THE INDEPENDENT BUDGET

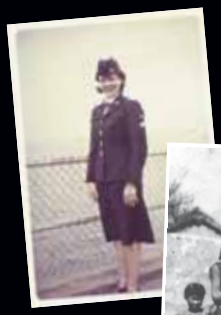
A Comprehensive Budget & Policy Document Created by Veterans for Veterans

for the Department of Veterans Affairs

Fiscal Year

2008

Portraits of Courage



Prologue

This is the 21st year *The Independent Budget (IB)* has been developed by four veterans service organizations: AMVETS, Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States. This document is the collaborative effort of a united veteran and health advocacy community that presents policy and budget recommendations on programs administered by the Department of Veterans Affairs (VA) and the Department of Labor.

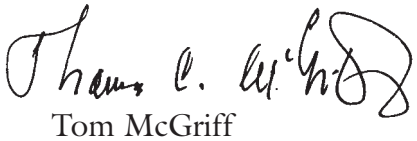
The *IB* is built on a systematic methodology that takes into account changes in the size and age structure of the veteran population, federal employee wage increases, medical care inflation, cost-of-living adjustments, construction needs, trends in health-care utilization, benefit needs, efficient and effective means of benefits delivery, and estimates of the number of veterans to be laid to rest in our national and state veterans cemeteries.

The President has stated that the war on terrorism is likely to be long, with dangers from unexpected directions and enemies who are creative and flexible in planning and executing attacks on our citizens and on our friends.

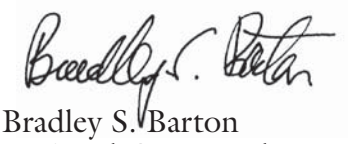
With this new reality ever present in our minds, we must do everything we can to ensure that VA has all the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners of the world, keeping the forces of anarchy, hatred, and intolerance at bay, need to know that they will come home to a country that not only cherishes their service but also honors them with the best medical care to make them whole, the best vocational rehabilitation to help them overcome the employment challenges created by injury, and the best claims processing system to deliver education, compensation, and survivors' benefits in a minimum amount of time to those most harmed by their service to our nation.

It is fitting that our 21st *Independent Budget* comes early in the 21st century. *The Independent Budget* veterans service organizations, or IBVSOs, work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

This year, as in the past, we call on Congress to find a better way to fund veterans' health-care spending by removing the veterans' budget from the battle over annual discretionary spending. We call on Congress to establish a formula to provide VA health-care funding from the mandatory side of the federal budget, ensuring an adequate and timely flow of dollars to meet the needs of sick and disabled veterans.

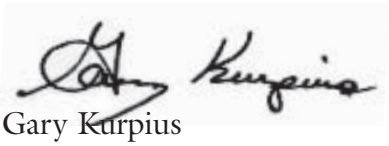


Tom McGriff
National Commander
AMVETS



Bradley S. Barton
National Commander
Disabled American Veterans

Randy L. Pleva, Sr.
National President
Paralyzed Veterans of America



Gary Kurpius
Commander-in-Chief
Veterans of Foreign Wars
of the United States

FY 2008 *INDEPENDENT BUDGET* SUPPORTERS

AAALAC International
Administrators of Internal Medicine
African American Post Traumatic Stress Disorder
Air Force Association
Air Force Women Officers Association
Alliance for Academic Internal Medicine
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Veterans Alliance, USA
Association of American Medical Colleges
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Subspecialty Professors
Blinded Veterans Association
Catholic War Veterans, USA, Inc.
Christopher Reeve Foundation
Clerkship Directors in Internal Medicine
Enlisted Association of the National Guard of the United States
Fleet Reserve Association
FOVA
Georgia Department of Veterans Affairs
Gold Star Wives of America, Inc.
Iraq & Afghanistan Veterans of America
Japanese American Veterans Association
Jewish War Veterans of the USA

continued on next page

Lung Cancer Alliance

Mental Health America

Military Officers Association of America

Military Order of the Purple Heart of the USA, Inc.

National Alliance on Mental Health

National Association for Uniformed Services

National Association of American Veterans, Inc.

National Association of County Veterans Service Officers

National Association of State Veterans Homes

National Association of Veterans' Research and Education Foundations

National Coalition for Homeless Veterans

National Gulf War Resource Center, Inc.

National Organization on Disabilities

National Spinal Cord Injury Association

Naval Reserve Association

Navy Club of the United States of America

Navy Seabee Veterans of America

Non Commissioned Officer Association

P-47 Thunderbolt Pilots Association

Nurses Organization of Veterans Affairs

State of Washington

The Forty & Eight

United States Coast Guard CPOA/CGEA

United States Federation of Korea Veterans Organization

Veterans Affairs Physician Assistant Association

Vietnam Veterans of America

Guiding Principles

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

ACKNOWLEDGMENTS

We would like to thank the staff from the four *Independent Budget* veterans service organizations for their contributions in creating this document. We especially thank Steering Committee members William Bradshaw, VFW; David Greineder, AMVETS; Joseph Violante, DAV; and Carl Blake (FY 2008 chairman), PVA, for their guidance on and review of the document.

Sections of this year's Independent Budget *were written by:*

Adrian Atizado, DAV
Carl Blake, PVA
Gary Coates, PVA
Fred Cowell, PVA
Jim Doran, AMVETS
Bill Dozier, VFW
James Dudley, PVA
David Greineder, AMVETS
George Hawley, VFW
Joy Ilem, DAV
Bryan Lawrence, DAV
Carol Peredo Lopez, AIA, PVA
Gerald Manar, VFW
Chris Needham, VFW
Michael O'Rourke, VFW
Blake Ortner, PVA
Bo Rollins, PVA
Rick Surratt, DAV
Harley Thomas, PVA

Advisors:

Cheryl Beversdorf, National Coalition for Homeless Veterans
John M. Bradley III, Consultant to DAV
Thomas D. Davies, Jr., AIA
Ralph Ibson, National Mental Health Association
Tom Miller, Blinded Veterans Association
Robert Norton, Military Officers Association of America
Sheila Ross, Lung Cancer Alliance
Matthew Shick, Association of American Medical Colleges

Special Thanks to:

Kelly Saxton, PVA, for editorial assistance
Bill Gordon, PVA, for the cover design

Table of Contents

Tables

Charts

Introduction

As *The Independent Budget* begins its third decade, we are faced with predicting the needs of an ever-growing veterans population in the midst of a war. Even as the Department of Veterans Affairs (VA) continues to deny many veterans access to health care, many more men and women who have sacrificed themselves in the global war on terrorism are taking advantage of the VA health-care and benefits system. Unfortunately, the task of estimating the true resource needs for the VA to carry out a responsible budget has been significantly complicated by a lack of action on the part of Congress in 2006.

Yet last year proved to be a unique year for reasons very different from 2005. After the budget shortfall debacle that occurred in 2005, the Administration submitted a budget request last year for FY 2007 that nearly matched the recommendations of *The Independent Budget*. These actions simply validated the recommendations of *The Independent Budget* once again. These recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans. We are proud that more than 50 veterans, military, and medical service organizations have endorsed the 21st edition of *The Independent Budget* this year.

As our nation's service members continue to be placed in harm's way in conflicts around the world, it is important that their needs upon returning home from the battlefield are met. The VA health-care and benefits system is a critical national resource for our nation's increasing veteran population. Veterans depend on VA for the health-care, housing, education, vocational rehabilitation, and insurance benefits they earned serving our country. As the Administration and Congress consider the monetary needs of VA this fiscal year, they should pause to consider how much is at stake.

Year after year, we call on Congress to provide funding necessary to meet the health-care needs of veterans and to do so in a timely manner. Unfortunately, VA remains underfunded and unable to provide timely access to quality health care to many of our nation's veterans. A system praised for the work it does is held hostage by the very people charged with the responsibility of meeting veterans' needs. If Congress cannot fulfill its solemn obligation to these men and women through the current process, it is only appropriate that the VA health-care system be made mandatory funding. Mandatory funding would ensure that the government meets its obligation to ensure all veterans eligible for VA health care have access to timely, quality care.

With regard to veterans' benefits, *The Independent Budget* recognizes a vastly growing crisis that has not been properly addressed in years past. It is time to take real steps to fix the backlog in claims processing before the system collapses under its own weight. Continuing to study these problems without developing real solutions serves no other purpose than to delay

the benefits that veterans have earned and deserve. Moreover, a large number of adjudication decisions are incorrect or have technical or procedural errors, further exacerbating the problem. Veterans' benefits are part of a covenant between our nation and its defenders and should never be denied, reduced, or delayed.

The Independent Budget covers the broadest spectrum of veterans' benefits and services with recommendations on each to make certain we keep the nation's obligation to those who have served and sacrificed so much in its defense. We understand that veterans' health care and benefits cost a lot of money, but these are men and women who have paid the price. They have taken the oath and served this country with honor and distinction. It is time that the promises made to them are promises kept.

VA Accounts FY 2008

(Dollars in Thousands)

	FY 2007 Appropriation**	FY 2008 Admin	FY 2008 IB
Veterans Health Administration			
Medical Services	25,512,000	27,167,671	28,979,220
Medical Administration	3,177,000	3,442,000	3,378,067
Medical Facilities	3,569,000	3,592,000	3,991,152
Total, Medical Care	**32,258,000**	**34,201,671**	**36,348,439**
Medical and Prosthetic Research	413,700	411,000	480,000
Subtotal, Veterans Health Administration	**32,671,700**	**34,612,671**	**36,828,439**
Veterans Benefits Administration	1,168,445	1,198,294	1,905,300
General Administration	312,319	273,543	328,541
Total, General Operating Expenses (GOE)	**1,480,764**	**1,471,837**	**2,233,841**
Information Technology	1,213,820	1,859,217	1,340,098
National Cemetery Administration	160,733	166,809	218,335
Office of Inspector General	70,674	72,599	73,233
Subtotal, Dept. Admin. and Misc. Programs	**1,445,227**	**2,098,625**	**1,631,666**
Construction, Major	399,000	727,400	1,602,000
Construction, Minor	198,937	233,396	541,000
Grants for State Extended Care Facilities	85,000	85,000	150,000
Grants for Construction of State Vets Cemeteries	32,000	32,000	37,000
Subtotal, Construction Programs	**714,937**	**1,077,796**	**2,330,000**
Other Discretionary	154,158	155,501	158,629
Subtotal, Discretionary	**36,466,786**	**39,416,430**	**43,182,575**
Cost for Category 8 Veterans Denied Enrollment			365,977
Total, Discretionary			**43,548,552**

***FY 2007 Appropriations Amounts Based on H.J.Res. 20, Continuing Resolution for FY 2007*

Benefit Programs

Through the Department of Veterans Affairs (VA), our citizens provide a wide array of vital benefits to veterans. Included are disability compensation, dependency and indemnity compensation (DIC), pensions, vocational rehabilitation and employment, education benefits, housing loans, ancillary benefits for service-connected disabled veterans, life insurance, and burial benefits.

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

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

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

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserve. A group plan also covers service members and members

of the Ready Reserve and their family members. Mortgage life insurance protects veterans who have received VA specially adapted housing grants.

Through collaborative efforts of Congress, VA, and veterans service organizations, VA benefit programs have been carefully crafted. Experience has proven that they generally serve their intended purposes and taxpayers very well. Over time, however, we learn of areas in which adjustments are needed to make the programs better serve veterans or to meet changing circumstances. Unfortunately, failure to regularly adjust the benefit rates for increases in the cost of living or to make other needed changes erodes the value and effectiveness of some veterans' benefits.

Veterans' programs must remain a national priority. Additionally, they must be maintained, protected, and improved as necessary. To maintain or increase their effectiveness, we offer the following recommendations.

▼ ▼ ▼

Benefits Issues

COMPENSATION AND PENSIONS

Compensation

Annual Cost-of-Living Adjustment:

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

Veterans whose earning power is compromised or completely lost as a result of service-connected disabilities must rely on VA compensation for the necessities of life. Similarly, surviving spouses of veterans who died of service-connected disabilities often have little or no income other than dependency and indemnity compensation (DIC). Compensation and DIC rates are modest, and any erosion due to inflation has a direct and detrimental impact on recipients with fixed incomes. Therefore, these benefits must be adjusted periodically to keep pace with increases in the cost of living. Observant of this principle, Congress has traditionally adjusted compensation and DIC rates annually.

RECOMMENDATION:

Congress should enact a COLA for all compensation benefits sufficient to offset the rise in the cost of living.

▼ ▼ ▼

Full Cost-of-Living Adjustment for Compensation:

To maintain the effectiveness of compensation for offsetting the economic loss resulting from service-connected disability and death, Congress must provide cost-of-living adjustments (COLAs) equal to the annual increase in the cost of living.

Disability compensation and dependency and indemnity compensation (DIC) rates have historically been increased each year to keep these benefits even with the cost of living. However, as a temporary measure to reduce the budget deficit, Congress enacted legislation to require monthly payments, after adjustment for increases in the cost of living, to be rounded down to the nearest whole dollar amount. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress seemingly has become unable to break its recurring habit of extending this round-down provision and has extended it even in the face of prior budget surpluses. Inexplicably, VA budgets have recommended that Congress make the round-down requirement a permanent part of the law. While rounding down compensation rates for one or two years may not seriously degrade its effectiveness, the cumulative effect over several years will substantially erode the value of compensation. Moreover, extended—and certainly permanent—rounding down is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and their dependents and survivors, who must rely on their modest VA compensation for the necessities of life.

RECOMMENDATION:

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

▼ ▼ ▼

Standard for Service Connection:

Service-connected benefits should be provided for all disabilities incurred or aggravated in the line of duty.

The core veterans' benefits are those provided to make up for the effects of "service-connected" disabilities and deaths. When disability or death results from an injury or disease incurred or aggravated in the "line of duty," the disability or death is service-connected for purposes of entitlement to these benefits for veterans and their eligible dependents and survivors. A disability or death from injury or disease is in the line of duty if incurred or aggravated "during" active military, naval, or air service, unless it is due to misconduct or other disqualifying circumstances. Accordingly, a disability or death from an injury or disease that occurs or increases during service meets the current requirements of law for service connection.

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

A member on active duty in the armed forces is at the disposal of military authority and, in effect, serves on duty 24 hours a day, 7 days a week. Under many circumstances, such member may be directly engaged in performing tasks involved in his or her military vocation for far more extended periods than a typical eight-hour civilian workday and may be normally on call or standing by for duty the remainder of the hours in a day. Under other typical circumstances, a service member may live on or near the workstation 24 hours

a day, such as when on duty on submarine, ship, or remote military outpost. Even when a military service member is not actively or directly engaged in performing functions of his or her military occupational specialty, the member is indirectly on duty or involved in general military duties and ongoing responsibilities associated therewith. In America's military service, there is no distinction between on duty and off duty for purposes of legal status, and there is often no clear practical demarcation between being on and being off duty. Moreover, in the overall military environment, there are rigors, physical and mental stresses, and known and unknown risks and hazards unlike, and far beyond, those seen in civilian occupations and daily life. American military service members stationed overseas are often exposed to increased risks of injury and disease, both on and off military facilities.

For these reasons, current law requires only that an injury or disease be incurred or aggravated "coincident with" military service; there is no requirement that the veteran prove a causal connection between military service and a disability for which service-connected status is sought. For these same reasons, a requirement to prove service causation would be unworkable as long as it remains the purpose of the law to equitably dispose of questions of service connection and provide benefits when benefits are rightfully due those who risk their health and lay their lives on the line to bear the extraordinary burdens of defending our national interests, often in terrible hardship and risk of life. Of course, if it were to become the object of our government to limit as much as possible its responsibility for veterans' disabilities rather than to have a fair and practical legal framework for justice for them, requiring proof of service causation would accomplish that object effectively by making it more difficult to prove otherwise meritorious claims for compensation.

Surprisingly, during deliberations on the annual defense authorization bill for fiscal year 2004, key members of the leadership of the United States House of Representatives developed a scheme to accomplish that very purpose by replacing the "line of duty" standard with a strict "performance of duty" standard, under which service connection would not generally be granted unless a veteran could offer proof that a disability was caused by the actual performance of military duty. Although this scheme was not enacted into law, the final legislation did require the establishment of a federal advisory commission to study the foundations of disability benefit programs for veterans—presumably with the same ultimate goal in mind. This action seems to be consistent with current systematic efforts to reduce spending on military personnel and veterans' programs in order to devote more resources to mission programs, personnel, weapons and other military hardware, and the operational costs of war.

The Independent Budget veterans service organizations believe that current standards governing service connection for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. *The Independent Budget* veterans service organizations urge Congress to reject any revision of this longstanding policy standard for the purpose of permitting the federal government to coldly and expediently avoid its responsibilities for the human costs of war and our national defense.

RECOMMENDATION:

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

Concurrent Receipt of Compensation and Military Retired Pay:

All military retirees should be permitted to receive military retired pay and Department of Veterans Affairs (VA) disability compensation concurrently.

Some former service members who are retired from the armed forces on the basis of length of service must forfeit a portion of the retired pay they earned through faithful performance of military service to receive VA compensation for service-connected disabilities. This is inequitable because military retired pay is earned by virtue of a veteran's long service on behalf of the nation.

Entitlement to compensation, on the other hand, is for an entirely separate reason—because of disability incurred during that military service. Most nondisabled military retirees pursue second careers after serving, in order to supplement their income, thereby justly enjoying a full reward for completion of a military career along with the added reward of full pay in civilian employment. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential. Their earning potential is reduced commensurate with the degree of service-connected disability. To put them on equal footing with nondisabled military retirees, disabled retirees should receive full military retired pay and compensation, to account for diminution of their earning capacities.

To the extent that military retired pay and VA disability compensation now offset each other, the disabled retiree is treated less fairly than a nondisabled military retiree. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing the enlistment obligation can receive full VA compensation and full civilian retired pay—including retirement from federal civil service employment and employment in the U.S. Postal Service. A veteran who has served this country in the armed forces for 20 years or more, however, or one who was disabled and discharged before attaining the full military retirement service threshold, should have that same right. A disabled veteran should not suffer a financial penalty for choosing military service as a career rather than a civilian career, especially where in all likelihood a civilian career would have involved fewer sacrifices and greater rewards. Disability compensation to a disabled veteran should not be offset against military longevity retired pay. If a veteran must forfeit a dollar of retired pay for every dollar of VA disability compensation otherwise payable, our government is in effect compensating the veteran with *nothing* for the service-connected disability he or she suffered. *The Independent Budget* veterans service organizations urge Congress to correct this continuing inequity.

RECOMMENDATION:

Congress should enact legislation to totally repeal the inequitable requirement that veterans' military retired pay, based on longevity, be offset by an amount equal to their rightfully earned VA disability compensation.

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

Lump-sum settlements of disability compensation should not be used as a way to decrease the government's obligation to disabled veterans and save the government money.

Under current law, the government pays disability compensation monthly to eligible veterans on account of, and at a rate commensurate, with diminished earning capacity resulting form the effects of service-connected diseases and injuries. By design, compensation continues to provide relief from the service-connected disability for as long as the veteran continues to suffer its effects at a compensable level. By law, the level of disability determines the rate of compensation, thereby requiring reevaluation of the disability upon change in its degree. Lump-sum payments have been recommended as a way for the government to avoid the administrative costs of reevaluating service-connected disabilities and as a way to avoid future liabilities to service-connected disabled veterans when their disabilities worsen or cause secondary disabilities. Under such a scheme, VA would use the immediate availability of a lump-sum settlement to entice veterans to bargain away their future entitlement. Such lump-sum payments would not be, on the whole, in the best interests of disabled veterans, but rather would be for government savings and convenience. *The Independent Budget* veterans service organizations strongly oppose any change in law to provide for lump-sum payments of compensation.

RECOMMENDATION:

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

▼ ▼ ▼

Increase in Rates of Special Monthly Compensation:

Congress should increase rates of payment to veterans suffering from service-connected disabilities who are determined housebound or in need of regular aid and attendance because of these service-incurred disabilities.

The Department of Veterans Affairs, under the provisions of title 38, United States Code, section 1114(k) through (s), provides additional special compensation to select categories of veterans with very severe, debilitating disabilities, such as the loss of a limb, loss of certain senses, and to those who require the assistance of an aide for the activities of daily living, such as dressing, toileting, bathing, and eating.

A veteran who, as the result of a service-connected disability, has suffered the anatomical loss of use of a creative organ, or one foot, or one hand, or both buttocks, or blindness of one eye having only light perception, or who has suffered complete organic aphonia with constant inability to communicate through speech, or deafness of both ears having absence of air and bone conduction, and, in the case of a woman, the anatomical loss of one or both breasts (including loss by mastectomy), the rate of special compensation is at present $84 per month for each such devastating loss, or loss of use, beyond the service-connected compensation level of disability granted.

The payment of special monthly compensation, while minimally adjusted for inflation each year, is now no longer sufficient to compensate for the special needs of these veterans.

RECOMMENDATION:

Congress should enact legislation to increase the special monthly compensation under title 38, United States code, section 1114(l) through (s) by an immediate 20 *percent* above the current base amount and additionally, increase by 50 *percent* the current base amount of special monthly compensation under title 38, United States Code, Section 1114(k).

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

For combat veterans and those who had military occupations that typically involved noise exposure sufficient to cause hearing loss or tinnitus, service connection should be presumed.

Many combat veterans and veterans that had military duties involving high levels of noise exposure who now suffer from hearing loss or tinnitus likely related to noise exposure or acoustic trauma during service are unable to prove service connection because of inadequate testing procedures, lax examination practices, or poor record-keeping.

In a September 2005 report, "Noise and Military Service: Implications for Hearing Loss and Tinnitus," the Institute of Medicine found: "Patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel…Because large numbers of people have served in the military since World War II, the total number who experienced noise-induced hearing loss by the time their military service ended may be substantial, but the available data provide no basis for a valid estimate of the number."

Hearing loss and tinnitus are common among combat veterans. The reason is simple: Combat veterans are typically exposed to prolonged and frequent loud noises from unusual sources, such as the sound of gunfire and jet and other loud aircraft engines, just to name a few. Combat veterans are likely to have suffered acoustic trauma from black powder and other explosive sources. Exposure to loud noise and acoustic trauma are both known causes of high-frequency hearing loss and tinnitus. Yet, many combat veterans are unable to document that their hearing loss or tinnitus is due to military service. World War II veterans are particularly at a disadvantage because testing by spoken voice and whispered voice was insufficient to detect hearing loss in many instances.

Other veterans serve in military occupations that typically involve noise exposure sufficient to cause hearing loss. Today, ear protection is mandatory in these military occupations, but many performed the same jobs without protection during earlier periods.

With some regularity, audiometric testing or records of testing are insufficient or lacking for a variety of reasons. Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control and should do the same for combat veterans and veterans whose military duties are generally recognized (e.g., artillery gun crews) to have involved noise exposure sufficient to cause hearing loss and tinnitus. When these veterans suffer from tinnitus or the type of hearing loss that can result from noise exposure and when their medical records are insufficient to prove absence of service-related hearing loss or tinnitus during service, service connection should be presumed after reasonably ruling out any post-service causation.

RECOMMENDATION:

Congress should enact a presumption of service-connected disability for combat veterans and veterans who performed military duties typically involving high levels of noise exposure and who subsequently suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma. This presumption of disability should be applied when the veteran's record does not affirmatively prove such condition or conditions are unrelated to service.

Compensable Disability Rating for Hearing Loss Necessitating Hearing Aid:

The Department of Veterans Affairs (VA) disability rating schedule should provide a minimum 10 percent disability rating for hearing loss that requires use of a hearing aid.

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

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment itself and the disadvantages of artificial restoration of hearing, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device. For example, a veteran receives full compensation for amputation of a lower extremity although he or she may ambulate normally with a prosthetic limb. Providing a compensable rating for this condition would be consistent with minimum ratings provided elsewhere when a disability does not meet the rating formula requirements but requires continuous medication.

RECOMMENDATION:

VA should amend its *Schedule for Rating Disabilities* to provide a minimum 10 percent disability rating for any hearing loss for which the wearing of a hearing aid is medically indicated.

▼ ▼ ▼

Temporary Total Compensation Awards:

Temporary awards of total disability compensation should be exempted from delayed payment dates.

An inequity exists in current law controlling the beginning date for payment of increased compensation based on periods of incapacity due to hospitalization or convalescence.

Hospitalization in excess of 21 days for a service-connected disability entitles the veteran to a temporary total disability rating of 100 percent. This rating is effective the first day of hospitalization and continues to the last day of the month of discharge from hospital. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications, or where immobilization of a major joint by cast is necessary, a temporary 100 percent disability rating is awarded effective the date of hospital admission or outpatient visit.

