congress passed legislation authorizing the purchase of land to be used as "cemetery grounds . . . for soldiers who shall have died in the service of the country." Within one year, 14 national cemeteries were established. Eight years later, the total reached 73. Not surprisingly, the majority of these early cemeteries were located close to the southeastern battlefields and campgrounds of the Civil War. At the conclusion of the war, the US Army sent out teams to recover the remains of the fallen, and by 1870 over 300,000 Union soldiers had been honorably interred. After 1873, all honorably discharged Union veterans became eligible for burial in these newly minted national cemeteries.

Following the end of World War I, Congress established the American Battle Monuments Commission, which is responsible for maintaining burial grounds outside of the US for service members who die overseas. The commission maintains 24 American military cemeteries as well as monuments and memorials.

During the 1930s, because of the high concentration of veterans living in such metropolitan areas as New York, Baltimore, Minneapolis, San Diego, San Francisco, and San Antonio, new national cemeteries were established in those locations. Additionally, some cemeteries closely associated with major Civil War battlefields of historical significance (e.g., Gettysburg and Antietam), which had been under the control of the US Army, were transferred during this time to the National Park Service. In the early 1970s, Congress again authorized the transfer of 82 of our national cemeteries from US Army control to what would become VA. The 134 cemeteries and one national veterans' burial ground currently within the purview of the NCA comprise more than 3.5 million gravesites and are located in 40 states and Puerto Rico.

The most important obligation of the NCA is honoring the memory of the brave American men and women who have, over the course of our country's history, selflessly served in our armed forces. Therefore, it is with this sacred duty in mind that we expect the stewardship, accessibility, and maintenance of our entire NCA cemetery system be treated as a high priority. The IBVSOs call on the administration and Congress to provide the necessary resources to meet the expanding and critical nature of NCA and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.



The Veterans Cemetery Grants Program (VCGP)

RECOMMENDATIONS:

Congress should fund the VCGP at a level of at least \$46 million for FY 2018.

BACKGROUND AND JUSTIFICATION:

The VCGP complements the mission of NCA by establishing state veterans cemeteries in areas where NCA is not providing burial options for veterans or awards funding to states, territories, and tribal organizations for the establishment, expansion, or improvement of state veterans cemeteries. Several incentives are in place to assist states and tribal organizations in this effort. For example, 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.

Grantees under this program are required to adhere to the standards and guidelines pertaining to site selection, planning, and construction prescribed by VA. Cemeteries may only be operated solely for the burial of service members who die on active duty, veterans, and their eligible spouses and dependent children. All cemeteries assisted by a VCGP program grant must be maintained and operated according to the strict operational

standards and measures of NCA. To date, the VA program has helped establish, expand, improve, operate, and maintain 95 veterans' cemeteries in 47 states and territories, including tribal trust lands, the Northern Mariana Islands, and Guam, which provided more than 35,000 burials in FY 2015. Since its inception, NCA has awarded VCGP program grants totaling more than \$665 million.

The importance of the VCGP program, which continues to increase NCA's presence and veteran access in rural areas, cannot be overestimated. NCA predicts that within the next few years, the number of state and tribal cemeteries that provide a full complement of burial options and services will exceed the number of equivalent national cemeteries. The current roster of state and tribal cemetery projects on the FY 2017 priority list with pre-application grant requests totals \$156.1 million.

Increase the Value of Veterans Burial Benefits

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 \$749 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 non-service-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.

BACKGROUND AND JUSTIFICATION:

In 1973, VA 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 and \$300 for non-service-connected deaths, along with 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 non-service-connected death, and 54 percent of the cost of a burial plot.

The burial allowance, first introduced in 1917 to prevent veterans from being buried in potter's fields, was modified in 1923. 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. Then, in 1973, the allowance was further modified to reflect the status of service connection.

Veterans' burial benefits have lost their value. Initially introduced in 1973, the plot allowance was an attempt to provide burial plot benefits 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 increases in the benefit's value indicates the intent to provide a meaningful benefit.

The IBVSOs are pleased that the plot allowance for certain veterans has increased from \$300 in 2011 to \$749, effective October 1, 2016. However, there is still a serious deficit between the benefit's original value and its current value. In order to bring the benefit back up to its original intended value, the payment for service-

connected burial allowance would need to be increased to a minimum of \$6,160, the non-service-connected burial allowance would need to be increased to at least \$1,918, and the plot allowance would need to be increased to a minimum of \$1,150.

Based on accessibility and the desire to provide quality burial benefits, *The Independent Budget* recommends that NCA separate burial benefits into two categories:

- veterans who live inside the VA accessibility threshold model
- those who live outside the VA accessibility threshold model

Even for veterans who elect to be buried in a private cemetery, regardless of their proximity to a state or national veterans' cemetery that could accommodate their burial needs, the benefit should be adjusted. The IBVSOs believe that veterans' burial benefits should be minimally based on the average cost for VA to conduct a funeral. Using this formula, the benefit for a service-connected burial would approximately adjust to \$2,793, the amount for a non-service-connected burial would roughly 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 would be provided for veterans who do not have access to a state or national cemetery.

NCA Accounts

RECOMMENDATIONS:

Provide NCA with \$290 million in funding for its operation and maintenance needs.

Give VA the authority to provide an allowance for transportation of veterans' remains to tribal cemeteries.

Expand authority to provide headstones and markers to burial-eligible spouses and children who are interred in a tribal veterans' cemetery.

Grant NCA authority to make available the grave marker medallions to all qualifying veterans who died before November 1, 1990.

BACKGROUND AND JUSTIFICATION:

NCA has made tremendous progress as it relates expanding access to burial options and ensuring appearance of its cemeteries reflect the standard of the National Shrine Commitment. The IBVSOs recommend an operations budget of \$290 million for NCA for FY 2018 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

Building upon NCA's efforts to improve burial access, its 2013 budget request included an initiative to increase access for veterans residing in rural areas. NCA continued to make progress in establishing national rural veterans' cemeteries in areas where the veterans' population is less than 25,000 within a 75-mile service area. This initiative targets those states in which ' there is no national cemetery within the state open for first interments and areas within the state are not currently served by a state veterans cemetery or a national cemetery in an adjacent state. Eight states meet these criteria: Idaho, Montana, Nevada, North Dakota, Maine, Utah, Wisconsin, and Wyoming.³¹ NCA's current strategic target for the percent of the veterans' population served by a national, state, or tribal veterans' cemetery within 75 miles of their home is 95 percent.

³¹VA, *FY 2017 Budget Submission and 10 Year Capital Plan*, vol. 3 of 4, February 2016, NCA-32.

To better serve Native American veterans, NCA must also be authorized to provide an allowance for the transport of remains of veterans to tribal burial and state veterans cemeteries, as well as make headstones and markers available to burial-eligible spouses and children who are interred in tribal veterans cemeteries.

There must also be parity among veterans who are eligible for the private headstone medallion regardless of the veteran's date of death. Currently, NCA can only provide a medallion for veterans who died on or after November 1, 1990.



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