Although the effective date of the temporary total disability rating corresponds to the beginning date of hospitalization or treatment, the provisions of 38 U.S.C. § 5111 delay the effective date for payment purposes until the first day of the month following the effective date of the increased rating.

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

Therefore, *The Independent Budget* veterans service organizations urge Congress to enact legislation exempting these temporary total disability ratings, administered under title 38 C.F.R. §§ 4.29 4.30, from the provisions of title 38 U.S.C. § 5111.

RECOMMENDATION:

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

Pension for Nonservice-Connected Disability:

Congress must amend basic eligibility for pensions for nonservice-connected veterans who serve in combat circumstances, irrespective of whether these are declared wars.

Many veterans who have participated in hostile military operations do not fall within any defined or declared period of war as currently listed in title 38, Code of Federal Regulations, paragraph 3.2. Accordingly, these veterans are ineligible for nonservice-connected war pension benefits under title 38, United States Code, Chapter 15, "Pension for Nonservice-Connected Disability/Death."

Some expeditionary medals and combat badges are awarded to members of the armed forces who have served deployments in hostile regions, situations and circumstances other than those officially designated combat operations, or during a wartime era as declared by Congress. These veterans may have served our nation under more dangerous and threatening circumstances than veterans who served during official periods of war and those who, while serving in a period of war, were not directly involved in combat or infantry operations.

RECOMMENDATION:

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

▼ ▼ ▼

Dependency and Indemnity Compensation

Review of Adequacy of Overall Dependency and Indemnity Compensation Program:

Congress should review adequacy of dependency and indemnity compensation (DIC) to ensure the level of VA financial support is adequate to maintain these beneficiaries above the poverty level.

The VA Dependency and Indemnity Compensation program provides monthly financial support to the widow or widower of a veteran who dies from a service-connected disability (including the survivor of an active duty service member who dies while still in military service). Historically, DIC was intended to enable a survivor of a veteran to maintain a standard of living above the poverty level that might have ensued because of the loss of a spouse's life income and earning power. Current payment rates for DIC are set in law, and generally the maximum monthly payment is limited to $1,033, about 41 percent of the level of maximum service-connected disability payment to a totally disabled veteran—and considerably less than pensions paid to a survivor of a federal retiree, which is set in law at 55 percent of that federal annuity. Because of inflation and other economic factors, many widows (and some widowers) are in fact now living in poverty due to lack of income other than DIC. Their situations are often compounded by their own disabilities, child-care responsibilities, and consequent inability to work. *The Independent Budget* veterans service organizations feel strongly that no survivor of a veteran who died as a result of service-connected disability, and most certainly no survivor of a service member who died while serving our nation, ever should be reduced to poverty as a result of government compensation policy.

RECOMMENDATION:

Congress should use the General Accountability Office or another independent reviewer to examine the VA's DIC program to ensure that current policy adequately maintains the survivors of veterans who died as a result of service-connected disabilities and make legislative recommendations to Congress to correct any inequities observed from such examination.

Repeal of Offset Against Survivor Benefit Plan:

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

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

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

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

RECOMMENDATION:

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

▼ ▼ ▼

Increase of DIC for Surviving Spouses of Service Members:

Congress should elevate rates of DIC to survivors of active duty military personnel who die while on active duty.

Current law authorizes the Department of Veterans Affairs to pay additional, enhanced amounts of dependency and indemnity compensation, in addition to the basic rate, to the surviving spouses of veterans who die from service-connected disabilities, after at least an eight-year period of the veteran's total disability rating prior to death. However, surviving spouses of military service members who die on active duty receive only the basic rate of DIC.

Needless to say, this is inequitable because surviving spouses of deceased active duty service members face the same financial hardship as survivors of deceased service-connected veterans who were totally disabled for eight years prior to their deaths.

RECOMMENDATION:

We urge Congress to authorize DIC eligibility at increased rates to survivors of deceased military personnel on the same basis as that for the survivors of totally disabled service-connected veterans.

Retention of Remarried Survivors' Benefits at Age 55:

Congress should lower the age threshold for eligibility for restoration of dependency and indemnity compensation (DIC) to remarriage of survivors of veterans who die from service-connected disabilities.

Current law permits remarried survivors of veterans who die from service-connected disabilities to requalify for DIC benefits if the remarriage occurs at age 57 or older, or if already remarried, they apply for reinstatement of DIC at age 57. While *The Independent Budget* veterans service organizations appreciate the action Congress took to allow this restoration of rightful benefits, the current age threshold of 57 years is based on no objective data related to this population or its needs. Remarried survivors of retirees in other federal programs obtain a similar benefit at age 55. We believe the survivors of veterans who died from service-connected disabilities should not be further penalized for remarriage and that equity with beneficiaries of other federal programs should govern Congressional action for this deserving group.

RECOMMENDATION:

Congress should lower the existing eligibility age for reinstatement of DIC to remarried survivors of service-connected veterans, from 57 years of age to 55 years of age.

▼ ▼ ▼

READJUSTMENT BENEFITS

Montgomery GI Bill

Expansion of Montgomery GI Bill Eligibility:

Military service members who in every respect are at least equally entitled to participate in the Montgomery GI Bill as service members who first entered military service after June 30, 1985, are ineligible if they entered or had military service before that date.

Under current law, an active duty service member must have first become a member of the armed forces after June 30, 1985, to be eligible to participate in the Montgomery GI Bill. An active duty service member who entered active duty before that date and continues to serve cannot participate—unless he or she was enrolled in the prior educational assistance program and elected to convert to the Montgomery GI Bill when that opportunity was first offered. In this situation, service members who have served longer and are arguably more deserving of educational benefits are treated less favorably than members who have served in the armed forces for shorter periods.

Any person who was serving in the armed forces on June 30, 1985, or any person who reentered service in the armed forces on or after that date, if otherwise eligible, should be allowed to participate in the Montgomery GI Bill under the same conditions as members who first entered military service after that date.

RECOMMENDATION:

Congress should amend the law to remove the restriction on eligibility to the Montgomery GI Bill to those who first entered military service after June 30, 1985.

▼ ▼ ▼

Refund of Montgomery GI Bill Contributions for Ineligible Veterans:

The government should refund the contributions of individuals who become ineligible for the Montgomery GI Bill because of general discharges or discharges "under honorable conditions."

The Montgomery GI Bill–Active Duty program provides educational assistance to veterans who first entered active duty (including full-time National Guard duty) after June 30, 1985. To be eligible, service members must have elected to participate in the program and made monthly contributions from their military pay. These contributions are not refundable.

Eligibility is also subject to an honorable discharge. Discharges characterized as "under honorable conditions" or "general" do not qualify. *The Independent Budget* veterans service organizations believe that in the case of a discharge that involves a minor infraction or deficiency in the performance of duty the individual should at least be entitled to a refund of his or her contributions to the program.

RECOMMENDATION:

Congress should change the law to permit refund of an individual's Montgomery GI Bill contributions when his or her discharge was characterized as "general" or "under honorable conditions" because of minor infractions or inefficiency.

Matching Education Benefits to Service Performed— A 21st Century Montgomery GI Bill:

The nation's active duty, National Guard, and Reserve forces are operationally integrated under the Total Force policy. But educational benefits do not reflect the policy nor match benefits to service commitment.

Congress reestablished the GI Bill in 1984. The Montgomery GI Bill (MGIB) was designed to stimulate all-volunteer force recruitment and retention and to help veterans readjust to civilian life. Active duty veterans have up to 10 years post-service to use the MGIB. But Reservists who earn certain MGIB benefits during mobilization get no post-service use of those benefits. In the 1980s, policymakers and Congress never envisioned the routine use of Guard and Reserve forces for every operational mission, nor did many people perceive a need for a post-service readjustment benefit for Reserve participants. The Reserve MGIB worked well for the first 15 years of the MGIBs existence. Slippage of Reserve benefits in relationship to the active duty MGIB started at about the time that large and sustained call-ups of the Guard and Reserve began after the September 11, 2001, attacks. Congress attempted to respond to this benefit gap by authorizing a second Reserve Title 10 MGIB program—"Chapter 1607"—for reservists who were mobilized for more than 90 days for a contingency operation. However, the complexity of "Chapter 1607" program funding challenges, and the difficulty of correlating it with both the original Reserve MGIB—"Chapter 1606"—and the active duty program, have delayed its implementation, perhaps indefinitely.

The nation's total armed forces need a MGIB that supports recruitment and retention, readjustment to civilian life, proportionality of benefits for service rendered, and ease of administration.

The Total Force MGIB has two broad concepts. First, all active duty and reserve MGIB programs would be organized under title 38. (The responsibility for enlistment incentives, MGIB "kickers," and other incentives would remain with the Department of Defense under title 10.) Second, MGIB benefit levels should be simplified according to the military service performed.

To align benefits with service performed, National Guard and Reserve MGIB programs would be inte-

grated with the active duty program. Second, benefit rates would be structured as follows:

1. Tier one—similar to the current Montgomery GI Bill–Active Duty three-year rate—would be provided to all who enlist in the active armed forces. Service entrants would receive 36 months of benefits at the Active Duty Rate.

2. Tier two would be for nonprior service direct entry in the Selected Reserve (SELRES) for six years. Benefits would be proportional to the active duty rate. Historically, Selected Reserve Benefits have been 47 to 48 percent of active duty benefits.

3. Tier three would be for members of the Ready Reserve who are activated for at least 90 days. They would receive one month of benefits for each month of activation, up to a total of 36 months, at the active duty rate.

A service member would have up to 10 years to use remaining active duty or activated-service benefits—tier one and tier three—from the date of separation. A selected reservist could use remaining second tier MGIB benefits as long as he or she were satisfactorily participating in the SELRES and for up to 10 years following separation from the reserves if a separation were for disability or qualification for a reserve retirement at age 60.

RECOMMENDATION:

Congress should combine all active duty and reserve MGIB programs and tier benefits according to the service performed.

▼ ▼ ▼

Housing Grants

Increase in Amount of Grants and Automatic Annual Adjustments for Inflation:

Housing grants and home adaptation grants for seriously disabled veterans need to be adjusted automatically each year to keep pace with the rise in the cost of living.

VA provides specially adapted housing grants of up to $50,000 to veterans with service-connected disabilities consisting of certain combinations of loss or loss of use of extremities and blindness or other organic diseases or injuries. Veterans with service-connected blindness alone or with loss or loss of use of both upper extremities may receive a home adaptation grant of up to $10,000.

Increases in housing and home adaptation grants have been infrequent, although real estate and construction costs rise continually. Unless the amounts of the grants are periodically adjusted, inflation erodes the value and effectiveness of these benefits, which are payable to a select few but among the most seriously disabled service-connected veterans. Congress should increase the grants this year and amend the law to provide for automatic adjustment annually.

RECOMMENDATION:

Congress should increase the specially adapted housing grants and provide for future automatic annual adjustments indexed to the rise in the cost of living.

▼ ▼ ▼

Grant for Adaptation of Second Home:

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

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

RECOMMENDATION:

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

▼ ▼ ▼

Automobile Grants and Adaptive Equipment

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

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

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

Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile. With subsequent cost-of-living increases in the grant, Congress sought to provide 85 percent of the average cost of a new automobile, and later 80 percent. Until the 2001 increase to $9,000, the amount of the grant had not been adjusted since 1988, when it was set at $5,500.

Because of a lack of adjustments to keep pace with increased costs, the value of the automobile allowance has substantially eroded through the years. In 1946 the $1,600 allowance represented 85 percent of average retail cost and a sufficient amount to pay the full cost of automobiles in the "low-price field." By contrast, in 1997 the allowance was $5,500, and the average retail cost of new automobiles, according the National Automobile Dealers Association, was $21,750. The 1997 average cost of an automobile was 1,155 percent of the 1946 cost, but the automobile allowance of $5,500 was only 343 percent of the 1946 award. Currently, the $11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile, which is $28,105. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be $22,484.

Veterans eligible for the automobile allowance under 38 U.S.C. § 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance is only a fraction of the cost of even the modest and smaller models, which are often not suited to these veterans' needs.

Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles. The amount of the allowance should be increased to 80 percent of the average cost of a new automobile in 2006. And to avoid further erosion of this benefit, Congress should provide for automatic annual adjustments based on the rise in the cost of living.

RECOMMENDATION:

Congress should increase the automobile allowance to 80 percent of the average cost of a new automobile and provide for automatic annual adjustments in the future.

▼ ▼ ▼

Home Loans

No Increase in, and Eventual Repeal of, Funding Fees:

Funding fees are contrary to the principles underlying our benefit programs for veterans, and increased funding fees are negating the benefits and advantages of VA home loans.

Congress initially imposed funding fees upon VA guaranteed home loans under budget reconciliation provisions as a temporary deficit reduction measure. Now, loan fees are a regular feature of all VA home loans except those exempted. During its first session, the 108th Congress increased these loan fees. The purpose of the increases was to generate additional revenues to cover the costs of improvements and cost-of-living adjustments in other veterans' programs. In effect, this legislation requires one group of veterans (and especially our young active duty military), those subject to loan fees, to pay for the benefits of another group of veterans, those benefiting from the programs improved or adjusted for increases in the cost of living.

First and foremost, it is the position of *The Independent Budget* that veterans' benefits, provided to veterans by a grateful nation in return for their contributions and sacrifices through service in the armed forces should be entirely free. In addition, *The Independent Budget* finds it entirely indefensible that Congress can only make improvements or adjustments in veterans' programs for inflation by shifting the costs onto the backs of other veterans. The government, not veterans, should bear the costs of veterans' benefits. With these increased funding fees, the advantages of VA home loans for veterans are being negated. These fees are increasing the burdens upon veterans purchasing homes while the intent of VA's home loan program is to lessen the burdens.

RECOMMENDATION:

Congress should refrain from further increasing home loan funding fees and should, as soon as feasible, repeal these fees entirely.

▼ ▼ ▼

INSURANCE

Government Life Insurance

Value of Policies Excluded from Consideration as Income or Assets:

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

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

RECOMMENDATION:

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

▼ ▼ ▼

Lower Premium Schedule for Service-Disabled Veterans' Insurance:

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

Because of service-connected disabilities, disabled veterans have difficulty getting or are charged higher premiums for life insurance on the commercial market. Congress therefore created the SDVI program to furnish disabled veterans life insurance at standard rates. When this program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. VA continues to base its rates on mortality tables from 1941 however. Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer provide the intended benefit for eligible veterans.

RECOMMENDATION:

Congress should enact legislation to authorize VA to revise its premium schedule for SDVI to reflect current mortality tables.

▼ ▼ ▼

Increase in Maximum Service-Disabled Veterans' Insurance Coverage:

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

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

Today, more than 88 years later, maximum coverage under the base SDVI policy is still $10,000. Given that the annual cost of living is many times what it was in 1917, the same maximum coverage well more than three-quarters of a century later clearly does not provide meaningful income replacement for the survivors of service-disabled veterans.

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

RECOMMENDATION:

Congress should enact legislation to increase the maximum protection under base SDVI policies to at least $50,000.

▼ ▼ ▼

Veterans' Mortgage Life Insurance

Increase in VMLI Maximum Coverage:

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

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

RECOMMENDATION:

Congress should increase the maximum coverage under VMLI from $90,000 to $150,000.

▼ ▼ ▼

OTHER SUGGESTED BENEFIT IMPROVEMENTS

National Guard and Reserve Benefits:

Congress must improve and modernize federal benefits for members of the National Guard and Reserve forces.

The decade-long trend of our increasing reliance on National Guard, Air National Guard, and the Reserve forces of the Army, Navy, Marine Corps, Air Force, and Coast Guard for national security missions at home and peacekeeping and combat missions overseas, bears no sign of abatement. Reliance on Guard and Reserve forces has grown since the pre–Persian Gulf War era, and this trend continues even though both Reserve and active duty force levels remain far below their Cold War peak.

Since September 11, 2001, more than 410,000 individuals who serve in National Guard and Reserve forces have been mobilized for a variety of military, police, and security actions. Increasing demands on these serving members impose significant and repeated family separations (the single greatest disincentive for a military career) and create additional uncertainty and interruptions in their civilian career opportunities.

Furthermore, Guard and Reserve recruiting, retention, morale, and readiness are already at considerable risk. The nation cannot afford to promote the perception that we undervalue the great sacrifices and level of commitment being demanded from the Guard and Reserve community.

Various incentive, service, and benefit programs designed a half century ago for a far different Guard and Reserve philosophy are no longer adequate to address demands on today's Guard and Reserve forces. Accordingly, steps must be taken by Congress to upgrade National Guard and Reserve benefits and support programs to a level commensurate with the sacrifices being made by these patriotic volunteers. Such enhancements should provide Guard and Reserve personnel a level of benefits comparable to their active duty counterparts and provide one means to ease the tremendous stresses now being imposed on Guard and Reserve members and their families, and to bring the relevance of these benefits into 21st century application.

RECOMMENDATION:

With concern about the current missions of the Guard and Reserve forces, Congress must take necessary action to upgrade and modernize Guard and Reserve benefits, to include more comprehensive health care, equivalent Montgomery GI bill educational benefits, and full eligibility for the VA Home Loan guaranty program.

▼ ▼ ▼

Protection of Veterans' Benefits Against Claims of Third Parties

Restoration of Exemption from Court-Ordered Awards to Former Spouses:

Through interpretation of the law to suit their own ends, the courts have nullified plain statutory provisions protecting veterans' benefits against claims of former spouses in divorce actions.

Congress has enacted laws to ensure veterans' benefits serve their intended purposes by prohibiting their diversion to third parties. To shield these benefits from the clutch of others who might try to obtain them by a wide variety of devices or legal processes, Congress fashioned broad and sweeping statutory language. Pursuant to 38 U.S.C. § 5301(a), "[p]ayments of benefits due or to become due under any law administered by the Secretary shall not be assignable except to the extent specifically authorized by law, and such payments made to, or on account of, a beneficiary shall be exempt from taxation, shall be exempt from the claim of creditors, and shall not be liable to attachment, levy, or seizure by or under any legal or equi-

table process whatever, either before or after receipt by the beneficiary."

Thus, while as a general rule an individual's income and assets should rightfully be subject to legal claims of others, the special purposes and special status of veterans' benefits trump the rights of all others except liabilities to the United States government. Veterans cannot voluntarily or involuntarily alienate their rights to veterans' benefits. The justification for this principle in public policy is one that can never obsolesce with the passage of time or changes in societal circumstances.

However, unappreciative of the special character and superior status of veterans' rights and benefits, the courts have supplanted the will and plain language of Congress with their own expedient views of what the public policy should be and their own convenient interpretations of the law. The courts have chiseled away at the protections in § 5301 until this plain and forceful language has, in essence, become meaningless. Various courts have shown no hesitation to force disabled veterans to surrender their disability compensation and sole source of sustenance to able-bodied former spouses as alimony awards, although divorced spouses are entitled to no veterans' benefits under veterans laws. The welfare of ex-spouses has never been a purpose for dispensing veterans' benefits.

We should never lose sight of the fact that it is the veteran who, in addition to a loss in earning power, suffers the pain, limitations in the routine activities of daily life, and the other social and lifestyle constraints that result from disability. The needs and well being of the veteran should always be the primary, foremost, and overriding concern when considering claims against a veteran's disability compensation. Disability compensation is a personal entitlement of the veteran, without whom there could never be any secondary entitlement to compensation by dependent family members. Therefore, federal law should place strict limits on access to veterans' benefits by third parties to ensure compensation goes mainly to support veterans disabled in the service of their country. Congress should enact legislation to override judicial interpretation and leave no doubt about the exempt status of veterans' benefits.

RECOMMENDATION:

Congress should amend 38 U.S.C. § 5301(a) to make its exemption of veterans' benefits from the claims of others applicable "notwithstanding any other provision of law" and to clarify that veterans' benefits shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever "for any purpose."

General Operating Expenses

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

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

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

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION

VBA Management

More Authority Over Field Offices:

Department of Veterans Affairs (VA) program directors should have more accountability for benefits administration in the field offices.

The Veterans Benefits Administration (VBA) has introduced several new initiatives to improve its claims processes. Besides fundamental reorganization of claims processing methods to achieve increased efficiencies, the initiatives include several measures to improve quality in claims decisions. Among these measures are better quality assurance and accountability for technically correct decisions.

The VBA's current management structure presents a serious obstacle to enforcement of accountability, however, because program directors lack direct authority over those who make claims decisions in the field. Of VBA management, program directors have the most hands-on experience with and intimate knowledge of their benefit lines and have the most direct involvement in day-to-day monitoring of field office compliance. Program directors are therefore in the best position to advise the Under Secretary to enforce quality standards and program policies within their respective benefit programs. While higher-level VBA managers are properly positioned to direct operational aspects of field offices, they are indirectly involved in the substantive elements of the benefit programs. To enforce accountability for technical accuracy and to ensure uniformity in claims decisions, program directors logically should have more accountability for the field decision-making process and should be enabled to advise the Under Secretary to order remedial measures when variances are identified.

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

In its March 2004 "Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran," the VA Vocational Rehabilitation and Employment (VR&E) Task Force recommended that the director of the VR&E Service be given "some line-of-sight authority for the field administration of the program." We agree with this assessment as well.

RECOMMENDATION:

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

VBA Initiatives

Investment in VBA Initiatives:

To maintain and improve efficiency and services, the Veterans Benefits Administration (VBA) must continue to upgrade its technology and training.

To meet ever-increasing demands and maintain efficiency, any benefits system must continually modernize its tools. With the continually changing environment in claims processing and benefits administration, the VBA must continue to upgrade its information technology infrastructure and revise its training to stay abreast of program changes and modern business practices.

Despite these undeniable needs, Congress has steadily and drastically reduced funding for VBA initiatives over the past five fiscal years. In FY 2001, Congress provided $82 million for VBA initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and, in 2006, $23 million. Funding for FY 2006 was only 28 percent of FY 2001 funding, without regard to the added loss of buying power due to inflation.

With restored investments in initiatives, the VBA could complement staffing adjustments for increased workloads with a support infrastructure designed to increase operations effectiveness. The VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrading and enhancement of training systems, to improve operations and service delivery.

Some initiative priorities for funding follow:

- Replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with the Veterans Service Network (VETSNET) for the Compensation and Pensions Service, the Education Expert System (TEES) for the Education Service, and Corporate WINRS (CWINRS) for the Vocational Rehabilitation and Employment Service.

  VETSNET serves to integrate several subsystems into one nationwide information system for claims development and adjudication and payment administration. TEES serves to provide for electronic transmission of applications and enrollment documentation along with automated expert processing. CWINRS is a case management and information system allowing for more efficient award processing and sharing of information nationwide.

- Continued development and enhancement of data-centric benefits integration with "Virtual VA" and modification of The Imaging Management System (TIMS), which serve to replace paper-based records with electronic files for acquiring, storing, and processing of claims data.

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

- Upgrading and enhancement of training systems.

  VA's Training and Performance Support Systems (TPSS) is a multimedia, multi-method training tool that applies Instructional Systems Development methodology to train and support employee performance of job tasks. These TPSS applications require technical updating to incorporate changes in laws, regulations, procedures, and benefit programs. In addition to regular software upgrades, a help desk for users is needed to make TPSS work effectively.

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

- Accelerated implementation of Virtual Information Centers (VICs).

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

With the effects of inflation, the growth in veterans' programs, and the imperative to invest more in advanced information technology, *The Independent Budget* veterans service organizations believe a conservative increase of at least 5 percent annually in VBA initiatives is warranted. Had Congress increased the FY 2001 funding of $82 million by 5 percent each year since then, the amount for FY 2008 would be $115.4 million.

RECOMMENDATION:

Congress should provide $115.4 million for VBA initiatives to improve its information systems.

▼ ▼ ▼

Compensation and Pension Service

Improvements in Claims Processing Accuracy:

To overcome the persistent and longstanding problem of large claims backlogs and consequent protracted delays in the delivery of crucial disability benefits to veterans and their families, the administration must invest adequate resources in a long-term strategy to improve quality, proficiency, and efficiency within the Veterans Benefits Administration.

A core mission of the Department of Veterans Affairs is to provide financial disability compensation, dependency and indemnity compensation, and disability pension benefits to veterans and their dependent family members and survivors. These payments are intended by law to relieve economic effects of disability (and death) upon veterans and to compensate their families for loss. For those payments to effectively fulfill their intended purposes, VA must deliver them promptly, based on accurate adjudications. The ability of disabled veterans to feed, clothe, and provide shelter for themselves and their families often depends on these benefits. Also, the need for financial support among disabled veterans is generally urgent. While awaiting action by VA on their pending claims, they and their families must suffer hardships; protracted delays can lead to deprivation and even bankruptcy. Some veterans have died while their claims for disability were unresolved for years at VA. In sum, VA disability benefits are critical, and meeting the needs of disabled veterans should always be a top priority of the federal government.

Recently VA has adopted a tactic of diverting public attention away from the structural claims backlog it holds by demonstrating great speed and efficiency in adjudicating the claims of wounded soldiers and Marines from the current conflicts in Iraq and Afghanistan. While boasting it is breaking all records in awarding these new veterans their rightful benefits, hundreds of thousands of claims of older veterans from prior conflicts and military services during earlier periods lie dormant, awaiting some future resolution. While we applaud VA's efforts to help new veterans, VA continues to fail older veterans every day that the backlog grows.

VA can promptly deliver benefits to veterans only if it can adjudicate and process their claims in a timely and accurate fashion. Given the critical financial importance of disability payments, VA has an undeniable responsibility to maintain an effective delivery system, and to take decisive and appropriate action to correct deficiencies as soon as they become evident. However, VA has neither maintained the necessary capacity to match and meet its growing claims workload nor corrected systemic deficiencies that compound the problem of inadequate capacity.

Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in disposition of claims, VA has lost ground on that problem, with

the backlog of pending claims growing substantially larger in recent years. In fact, looking retrospectively over the past six years, the backlog of compensation claims has moved from the December 2000 total of 363,412, to the September 2006 level of 589,583, a more than 50 percent increase during a period when three VA Secretaries of both political parties have stated publicly on multiple occasions that reducing this chronic backlog was their highest management priority. We also note that during this same period as these promises were being made, VBA staffing has essentially remained flat at about 9,000 FTEEs.

Historically, many underlying causes have acted in concert to bring on this seemingly intractable problem. These include poor management, misdirected goals, lack of focus or the wrong focus on cosmetic fixes, poor planning and execution, and outright denial of the existence of the problem—rather than the development and execution of real strategic remedial measures. These dynamics have been thoroughly detailed in several studies and reviews of the continuing problem, but they persist without remedy. While the problem has been exacerbated by lack of action, the IBVSOs believe most of the causes can be directly or indirectly traced to availability of resources. The problem was primarily triggered and is now perpetuated by insufficient resources.

Instead of requesting the additional funds and personnel needed to accomplish better results, the Administration has sought and Congress has provided fewer VBA resources. Recent budgets have requested actual reductions in full-time employees for the Veterans Benefits Administration—those who process the claims. Such reductions in staffing are clearly at odds with the realities of VA's growing workload and VA's own well-established adjudication policies and procedures. Adjudication of veterans' claims is a labor-intensive and "hands on" system of decision-making with lifelong consequences. These management and political decisions have conspired to diminish VA's quality of claims processing and to lose ground against the claims backlog. During Congressional hearings, VA is routinely forced to defend VBA budgets that it knows to be inadequate to the task at hand. The priorities and goals of the immediate political stagnation are at odds with the need for a long-term strategy by VA to fulfill its mission and confirm the nation's moral obligation to disabled veterans.

VA must establish a long-term strategy focused principally on attaining quality and not merely achieving production quotas in claims processing, or emphasizing how well and efficient it deals with the needs of new veterans of current wars. It must obtain supplementary resources for VBA, and it must invest these in that long-term strategy rather than reactively targeting them to short-term, temporary, and superficial gains. Only then can VBA proceed in a way that veterans' needs are addressed timely with the effects of disability alleviated by prompt delivery of appropriate benefits. Already-disabled veterans should not have to needlessly suffer additional economic deprivation because of the inefficiency and ultimately, the benign neglect, of their government. We believe this situation defines the very concept of "unconscionable."

As directed by law, VA has a duty to assist veterans in developing and presenting their claims. Congress established a special Federal Court to hear any disputes that arise as VA adjudicates those claims, and veterans possess the right by law to appeal their disagreements with adjudication decisions to a special appeals board as well. That self-checking system exists because national veterans organizations including the *IBVSOs* have insisted historically that veterans' war injuries and other service-related health problems be dealt with in a humane manner, and without rancor to the greatest extent practicable. The *IBVSOs* believe that each veteran who is awarded compensation is entitled to *full payment* and that no disabled veteran should be forced to obtain a private attorney to secure a proper and accurate disability rating from VA.

RECOMMENDATIONS:

To seek the beginning of the end of this long series of repeated failures from inadequate resources and misplaced priorities, *The Independent Budget* recommends funding levels for fiscal year 2008 adequate to meet the real staffing and other needs of the Veterans Benefits Administration. We urge the Administration and Congress to enact a higher level of resources in VA's fiscal year 2008 appropriation.

VA should establish a new strategy, premised on obtaining sufficient staff and other resources, to reduce the claims backlog with accurate adjudications to an irreducible minimum backlog. As a part of this strategy, VA should implement a new communications plan that will better inform veterans and the organizations that represent them of the status and progress of their claims.

Sufficient Staffing Levels:

To overcome its claims backlog and meet an increasing workload, the Department of Veterans Affairs (VA) must be authorized to increase its staffing for the Compensation and Pension (C&P) Service.

Despite ongoing efforts to reduce the unacceptably large claims backlog, the C&P has been unable to gain ground on its pending claims. Experience has shown that this problem has persisted primarily because inadequate resources compounded by higher claims volumes.

During FY 2004 and FY 2005, the total number of compensation, pension, and burial claims received in C&P increased by 9 percent, from 735,275 at the beginning of FY 2003 to 801,960 at the end of FY 2005. This represents an average annual growth rate in claims of 4.5 percent. During this same period, the number of pending claims requiring rating decisions increased by more than 33 percent. (As the Under Secretary for Benefits has stated, "[c]laims that require a disability rating determination are the primary workload component because they are the most difficult, time consuming, and resource intensive.") With an aging veterans' population and ongoing hostilities in Iraq and Afghanistan, no reason exists to believe that growth rate will decline during FY 2006 and FY 2007. With a 9 percent increase over the FY 2005 number of claims, VA can expect 874,136 claims for C&P in FY 2007, although it should be acknowledged that actual receipts totaled 810,000 in FY 2006, while VBA had expected to see more than 900,000 during the period. Whatever levels of C&P claims are received in FY 2007 and 2008, it is true that the overall backlog is growing, not shrinking. Without adequate resources and better performance by claims processing staffs, no reason exists to believe VA will be able to hold its pending claims backlog to existing levels, much less ever reduce it.

Moreover, legislation requiring VA to invite veterans in six states to request review of past claims decisions and ratings in their cases and to conduct outreach to invite new claims from other veterans in these states will add substantially to the expected increased workload. It is projected that, of the approximately 325,000 veterans receiving disability compensation and the additional estimated 50,000 who will be invited to file new claims, 15 percent will seek new or increased benefits, resulting in an estimated 56,000 additional claims. Given past claims-processing times, much of this workload will carry over into FY 2008, making the new total more than 930,000 claims in FY 2008.

In its budget submission for FY 2007, VA projected production based an output of 109 claims per direct program full-time employee (FTE). *The Independent Budget* veterans service organizations (IBVSOs) have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, thus resulting in compromised quality, higher error and appeal rates, even greater system overload, and further adding to the claims backlog. We believe a more reasonable estimate of accurate productivity is 100 claims per FTE. In addition to recommending staffing levels more commensurate with its expected workload, we have maintained that VA should invest more in training adjudicators and that it should identify ways to hold them more directly accountable for higher standards of accuracy in the claims they process or oversee.

In response to survey questions from VA's Office of Inspector General, nearly half of the adjudicators responding admitted that many claims are decided without adequate record development. They saw an incongruity between their objectives of making legally correct and factually substantiated decisions and management objectives of maximizing decision output to meet production standards and reduce backlogs. Nearly half reported that it is generally or very difficult to meet production standards without sacrificing quality. Fifty-seven percent reported difficulty meeting production standards when ensuring there is sufficient evidence for rating each case and thoroughly reviewing the evidence. Most attributed VA's inability to make timely and high-quality decisions to insufficient staff. They indicated that adjudicator training had not been a high priority in VA.

To allow for more time to be invested in training, the IBVSOs believe it prudent to recommend staffing levels based on an output of 100 cases per year for each direct program FTE. With an estimated 930,000 claims in FY 2008, that would require 9,300 direct program FTEs. With the FY 2007 level of 1,375 support FTEs added (primarily for management support and information

technology), this would require C&P to be authorized 10,675 total FTEs for FY 2008. These totals do not accommodate the kinds of demands that may arise as a consequence of Congressional injection of attorneys into the claims process, which may eventuate even more increases in C&P staffing in future years, but it is reasonable to expect that involving attorneys will negatively impact per capita productivity in the claims adjudication process.

RECOMMENDATIONS:

Congress should authorize 10,675 total FTEs for the C&P Service for FY 2008.

Congress should authorize the VBA to contract for disability medical examinations using its mandatory funding account without limitation. Currently, the VBA operates under "pilot" legislative language that confines the use of the mandatory account to an original 10 VA regional office sites. Should the Under Secretary determine that the need exists to go beyond those sites in getting these examinations scheduled more timely using contract physicians, the VBA must use its discretionary dollars to do so. This new flexibility of funds use would enable the VBA to improve processing timeliness of claims—a goal of *The Independent Budget.*

Vocational Rehabilitation and Employment

Adequate Staffing Levels:

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

Given its increased reliance on contract services, VR&E needs approximately 100 additional full-time employees (FTE) dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force recommended in its March 2004 report creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

To implement reforms to improve the effectiveness and efficiency of its programs, the task force recommended that VA should add approximately 200 new FTE positions to the VR&E workforce. The FY 2007 total of 1,125 FTEs for VR&E should be increased by 250, to 1,375 total FTEs.

RECOMMENDATION:

Congress should authorize 1,375 total FTEs for the VR&E Service for FY 2008.

Education Service

Adequate Staffing:

To meet its increasing workload demands, the Education Service needs to increase direct program full-time employees (FTEs).

As it has with its other benefit programs, the Department of Veterans Affairs (VA) has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during FY 2004 and FY 2005, direct program FTEs were reduced from 708 at the end of FY 2003 to 675 at the end of FY 2005. Based on experience during FY 2004 and FY 2005, it is very conservatively estimated that the workload will increase by 5.5 percent in FY 2008. VA must increase staffing to meet the existing and added workload, or service to veterans seeking educational benefits will decline. Based on the number of direct program FTEs at the end of FY 2003 in relation to the workload at that time, the Veterans Benefits Administration must increase direct program staffing in its Education Service in FY 2008 to 873 FTEs, 149 more direct program FTEs than authorized for FY 2007. With the addition of the 160 support FTEs as currently authorized, the Education Service should be provided 1,033 total FTEs for FY 2008.

RECOMMENDATION:

Congress should authorize 1,033 total FTEs for the VA Education Service.

Judicial Review in Veterans' Benefits

In 1988, Congress recognized the need to change the situation that had existed throughout the modern history of veterans' programs in which claims decisions of the Department of Veterans Affairs (VA) were immune to judicial review. Congress enacted legislation to authorize judicial review and created what is now the United States Court of Appeals for Veterans Claims (CAVC) to hear appeals from VA's Board of Veterans' Appeals (BVA).

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

For the most part, judicial review of the claims decisions of VA has lived up to positive expectations of its proponents. To some extent it has also brought about some of the adverse consequences foreseen by its opponents. Based on past recommendations in *The Independent Budget*, Congress made some important adjustments to correct some of the unintended effects of the judicial review process. In its initial decisions construing some of these changes, the CAVC has not given them the effect intended by Congress to ensure that veterans have meaningful judicial review in all aspects of their appeals. More precise adjustments are still needed to conform CAVC review to congressional intent.

In addition, most of VA's rulemaking is subject to judicial review, either in connection with a case before the CAVC or upon direct challenge to the United States Court of Appeals for the Federal Circuit. Here again, changes are needed to bring the positive effects of judicial review to all of VA's rulemaking.

Accordingly, *The Independent Budget* veterans service organizations make the following recommendations to improve the processes of judicial review in veterans' benefits matters.

Judicial Review Issues

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review

Standard for Reversal of Erroneous Findings of Fact:

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

The CAVC upholds Department of Veterans Affairs (VA) factual findings unless they are clearly erroneous. Clearly erroneous is the standard for appellate court reversal of a district court's findings. When there is a "plausible basis" for a factual finding, it is not clearly erroneous under the case law from other courts, which the CAVC has applied to Board of Veterans' Appeals (BVA) findings.

Under the statutory "benefit-of-the-doubt" standard, the BVA is required to find in the veteran's favor when the veteran's evidence is at least of equal weight as that against him or her, or stated differently, when there is not a preponderance of the evidence against the veteran. Yet, the court has been affirming any BVA finding of fact when the record contains the minimal evidence necessary to show a plausible basis for such finding. This renders the statutory benefit-of-the-doubt rule meaningless because veterans' claims can be denied and the denial upheld when supported by far less than a preponderance of evidence against the veteran.

To correct this situation, Congress amended the law to expressly require the CAVC to consider, in its clearly erroneous analysis, whether a finding of fact is consistent with the benefit-of-the-doubt rule. With this statutory requirement, the CAVC can no longer properly uphold a BVA finding of fact solely because it has a plausible basis inasmuch as that would clearly contradict the requirement that the CAVC's decision must take into account whether the factual finding adheres to the benefit-of-the-doubt rule. The court can no longer end its inquiry after merely searching for and finding a plausible basis for a factual determination. Congress intended for the CAVC to afford a meaningful review of both factual and legal determinations presented in an appeal before the court. Congress also amended the law to specify that the CAVC should, as a general rule, reverse erroneous factual findings rather than set them aside and allow the BVA to decide the question anew on remand.

While Congress chose not to replace the clearly erroneous standard of review, it did foreclose the application of this standard in ways inconsistent with the benefit-of-the-doubt rule. Also, Congress made it clear that the CAVC is not to routinely remand cases for new BVA fact-finding when the findings of fact before the court did not have sufficient support in the record, and the current record supports a conclusion opposite of that reached by the BVA. However, the CAVC has construed these amendments—intended to require a more searching appellate review of BVA fact-finding and to enforce the benefit-of-the-doubt rule—as making no substantive change. The court's precedent decisions now make it clear that it will continue to defer to and uphold BVA fact-finding without regard to whether it is consistent with the statutory benefit-of-the-doubt rule as long as the court's scope of review retains the clearly erroneous standard. To ensure that the CAVC enforces the benefit-of-the doubt rule, Congress should replace the clearly erroneous standard with a requirement that the court will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

RECOMMENDATION:

Congress should amend 38 U.S.C. § 7261 of title 38 United States Code to provide that the court will hold unlawful and set aside any finding of material fact that is not reasonably supported by a preponderance of the evidence.

Court Facilities

Courthouse and Adjunct Offices:

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

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

Construction of a courthouse and justice center requires an appropriate site, authorizing legislation, and funding.

RECOMMENDATION:

Congress should enact legislation and provide the funding necessary to construct a courthouse and justice center for the CAVC.

▼ ▼ ▼

COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Review of Challenges to VA Rulemaking

Authority to Review Changes to VA *Schedule for Rating Disabilities:*

The exemption of Department of Veterans Affairs (VA) changes to the rating schedule from judicial review leaves no remedy for arbitrary and capricious rating criteria.

Under 38 U.S.C. § 502, the Court of Appeals for the Federal Circuit (CAFC) may review directly challenges to VA's rulemaking. Section 502 exempts from judicial review actions relating to the adoption or revision of the VA *Schedule for Rating Disabilities*, however.

Formulation of criteria for evaluating reductions in earning capacity from various injuries and diseases requires expertise not generally available in Congress. Similarly, unlike other matters of law, this is an area outside the expertise of the courts. Unfortunately, without any constraints or oversight whatsoever, VA is free to promulgate rules for rating disabilities that do not have as their basis reduction in earning capacity. The coauthors of *The Independent Budget* have become alarmed by the arbitrary nature of recent proposals to adopt or revise criteria for evaluating disabilities. If it so desired, VA could issue a rule that a totally paralyzed veteran, for example, would only be compensated as 10 percent disabled. VA should not be empowered to issue rules that are clearly arbitrary and capricious. Therefore, the CAFC should have jurisdiction to review and set aside VA changes or additions to the rating schedule when they are shown to be arbitrary and capricious or clearly violate basic statutory provisions.

RECOMMENDATION:

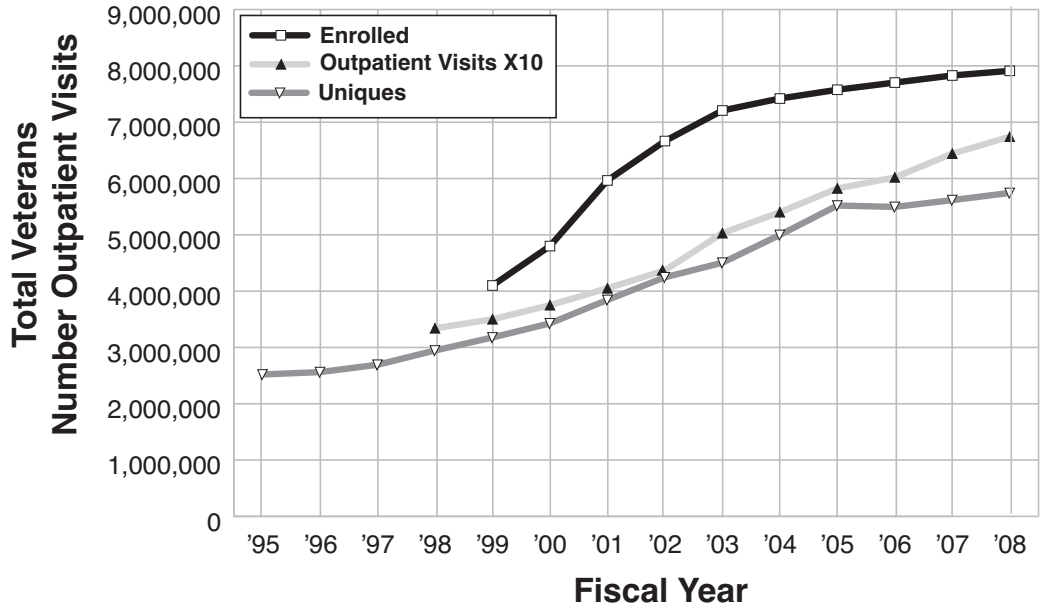
Congress should amend 38 U.S.C. § 502 to authorize the CAFC to review and set aside changes to the *Schedule for Rating Disabilities* found to be arbitrary and capricious or clearly in violation of statutory provisions.

Medical Care Introduction

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

Of the 7.7 million veterans enrolled in fiscal year 2006, the VHA provided health care to more than 5.5 million of them. The quality of VHA care is equivalent to, or better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any other system in the United States or worldwide. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors.

CHART 1. UNIQUE VHA PATIENTS ENROLLED VETERANS AND TOTAL OUTPATIENT VISITS



This chart shows the trend toward the increasing number of patients treated in VHA facilities and the increase of veterans enrolled for care. The total number of estimated outpatient visits in fiscal year 2007 is expected to approach 65 million.

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

Year after year, the Department of Veterans Affairs (VA) faces inadequate appropriations and is forced to ration care by lengthening waiting times. Although the backlog of veterans waiting more than 60 days for their first appointment has been significantly reduced during the past couple of years, *The Independent Budget* veterans service organizations are concerned that the methodology used in producing the statistics that indicate this reduction in the backlog may be skewed.

The annual shortfall in the VA Medical Care budget translates directly into higher national health-care expenditures. When veterans cannot get needed health-care services from VA, they go elsewhere, and the cost of care is shifted to Medicare or safety net hospitals, often at higher per patient costs. In any case, society pays more while the veteran suffers. A method to ensure VA receives adequate funding annually to continue providing timely, quality health care to all veterans must be put in place.

Full implementation of VA electronic records into DOD health-care facilities

There has been a great deal of effort to develop proposals to promote VA/DOD initiatives within the medical care arena. Unfortunately, the results of those efforts have had minimal impact on agency operations. One very important link for the two agencies is the medical record. VA has developed an electronic record that has received major recognition throughout the medical community. It has allowed VA to continue to meet the needs of its patients in an expeditious, efficient manner while reducing medical mistakes and duplication of testing while providing immediate availability of records at any of it locations nationwide. The IBVSOs believe the DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information.

Better coordination of the two electronic medical record systems will afford the opportunity to see tangible initiatives of VA/DOD programs. It will also expedite the handling of patient information especially in the transition of the patient from the DOD system to the VA system. It will provide a "complete" medical record that could be viewed by any appropriate provider within either system. It will also serve as a basic database for patients seeking compensation for service-related injuries. This database would be easily accessible and have a common language and arrangement of file information, making it easy for examiners to evaluate a patient's condition and needs.

MEDICAL CARE ISSUES

Financing Issues

Adequate Funding for VA Health Care Needed:

The Department of Veterans Affairs (VA) must receive adequate funds to meet the ever-increasing demands of veterans seeking health care.

Last year (2006) proved to be a unique year for reasons very different from 2005. VA faced a tremendous budgetary shortfall during fiscal year (FY) 2005 that was subsequently addressed through supplemental appropriations and additional funds added to the FY 2006 appropriation. For FY 2007, the Administration submitted a budget request that nearly matched the recommendations of *The Independent Budget*. These actions simply validated the recommendations of *The Independent Budget* once again.

For FY 2007, the Administration requested $31.5 billion for veterans' health care, a $2.8 billion increase over the FY 2006 appropriation. Although this was a significant step forward, Congress took a giant step backward by not following through on its responsibility to provide these funds. As of the start of the calendar year—and more than one-third of the way through the new fiscal year—VA still had not received its appropriation. It is unconscionable that Congress has allowed partisan politics and political wrangling to trump the needs of the men and women who have served and continue to serve in harm's way. When VA does not receive its funding in a timely manner, it is forced to ration health care. VA is unable to hire much-need medical staff to prepare for the needs of veterans who will be seeking health care. Waiting times will continue to increase and the quality of care will decrease as VA will actually be forced to cut staff. These factors continue to place enormous stress on the system and will leave VA struggling to provide the care that veterans have earned and deserve.

Last year the Administration finally recognized the work of *The Independent Budget* when it indicated that it would actually take $25.5 billion to fund Medical Services, an amount very close to what *The Independent Budget* veterans service organizations (IBVSOs) recommended. However, the IBVSOs certainly disagreed with the Administration's desire to use a new enrollment fee and an increase in prescription drug copayments to achieve that funding level. Once again the President's recommendation included the $250 enrollment fee for veterans in categories 7 and 8 and an increase in prescription drug copayments from $8 to $15 for a 30-day supply. VA estimated that these proposals would force nearly 200,000 veterans to leave the system and more than 1 million veterans to choose not to enroll. As in previous years, the Congress soundly rejected these proposals, and we urge Congress to continue to do again so if these fees are proposed this year.

Unfortunately, this delayed budget will also have a significant impact on the nursing shortage that VA is experiencing. When managers do not have a budget for the coming year, they are unable to plan for new hires of critical staff. VA is forced to place hiring freezes on its medical centers nationwide. The hiring freezes have forced individual medical facilities to assign non-nursing duties to current nurses. This detracts from immediate bedside care and ultimately jeopardizes the health of the veteran.

For FY 2008, *The Independent Budget* recommends $36.3 billion for VA health care. Unfortunately, Congress chose not to enact the VA appropriations bills during the 109th Congress, and it remains to be seen when the legislation will be completed. In order to form a baseline for funding for VA for FY 2008, we used the appropriations figures contained in H.R. 5385, the "Military Quality of Life and Veterans Affairs Appropriations Act for FY 2007." These amounts most closely represent the recommendations that we made in *The Independent Budget for FY 2007*.

The medical care appropriation includes three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2008, *The Independent Budget* recommends approximately $29.0 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

MEDICAL SERVICES RECOMMENDATIONS

(Dollars in Thousands)

Current Services Estimate	$26,302,464
Increase in Patient Workload	$ 1,446,636
Increase in Full-time Employees	$ 105,120
Policy Initiatives	$ 1,125,000
Total FY 2008 Medical Services	**$28,979,220**

Our increase in patient workload is based on a 5.5 percent increase in workload. The policy initiatives include $500 million for improvement of mental health services, $325 million for funding the fourth mission, and $300 million to support centralized prosthetics funding.

For Medical Administration, *The Independent Budget* recommends approximately $3.4 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $4.0 billion.

Although *The Independent Budget* health-care recommendation does not include additional money to provide for the health-care needs of category 8 veterans being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy decision. VA estimates that more than 1.5 million category 8 veterans will have been denied enrollment in the VA health-care system by FY 2008. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that VA will require approximately $366 million. The IBVSOs believe the system should be reopened to these veterans and that this money should be appropriated in addition to our Medical Care recommendation.

Furthermore, previous inadequate budgets have exacerbated the problem. In the past several years, the VA health-care budget has not even kept pace with the rising cost of inflation. VA has testified in the past that the Veterans Health Administration requires a minimum 13 percent to 14 percent increase just to meet this cost. VA cannot be competitive in the market for health-care professionals if it does not have the funding necessary to do so. For example, the IBVSOs believe that the basic salary for nurses who provide direct bedside care is too low to be competitive with community hospitals. This leads to high attrition rates as these nurses seek better pay in the community.

In order to address the problem of adequate resources provided in a timely manner, *The Independent Budget* has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. This would not create a new entitlement; rather, it would change the manner of health-care funding, removing VA from the vagaries of the appropriations process. Until this proposal becomes law, however, Congress and the Administration must ensure that VA is fully funded through the current process.

The Independent Budget's recommendations enable VA to meet the demands of current veterans and those who are now being denied care by VA. It ensures that VA is not faced with the possibility of a shortfall due to faulty modeling or any other reason. As the number of new veterans seeking health care continues to grow, and VA continues to care for veterans of prior conflicts, we must ensure that VA provides the quality health care that they have earned with their service and their sacrifices.

RECOMMENDATION:

Congress and the Administration must provide adequate funding for veterans' health care in a timely manner to ensure that VA can continue to provide the necessary services to all veterans seeking care.

Accountability:

Department of Veterans Affairs (VA) Veterans Health Administration (VHA) managers must be held individually responsible for their areas of operation to achieve needed enhancements to operations efficiency and effectiveness.

The Independent Budget veterans service organizations (IBVSOs) firmly believe that sufficient funding in and of itself is not enough to achieve greater efficiency of processes and people within VA and increased effectiveness of results in order to further its mission. Enforcing accountability within VA will directly contribute toward providing greatly enhanced benefits and services to veterans within the context of finite budgetary resources.

To make management structure and function more effective, VHA employees—at all levels—must be held individually responsible for their areas of operation. *The Independent Budget* insists upon much greater focus and, ultimately, meaningful improvement through enforceable accountability in such areas as waiting times for medical appointments; supervision of part-time physicians; contract care coordination, particularly specialty care from academic affiliates; fee-basis care; formulation of valid and reliable workload data and program reporting; timeliness of claims processing; and quality in claims adjudication.

■ Waiting times for medical appointments

VA embarked on a nationwide initiative (the Advanced Clinic Access initiative) to provide frontline personnel the ability to maximize resources to treat more patients in a timely manner. As part of this initiative, the electronic wait list is utilized as a measuring tool for success. VA reports substantial reductions in the number of veterans on wait lists, and the VHA has also reduced the number of new enrollees waiting for their first clinic appointment. However, the accuracy of reported veterans' waiting times and facility wait lists is undermined by variability in VA's compliance with outpatient scheduling procedures and the cumbersome scheduling software being utilized from which waitlist data are being obtained.

While the current electronic waiting list has undergone a number of revisions since inception, reporting accuracy continues to be suspect and undermines the ability to produce effective and meaningful policy and procedures to best capture what is considered a symptom of an inadequately funded health-care system.

■ Contract care, particularly specialty care provided by academic affiliates

Many VA facilities award contracts with academic affiliates to provide needed medical care to sick and disabled veterans. However, some contracts contain no procedures for VA to monitor contract physician presence and level of performance to ensure that the level of services VA pays for under the contract is actually provided.

Flaws in the procurement process must be addressed and appropriately corrected; otherwise, these factors affect the contract's "price reasonableness determination" (whether the contract itself is in the best interest of the government). For example, solicitation during the procurement process does not adequately compensate VA for any losses incurred as a result of noncompliance nor require penalties for noncompliance with the terms and conditions of the contract. Furthermore, there are instances where VA physicians receiving compensation from the affiliate or its practice group are involved in the contracting process in violation of federal ethics laws and regulations.

■ Fee-basis care

To ensure access to and a full continuum of health-care services, VA should better coordinate clinical and claims information for veterans authorized to receive medical care from private community-based providers at VA expense. While required to receive minimal treatment records from a veteran's private physician as part of authorization to receive non-VA care, there is no requirement to ensure that VA receives the complete medical record of the veteran to be made part of his or her electronic VA health record. In addition to maintaining the quality or care veterans receive through this program, requiring the receipt of all medical records for the episode of care also would decrease the likelihood that the claim for services rendered will not be paid or delayed as a result of VA determination that the claim is incomplete to adjudicate for payment.

Timeliness of claims processing and quality in claims adjudication

There has been an ongoing challenge to reduce the backlog of claims being processed by VA. In many cases it can take years to get proper adjudication of a claim. Of greater concern is the number of errors in processing claims and the number of times claims must be remanded. The Veterans Benefits Administration's current focus on reducing the quantity of claims without an equal or greater focus on increasing the quality of decisions potentially increases the backlog. The focus on quantity of claims completed rather than a properly adjudicated claim is an easy way out of the backlog dilemma. It is easy to track and allows VA to claim success. But the focus should be on proper completion of an initial claim.

Issues that contribute to the focus on claims processing are awards and evaluations that are based on claims completed or on the reduction of backlog. This invariably forces the focus to production and not quality. A focus on quantity may also reduce quality because of the lack of accountability for incorrect claims. Without a doubt, most claims adjudicators are conscientious VA employees that desire to do the best job they can. But because claims are no longer remanded to the regional office that is processing the claim, there is no overt indication of a reduction in quality by the claims office. Only in the most remote of circumstances will responsibility for an improperly completed claim come back to reflect on the rating veterans service representative or Dispute Resolution Office adjudicator.

It is critical that a more objective method be developed for claims oversight and adjudicator evaluation. By setting specific performance standards that emphasize accuracy and quality, in addition to quantity, a more successful process may be created. Speed in claims processing cannot be ignored, and a requirement for the number of claims processed is helpful in evaluating employee work. But this is only beneficial when considered in conjunction with accurate work.

In order to have meaningful accountability, so as to provide greatly enhanced benefits and services to veterans, it is essential that management be provided all the requisite guidance and tools to enforce performance standards among the personnel under their direction. Management must be able to create an environment that promotes superior service, discourages mediocrity, and precludes substandard performance. Correspondingly, performance appraisals and senior executive contracts must accurately reflect execution in achieving specific outcomes. Success should be fittingly rewarded and failure appropriately sanctioned to enforce accountability and to promote a more efficient and effective provision of benefits and services to veterans. Furthermore, there must be greater transparency and oversight of network and facility performance plans to adjust the aspect of responsibility and accountability toward those that this federal agency was created to serve: sick and disabled veterans.

VA faces many challenges in its effort to use its limited resources efficiently, ensure reasonable access to high-quality health care, and manage its disability programs effectively. VA executives must be effective leaders, not just competent managers, particularly when making difficult decisions and taking decisive actions in a resource constrained environment.

RECOMMENDATIONS:

VA management must be provided with the requisite tools to enforce performance standards among the personnel under their direction.

VA must enforce meaningful performance standards. VA should then reward those individuals who exceed the standards and properly sanction those whose performance is substandard or unacceptable.

Assured Funding:

The Administration's discretionary budget formulation for Department of Veterans Affairs (VA) health care and the manner in which Congress addresses these needs in the budget and appropriations acts are deeply flawed and cry out for true reform.

Budget formulation for veterans' health care continues to confound Congress and the Administration. While leaders in both government branches continue to boast about the "record-setting" increases they have produced compared to their predecessors, VA sources and sick and disabled veterans seeking VA health care tell a different story of crisis in the daily operating environment of the VA health-care system.

In both fiscal years 2005 and 2006, Congress was forced to confront VA health-care funding shortages with emergency or supplemental appropriations totaling nearly $3 billion. In 2006, VA continued to face challenges to meet known and expected demands for health care. Now, several months into fiscal year 2007, VA remains under the burden of a Continuing Resolution (CR) that maintains funding at the FY 2006 level. Likewise, we continue to hear reports that VA facilities must restrict services provided to veterans, delay hiring of new clinical staff, institute local and regional freelance policies to restrict eligibility and care, and impose a variety of questionable—and potentially hazardous—cost-cutting measures just to make ends meet. With the acknowledged budget shortfalls for veterans' health care in FY 2005 and FY 2006, and another CR for the first several months of FY 2007, the record is clear that VA operates in a state of management paralysis, planning chaos, and structural financial crisis as a direct consequence of the discretionary budget process.

Although welcomed, temporary funding supplements provided by Congress in urgent circumstances do not solve the underlying problem. For this reason, *The Independent Budget* veterans service organizations (IBVSOs) propose a lasting solution in the form of mandatory, assured, or guaranteed funding, or a workable combination of mandatory and discretionary funding, for veterans' health care. An assured system, even one that provided only partial guarantees, would make the management of veterans' health care more dependable and stable and eliminate the uncertainties that have perennially disrupted management of VA health care. Funding uncertainty has prevented VA executives and managers from being able to adequately plan for and meet the needs of a growing enrolled-veteran population, of which a large majority either service-disabled or poor. A guaranteed system of funding also would resolve the serious challenges created by late-arriving supplemental funds and stop the meddling on policy and politically motivated budget gimmicks proposed by the Office of Management and Budget.

Reforming VA's health-care budget is more important today than ever. The current conflicts in which our nation is engaged are producing a significant number of veterans suffering from traumatic amputations, brain injuries, blindness, burns, spinal cord injuries, and post-traumatic stress disorder (PTSD). These severely disabled veterans will need a lifetime of specialized health care. Veterans injured in Iraq, Afghanistan, and other parts of the world, as well as veterans wounded in previous conflicts, need the government's assurance that VA will remain a stable and reliable provider that receives sufficient funding to provide the specialized services they will need and have earned through their military service.

The Administration must also consider other costs the Veterans Health Administration (VHA) has incurred as it struggles to fulfill its core mission and mandates. Even with the stress of a chronic budget shortfall, VA was an integral part of the national and regional response providing emergency relief to veterans and all residents affected by the 2005 storms in Louisiana, Mississippi, Alabama, Texas, and Florida. During these disasters, VA played an indispensable role, not only in continuing to serve sick and disabled veterans but also serving the Gulf Coast community in general with rescue, security and police, health-care, transport, and other lifesaving services. Although necessary and admirable, VA is not funded to carry out this type of mission without compromising or disrupting its ability to care for veterans in routine operations. The IBVSOs continue to strongly recommend that VA be provided funds to replenish its expenditures for such additional services in times of emergency.

The IBVSOs also remain concerned that under a discretionary budgeting method the VHA remains vulnerable to the political pressures of cost-cutting proposals, such as those suggested in 2006. If higher copayments or other cost-saving measures are imposed,

some veterans undoubtedly will be forced out of the VA system only to fall back on Medicaid, Medicare, and other government-sponsored programs. VA's existence reduces the financial burden on other federal and state health-care systems. If funded adequately, the VA health-care system, by many measures, offers the most cost-effective and highest quality health-care services available in the United States to care for America's sick and disabled veterans.

During the 109th Congress, assured funding bills were introduced in both chambers. Unfortunately, none of these measures were enacted. The Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations, has urged the Administration and Congress to reform the method for funding veterans' health care. Our repeated requests for hearings and public debate on this key issue were denied or ignored by the House and Senate authorizing and appropriations committees. Additionally, during the 109th Congress an alternative funding plan (combining mandatory with discretionary funding) was proposed to resolve VA's health-care funding crisis. Unfortunately, this proposal was also defeated—even with full support of the Partnership. In spite of an obvious need to reform the way VA health care is funded, the Administration and Congress embraced other prerogatives, such as tax cut extensions and massive pork barrel spending, that took precedence over ensuring health-care funding for millions of older veterans dependent on VA care and tens of thousands of men and women returning sick and disabled as a result of current military service for our country.

Providing health care to our nation's sick and disabled veterans is a continuing cost of defense and national security and should be a top priority of our government. We are hopeful that the 110th Congress will be open to addressing the issue of assured funding by holding hearings and making the necessary changes to reform the budget process for veterans' health care.

Without reform, all the current advantages of VA health care, originating from a decade of internal improvements, are at risk. The manner in which the Administration and Congress provide funding for VA health care poses well-documented annual uncertainty that prevents VA managers from planning effectively to continue these vital services. When funding is eventually secured, it has proven time and again to be insufficient, causing VA practitioners to ration and delay care needed by sick and disabled veterans who depend on VA, and even forcing a former VA Secretary to restrict access to new priority group 8 enrollments. Including VA's projection estimates for FY 2007, nearly one million veterans will have been denied access to VA health care as a result of that decision. Currently, combat veterans of the global war on terrorism have eligibility for two years of free VA health care for conditions potentially related to their military service after discharge or release—and according to VA will have continued access to such care after that time period regardless of the priority group to which they are assigned. However, we are concerned that if these veterans need to access the system after this two-year period, but have not used the system within the specially prescribed eligibility period and fall into priority group 8, they, too, would be ineligible for VA health-care services.

Our government needs to take the politics, guesswork, and political gamesmanship out of VA health care and fully fund this transparent need with an assured mechanism. The Administration has a fundamental obligation to provide Congress an honest, accurate statement of the VA's known financial needs. And Congress is obligated to fully fund VA health care in a timely manner. The best way to meet these obligations is to overhaul the budget and appropriations process to guarantee an adequate, predictable, reliable, and available funding stream to meet the health-care needs of America's sick and disabled veterans.

RECOMMENDATIONS:

The Administration and Congress must address the acknowledged shortfalls of the current approach and support legislation to reform funding for VA health care. This reform should move VA from its current status in domestic discretionary appropriations to full mandatory funding—or some combination of discretionary and assured funding—in order to ensure all eligible and enrolled veterans may gain and retain access to VA health care programs and services in a timely manner.

When funding has been ensured, VA should reopen enrollments to so-called "priority 8" veterans, or, at minimum, extend the two-year period of eligibility for free VA health care offered to combat veterans of the global war on terrorism for conditions potentially related to their military service after discharge or release.

Homeland Security/Funding for the Fourth Mission:

The Veterans Health Administration (VHA) is playing a major role in homeland security and bioterrorism prevention without additional funding to support this vital statutory fourth mission.

The Department of Veterans Affairs (VA) has four critical health-care missions. The primary mission is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission is to conduct medical research. The VA's fourth mission, as stated in a General Accounting Office Report of October 2001, is to "serve as a backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters[.]"

In 2005, the devastation created by Hurricanes Katrina and Rita in the Gulf Coast region more than met the criteria for the fourth mission. VA proved to be fully prepared to care for veterans affected by the hurricanes. Nearly 10,000 VA employees around the country received recognition for their actions during the hurricanes, including 73 Valor Awards for risking personal safety to prevent the loss of human life or government property, and 3,000 official commendations. After Katrina, VA facilities along the Texas Gulf Coast prepared for Rita by stocking up on food, water, medical supplies, emergency communications (satellite telephones), and extra fuel for emergency generators and vehicles. VA facilities outside the Gulf Coast region were on standby to evacuate patients, and health-care professionals were ready to travel to the storm area if called upon. Yet the skills and abilities of VA were not leveraged to support other federal, state, and local agencies that struggled to react to these events. Had this occurred, it might have reduced the suffering of the region.

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

As part of its fourth mission, VA has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System (NDMS), created by P.L. 107-188 (the "Public Health Security and Bioterrorism Preparedness Response Act of 2002") has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters. These disasters include natural disasters, technological disasters, major transportation accidents, and acts of terrorism, including weapons of mass destruction events, in accordance with the National Response Plan. The NDMS is a partnership between the Department of Homeland Security, VA, the DOD, and the Department of Health and Human Services. According to the VA website (www.va.gov), some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance, and evaluation of the local NDMS program. VA has also assigned "area emergency managers" to each VISN to support this effort and assist local VA management in fulfilling this responsibility.

In addition, P.L. 107-188 required VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other emergency supplies. The Secretary was also directed to enhance the readiness of medical centers and provide mental health counseling to those individuals affected by terrorist activities.

In 2002, Congress also enacted P.L. 107-287, the "Department of Veterans Affairs Emergency Preparedness Act of 2002." This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and would develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary, or other explosive weapons or devices posing threats to the public health and safety. In addition, the centers would provide education, training, and advice to health-care professionals. They would also provide laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or

responding to a disaster or emergency. These centers, although authorized by law, have not received any funding.

The Independent Budget veterans service organizations (IBVSOs) are concerned that VA lacks the resources to meet its fourth mission responsibilities. The actions of VA in Louisiana, Mississippi, and Alabama in 2005 prove that VA has done everything it can to prepare itself under the requirements of the fourth mission. It has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not specifically received any funding to support the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. This funding is simply drawn from the Medical Care Account, providing VA with fewer resources with which to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, already-scarce resources will continue to be diverted from direct health-care services.

The VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. In light of the natural disasters that have recently wreaked havoc on this country, this fact has never been more apparent. These important roles once again reiterate the importance of maintaining the integrity of the VA system and its ability to provide a full range of health-care services. The IBVSOs do not believe that VA currently has the resources it will need to adequately care for veterans. If VA is to fulfill its responsibilities, it must be provided these resources.

RECOMMENDATIONS:

Congress should provide funds necessary in the VHA's FY 2008 appropriation to fund VA's fourth mission.

Funding for the fourth mission should be included in a separate line item in the Medical Care Account.

Congress and the Administration should provide the funds necessary to establish and operate the four emergency preparedness centers created by P.L. 107-287.

▼ ▼ ▼

Seamless Transition from the Department of Defense to Veterans Affairs:

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

As military service personnel return from the conflicts in Iraq and Afghanistan, the DOD and VA must provide them with a seamless transition of benefits and services when they leave military service and become veterans. Currently, the transition from the DOD to VA is anything but seamless, and undue hardship is placed on many new veterans trying to gain access to VA. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The Independent Budget supported the recommendations of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report, released in May 2003, regarding transition of soldiers to veteran status. The PTF stated that "providing these individuals [veterans] timely access to the full range of benefits earned by their service to the country is an obligation that deserves the attention of both VA and the DOD. To this end, increased collaboration between the Departments for the transfer of personnel and health information is needed." This need has not been fully met.

The IBVSOs believe the DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. We applaud the DOD for beginning to collect medical and environmental exposure data electronically while personnel are still in theater, and are confident this practice will continue. But it is equally important that this information be provided to VA. These electronic medical records should also include an easily transferable electronic DD214 forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and benefits.

The Joint Electronic Health Records Interoperability plan, as agreed to by both VA and the DOD through the Joint Executive Council and overseen by the Health Executive Council, is a progressive series of exchange of related health data between the two departments culminating in the bidirectional exchange of interoperable health information. However, with continued successes from the first phase through milestones in the second phase, achieving real-time sharing of computable health information is heavily dependent upon agreement on common health data standards and the development of technology not wholly under the control of either department. Moreover, the IBVSOs are not encouraged by reports that in some instances medical data gathered in theater and stored on electronic smart cards provided to the soldier are not even readable by other military medical facilities upon the service member's return. This does not bode well for an electronic system meant to exchange information between federal agencies.

The Independent Budget is not the only party concerned about this exchange. In June 2004, the Chairman and Ranking Member of both the House Committee on Veterans' Affairs and Committee on Armed Services sent letters to then-VA Secretary Principi and then-DOD Secretary Rumsfeld expressing concern with the current transition of servicemen and -women and indicating that "despite earnest desire by both the DOD and VA to provide each service member with a seamless transition, their efforts remain largely uncoordinated in important respects and suffer from the failure to make planning for transition a high priority for the Executive Branch."

The Independent Budget concurs with the PTF's recommendation that "DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process." The problem with separation physicals identified for active duty members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists. Though the physical examinations of demobilizing reservists have improved in recent years, there are still a number of soldiers who "opt out" of the physical exams, even when encouraged by medical personnel to have them. Though the expense, manpower, and delays needed to facilitate these physicals might be significant, the separation physical is critical to the future care of demobilizing soldiers. We cannot allow a recurrence of the lack of information that led to so many issues and unknowns with Gulf War syndrome, particularly among our National Guard and Reserve forces. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

The IBVSOs also support the Army Wounded Warrior Program (AW2), formerly called the Disabled Soldier Support System, implemented in spring 2005, as well as the Marine for Life program. Their responsibility is to assist the most severely injured service members and their families in transition from military to civilian life. However, the AW2 program maintains only minimal staff with a limited budget. With a high number of severely injured service members returning from Iraq and Afghanistan, it is essential that Congress and the Administration support and enhance these successful programs.

While more progress needs to occur on health-care transition, in the past several years the DOD and VA have made some good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's (DOL's) Transition Assistance Program (TAP) handled by the Veterans Employment and Training Service (VETS) and VA Vocational Rehabilitation and Employment Disabled Transition Assistance Program (DTAP) are generally the first services that a separating service member will receive. In fact, local military commanders, through the insistence of the DOD, began to allow their soldiers,

sailors, airmen, and marines to attend well in advance so as to take greatest advantage of the program. Under this scenario, the programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their individual circumstances and then seek answers prior to discharge.

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

The DOD, the DOL, and VA seem ill-prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. Despite the successes of TAP, the program lacks the flexibility required to meet the erratic surges in demand from soldiers who are rapidly discharged and demobilized en masse just a few months after returning from the front lines. Such short timelines force service members to enter veteran status without the benefits of TAP. Unless these soldiers are injured, they may clear the demobilization station in a few days or be discharged from active duty in a few weeks. DOD personnel at these sites are most focused on processing service members through the site, and little time is dedicated to informing them about veterans' programs. Lack of space and facilities often allows for limited contact with the demobilizing service members by VA representatives. Moreover, waiting lists for the TAP program have surfaced at some sites, primarily a result of the reduction in the number of TAP providers and the resulting limited class capacity in combination with large numbers of rapidly transitioning service members.

To address these issues, the number of TAP providers should be increased and the DOD should formally incorporate TAP at every demobilization station to ensure all new veterans are exposed to necessary information on VA benefits and services. In addition, those veterans who are unable to avail themselves of TAP while on active duty should be allowed to participate. For this purpose, the restriction that only active duty service members may participate in TAP should be eliminated. We recommend however that some prerequisites are met, including that veterans who are requesting to attend a TAP class not displace a service member. Furthermore, it is crucial that demand for such services be captured where each station providing TAP must report the number of recently discharged veterans requesting participation and, of those, the number of veterans who eventually completed TAP.

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

RECOMMENDATIONS:

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

The DOD and VA must develop electronic medical records that are interoperable and bidirectional, allow-

ing for two-way electronic exchange of computable health information and occupational and environmental exposure data. The records should also include an electronic DD214.

The DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process.

Congress and the Administration must provide additional funding for the AW2 and Marine for Life programs to allow for appropriate expansion of these programs to address the needs of more seriously disabled soldiers.

▼ ▼ ▼

Mental Health Services:

Mental health services for older veterans must be maintained in addition to Department of Veterans Affairs (VA) efforts to address increased mental health challenges arising from the ongoing conflicts in Iraq and Afghanistan.

■ President's New Freedom Commission on Mental Health/VA Mental Health Strategic Plan

Following the release of the report of the President's New Freedom Commission on Mental Health in July 2003, VA undertook an unprecedented, critical examination of its mental health programs. Like other institutions providing mental health care, VA found that it tended to focus on managing symptoms, rather than aiding patients' recovery and restoration. The New Freedom Commission found that many people with mental illness can regain productive lives, and the effort provided the President and the government a bold new blueprint for system change based on the goal of recovery. VA leaders embraced the change the commission envisioned for the mental health system and developed an agenda for realizing that goal. VA established a National Mental Health Strategic Plan (MHSP) as an outgrowth of the President's New Freedom Commission report and promised to commit $100 million in fiscal year 2005 and $200 million in fiscal year 2006 to fund new mental health initiatives.

In November 2006, the United States Government Accountability Office (GAO) issued a report on resources allocated for VA's MHSP initiatives. The GAO found that VA did not allocate all of the funding it planned to commit in fiscal year 2005 for new mental health initiatives to address identified gaps in mental health services. Funding was intended to be used for such priorities as the expansion of post-traumatic stress disorder (PTSD) services, post-deployment mental health services for veterans returning from combat in Iraq and Afghanistan, and expansion of programs for the treatment of substance-use disorders. Additionally, the GAO reported that the VA Central Office did not inform network and medical center officials that certain funds were to be used for these specific mental health initiatives, and therefore it is likely some funds went for other health-care priorities. Likewise, according to the GAO, some medical center officials were not certain they would be able to spend all the funds planned for fiscal year 2006 for plan initiatives by the end of the year. These findings illustrate the need for continued Congressional oversight to ensure proper use of dedicated mental health funds for MHSP initiatives.

Additionally, *The Independent Budget* veterans service organizations (IBVSOs) understand that VA's internal policy on funding certain new initiatives to address gaps in services related to psychosocial rehabilitation and recovery-oriented services will be limited to only two years. The expectation is that this "seed money" provided to specific initiatives will generate sufficient creditable patient care workload counts through VA's internal resource allocation system to make further earmarks unnecessary after the first two years. This is an untested concept that may dampen local interest in proposing or embracing these new initiatives. If a VA medical center director believes that a centrally controlled earmark is temporary, there may be tempta-

tion to limit investment in the program. The aftereffects of this two-year funding policy warrant close scrutiny from mental health advocates and Congress.

Overseas Engagement

The U.S. military engagement in Southwest Asia extends into its fifth year. This is a difficult, dangerous campaign for American troops, whether they are regular active duty members, Reserves, or National Guard. Ground combat units have faced fierce fighting, whether in close combat in the streets and buildings of urban area or while traversing rugged mountain passes. Danger is imminent, even for military members working in support positions. The ever-present improvised explosive device (IED) threatens U.S. convoys as they travel treacherous roadways. Vehicular accidents are commonplace, and no one is immune. Despite the threats and risks, our regular active duty, National Guard, and Reserve forces are performing magnificently in current conflicts. Many Guard and Reserve members have served multiple tours of duty, leaving families and full-time civilian jobs when they were called to duty as citizen soldiers. Their families are also making extreme sacrifices.

Issues Affecting our Newest Generation of Combat Veterans

VA and the Department of Defense (DOD) are well aware that combat veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) are at higher risk for PTSD and other mental health problems. In a 2006 study published in the *Journal of the American Medical Association*, Col. Charles Hoge, MD, of the Walter Reed Military Research Institute, evaluated relationships between combat deployment and mental health-care use in the first year following return from the war. The study also reviewed lessons learned from postdeployment mental health screening efforts, correlation between screening results and subsequent use of military mental health services, and attrition from military service.

The Hoge study found that 19 percent of soldiers and marines who had returned from Iraq screened positive for mental health problems, including PTSD, generalized anxiety, and depression. Hoge reported that mental health problems recorded on the postdeployment self-assessments by military service members were significantly associated with combat experiences and mental health-care referral and utilization. Thirty-five percent of Iraq war veterans had received mental health services in the year after returning home, and 12 percent each year were diagnosed with a mental problem. According to study findings, mental health problems remained elevated at 12 months postdeployment among soldiers preparing to return to Iraq for a second deployment. Hoge postulated that although OIF veterans are using mental health services at a high rate, many military personnel with mental health concerns do not seek help due to fear of stigma and other barriers. The study revealed that service members resisted care because of personal concerns over being perceived as weak—or that seeking treatment would have a negative impact on their military career. Finally, Hoge noted that the high use rate of mental health services among veterans who served in Iraq following deployment illustrates the challenges in ensuring that there are adequate resources to meet the mental health needs of this group, both within the military services themselves and in follow-on VA programs.

The VA health-care system is also seeing increasing trends of health-care utilization among OEF/OIF veterans. VA reports that veterans of these current wars seek care for a wide range of possible medical and psychological conditions, including mental health conditions, such as adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. As of November 2006, VA reported that of the 205,000 separated OEF/OIF veterans who have sought VA health care since fiscal year 2002, a total of 73,157 unique patients had received a diagnosis of a possible mental health disorder. Nearly 34,000 of the enrolled OEF/OIF veterans had a probable diagnosis of PTSD.

VA has intensified its outreach efforts to OEF/OIF veterans and reports that the relatively high rates of health-care utilization among this group reflect the fact that these veterans have ready access to VA health care, which is free of charge for two years following separation from service for problems related to their wartime service. However, VA estimates that only 109,191 veterans of the Iraq and Afghanistan wars will be seen in VA facilities in 2007 (1,375 fewer than expected to see in 2006). With increased outreach, internal mental health screening efforts under way, and expanded access to health care for OEF/OIF veterans, we are concerned that these estimates are artificially low and could result in a shortfall in funding necessary to meet the demand. Experts agree that if newly returning

veterans do not have timely access to PTSD counseling and other readjustment services, an opportunity will be lost to reduce the severity of symptoms and more serious long-term chronic mental health problems in this population.

VA's Specialized PTSD Programs

According to VA, it operates a network of more than 190 specialized PTSD outpatient treatment programs throughout the country, including specialized PTSD clinical teams or a PTSD specialist at each VA medical center. Vet centers, which provide readjustment counseling in 207 community-based centers, have reported rapidly increasing enrollment in their programs, with nearly 77,000 readjustment counseling visits of OEF/OIF veterans in fiscal year 2005 and projected visits of 242,000 in fiscal year 2006.

In 1989, VA established the National Center for Post-Traumatic Stress Disorder as a focal point to promote research into the causes and diagnosis of this disorder, to train health-care and related personnel in diagnosis and treatment, and to serve as an information clearinghouse for professionals. The center offers a monthly five-day clinical training program to VA clinical staff and maintains a website (www.ncptsd.va.gov) with information about trauma and PTSD. The center also offers guidance on the effects of PTSD on family and work and notes treatment modalities and common therapies used to treat the disorder. Last year the center provided a guide for military personnel titled "Returning from the War Zone." This guide discusses common experiences in combat, postdeployment readjustment issues including the primary symptoms of PTSD, as well as other common stress reactions, such as depression, anger, aggressive behavior, alcohol and drug abuse, shame, guilt, and suicidal ideation. The center offers guidance on the effects of PTSD on family and work, and notes treatment modalities and common therapies used to treat the condition. Included in the guide is a checklist of trauma symptoms for self-assessment, eligibility requirements for VA services, and guidance for seeking further help.

Because of increased roles of women in the military and their exposure to combat in OEF/OIF theaters, we encourage VA to continue to address, through its treatment programs and research initiatives, the unique needs of women veterans related to treatment of PTSD and military sexual trauma.

Although VA has improved access to mental health services at its 800-plus community-based outpatient clinics, such services are still not readily available at all sites. Likewise, VA has not yet achieved its goal of integration of mental health staff in all its primary care clinics. Also, we remain concerned about the capacity in specialized PTSD programs and the decline in availability of VA substance-use disorder programs of all kinds, over time, including virtual elimination of inpatient detoxification and residential treatment beds. Although additional funding has been dedicated to improving capacity in some programs, VA mental health providers continue to express concerns about inadequate resources to support, and consequent rationed access to, these specialized services.

Traumatic Brain Injury and Mental Health

It has been said that traumatic brain injury (TBI)—caused by IEDs, vehicular accidents, gunshot or shell fragment wounds, falls, and other traumatic injuries to the brain and upper spinal cord—is the signature injury of Operations Enduring and Iraqi Freedom. Severe TBI resulting from blast injuries or powerful bomb detonations that severely shake or compress the brain within the skull often causes devastating and permanent damage to brain tissue. Likewise, veterans who are in the vicinity of an IED blast or involved in a motor vehicle accident can suffer from a milder form of TBI that is not always immediately detected and can produce symptoms that mimic PTSD or other mental health disorders. It is believed that many OEF/OIF veterans have suffered mild brain injuries/concussions that have gone undiagnosed and that symptoms will only be detected later, when these veterans return home. We are concerned about emerging literature (August 11, 2006, memorandum, issued by the Armed Forces Epidemiological Board regarding Traumatic Brain Injury in Military Service Members) that strongly suggests that even "mild" TBI patients may have long-term mental and medical health consequences. The DOD admits that it lacks a systemwide approach for proper identification, management, and surveillance for individuals who sustain mild to moderate TBI/concussion, in particular mild TBI/concussion. Therefore, VA should coordinate with the DOD to better address mild TBI/concussion injuries and develop a standardized follow-up protocol utilizing appropriate clinical assessment techniques to recognize neurological and behavioral consequences of TBI as recommended by

the Armed Forces Epidemiological Board. The influx of OEF/OIF service members returning with brain trauma has provided an increased opportunity for research into the evaluation and treatment of these injuries in newer veterans; however, we suggest that any studies include older veterans of past conflicts who may have also suffered similar injuries that went undetected, undiagnosed, and untreated.

The most severely injured service members will require extensive rehabilitation and lifelong personal and clinical support, including home caregiver, neurological and psychiatric services, physical, psychosocial, occupational, and vocational therapies. Currently VA has four designated TBI facilities: in Minneapolis, Minnesota; Palo Alto, California; Richmond, Virginia; and Tampa, Florida. These TBI lead centers provide a full spectrum of TBI care for patients suffering moderate to severe brain injuries. VA is also establishing polytrauma centers in each of its Veterans Integrated Service Networks for follow-up care of polytrauma and TBI patients referred from the four lead centers or from military treatment facilities. In an attempt to raise awareness of TBI issues, VA requires training of primary care, mental health, spinal cord, and rehabilitation providers via a web-based independent study course. However, VA is still working to develop a systemwide screening tool for clinicians to use to assess TBI patients.

The VA's Office of the Inspector General (OIG) issued a revealing report in July 2006, "Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation." The report assessed health care and other services provided for VA patients with TBI and then examined their status approximately one year following discharge from inpatient rehabilitation. The OIG found that improvement and better coordination of care were needed so veterans could make a smoother transition between the DOD and VA health-care services. The report also called for additional assistance to immediate family members of brain-injured veterans, including additional caregivers and improved case management.

VA has designated TBI as one of its special emphasis programs and is committed to working with the DOD to provide comprehensive acute and long-term rehabilitative care for veterans with brain injuries. We are encouraged that VA has responded to the growing demand for specialized TBI care and, fulfilling the requirements of Public Law 108-422, established four polytrauma rehabilitation centers (PRCs) that are colocated with the existing TBI lead centers. However, we remain concerned about capacity and whether VA has fully addressed the resources and staff necessary to provide intensive rehabilitation services, treat the long-term emotional and behavioral problems that are often associated with TBI, and to support families and caregivers of these seriously brain injured veterans. During a September 2006 House Veterans' Affairs Subcommittee on Health hearing, a statement was provided for the record that indicated the 20-year health-care costs for TBI could exceed $14 billion. As noted in the OIG report, "these problems exact a huge toll on patients, family members, and health care providers." There are several challenges we face in ensuring these veterans and their families get the specialized care and support services they need. Clinicians indicate that in the case of mild TBI, the [veteran's] denial of problems that can accompany damage to certain areas of the brain often leads to difficulties receiving services. Likewise, with more severe injuries, the extreme family burden can lead to family disintegration and loss of this major resource for patients.

To help facilitate access to services, VA assigns a case manager to each OEF/OIF veteran seeking treatment at one of its medical facilities. The case manager is responsible for coordination of all VA services and benefits. Additionally, VA has created liaison and social work positions at DOD facilities to assist injured service members. In interviewing these case managers, the OIG found several problems that warrant attention. These case managers reported continued problems related to transfer of medical records from referring military facilities; difficulty in securing long-term placements of TBI patients with extreme behavioral problems; difficulty in obtaining appropriate services for veterans living in geographically remote areas; limited ability to follow patients after discharge to remote areas; poor access to transportation and other resources; and inconsistency in long-term case management. The report found that while many of the patients they assessed had achieved a substantial degree of recovery, *"…approximately half remained considerably impaired."* The report concluded that improved coordination of care is necessary between agencies, and that families need additional support in the care of TBI patients.

Finally, the IBVSOs are concerned about media accounts and reports from veteran patients with TBI and their family members who claim that VA care for TBI is not up to par—requiring them to seek rehabilitation services in the private sector. We encourage VA and Congress to address these types of complaints to ensure severely wounded TBI veterans are receiving the best rehabilitative care available.

Summary

Overall, we are pleased with the direction VA has taken and the progress it has made with respect to its mental health programs. We are also pleased that the DOD has acknowledged that it needs to conduct more rigorous pre- and postdeployment health assessments and reassessments with military service personnel who serve in combat theaters and that it is working to improve collaboration with VA to ensure this information is accessible to VA clinicians. Likewise, VA and the DOD are to be commended for attempting to deal with the issue of stigma and the barriers that prevent service members and veterans from seeking mental health services. Although we recognize and acknowledge both agencies' efforts, the DOD and VA are still far from achieving the universal goal of "seamless transition."

Emerging evidence suggests that the burden of combat-related mental illness from OEF/OIF will be high. Utilization rates for health care and mental health services predict an increasing demand for such services in the future, and evidence suggests that the current wars are presenting new challenges to the DOD and VA health-care systems. Fortunately, Americans are united in agreeing that care for those who have been wounded as a result of military service is a continuing cost of national defense. PTSD, TBI, and other injuries with mental health consequences that are not so easily recognizable can lead to serious health catastrophes, including occupational and social disruption, personal distress, and even suicide, if not treated. We can meet that challenge by ensuring a stable, robust VA health-care system that is dedicated to the unique needs of the nation's veterans—one that is there now for aging veterans of World War II, Korea, and Vietnam and will remain viable for the newest generation of war fighters who will need specialized medical and mental health services for decades to come.

The DOD and VA share a unique obligation to meet the health-care (including mental health care) and rehabilitation needs of veterans who are suffering from readjustment difficulties as a result of combat service or have been wounded as a result of a TBI. Therefore, the DOD, VA, and Congress must remain vigilant to ensure that federal mental health programs are sufficiently funded and *adapted* to meet the unique needs of the newest generation of combat service personnel and veterans, while continuing to address the needs of older veterans with PTSD and other combat-related mental health challenges.

RECOMMENDATIONS:

The IBVSOs recommend that VA work more effectively with the DOD to ensure it establishes a seamless transition of early intervention services to help returning service members from Iraq and Afghanistan obtain effective treatment and follow-up services for war-related mental health problems.

VA must do its part to sustain VA mental health care as a high priority grounded in the principles of the New Freedom Commission on Mental Health. The system must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes the guiding beacon for VA mental health planning, programming, budgeting, and clinical care.

Congress should carefully monitor VA's two-year limit on providing start-up funding for new initiatives under VA's National Mental Health Strategic Plan and provide oversight to ensure resources allocated to expand and improve mental health services are used for this express purpose.

The IBVSOs believe more research into the consequences of brain injury and best practices in its treatment is needed and is warranted by VA to deal with both medical and mental health aspects of TBI, including research into the long-term consequences of mild TBI in OEF/OIF veterans, as well as similar injuries in previous generations of combat veterans.

To ensure a smoother transition for veterans with TBI and their caregivers, VA should evaluate ways to provide additional assistance to immediate family

members of brain-injured veterans, including additional resources, improved case management, and continuous follow-up. In this connection we urge VA to implement the family caregiver authorization recently enacted by Congress, Public Law 109-461, at the earliest possible time.

The goal of achieving optimal function of each individual TBI patient requires improved coordination and interagency cooperation between the DOD and VA. Veterans should be afforded the best rehabilitation services available and the opportunity to achieve maximum functioning so they can reenter society or, at minimum, achieve stability of function in an appropriate setting.

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

▼ ▼ ▼

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

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

Veterans meeting the definition of having catastrophic disabilities as a result of nonservice-connected causes and who have incomes above means-tested levels can still enroll in the Department of Veterans Affairs (VA) as priority 4 veterans instead of the less preferential categories 7 and 8. This heightened priority for VA health-care eligibility was granted in recognition of the unique nature of these disabilities and the need for these veterans to avail themselves of the complex specialized health-care services in many cases unique to the mission of the VA health-care system. The higher priority 4 enrollment category would also protect these veterans from not having access to the system were they, under usual circumstances, to be considered in the lower priority categories 7 or 8 if VA health-care resources were to be curtailed.

However, current VA regulation stipulates that even though these veterans are to be considered priority 4 for the purpose of enrollment because of their specialized needs, they still have to pay all health-care fees and copayments as though they were still in the lower eligibility category. This interpretation violates the intent of the statute in recognizing the unique needs of these veterans and the role of VA in providing their care. These veterans are not casual users of VA health-care services. Because of the nature of their disabilities, they require a lot of care and a lifetime of services. Private insurers do not offer the kind of sustaining care for spinal cord injury found at VA even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. In most instances, VA is the only as well as the best resource for a veteran with a catastrophic disability, yet these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they had no priority at all. This puts great financial hardship on these catastrophically disabled veterans who need to use far more VA health-care services at a far greater extent than the average VA health-care user. In many instances fees for medical services equipment and supplies can climb to thousands of dollars per year.

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and other federal and state support systems. In so doing, they fall within the complete definition of priority 4 health-care enrollment and are exempt from all fees and copayments. Yet when of a veteran's industry and employ-

ment bring annual income above the means-test levels, he or she is then unduly penalized by exorbitant fees. This "catch-22" status does little to reward or provide an incentive for a highly disabled veteran to maintain employment and a productive life.

RECOMMENDATION:

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

▼ ▼ ▼

Access Issues

While the Veterans Health Administration (VHA) has made commendable improvements in quality and efficiency, veterans' access to the VA health-care system is severely limited. Excessive waiting times and delays imposed to keep health-care demand within the limits of available resources amount to health-care rationing for enrolled veterans.

Advanced Clinic Access Initiative:

Veterans have to wait too long for appointments.

Limited access is the primary problem in veterans' health care. Demand for care at many Department of Veterans Affairs (VA) facilities is straining capacity, and with limited resources, VA has continued to restrict enrollment. Perennially inadequate health-care budgets have resulted in a VA health-care system struggling to meet the needs of our nation's sick and disabled veterans. Without funding to increase clinical staff, veterans' demand for health care will continue to outpace the VHA's ability to supply timely health-care services and erode the world-renowned quality of VA medical care.

At its peak in July 2002, the VHA had more than 310,000 veterans waiting for medical appointments, half of whom had to wait six months or more for care and the other half having no scheduled appointment. In response, regulations were instituted, and subsequent business practices now allow the most severely disabled service-connected veterans priority access in the VA health-care system. Though VA is committed to providing priority care for veterans of Operations Enduring and Iraqi Freedom and veterans with service-connected disabilities, these actions have not equitably provided timely access to quality heath care for veterans eligible for VA health care under the provisions of the Health Care Eligibility Reform Act of 1996.

To reduce waiting times for sick and disabled veterans seeking care, the Advanced Clinic Access (ACA) Initiative, a program designed to eliminate waiting times and reject the supply constraint theory of managing outpatient health-care demand, has been implemented and continues to show promise. The goal is to build a system in which veterans can see their health-care providers when needed. Through the work of a few leaders, this program reduced average waiting times and significantly improved veterans' access to their health-care system.

We commend Veterans Integrated Service Network (VISN) and facility leadership for their support, which is instrumental in the wide acceptance and success of the ACA initiative. However, their respective performance plans measure waiting times for only 9 clinics, while VHA currently monitors 50 clinics for which its waiting list report captures a large majority of medical appointments made. Such a disparity must be reconciled to ensure sweeping support for the ACA initiative.

Measuring improvement in access to care with wait-time reports is part of this initiative, and in 2004 a change in reporting measurements was established. Operating on the premise that not all veterans waiting six months or greater should automatically be considered delayed because of limited access to care—particularly for such appointments as routine or follow-up care—VA instituted a new standard of measuring waiting times. Waiting times were to be reported on two

veteran patient populations: new enrollees and established patients. Since this change in reporting, *The Independent Budget* veterans service organizations (IBVSOs) have been concerned that a true measurement remains elusive with regard to the demand for medical care and the existing capacity for VA to provide such care. Despite the validation of some aspects of the VA waitlist report for new enrollees, the data remain suspect in light of established business practices of measuring true waiting time, demand, and capacity. In addition, it is a concern that wait list reports have been relegated to providing only "the number of new enrollees waiting for their first appointment where an appointment has not been scheduled," while ignoring a significant portion of the veteran patient population: the established patient.

Despite any measurable improvements in waiting times for needed appointments, continued disparities exist in the implementation of the ACA initiative nationwide. With a growing number of volunteer coaches who serve as consultants and trainers and growing support from VISNs and facility leadership, success is largely dependent upon the availability of funding. In addition to a fully staffed ACA initiative, the IBVSOs encourage greater support from VA leaders for recommendations made by the ACA initiative toward a more robust tool to accurately measure patient experiences and waiting times, link performance measures to improvements in waiting times, improve decision support by improving clinic efficiency, and compare VHA patients' waiting times with those of private sector patients.

VA's struggle to best capture and measure the veterans' experience in seeking VA medical care with the software system currently in use is clear. While much of the criticism for limited access to VA medical care has been met by the ACA initiative, business processes remain inefficient, primarily due to the aging and cumbersome VistA scheduling software being used to manage appointment activities. The VHA should replace the current scheduling software system to be in line with VA's emerging web-based electronic health system enterprise to provide more comprehensive capacity and demand data to improve resource utilization, to increase provider and patient satisfaction as well as reduce waiting times.

While the IBVSOs believe it is imperative that our government provide a health-care budget that will enable VA to serve the needs of disabled veterans nationwide, both increased medical care appropriations and VA's Advanced Clinical Access Initiative are needed to improve veterans' access and ensure that all service-connected disabled veterans and all other enrolled veterans have access to the system in a timely manner.

RECOMMENDATIONS:

VISNs and facility directors should evaluate whether veterans, as well as the clinics in their area, would benefit from the Advanced Clinic Access Initiative.

The VHA should improve the way it measures administrators' performance on waiting times for appointments.

The VHA should provide the necessary support to implement the Advanced Clinic Access Initiative recommendations for a replacement scheduling software package.

Community-Based Outpatient Clinics:

Many community-based outpatient clinics (CBOCs) lack staff and equipment to serve the specialized needs of veterans.

The Independent Budget veterans services organizations (IBVSOs) commend Veterans Health Administration (VHA) efforts to expand access to needed primary care services. For many veterans who live long distances from Department of Veterans Affairs medical centers (VAMCs) and for those whose medical conditions make travel to VAMCs difficult, CBOCs reduce the need/necessity for travel. CBOCs also improve veterans' access to timely attention for medical problems, reduce hospital stays, and improve access to and shorten waiting times for follow-up care. As VA proceeds in implementing the CBOCs and engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant. VA will need to enhance access to care in underserved areas with large numbers of veterans outside of access guidelines and in rural areas. VA also needs to enable overcrowded facilities to better serve veterans and must support sharing initiatives with the Department of Defense.

While the IBVSOs support establishment of CBOCs, we remain concerned that they often fail to meet the needs of veterans who require specialized services. For example, many CBOCs do not have appropriate mental health providers on staff, nor do they necessarily improve access to specialty health care for either the general veteran population or those with service-connected mental illness. To VA's credit, the revised criteria for establishment of CBOCs includes the availability of mental health with disease specific documentation. Moreover, too often CBOC staff lack the required knowledge to properly diagnose and treat conditions commonly secondary to spinal card dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, some veterans service organizations caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care programs.

Inadequately trained providers are less likely to render appropriate primary or preventive care or to accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with required accessibility standards in Section 504 of the Rehabilitation Act (29 U.S.C. § 791 et seq.). Regarding physical accessibility to medical facilities, veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the VHA mission to provide health services to veterans with specialized needs. Veterans with specialized needs require primary and preventive care, which in many cases can be appropriately provided in CBOCs that use clinically specified referral protocols to ensure veterans receive care at other facilities when CBOCs cannot meet their specialized needs.

Unless the VHA is adequately funded and properly managed, the proliferation of CBOCs could ultimately reduce the comprehensive scope of VA hospitals and impact in VHA care.

RECOMMENDATIONS:

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

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

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

Veterans' Rural Health Care Access and "Veterans Rural Access Hospitals":

The Department of Veterans Affairs (VA) should work to improve access to VA health-care services for veterans living in rural areas.

The Independent Budget veterans service organizations (IBVSOs) believe that after serving their country, veterans should not see their health-care needs neglected by VA because they choose to live in rural and remote areas far from major VA health-care facilities.

We have gathered some pertinent findings dealing with rural veterans in general as well as newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). For example, one in five veterans nationwide who is enrolled to receive VA health care lives in a rural area. *(Am. J. Pub. Health,* Oct. 2004). Likewise 44 percent of today's active duty military service members and tomorrow's veteran population list rural communities as their homes of record.

Also, from other studies we are able to provide insight on the special, and even unique, needs of rural veterans:

- Veterans who live in rural settings are older and have more physical and mental health diseases compared to veterans who live in suburban or urban settings. *(Am. J. Pub. Health,* Oct. 2004)

- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive compensation. *(Am. J. Pub. Health,* Oct. 2004)

- According to "The Future of Rural Health," report, "the smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services." ("Quality Through Collaboration: The Future of Rural Health," Institute of Medicine, Committee on the Future of Rural Health Care, 2005)

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and concerns for suicide, stress, depression, and anxiety disorders as major rural health concerns. ("Rural Healthy People 2010," Vol. 2, Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center)

- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas. (President's New Freedom Commission on Mental Health, Final Report, July 2003)

- Nearly 22 percent of our elderly live in rural areas. Rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term-care systems. In rural areas some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care. ("Rural Healthy People 2010," Vol. 3, Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center)

Without question, section 212 of Public Law 109-461, signed into law by the President on December 22, 2006, is the most significant advance to date to address health-care needs of veterans living in rural areas. Under this legislation, VA must establish a new Office of Rural Health within the Veterans Health Administration. This office must carry out a series of requirements in an effort to improve VA health care for veterans in rural and remote areas. This legislation is also aimed—of particular importance—at better addressing the needs of returning veterans who have served in Iraq and Afghanistan. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in these communities. In that connection, VA is required to collaborate with employers, state agencies, community health centers, rural health clinics, Critical Access Hospitals (as designated by Medicare), and the National Guard to ensure that returning veterans and Guard members who, after completing their deployments, can have ready access to the VA health benefits they have earned by that service. The legislation also requires an extensive assessment of the existing VA fee-basis system of contract care and

the development of a plan to improve access and quality of care for enrolled veterans in rural areas.

Although the authors of *The Independent Budget* acknowledge this legislative measure will be beneficial to veterans living in rural and remote areas, the legislation also raises potential concerns about the unintended consequences it may have on the mainstream VA health-care system. As we indicate elsewhere in this *Independent Budget,* in general, current law places limits on VA's ability to contract for private health-care services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract for the services in VA facilities of scarce medical specialists. Beyond these limits, there is no general authority in the law to support broad-based contracting for the care of populations of veterans, whether rural or urban. The IBVSOs believe VA contract care for eligible veterans should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems, such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health care programs only exacerbates the problems currently encountered.

VA has had continuing difficulty securing sufficient funding through the Congressional discretionary budget and appropriations process to ensure basic and adequate access for the care of sick and disabled veterans. Congress repeatedly has been forced to add additional funds to maintain VA health-care services. Also, VA receives no Congressional appropriation dedicated to support the establishment of rural community-based outpatient clinics or to aid Veterans Rural Access Hospital (VRAH)–designated facilities, and thus VA must manage any additional expenses from within generally available Medical Services appropriations. VA has established and is operating more than 711 community-based outpatient clinics, of which 100 are located in areas considered by VA to be rural or highly rural. Given current financial circumstances, we are skeptical that VA can cost-effectively justify establishing additional remote facilities in areas with sparse veteran populations.

Under the federal Medicare program, a critical access hospital (CAH) is a private hospital that is certified to receive cost-based reimbursements from Medicare. The higher reimbursements that CAHs receive under this program compared to urban facilities are intended to improve their financial security and thereby reduce rural hospital closures. In other words, the federal policy is to financially aid struggling rural hospitals in hopes that they will survive. Also CAH facilities are certified under Medicare "conditions of participation" that are more flexible than those used for other acute care hospitals. As of March 2006 [the latest data available], there were 1,279 certified CAH facilities in rural and remote areas.

As a part of the CARES initiative, VA employed Medicare's CAH model as a guide to establish a new VA policy to govern operations of, and planning for, many of VA's rural and remote facilities, now designated VRAH. In 2004, however, the CARES Advisory Commission questioned whether VA's policy was adequate and recommended VA "…establish a clear definition and clear policy on the CAH [now VRAH] designation prior to making decisions on the use of this designation."

Following this guidance from the CARES Commission, on October 29, 2004, VA issued a directive [still in force] that sets a significant number of parameters for VRAH designation, but seems pointed in a direction opposite from that of Medicare for the CAH facilities in the private sector. Illustrative is the basic definition of VRAH, as follows:

> "A VRAH is a VHA facility providing acute inpatient care in a rural or small urban market in which access to health care is limited. The market area cannot support more than forty beds. The facility is limited to not more than twenty-five acute medical and/or surgical beds. Such facilities must be part of a network of health care that provides an established referral system for tertiary or

> other specialized care not available at the rural facility. The facility should be part of a system of primary health care (such as a network of Community-Based Outpatient Clinics (CBOCs)). The underlying principle is that the facility must be a critical component of providing access to timely, appropriate, and cost-effective health care for the veteran population served. The activation and operation of a VRAH will be similar to that of any other VHA hospital. The designation of a facility as a VRAH will not remove or diminish that facility's responsibility in meeting appropriate VHA requirements, directives, guidance, etc." (VHA Directive 2004-061, October 29, 2004)

We believe VA must carefully monitor the scope of services performed at its smaller, rural facilities, specifically for those procedures that are complex in nature. Further, as medical care advances in the use of high technology and thereby elevates the standard of care, small VA inpatient facilities may find it increasingly difficult to effectively maintain, and actually use these new tools, to provide health care at its most sophisticated levels. However, we believe VA must maintain a safe and high-quality health-care service within each of its facilities, and to the greatest degree possible offer comprehensive care to veterans at each of its facilities, whether rural, suburban, or urban.

The IBVSOs remain concerned about whether VA's VRAH policy fully considers the implications of large-scale referrals from rural VA medical centers in continuing to provide high quality health care in those locations, particularly when veterans are referred to other far off medical centers within a Veterans Integrated Service Network or to private facilities. VA must also consider patient satisfaction, family separation, and travel burdens in the criteria they use for determining which rural facilities should retain acute care services. If acute care beds are to be retained in one facility because of distances that veterans must travel to access inpatient care or receive specialized services, we believe this logic should be standardized and used systemwide to the greatest extent possible.

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IBVSOs believe that these veterans, too, should have access to specialized services offered at VA's vet centers.

Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives counseling for military-related trauma. Building on the strength of the Vet Centers program, VA should be required to establish a pilot program to have mobile Vet Centers that could help reach veterans in rural and remote areas.

The new legislation holds VA accountable for improving access for rural veterans through CBOCs and other access points by requiring VA to develop and implement a plan for improving veterans' access to care in rural areas. The May 2004 Secretary's CARES decision identified 156 priority CBOCs and new sites of care nationwide. The VA Secretary is also required to develop a plan for meeting the long-term and mental health care needs of rural veterans. We urge Congress to include funding in fiscal year 2008 to specifically support at least some of these needs in rural areas.

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

Helping homeless veterans in rural and remote locations recover, rehabilitate, and reintegrate into society is complex and challenging. VA has no specific programs to help community providers who focus on rural homeless veterans. The rural homeless also deserve attention from VA to aid in their recoveries.

Likewise, Native American, Native Hawaiian, and Native Alaskan veterans have unique health-care needs that VA needs to address with outreach and other activities.

Rural veterans, veterans service organizations, and other experts need a seat at the table to help VA consider important program-and-policy decisions, such as those described here, that would have positive effects on veterans who live in rural areas. The final legislative language of Public Law 109-461 failed to include a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans, and other rural experts to recommend policies to meet the challenges of veterans' rural health care. We are disappointed that Congress did not include this requirement in law, but the Secretary of Veterans Affairs retains the authority to establish such a committee. The IBVSOs urge the Secretary to take this action.

RECOMMENDATIONS:

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

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

Mobile Vet Centers should be established, at least on a pilot basis, to provide outreach and counseling for veterans in rural and remote areas.

Through its affiliations with schools for the health professions, VA should develop a policy to help supply health-professions clinical personnel to rural VA facilities and to rural areas in general.

VA must focus some of its homeless veteran program resources, including contracts with, and grants to, community-based organizations, to address the needs of homeless veterans in rural and remote areas.

VA rural outreach should include a special focus on Native American, Native Hawaiian, and Native Alaskan veterans' unmet health-care needs.

The VA Secretary should use existing authority to establish a Rural Veterans Advisory Committee, to include membership by the veterans service organizations among those that have offered this *Independent Budget*.

VHA-DOD Sharing:

The Independent Budget ***encourages collaboration between Department of Veterans Affairs (VA) and Department of Defense (DOD) health care and recommends careful oversight of sharing initiatives to ensure beneficiaries are assured timely access to partnering facilities.***

The Independent Budget veterans service organizations (IBVSOs) have been discussing this initiative for a number of years, as has Congress, with little success for our efforts. The United States Constitution, Article I, Section 8 requires Congress: "To raise and support Armies…To provide and maintain a Navy…[and] To make all laws which shall be necessary and proper for carrying into Execution the foregoing Powers…" Additionally, federal law (38 U.S.C. § 8111(a)) states: "The Secretary and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed to operate such facilities properly[.]."

However, there appear to be a number of gaps in what is required by statute and what actually occurs. In a report released in January 1999, the Congressional Commission on Servicemembers and Veterans Transition Assistance (The Principi Commission) addressed the need for greater sharing between VA and the DOD. The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), created by Executive Order in May 2001, was asked to:

- "identify ways to improve benefits and services for VA beneficiaries and DOD military retirees who are also eligible for benefits from VA through better coordination of the two departments;
- review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and
- identify opportunities for partnership between VA and the DOD to maximize the use of resources and infrastructure."

The Capital Asset Realignment for Enhanced Services (CARES) Commission report of February 12, 2004, states: "Over the past decade, a number of commissions, advisory organizations, and the General Accounting Office [now the General Accountability Office] have studied various approaches to providing quality health care to veterans. One of the recurring recommendations to fulfill this obligation has been to improve collaboration and sharing between VA and DOD."

Presidential Review Directive 5 of August 1998 requires VA and the DOD to develop a computer-based patient record system that would accurately and efficiently exchange information between the departments. Eight years later the envisioned system still remains a challenge.

It is time to stop doing studies, writing reports, and taking minimal action. In this time of tight funding and a war against world terrorism, it is imperative that VA and the DOD begin implementing many of the recommendations made by these various reports, as well as take further actions to foster VHA-DOD sharing.

The IBVSOs continue to support the careful expansion of VA-DOD sharing agreements. However, we concur with the statement of Dr. C. Ross Anthony (one of the PTF commissioners) before the House Committee on Veterans' Affairs in June 2003, when he said that the PTF "concluded that it would be almost impossible for there to be effective collaboration between two systems if one was well funded and the other was not. While not always the case, the DOD appears at present to have adequate funding to fulfill its health-care responsibilities. As this committee is well aware and our report details, the same is not true in the case of the Department of Veterans Affairs. As an economist, I feel that it is important to fashion good policy and then finance it adequately—hopefully, in a manner that creates incentives for efficiency." VA and the DOD will not be able to accomplish either their mandated or recommended sharing goals until Congress addresses the mismatch between the veterans' demand for services and the appropriated resources made available to the Veterans Health Administration of VA.

■ Leadership and Reporting

The VA-DOD Joint Executive Council should report, at least annually, to the House Committees on Armed Services and Veterans Affairs on collaborative activities, including development of tools to measure outcomes

relating to access, quality, cost, and progress toward meeting goals set for collaboration, sharing, and outcomes. Not only do the IBVSOs believe that there has been insufficient transparency in the work of various DOD and VA executive planning forums, but we also believe that without direct guidance from the respective Secretaries, to include responsibility and accountability of local management personnel, these sharing agreements are doomed to failure. This has also been announced as the viewpoint of the previous Chairman of the House Committee on Veterans' Affairs.

It has been noted, specifically in GAO report GAO-06-794R, that rather than resolve the issues pertaining to various proposed joint-sharing programs, the DOD prefers to "throw stones" at the GAO and VA. The DOD refuses to acknowledge, citing the Health Insurance Portability and Accountability Act, that the health-care and medical records of our veterans and service members fall under the purview of both the DOD and VA. In this report, the DOD admonishes VA for a security breach resulting in the loss of a laptop with 28.6 million files on it. In actuality, from February 15, 2005, to November 3, 2006, VA had six security breaches that affected millions of veteran records. At the same time, the DOD had 10 breaches that affected millions of service member records (Privacy Rights Clearinghouse).

Neal P. Curtin, director, Operations and Readiness Issues, General Accountability Office, stated, in GAO Letter GAO-04-292R to the Chairman of House Committee on Veterans' Affairs, "VA and DOD have been pursuing ways to share in their health information systems and create electronic records since 1998…." They still haven't accomplished that goal. Without the successful electronic integration of health-care information, neither "seamless transition" nor joint ventures will be successful. The CARES Commission report states: "At those locations where collaboration was not successful or where it had been proposed for some time but had not gained momentum, the Commission found…no mutual commitment to the proposed collaboration, no dedication, and no effort. At such sites the Commission also detected a lack of direction from national leadership, in some instances, particularly from the Department of Defense to the local leadership in support of the collaboration."

From its review, the commission concluded that to ensure a successful collaborative relationship between the DOD and VA, there must be a clear commitment from their senior leadership, both to the initial establishment of collaboration and to its ongoing maintenance, especially when there is a change in leadership. The commission noted a number of collaborations that did not continue after one or both of the senior local leaders was reassigned or retired.

To this end, the IBVSOS believe that sharing agreements should be negotiated and written by local leadership, as they are now, but when ready for signature, they should be signed by the VA Under Secretary for Health and the appropriate service Secretary. This would preclude future local management personnel from repudiating the agreements.

The Departments signed a memorandum of agreement (MOA) November 17, 2004, concerning Cooperative Separation/Process Examinations. However, this MOA simply allows only the local Veterans Affairs medical center and military treatment facility (MTF) at benefits delivery at discharge sites to sign individual memorandums of understanding (MOU). According to the appendices to the MOA, this will be require 138 separate MOUs be negotiated and signed.

■ Joint Venture Sites

The DOD and VA have identified 74 sharing initiatives at the facility level, 35 of which appear promising to VA. The DOD has identified 20 and VA has identified 21 of these as priority initiatives. In addition, the DOD and VA announced, in October 2003, a series of demonstrations, required by P.L. 107-314, to test improving business collaboration between the DOD and VA health-care facilities. The Departments will use the demonstration projects at eight locations to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. *The Independent Budget* does not object to these ventures, but we do have serious concerns about maintaining an independent presence in serving enrolled veterans as its top priority.

One issue regarding joint venture sites of real concern to the IBVSOs is physical access. Appendix A of the Secretary of Veterans Affairs CARES decision, released in May 2004, lists a number of existing or proposed joint venture sites located aboard military installations. In event of an increase in either terrorist threat level, or force protection level, the probability is that military

installations will go into "lock down" status. This would effectively deny Veterans Health Administration (VHA)–enrolled patients, who are not military retirees, access to their health-care facility. We suggest that the involved military installations accept the VA universal identification card for access to the installation and issue a vehicular decal to VHA patients. Currently, the DOD issues color-coded vehicular decals to personnel requiring access to the facility. These decals are blue for military officers, red for enlisted personnel, green for civilian employees, and black for vendors and contractors. A fifth color could be used for VHA patients.

Of the 21 sites identified by VA as primary joint venture locations, only two have been opened: Bassett ACH, Alaska, and Patterson ACH, New Jersey. However, Patterson ACH is a joint venture with Fort Monmouth, New Jersey. The 2005 Base Realignment and Closure recommended Fort Monmouth be closed. Of the two joint venture clinics in Puerto Rico, one was to have been in conjunction with Naval Hospital Roosevelt Roads, which was closed in 2004. Of the remaining 19 sites, 2 were heavily damaged by Hurricane Katrina, and, to the best of our knowledge, only the VAMC North Chicago-USNACC Great Lakes project is being implemented. Of the other 16 sites, 9 of them could result in veterans being denied health care during increased force readiness conditions.

■ VA and DOD Access Standards

VA has had access standards since 1995, but *these standards have not been enforced*. The DOD, however, has mandatory standards and is required, by statute, to meet them. The DOD standards drive funding levels to meet demand for care at MTF and within TRICARE. In examining the funding mismatch, the PTF, in its report, concluded that the VHA should receive "full funding to meet demand, within access standards[.]" PTF Report at 81.

■ Fully Funded Enrolled Veterans

The PTF recommended that the "Federal Government should provide full funding to ensure that enrolled veterans…are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism[.]" PTF Report at 77.

The PTF recommendation is clear: The gap between resources and demand must be closed by increasing, *and by sustaining*, VA health-care funding. As outlined elsewhere, *The Independent Budget* strongly recommends mandatory funding for all enrolled veterans for whom the Secretary has directed care be provided.

The IBVSOs appreciate that the PTF acknowledged the funding mismatch problem and expressed concern that VA-DOD collaboration cannot work without fundamentally addressing this issue.

RECOMMENDATIONS:

Congress should provide the necessary resources to accelerate the creation of a single separation physical and "one-stop shopping" to enable veterans' benefits decisions to be made more expeditiously.

Congress should provide sufficient resources to enable the DOD and VA to enhance information management interoperability and efficiency.

Congress should mandate establishment of VA's published access standards in Title 38 United States Code.

Congress should mandate that all interdepartmental agreements between departments of the executive branch be approved/signed off at the Under Secretary level or higher.

Congress should mandate that, in the case of joint health-care facilities operated by the DOD/VA, procedures be implemented to preclude the loss of health care to veterans in case of an increased force protection condition.

Congress should mandate that, in locations where VA-DOD joint-sharing agreements exist, in event of involuntarily dissolution due to a base realignment and closure, VA be completely funded to assume total control of the facility or facilities.

Congress should require mandatory funding of VA health care.

Priority 4 Veterans

Classification of Priority 4 Veterans Remains a Problem:

Catastrophically disabled veterans may be incorrectly classified and, as a result, denied care within the Department of Veterans Affairs (VA) health-care system. Current benefits for the catastrophically disabled veteran should be enhanced.

Reports of catastrophically disabled veterans being denied care still persist. VA has acknowledged Public Law 104-262, which specifies that veterans who are receiving an increased pension based on a need for regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled will be classified as enrollment priority 4. However, after nine years, the Veteran's Health Administration (VHA) has not developed a consistent and effective mechanism for identifying eligible veterans and properly classifying them.

Individual requests are processed when brought to the attention of the VA; however, national service officers still experience some reluctance when requesting a reclassification. This has a direct effect on those with new injuries and those who have not enrolled in the VA health-care system. Many of these veterans may have been classified as a priority 8 prior to the injury, and now when they need the services of the VA, may be denied care as they are not accepting priority 8 veterans. This is further affected by concerns for future VA reductions in priority levels which could result in denied care for the catastrophically disabled veteran.

Currently, priority group 4 includes veterans granted VA Aid and Attendance (A&A) or Housebound benefits and veterans who are determined by VA as "catastrophically disabled." Those veterans determined as "catastrophically disabled" who are not otherwise exempt from copayments and/or eligible for beneficiary travel benefits are still required to make applicable copayments for medical care and medications and/or denied beneficiary travel assistance. The hardship endured by a catastrophic injury or disease is unique and devastating to the veteran and the families who may be responsible for his or her care. At a time when a veteran is in need of specialized assistance to regain some independence and quality of life, the financial burden of medical bills should be lifted. Any veteran determined by VA to be "catastrophically disabled" and placed in the priority group 4 should be afforded the same benefits as if rated as entitled to A&A to eliminate medical/prescription copays and provide assistance with travel for that care.

RECOMMENDATIONS:

The VHA should develop a program to identify veterans with disabilities as defined in PL 104-262 and properly classify them as priority 4.

The VHA should report to Congress the number of veterans reclassified as a result of PL 104-262.

VA should, based on a catastrophic disability determination, exempt all enrollment priority group 4 veterans from copayments and provide them with the medical and travel benefits that are due a veteran who is entitled to A&A.

Non-VA Emergency Services:

Enrolled veterans are being excluded from non–Department of Veterans Affairs (VA) emergency medical services as a result of established eligibility restrictions.

The non-VA emergency medical care benefit was established as a safety net for veterans who have no other health-care insurance coverage and experience a medical emergency. Under this benefit, VA will pay for services rendered to a veteran who is found eligible and files a claim for payment for emergency treatment received from a private facility. However, some veterans' claims are denied payment due to the restrictive nature of the eligibility criteria.

To qualify under this provision, a veteran must be enrolled in the VA health-care system and must have been seen by a VA health-care professional within the 24 months prior to the emergency. In addition, the veteran must not be covered by any other form of health-care insurance, including Medicare or Medicaid.

The Independent Budget veterans service organizations object to eligibility limitations on enrolled veterans: All enrolled veterans should be eligible for VA payment of emergency medical services provided at non-VA medical facilities.

The frequency with which VA denies payment for the emergency care veterans receive, and who are then held liable by the private facilities, is alarming. In addition to denial by eligibility requirements, VA denies payment even after advising the veteran (or family member) to request transport by emergency medical services to receive emergency care at a non-VA medical facility. On occasion, the decision relative to approval or denial of a claim is based on the discharge diagnosis, e.g., "esophogitis," rather than the admitting diagnosis, e.g., "chest pain." Veterans should not be penalized for seeking emergency care when experiencing symptoms that they believe manifest a life-threatening condition.

RECOMMENDATIONS:

Congress must enact legislation eliminating the provision requiring veterans to be seen by a VA health-care professional at least once every 24 months to be eligible for non-VA emergency care service.

VA must establish and enforce a policy that it will pay for emergency care received by veterans at a non-VA medical facility when they exhibit symptoms that a reasonable person would consider a manifestation of a life- or health-threatening medical emergency.

Rather than an arbitrary medical contact requirement, veterans' enrollment should govern VA's policy of reimbursement for emergency medical services in private facilities.

VA should establish a policy consistent with these recommendations that would appropriately allow all enrolled veterans to be eligible for emergency medical services when needed.

SPECIALIZED SERVICES

Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

Centralized prosthetic and sensory aids funding for the Department of Veterans Affairs (VA) has been an improvement; however, veterans continue to encounter problems in the timely distribution of service and equipment. Program enhancements have been developed to eliminate or minimize obstacles; however, they have not been fully implemented throughout the VA health-care system.

The protection of these funds by a centralized budget for prosthetics has had a major positive impact on disabled veterans. *The Independent Budget* veterans service organizations (IBVSOs) applaud Veterans Health Administration (VHA) senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the prosthetics budget, to meet the prosthetics needs of veterans with disabilities.

The IBVSOs also are in full support of the decision to distribute FY 2007 prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures and utilization reporting. This decision continues to improve the budget-reporting process.

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

The IBVSOs continue to applaud senior VHA officials for implementing and following the proper accounting methods and holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate accounting and requesting of prosthetics funds.

The IBVSOs are pleased that centralized funding continued in FY 2007. The present 2007 allocated budget for prosthetics is $1,231,512,000. Funding allocations for FY 2007 were primarily based on FY 2006 NPPD expenditure data, coupled with Denver Distribution Center billings, and other pertinent items. The VHA also looked at VISN requests, past accuracy between request and expenditures, and new programs being established. The prosthetics budget also includes funds for surgical, dental, and radiology implants.

It is anticipated that, $1,339,131,000 will be required to cover the FY 2008 prosthetics budget. This is a result of advancements in prosthetics technology, telehealth, and the increase in unique health-care issues of veteran patients who require specialized prosthetics needs.

Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are appropriately issued to veterans and that funding is available for such issuance.

Listed on the next page are examples of NPPD expense costs in fiscal year 2006 with projected expense costs for fiscal year 2007.

NPPD EXPENSE COSTS

Prosthetic Item	Total Cost Spent in FY 06	Projected Expenditure in FY 07
Wheelchairs & Access	$ 129,506,709	$ 140,636,876
Artificial Legs	$ 69,144,331	$ 75,086,787
Artificial Arms	$ 3,438,282	$ 3,733,778
Orthosis/Orthotics	$ 32,929,691	$ 35,759,760
Shoes/Orthotics	$ 26,738,433	$ 29,036,408
Sensori-Neuro Aids	$ 56,311,246	$ 61,150,791
Restorations	$ 3,003,352	$ 3,261,468
Oxygen & Respiratory	$ 156,873,103	$ 170,355,215
Medical Equipment & Supplies	$ 133,657,071	$ 145,143,932
Home Dialysis	$ 1,298,507	$ 1,410,104
HISA	$ 6,235,912	$ 6,771,844
Surgical Implants	$ 340,735,579	$ 370,019,344
Other Items	$ 147,667,468	$ 189,145,693
Total Spent	**$ 1,107,539,684**	**$ 1,231,512,000**

RECOMMENDATIONS:

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including covering the latest advances in technology, so that funding shortfalls do not compromise other programs.

The Administration must allocate an adequate portion of its appropriations to prosthetics to ensure that the prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

The VHA must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

The VHA should continue to utilize the PRUW to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the NPPD.

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

▼ ▼ ▼

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

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

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

The IBVSOs are concerned with the procedures that are being used as part of the PCMP process to award single-source national contracts for specific prosthetic

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

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

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

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

RECOMMENDATIONS:

The VHA should continue the prosthetics clinical management program, provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

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

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

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

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent regarding the appropriate provision of care and services. Such policies and procedures should address issues of prescribing, ordering, and purchasing based on patient needs—not cost considerations.

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

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

Restructuring of Prosthetics Programs:

The prosthetics program continues to lack timely and consistent service to the patients.

The Independent Budget veterans service organizations (IBVSOs) believe Veterans Health Administration (VHA) headquarters must provide more specific information and direction to Veterans Integrated Service Networks (VISNs) on the restructuring of their prosthetics programs. The current organizational structure has communication inconsistencies that have resulted in the VHA central office trying to respond to various local interpretations of Department of Veterans Affairs (VA) policy.

VHA HEADQUARTERS MUST DIRECT VISN DIRECTORS TO:

- Designate a qualified VISN prosthetic representative who will be the technical expert responsible for ensuring implementation and compliance with national goals, objectives, policies, and guidelines on all issues of interpretation of the prosthetics policies.
- Ensure that the VISN prosthetic representative has direct input into the performance evaluation of all prosthetics full-time employees at local facilities that are organized under the consolidated prosthetics program or product line.
- Ensure that the VISN prosthetic representative not have collateral duties as a prosthetic representative for a local VA facility within his or her VISN.
- Establish a single VISN budget for prosthetics and steps taken to ensure that the VISN prosthetic representative has control of and responsibility for that budget.
- Establish time limits for prosthetic denials in order to expedite the appeal process.

RECOMMENDATIONS:

The VHA must require all VISNs to adopt consistent operational parameters and authorities in accordance with national prosthetics policies. VISN directors as well as VHA central office staff should be held responsible for implementing a consistent prosthetics program that reduces the need for central office intervention. Time limits for denial of prosthetics requests should be established and adhered to.

The VHA should establish a time limit for denials of prosthetic requests.

▼ ▼ ▼

Failure to Develop Future Prosthetics Staff:

There continues to be a shortage in the number of qualified prosthetics staff available to fill current or future vacant positions.

The Veterans Health Administration (VHA) has developed and requested 12 training billets for the National Prosthetic Representative Training Program projected in fiscal year 2007 and 2008. Interns in this program are invited to the annual National Prosthetic Representative Training Conference for a one-week intense prosthetics forum. In fiscal year 2005, trainee recruitment for the program was suspended by the Technical Career Field (TCF) per request of the National Leadership Board (NLB). It was reestablished in 2006 and 2007. *The Independent Budget* veterans service organizations (IBVSOs) would like ensure that this training program be established on a permanent basis.

This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. In the past, some Veterans Integrated Service Networks (VISNs) have selected individuals who do not have the requisite training and experience to fill the critical VISN prosthetic representative positions. There are some VISNs who have developed their own Prosthetic Representative Training Program.

These VISN interns are included in the annual National Prosthetic Representative Training Conference. The IBVSOs recommend that all VISNs have a Prosthetic Representative Training Program to enhance the quality of health-care service within the VHA system. The IBVSOs believe the future strength and viability of VA's prosthetics program depends on the selection of high-caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients.

We are seeing an increasing number of injuries as a direct result of Operation Enduring Freedom and Operation Iraqi Freedom, and our returning military personnel are being issued complex technological prosthetic devices. Each major prosthetics department within the VA must have trained certified technologists that can maintain and repair these devices.

RECOMMENDATIONS:

The VHA must fully fund and implement its National Prosthetic Representative Training Program on an ongoing basis, with responsibility and accountability assigned to the chief consultant for Prosthetics and Sensory Aids. Sufficient training funds and employee staff must be dedicated to this program to ensure success.

VISN directors must ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences and meetings for appropriate managerial, technical, and clinical personnel.

The VHA must be assured by the VISN directors that selected candidates for vacant VISN prosthetic representative positions possess the necessary competency to carry out the responsibilities of these positions.

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

▼ ▼ ▼

Hearing Loss and Tinnitus:

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

While loud noise has been part of military life since muskets and cannons were part of the arsenal, Iraq is proving one of the noisiest battlegrounds yet. Roadside bombs—the signature weapon of the country's insurgency—regularly hit patrols, popping eardrums in their wake.

According to Veterans Affairs' (VA) data, major hearing loss disability cases held steady through the late 1990s. The number rose markedly from nearly 40,000 cases in 2002 to about 50,000 in 2005, the latest year for which data were available. In 2005 the Department of Veterans Affairs spent nearly $800,000 treating major hearing loss—a nearly 20 percent jump from 2004.

■ Invisible Injury

Many service members returning from war are physically disabled. Those types of injuries are easily seen by a physician and are often easily diagnosed and treated. Many soldiers exposed to blasts from roadside bombs suffer internal injuries that are not as easy to detect and treat. One of the most prevalent disabilities from exposure to IEDs (improvised explosive devices) is an injury that is one of the hardest to detect—and even harder to treat. Soldiers may even be unaware of this injury upon separation from the military. It is called tinnitus.

Tinnitus is defined as the perception of sound in the ears where no external source is present. Some with tinnitus describe it as "ringing in the ears," but people

report hearing all kinds of sounds, such as crickets, whooshing, pulsing, ocean waves, or buzzing. For millions of Americans, tinnitus becomes more than an annoyance. Chronic tinnitus can leave an individual feeling isolated and impaired in their ability to communicate with others. This isolation can cause anxiety, depression, and feelings of despair. Tinnitus affects an estimated 30 million, or more, people in the United States to some degree. Ten to 12 million are chronically affected and 1 to 2 million are incapacitated by their tinnitus (Brown et al., 1990). It is estimated that 250 million people worldwide experience tinnitus (Holme et al., 2005).

Adding to the Rolls Every Year

The number of veterans who are receiving disability compensation for their tinnitus has risen steadily over the past 10 years and spiked sharply in the past 5 years. From 2004 to 2005, the number of veterans receiving compensation for their tinnitus increased by 20 percent. That's the single largest one-year increase since tinnitus became compensable in 1945. Veterans with tinnitus may be awarded up to a 10 percent disability, which currently equals about $115 a month. Though it is considered to be a "disease of the ear" according to Title 38 of United States Code (the veterans disability rating handbook), only one "ear" is considered in determining disability rating for tinnitus.

Translated into economic terms, the government paid out nearly $418 million in disability compensation for tinnitus in 2005. If you couple that dollar amount with what was paid out for hearing loss disability compensation, the total is more than $1 billion for fiscal year 2005 alone. If tinnitus continues on the upward trend seen over the past five years, which is an average annual rate of $53.6 million, the cost to taxpayers for tinnitus disability claims will reach $1.2 billion by 2025. This is one of the many reasons why the federal government needs to begin addressing this epidemic from an effective medical research and prevention standpoint.

Noise-Induced Hearing Loss and Tinnitus

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

According to the National Institute on Deafness and other Communication Disorders (NIDCD), any sounds that emit noise of 80 decibels (dBA) or higher can cause tinnitus and hearing damage. Prolonged exposure from sounds at 85+ dBA can also be damaging, depending on the length of exposure time. As decibel levels intensify, the time an individual needs to be exposed decreases and the chance of noise-induced hearing loss and tinnitus increases. A single exposure at 140+ dBA may cause tinnitus and damage hearing immediately. The table below shows a few common military operations and their associated noise levels.

NOISE LEVELS–COMMON MILITARY OPERATIONS

Type of Artillery	Position	Decibel Level (dBA) (Impulse Noise)
105 mm Towed Howitzer	Gunner	183
Hand Grenade	At 50 feet from target	164
Rifle	Gunner	163
9 mm Pistol	N/A	157
F18C Handgun	N/A	150
Machine Gun	Gunner	145

Source: U.S. Army Center for Health and Preventative Medicine, http://chppm-www.apgea.army.mil/

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

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

Many soldiers develop tinnitus and other hearing impairments prior to active combat as a result of training. If a soldier is disabled prior to combat, his or her effectiveness already may be compromised at the beginning of active duty. A study in "Tank Gunner Performance and Hearing Impairment" (Garinther & Peters, *Army RD&A Bulletin* 1990) concluded that hearing impairments may delay a soldier's ability to identify his or her target by as much as 50 seconds.

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

The Role of Medical Research

Research has increased our knowledge on hearing loss and how the ear loses the ability to hear, while less has been discovered about tinnitus. We do know that tinnitus is a condition of the auditory system. The sound a person hears is actually generated in the brain. This raises another question of possible correlation to another injury that has seen a recent increase. Traumatic brain injuries (TBIs) have been on the rise as more and more soldiers have been exposed to IEDs. Of 692 TBI patients at Walter Reed Army Medical Center between January 2003 and March 2006, nearly 90 percent had nonpenetrating head injuries *(National Geographic,* Dec. 2006).

Since tinnitus is something that happens in the brain, could there be a correlation between tinnitus and TBIs? It's a question that will remain unanswered unless the federal government funds more medical research as encouraged by *The Independent Budget* veterans services organizations (IBVSOs).

In FY 2005, VA funded about $4.4 million in auditory research. About one-tenth of that was spent on clinical research to learn best practices for treating veterans with tinnitus. Based on evidence from VA data, an audiological evaluation should be mandatory upon separation from the military.

Even though tinnitus research has come a long way, especially in recent years, we need to know much more. With so many veterans being added to the rolls every year for service-connected tinnitus, VA and the DOD should be emerging as leaders in tinnitus research.

The total number of veterans disabled for hearing loss and tinnitus: 414,025 veterans were disabled for hearing loss; 339,573 veterans were disabled for tinnitus. In total, 753,598 veterans were disabled for hearing loss or tinnitus.

RECOMMENDATIONS:

The VHA must rededicate itself to the excellent of program for hearing loss and deficiency.

The VHA must continue its work with networks to restore clinical staff resources in both inpatient and outpatient audiology programs.

Congress must continue to work for increased funding for VA and the DOD to prevent and treat tinnitus.

Blinded Veterans:

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

The Department of Veterans Affairs (VA) Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. VA currently operates 10 comprehensive residential blind rehabilitation centers (BRCs) located across the country with plans for three new BRCs. Approximately 44,438 blind veterans were enrolled in FY 2005 with the visual impairment service team (VIST) coordinators offices, and projected demographic data suggest that by 2009 the VA system could realize an increase to approximately 53,000 enrolled blind and visually impaired veterans requiring services.

The Independent Budget veterans service organizations (IBVSOs) emphasize that data compiled between March 2003 and April 2005 by the Department of Defense (DOD) show that **16 percent** of those evacuated from Iraq have eye injuries. As of August 2006, Walter Reed Army Medical Center has surgically treated approximately 670 soldiers with either blindness or moderate to severe significant visual injuries. The National Naval Medical Center has a list of more than 350 veterans with eye injuries that will require surgery. Approximately 40 of these service members have received treatment at the 10 VA BRCs while others are in the process of being referred for admission. Nevertheless, we fear that many are unaccounted for and lost in the DOD system and that the BVA has found some in medical hold companies that had never been referred to the VA BRS. With some 22 percent of the wounded being Army National Guard or Reserves, *The Independent Budget* veterans service organizations are concerned that many others who could benefit from VA rehabilitative services are being lost in the seamless transition process, and we request that Congress exercise greater oversight on the lack of tracking of these eye-injured service members from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

As of January 14, 2006, the DOD had reported more than 11,852 returning wounded service members had suffered exposure to blast injuries, the most common being from improvised explosive devices (IEDs). Traumatic brain injury (TBI) has become the "signature injury" of OEF and OIF. Blast-related injury is now the most common cause of trauma in Iraq. A recent study found that 88 percent of military troops treated at an echelon II medical unit in Iraq had been injured by IEDs, and 47 percent of those suffered TBI. Data from screening of 7,909 marines with the 1st Marine Division revealed that 10 percent suffered from TBI 10 months after returning from Iraq. At Fort Irwin, 1,490 soldiers were screened in May of 2006, and almost 12 percent of them had suffered concussions resulting in mild to moderate TBI injuries.

More than 1,750 of the total of service members with TBI have sustained severe enough TBI to result in neurosensory complications, with epidemiological TBI studies finding that 24 percent have associated visual disorders of diploplia, convergence disorder, photophobia, ocular-motor dysfunction, and inability to interpret print, with some TBIs resulting in legal blindness and other manifestations known as post-trauma vision syndrome. *The Independent Budget* fully endorsed the increased funding of $19 million for the Defense and Veterans Brain Injury Center for FY 2007 and supports increases in FY 2008 to meet new injuries. According to a recent study by researchers at Harvard and Columbia, it is estimated that the cost of medical treatment for service members with TBI will be at least $14 billion over the next 20 years. The current discretionary budget process does not address this issue.

Historically, the residential BRC program has been the primary option for severely visually impaired and blinded veterans to receive services. As the VHA made the transition to more outpatient primary care systems of healthcare delivery in the 1990s, the BRS failed to make the same transition for blind rehabilitation services for veterans. During Congressional testimony on July 22, 2004, the Government Accountability Office recommended that the VA BRS expand its capacity to provide a full continuum of blind rehabilitation services. This has not occurred because of a lack of overall funding. By the VHA's own estimates, it needs $14.4 million to implement the full continuum of rehabilitative care. At present, approximately 1,200 blinded veterans are waiting an average of 24 weeks for entrance into 1 of the 10 VA BRCs. Under the present system, many older veterans will not attend a residential BRC—so they do not receive any type of rehabilitation.

The Independent Budget encourages directed funding of an additional $9.6 million in FY 2008 for new models of blind rehabilitation outpatient services. By encompassing the full spectrum of visual impairment services—blind rehabilitative outpatient specialists (BROS), Visual Impairment Center to Optimize Remaining Sight a specialized low vision optometry program, and the Visual Impairment Services Outpatient Rehabilitation Program—all the various outpatient programs could screen those service members with high risk or history of TBI for neurological visual complications that might otherwise be undiagnosed—plus be effective outpatient programs for the aging population requiring outpatient services.

Now is the time for implementation of the full continuum of outpatient services for all visually impaired veterans. Congressionally mandated BRS capacity must be maintained. BRS continues to suffer losses in critical full-time employee equivalents, compromising the BRS's capacity to provide comprehensive residential blind rehabilitation services with some of the blind rehabilitation centers operating at only 82 percent of all of their beds because of staff reductions caused by overall funding shortages. Other critical BRS positions, such as full-time VIST coordinators and the current 26 BROS, must be increased and are necessary for the four polytrauma centers and the 17 secondary polytrauma centers. Blind rehabilitative outpatient specialists (BROS), in addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center, also provide blind rehabilitation training in veterans' homes. They also assist in follow-up training when veterans return from a blind rehabilitation center.

RECOMMENDATIONS:

The VHA must restore the bed capacity in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

The VHA must rededicate itself to the excellence of the full continuum of programs for blinded veterans.

The VHA must require the networks to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

VHA headquarters must undertake aggressive oversight and allocate an additional $9.6 million to ensure the full continuum of care for blind services.

The VHA should expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they can be identified.

The VHA should ensure that concurrence is obtained from the director of the Blind Rehabilitation Service in VA headquarters before a local VA facility selects and appoints key BRS management staff and disputes must be elevated to the Under Secretary for Health for resolution.

Spinal Cord Dysfunction:

Quality health care delivered to the patient with spinal cord dysfunction continues to be hindered by the lack of qualified staff to support the mission of the Spinal Cord Injury/Spinal Cord Dysfunction (SCI/D) program.

SCI/D leadership

Several major SCI/D programs are under "acting" management, with a serious shortage of qualified, board-certified SCI physicians. The shortage of qualified board-certified SCI physicians has resulted in delays in policy development and a loss of continuity of care.

It must be recognized that SCI medicine is a major subspecialty and clinical leadership of these departments is as vital to the Department of Veterans Affairs (VA) health-care program as the specialties of general medicine and surgery. Vacancies, specifically in chief positions, reflect adversely on the management of the local VA hospital and the Veterans Health Administration (VHA) system of care. It can be assumed that either the hiring process is flawed, applicants were not available, or that appropriate incentives have not been included to make these positions attractive.

Nursing staff

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

Recruitment and retention bonuses have been effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans and the morale of the nursing staff. Unfortunately, facilities are faced with the local budget dilemma when considering the offering of any recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus shorting other needed medical programs. Because these efforts have only been used at local or regional facilities, there is only a partial improvement of a systemwide problem.

A consistent national policy of salary enhancement should be implemented across the country to ensure qualified staff is recruited. Funding to support this initiative should be made available to the medical facilities from the network or central office to supplement their operating budget.

Patient Classification

VA has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of injury, amount of time spent with the patient, technical expertise, and clinical needs of each patient. A category III patient, in the middle of the scoring system, is the "average" SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of full-time employee equivalents (FTEEs) needed for continuous coverage. This formula covers *bedside nursing care hours* over a week, month, quarter, or the year. It is adjusted for net hours of work with annual, sick, holiday, and administrative leave included in the formula.

The emphasis of this classification system is based on *bedside nursing care*. It does not include administrative nurses, non-bedside specialty nurses or light-duty nursing personnel because these individuals do not or are not able to provide full-time labor-intensive bedside care for the patient with SCI/D. According to the *California Safe Staffing* Law, dealing with registered nurses to patient staffing ratios, "Nurse administrators, nurse supervisors, nurse managers, and charge nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those administrators are providing direct patient care."

Nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.1 and VHA Directive 2005-001. It was derived on 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. Currently, nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2005-001 mandates 1,347.6 bedside nurses to provide nursing care for 85 percent of the available beds at the 23 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians.

At the end of fiscal year 2006, nurse staffing was 1,297.7. This number is 49.9 FTEEs short of the mandated requirement of 1,347.6. The 1,297.7 FTEEs includes nursing administrators and non-bedside RNs (79.5) and light duty staff (35). Removing the administrators and light duty staff makes the total number of nursing personnel at 1,183.2 FTEEs to provide *bedside nursing care*.

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio of professional nurses to other nursing personnel. There are 515.6 RNs working in SCI/D. Out of that, 79.5 are in non-bedside or administrative positions, leaving 436.1 RNs providing bedside nursing care. With 1,297.7 nursing personnel and 515.6 of those RNs, this leaves an RN ratio of 40 percent to provide *bedside nursing care*. If the non-bedside RNs were excluded, the percentage of RNs drops to 36 percent. These numbers are well below the mandated 50 percent RN ratio.

SCI/D facilities recruit only to the minimum nurse staffing required by VHA Directive 2005-001. As shown above, when the minimal staffing levels include non-bedside nurses and light duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of nurses.

The low percentage of professional registered nurses providing bedside care and the high acuity of SCI/D patients puts SCI/D veterans at increased risk for complications secondary to their injuries. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

This nurse shortage has manifested itself by VA facilities beginning to restrict admissions to SCI/D wards. Reports of bed consolidations or closures have been received due to nursing shortages. Such situations create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

RECOMMENDATIONS:

The VHA should authorize substantial recruitment incentives and bonuses to attract board-certified physicians for staff as well as the SCI chief position.

The VHA needs to centralize policies and funding for systemwide recruitment and retention bonuses for nursing staff.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses.

Gulf War Veterans:

Gulf War veterans still suffer from illnesses related to their military service.

In the 15 years since the Gulf War, both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) have seen many service members and veterans who participated in the Gulf War and have concerns regarding chronic illnesses and disabilities possibly related to their military service. The controversy over "Gulf War syndrome" still exists, but it is clear that many Gulf War veterans suffer from a wide range of chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, gastrointestinal problems, and chest pain.

Scientists and medical researchers who continue to search for answers and contemplate the various health risks associated with service in the Persian Gulf theater report illnesses affecting many veterans who served there. To date, experts have concluded that while Gulf War veterans suffer from real illnesses, there is no syndrome, single disease, or medical condition affecting them. Some progress has been made in focusing and managing research by both departments, but there is room for improvement, particularly when laboratory and research findings offer improved clinical care and new therapies for Gulf War veterans.

We are concerned that the current conflict in Iraq has, once again, placed our ground troops fighting and living in the same areas as Gulf War veterans did. VA's response to this unique situation was to broaden the scope of Gulf War illness research to include "deployment related health research." In reviewing VA-funded research on Gulf War illnesses, the Research Advisory Committee on Gulf War Veterans' Illnesses has raised questions on the nature of some VA-funded research as to whether these research projects will directly affect veterans suffering from Gulf War illnesses. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that the decision to extend the umbrella of Gulf War illness research will dilute the focus and erode the management of VA research.

While it is unclear whether veterans of the current Persian Gulf conflict should be categorically grouped with veterans of the first Gulf War for purposes of VA research on Gulf War illnesses, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of the others. We believe that funding for research proposals categorized under Gulf War illnesses should be subject to a review by experts in this area to ensure precious research funding that is committed is properly managed, particularly with Congress's sustained interest in this issue depicted in the conference report of the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (Public Law 109-114), which directs VA to provide no less than $15 million to be used for Gulf War illness research and to evaluate establishing a research center of excellence devoted specifically to Gulf War illness.

As testing and research continue, veterans affected by these multisymptom-based illnesses hope answers will be found and that they will be properly recognized as disabled as a result of their military service in the Gulf War. The IBVSOs expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses that veterans of the Gulf War have experienced.

Unfortunately, veterans returning from all of our nation's wars and military conflicts have faced similar problems attempting to gain recognition of certain conditions as service connected. With respect to Gulf War veterans, even after countless studies and extensive research, there remain many unanswered questions. Accordingly, the IBVSOs urge that Congress extend the provision of P.L. 107-135, thus prolonging eligibility for VA health care of veterans who served in Southwest Asia during the Gulf Wars. In this connection, we strongly recommend establishment of an open-ended presumptive period until it is possible to determine "incubation periods" in which conditions associated with Gulf War service may manifest.

Many sick and disabled Gulf War veterans are frustrated over ineffective VA medical treatment and frequent denial of compensation for their poorly defined illnesses. Likewise, VA health-care professionals face a variety of unique challenges when treating these veterans, many of whom are chronically ill and complain of numerous, seemingly unrelated symptoms. Physicians must devote ample time to properly assess and treat these chronic, complex, and debilitating illnesses. For example, VA uses clinical practice guidelines for chronic pain and fatigue; however, VA has not

yet developed clinical practice or treatment guidelines for management of patients with multisymptom-based illnesses. Nor has VA tailored its health-care or benefits systems to meet the unique needs of Gulf War veterans; instead, VA continues to medically treat and handle these cases in a more traditional manner.

The IBVSOs believe Gulf War veterans would greatly benefit from such guidelines, as well as from a medical case manager. Oversight, coupled with a thorough and comprehensive medical assessment, is not only crucial to treatment and management of the illnesses of Gulf War veterans, but also to VA's ability to provide appropriate and adequate compensation.

Equally essential is continuing education for VA health-care personnel who treat this veteran population. VA physicians need current information about the Gulf War experience and related research to appropriately manage their patients. VA should request expedited peer reviews of its Gulf War–related research projects, such as the antibiotic medication trial and the exercise and cognitive behavioral therapy study. Moreover, the Secretary should support significant increases in the effort and funds devoted to such research by both federal government and private entities.

RECOMMENDATIONS:

Congress should ensure continued funding is provided for Gulf War veterans' illness research.

VA should continue to foster and maintain a close working relationship with the National Academy of Sciences in an effort to determine the toxins to which Gulf War veterans were exposed and what illnesses may be associated with such exposure.

Congress should continue prudent and vigilant oversight to ensure both VA and the NAS adhere to time limits imposed upon them so they effectively and efficiently address the continuing health-care needs of Gulf War veterans.

▼ ▼ ▼

Lung Cancer Screening and Early Disease Management Pilot Program:

More than 50 percent of new lung cancer cases are diagnosed in former smokers, including many who had quit 20 or 30 years ago. Another 15 percent of new lung cancer cases occur in people who have never smoked, with possible causes including radon, asbestos, Agent Orange and other herbicides, beryllium, nuclear emissions, diesel fumes, and other toxins.

Over the next six years, one million Americans will die from lung cancer, most within months of diagnosis. It is the leading cause of cancer death, responsible for nearly 30 percent of all cancer mortality, more than breast, prostate, colon, liver, melanoma, and kidney cancers combined.

Since Congress passed the National Cancer Act in 1971, the five-year survival rates for breast, prostate, and colon cancers have risen to 88 percent, 99 percent, and 65 percent respectively, primarily because of major funding investments in research and early detection for those cancers. Lung cancer's five-year survival rate is still at 15 percent, reflective of the persistent underfunding of research and early detection. Lung cancer now kills three times as many men as prostate cancer and nearly twice as many women as breast cancer.

■ Impact on Military and Veteran populations

The Department of Defense (DOD) routinely distributed free cigarettes and included cigarette packages in K-rations until 1976. The 1997 Harris report to the Department of Veterans Affairs (VA) documented the higher prevalence of smoking and exposure to carcinogenic materials among the military and estimated costs to VA and TRICARE in the billions of dollars per year. For example, the percentage of Vietnam veterans who ever smoked is more than 70 percent, double the civilian "ever smoked" rate of 35 percent. Asbestos in

submarines, Agent Orange, Gulf War battlefield emissions, and other toxins are additional factors that have led to a 25 percent higher incidence and mortality rate for lung cancer among veteran populations.

A 2004 report by the Board on Health Promotion and Disease Prevention (HPDP) of the Institute of Medicine (IOM), "Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer (2004)," concluded that the presumptive period for lung cancer is 50 years or more. Another report issued in 2005 by the HPDP, "The Gulf War and Health: Volume 3, Fuels, Combustion Products and Propellants (2005)," concluded that there is sufficient evidence for an association between battlefield combustion products and lung cancer.

Lung cancer is an indolent cancer that takes decades to develop, and in most cases no symptoms present until the cancer is already at late stage. Thus, while the disease may initiate under circumstances encountered during service under the DOD, the disease burden will fall most heavily on VA, and to a lesser extent on TRICARE. Because of the predominance of late stage diagnoses, more than 60 percent of lung cancer patients die within the first year, and late stage treatment is more than twice as costly as early stage.

■ JUSTIFICATION

On October 26, 2006, the *New England Journal of Medicine* published the results of a 13-year study on CT screening of 31,500 asymptomatic people by a consortium of 40 centers in 26 states and 6 foreign countries. Lung cancer was diagnosed in 484 participants, 85 percent at stage 1 (versus 16 percent nationally) and the estimated 10-year survival rate for those treated promptly is 92 percent (versus a 15 percent 5-year survival rate nationally).

The benefits of this early detection and disease management protocol should be extended to veterans, especially those whose active duty service has placed them at higher risk for lung cancer.

■ LEGISLATIVE HISTORY

Senate Report 108-087 on the Department of Defense Appropriations Bill, 2004 contains the following language:

"Lung Cancer Screening – The Committee urges the Secretary of Defense, in consultation with the Secretary of Veterans Affairs, to begin a multi-institutional lung cancer screening program with centralized imaging review incorporating state-of-the-art image processing and integration of computer assisted diagnostic tools."

Senate Report 109-286, Military Construction and Veterans Affairs and Related Agencies Appropriations Bill, 2007 contains the following language:

"Lung Cancer Screening – The Committee encourages the Secretary of Veterans Affairs to institute a pilot program for lung cancer screening, early diagnosis and treatment among high-risk veteran populations to be coordinated and partnered with the International Early Lung Cancer Action Program and its member institutions and with the designated sites of the National Cancer Institute's Lung Cancer Specialized Programs of Research Excellence. The Department shall report back to the Committee on Appropriations within 90 days of enactment of this act, on a proposal for this program."

■ DEPARTMENT OF ENERGY (DOE) AND LUNG CANCER

Over the past eight years the DOE Office of Environment, Safety and Health has supported a medical screening program for DOE defense nuclear workers who were exposed to toxic and radioactive substances. The Worker Health Protection Program was originally authorized under Section 3162 of the 1993 Defense Authorization Act and has been funded through DOE appropriations. Currently more than 7,000 workers at seven different munitions plant sites are being screened free of charge annually for lung cancer. In FY 06, funding was increased to $14 million to cover an expansion of sites and the number of participants.

RECOMMENDATIONS:

VA should request and Congress should appropriate at least $3 million to conduct a pilot screening program for veterans at high risk of developing lung cancer.

VA should partner with the International Early Lung Cancer Action Program to provide early screening of veterans at risk.

Women Veterans:

The Department of Veterans Affairs (VA) must be prepared to meet the needs of the increasing numbers of women veterans seeking health-care services and ensure that its special disability programs are tailored to meet the unique health concerns of our newest generation of women veterans, especially those who have served in combat theaters.

In contrast to the overall declining veteran population in the United States, the female veteran population is increasing. According to VA, there are approximately 1.7 million women veterans comprising 7 percent of the total veteran population. VA estimates that by 2020 women veterans will comprise 10 percent of the veteran population.

As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services. As of June 2006, there were nearly 400,000 women veterans enrolled in the veterans' health-care system. Women veterans comprise approximately 5 percent of all users of VA health-care services, and within the next decade, this figure is expected to double. The average female veteran is younger (estimated median age 46) than her male counterpart (estimated median age 60) and more likely to belong to a minority group. Additionally, according to the VA Women Veterans Health Program Office, as of August 31, 2006, approximately 70,000 women veterans served in military service in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) theaters of operations and have separated from service. Among the nearly 70,000 women having served in OEF/OIF, 37.2 percent, or 25,960, have received health care from VA since separation (up from 31.2 percent, or 13,693, approximately one year ago).

With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is responsive to the unique demographics of this veterans' population and adjusts programs and services as needed to meet its changing health-care needs. As we see growth in the number of women veterans using VA health-care services, we also expect to see increased VA health-care expenditures for women's health programs.

The VA Veterans Health Administration (VHA) mandates that each facility, independent clinic, and community-based outpatient clinic (CBOC) ensures that eligible women veterans have access to all necessary medical care, including care for gender-specific conditions, that is equal in quality to that provided to male veterans.

The Independent Budget veterans service organizations (IBVSOs) are concerned that although VA has markedly improved the way health care is provided to women veterans, privacy issues and other deficiencies still exist at some facilities. VA needs to monitor and enforce, at the Veterans Integrated Service Network (VISN) and local levels, the laws, regulations, and policies specific to health-care services for women veterans. Only then will women veterans receive high-quality primary and gender-specific care, continuity of care, and the privacy they expect and deserve at all VA facilities.

The model used for delivery of primary health care to women veterans using VA health-care services is variable. There has been a trend in the VHA away from comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. According to VA, 46 percent of VA facilities surveyed provide care to women through mixed gender primary care teams and refer these patients to specialized women's health clinics for gender-specific care. In the mid-1990s, VA reorganized from a predominantly hospital-based care delivery model to an outpatient health-care delivery model focused on preventative medicine. The IBVSOs are concerned about the incidental impact of the primary care model on the quality of health care delivered by VA to women veterans. VA's 2000 conference report "The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services" noted that with the advent of primary care in VA, many women's clinics were dismantled and that women veterans were assigned to primary care teams on a rotating basis. Findings from the report indicate that this practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

VA acknowledges, and the IBVSOs agree, that full-service women's primary care clinics that provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care for women veterans. Or, in cases where there are relatively low numbers of women being treated at a given facility, it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of the provider's clinical skills in women's health. Likewise, we agree that the health-care environment directly affects the quality of care provided to women veterans and has a significant impact on the patient's comfort, feeling of safety, and sense of welcome.

According to VA researchers, although women veterans report that they prefer receiving primary and gender-specific health care from the same provider or clinic, in actuality their care is fragmented, with different components of their care being provided by different clinicians with varying degrees of coordination. Additionally, researchers report there are a number of barriers to delivering high-quality health care to women veterans. Specifically, insufficient funding for women's health programs, competing local or network priorities, limited resources for outreach, inability to recruit specialists, small women veterans' caseloads at certain locations, limited availability of after-hours emergency women's health services, and an insufficient number of clinicians skilled in women's health. The findings of a 2006 study indicated that military sexual trauma quadruples the risk of homelessness among women veterans.

Researchers made several recommendations to address these barriers, including concentrating women's primary care delivery to designated providers with women's health expertise within primary care or women's health clinics; enhancing provider skills in women's health; providing telemedicine access to experts to aid in emergency women's health-care decision making; and increasing communication and coordination of care for women veterans using fee-based or contracted care services. We are pleased that funding has been approved for VA researchers to study the impact of the practice structure on the quality of care for women veterans and fragmentation of care for women veterans including unmet health-care needs for women with chronic physical and mental health conditions.

VA, in recognition of the changing demographics in the veteran population and the special health-care needs of women veterans, has established women's health as a research priority to develop new knowledge about how to best provide for the health and care of women veterans. In 2004, VHA's Office of Research and Development held a groundbreaking conference, "Toward a VA's Women's Health Research Agenda: Setting Evidence-Based Research Priorities for Improving the Health and Care of Women Veterans." The participants of the conference were tasked with identifying gaps in understanding women veterans' health and health care and with identifying the research priorities and infrastructure required to fill these gaps. In April 2005, a special solicitation was issued for research that will assess health-care needs of women veterans and demands on the VA health-care system in targeted areas, such as mental health and combat stress, military sexual trauma (MST), post-traumatic stress disorder (PTSD), homeless women veterans, and differences in era of service (e.g., Iraq versus Gulf War). An entire issue of the *Journal of General Internal Medicine* was dedicated to VA research and women's health in March 2006. Published findings include articles on the following topics: why women veterans choose VA health care; barriers to VA health care for women veterans; health status of women veterans; PTSD and increased use in certain VA medical care services; and PTSD and military sexual trauma.

The IBVSOs strongly encourage VA, as it takes steps to advance this agenda, to focus on research and programs that enhance VA's understanding of women veterans' health issues and ways to optimize health-care delivery and health outcomes for this patient population.

Equal access to quality mental health services is critical for women veterans, especially women veterans who have mental health conditions associated with serving in a combat theater or those who have suffered sexual trauma during military service. The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that active duty military personnel report rates of sexual assault higher than comparable civilian samples, and there is a high prevalence of sexual assault and harassment reported among women veterans accessing VA services. The study noted, and the IBVSOs agree, that it is "essential that VA staff recognize the importance of the environment in which care

is delivered to women veterans, and that VA clinicians possess the knowledge, skill, and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault."

According to VA, approximately 19 percent of the women screened between fiscal years 2002 and 2006 responded "yes" to experiencing military sexual trauma, compared to 1 percent of men screened. In response to these reports, VA established a committee to explore ways to address the mental health needs of women veterans and to improve mental health services to women who have experienced MST. In 2006, VA developed an MST support team under its mental health service to specifically work with MST coordinators in the field to better monitor tracking, screening, treatment, and training programs for MST. We still encourage the VHA to implement earlier recommendations made by the Mental Health Strategic Health Care Group Subcommittee on Women's Mental Health, including development of an MST provider certification program, providing separate subunits for inpatient psychiatry and other residential services, and improved coordination with the Department of Defense (DOD) on transition of women veterans.

Given the increasing role of women in combat and with more than 70,000 women having served in OEF/OIF combat theaters, we are pleased that VA's Women's Health Science Division of the National Center for PTSD is evaluating the health impact of combat service on women veterans, including the dual burden of exposure to traumatic events in the war zone and military sexual trauma. According to the center, although there is no current empirical data to verify MST is occurring in Iraq, there have been numerous reports in the popular press citing cases of sexual misconduct and anecdotal reports to health care workers. In the center's Women's Stress Disorder Treatment Team, of 49 returning female veterans, 20 (41 percent) report MST.

The center notes that anecdotal reports from OEF/OIF veterans suggest a number of unique concerns that have a more direct impact on women than their male counterparts returning from combat theaters, including lack of privacy in living, sleeping, and shower areas; lack of gynecological health care; impact of women choosing to stop their menstrual cycle; gender-specific differences in urinating leading to health concerns for women, including dehydration and urinary tract infection. There are also reported findings that suggest distinct differences at homecoming, including that women may be less likely to have their military service recognized or appreciated; possible differential access to treatment services; and possible increased parenting and financial stress. Additionally, women may be more likely to seek help for psychological difficulties.

The center is looking at gender differences in mental health, military sexual trauma in the war zone, and gender differences in other stressors associated with OEF/OIF service and homecoming. A number of research initiatives/projects are focused on treatment of PTSD in women, enhancing sensitivity toward and knowledge of women veterans and their health-care needs among VA staff, and military sexual trauma among Reserve components of the armed forces.

The IBVSOs are pleased that VA is attempting to address the needs of women veterans returning from combat theaters in a variety of ways and has provided guidance for medical facilities to evaluate the adequacy of programs and services for returning OEF/OIF women veterans in anticipation of gender-specific health issues. Additionally, we understand that VA intends to hold a special conference in early 2007 to better assess the unique needs of this newest generation of combat veterans. These women will have an opportunity to share their personal experiences and concerns so that VA programs and services can be improved and tailored to their specific physical and mental health care needs.

The Women Veterans Health Program Office and the local women veterans program managers (WVPMs) have partnered with the VA Seamless Transition Office to provide information at National Guard, Reserves, and family member demobilization briefings on VA services and programs for women veterans. VA should continue to strengthen its partnership with the DOD to ensure a seamless transition for women from military service to veteran status. Improvements in sharing data and health information between the departments is essential to understanding and best addressing the health concerns of women veterans.

WVPMs and benefits coordinators are another key component to addressing the specialized needs of women veterans. These program directors and benefits coordinators are instrumental in the development,

management, and coordination of women's health and benefits services at all VA facilities.

Given the importance of this position, the IBVSOs are concerned about the actual amount of time WVPMs are able to dedicate to women veterans' issues and whether they have appropriate administrative support to carry out their duties. According to VA, 71 percent of all WVPMs serve in a collateral role. Only 20 percent reported they were allocated more than 20 administrative hours per week to fulfill their program responsibilities during the fiscal year. With increasing numbers of women veterans, VA WVPMs must have appropriate support staff and adequate time allocated to successfully perform their program duties and to conduct outreach to women veterans in their communities. Increased focus on outreach to these veterans is especially important because they tend to be less aware of their veteran status and eligibility for benefits than male veterans.

In a period of fiscal austerity, VA hospital administrators have sought to streamline programs and make every possible efficiency. Often, smaller programs, such as programs for women veterans, are left at risk of discontinuation. The loss of a key staff member responsible for delivering specialized health-care services or developing outreach strategies and programs to serve the needs of women veterans can threaten the overall success of a program.

VA needs to ensure priority is given to women veterans' programs so quality health care and specialized services are equally available to women veterans as to male veterans. VA must continue to work to provide an appropriate clinical environment for treatment where there is a disparity in numbers, such as exists between women and men in VA facilities. Given the changing roles of women in the military, VA must also be prepared to meet the specialized needs of women veterans who were sexually assaulted in military service or catastrophically wounded in combat theaters, suffering amputations, blindness, spinal cord injury, or traumatic brain injury. Although it is anticipated that many of the medical problems of male and female veterans returning from combat operations will be the same, VA facilities must address the health issues that pose special problems for women. The IBVSOs also recommend that VA focus its women's health research on finding the health-care delivery model that demonstrates the best clinical outcomes for women veterans. Likewise, VA should develop a strategic plan with the DOD to collect critical information about the health and health-care needs of women veterans with a focus on evidence-based practices to identify other strategic priorities for a women's health research agenda.

RECOMMENDATIONS:

VA must ensure laws, regulations, and policies pertaining to the health care of women veterans are enforced at VISN and local levels.

VA must ensure that priority is given to women veterans' programs and determine which health-care delivery model demonstrates the best clinical outcomes for women.

VA needs to increase its outreach efforts to women veterans, as women veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

VA must ensure that clinicians caring for women veterans are knowledgeable about women's health, participate in ongoing education about the health-care needs of women, and are competent to provide gender-specific care to women.

VA must ensure that WVPMs are authorized appropriate support staff and sufficient time to successfully perform their program duties and to conduct outreach to women veterans in their communities.

VA must ensure that its specialized programs for post-traumatic stress disorder, spinal cord injury, prosthetics, and homelessness are equally available to women veterans as to male veterans.

VA should collaborate with the DOD to collect critical information about health and the health-care needs of women veterans to best identify strategic priorities for a women's health research agenda.

Ending Homelessness Among Veterans:

All veterans deserve access to comprehensive, high-quality, and affordable health care; an income at a level sufficient for obtaining and maintaining permanent housing, food, health care, and other basic human needs; and permanent, safe, high-quality, and affordable housing. No veteran should experience homelessness.

In testimony presented to Congress in 2006, a Department of Veterans Affairs (VA) representative reported that the number of homeless veterans on the streets of America on any given night had decreased by nearly 25 percent over the previous five years, from about 250,000 to 190,000.

VA reports homeless veterans are mostly males (97 percent), and the vast majority are single, although service providers are reporting an increased number of veterans with children seeking their assistance. About half of all homeless veterans have a mental illness, and more than two-thirds suffer from alcohol or other substance abuse problems. Nearly 40 percent have both psychiatric and substance abuse disorders. VA reports the majority of women in homeless veteran programs have serious trauma histories, some life-threatening, and many of these women have been raped and have reported physical harassment while in the military.

According to VA, male veterans are 1.3 times as likely to become homeless as their nonveteran counterparts, and female veterans are 3.6 times as likely to become homeless as their nonveteran counterparts. Like their nonveteran counterparts, veterans are at high risk of homelessness because of having extremely low or no livable income, the extreme shortage of affordable housing, and a lack of access to health care.

Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder or have addictions acquired during or worsened by their military service. These conditions can interrupt their ability to keep a job, establish savings, and in some cases, maintain family harmony. Veterans' family, social, and professional networks may have been broken as a result of extensive mobility while in service or lengthy periods away from their hometowns and their civilian jobs. These problems are directly traceable to their experience in military service or to their return to civilian society without having had appropriate transitional supports.

While most Americans believe our nation's veterans are well-supported, in fact many go without the services they require and are eligible to receive. According to VA, 1.5 million veterans have incomes that fall below the federal poverty level, including 634,000 with incomes below 50 percent of poverty. Neither VA nor its state and county departments are adequately funded to respond to these veterans' health, housing, and supportive services needs. Moreover, community-based and faith-based service providers also lack sufficient resources.

VA reports its homeless treatment and community-based assistance network serves 100,000 veterans annually. Community-based organizations (CBOs) serve 150,000 annually. With an estimated 500,000 veterans experiencing homelessness at some time during a year—VA reaching only 25 percent and CBOs 30 percent of those in need—undoubtedly a substantial number of homeless veterans do not receive much-needed services. Likewise, other federal, state, and local public agencies—notably housing and health departments—are not adequately responding to the housing, health-care, and supportive services needs of veterans. Indeed, it appears veterans fail to register as a target group for these agencies.

Despite the decrease in the number of homeless veterans over the past five years, many veterans still need help. Additionally, this population may be experiencing significant changes. Homeless veterans receiving services today appear to be aging, and the percentage of women veterans seeking services is growing. Moreover, combat veterans of Operation Iraqi Freedom, Operation Enduring Freedom, and the global war on terrorism are returning home and suffering from war-related conditions that may put them at risk for homelessness.

These men and women are beginning to trickle into the nation's community-based homeless veterans service provider organizations and need help—from mental health programs to housing, employment training, and job placement assistance. With greater numbers of women in combat operations, along with increased

identification of and a greater emphasis on care for victims of sexual assault and trauma, new and more comprehensive services are needed. Poverty, lack of support from family and friends, and unstable living conditions in overcrowded or substandard housing may also be contributing factors. In the next 10 years, significant increases in services over current levels will be needed to serve aging Vietnam veterans, women veterans, and combat veterans of America's current operations in Iraq and Afghanistan.

In addition to the recommendations listed below, Congress and the Administration should also consider findings and recommendations included in the 2006 annual report of the VA Advisory Committee on Homeless Veterans.

RECOMMENDATIONS:

Congress should increase appropriations for the VA Medical Services Account in order to strengthen the capacity of the VA Health Care for Homeless Veterans program to serve more homeless veterans; enable VA to increase its mental health and addiction services capacity; and enable VA to increase vision and dental care services to homeless veterans as required by law.

Congress must ensure homeless veterans' access to and utilization of mainstream health insurance and health services programs.

Congress should authorize and appropriate funds for competitive grants to community-based, faith-based, and public organizations to provide health and supportive services to homeless veterans placed in permanent housing.

Congress must develop a new source of funding for the health-care services needed to complement existing permanent housing and new permanent housing being developed for veterans experiencing long-term homelessness.

Congress should increase the authorization level of and appropriations for the Homeless Veterans Reintegration Program (HVRP). Funded by the U.S. Department of Labor (DOL), the HVRP is the only federal program wholly dedicated to providing employment assistance and competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

Congress should increase appropriations for the Veterans Workforce Investment Program (VWIP). Funded by the DOL, the VWIP provides to states competitive grants geared toward training and employment opportunities for veterans with service-connected disabilities, those with significant barriers to employment (such as homelessness), and recently separated veterans.

Congress should establish a Veterans Work Opportunity Tax Credit program. The program would provide an incentive for hiring homeless veterans by providing employers a tax credit equal to a percentage of the wage paid to the homeless or other low-income veteran.

Congress should increase the authorization level of and appropriations for the VA Homeless Provider Grant and Per Diem (GPD) program to meet the demands for transitional housing assistance. GPD provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans.

Congress should ensure that grantees under the Homeless Provider Grant and Per Diem program are reimbursed for services to homeless veterans at the same rate that VA reimburses states for domiciliary care services provided in state veterans' homes, without decrementing the GPD per diem rate based on other income streams.

Congress should increase appropriations for the therapeutic residence (TR) component of the Compensated Work Therapy (CWT) program, while ensuring that veterans receive the support they need. The CWT program helps veterans with disabilities to obtain competitive employment in the community and allows them to work in jobs they choose. The TR component provides transitional housing assistance to veterans with disabilities while they participate in the CWT program.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers.

Congress should improve coordination between VA-supported Community Homelessness Assessment, Local Education, and Networking Groups and HUD Continuum of Care programs.

Congress should enhance the HUD-Veterans Affairs Supportive Housing Program, which provides permanent housing subsidies and case management services to homeless veterans with mental and addictive disorders, by appropriating funds for additional housing vouchers targeted to homeless veterans.

Congress should require applicants for HUD McKinney-Vento Homeless Assistance Act funds to develop specific plans for housing and services to homeless veterans. Organizations receiving HUD McKinney-Vento homeless assistance funds but not serving veterans should screen participants for military service and make referrals as appropriate to VA and homeless veterans service providers.

Congress should authorize and appropriate funds for a targeted permanent housing assistance program for low-income veterans.

Congress should hold federal agencies accountable for complying with statutory requirements pertaining to making available surplus, excess, underutilized, and unutilized federal properties, including VA capital assets, to nonprofit, profit, and public organizations for development of permanent and transitional housing units for veterans experiencing homelessness.

Congress should ensure that all service members separating from the armed forces are assessed to determine their risk of homelessness and are provided with life skills training to help them avoid homelessness.

Congress should ensure that, in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursement), VA facilities develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing and appropriate supportive services. Discharge planning protocols should include providing information about VA resources and assisting persons in applying for income security and health security benefits (such as supplemental security income, Social Security Disability Insurance, veterans disability compensation, and Medicaid) prior to release.

Congress should increase the authorization level of and appropriations for the Emergency Food and Shelter Program (EFSP) and add a homeless veterans service provider representative to the national and local EFSP boards. EFSP provides funds to community-based, faith-based, and public organizations to enable them to offer food, lodging, and mortgage, rental, or utility assistance to persons who are homeless or at risk of homelessness.

LONG-TERM-CARE ISSUES

Obviously, the Department of Veterans Affairs (VA) has examined the data, considered alternatives, and developed several options for meeting the surging demand for long-term-care services. The aging of the veteran population and its subsequent increasing need for long-term care has been well documented for more than a decade by the Government Accountability Office (GAO), *The Independent Budget (IB)*, and by VA itself. However, if VA has a strategic plan for providing long-term care, it is a well kept secret.

In the absence of a comprehensive strategic plan for long-term care, VA is forced to adapt existing programs, services, and budgets to meet current and future demand. It is also forced to experiment with new ideas within existing budgets to meet the increasing need for these services. Shifting workload from institutional programs to noninstitutional programs can only help for so long. Eventually, aging will take its toll and a wave of veterans who were able to remain at home, with appropriate noninstitutional services, will need institutional nursing home care. The aging of the veteran population and the growing number of young severely injured combat veterans will eventually strain VA's long-term-care capacity to a point at which quality will begin to falter.

The burning questions remain the same. How will veterans receive the care they have earned and deserve without a strategic plan for their care? How will VA receive the long-term-care resources it requires today and tomorrow without a long-term-care strategic plan? How will VA convince the Office of Management and Budget and Congress to fund the resources it needs to meet growing demand without a strategic plan? How well can VA care for America's elderly and young severely wounded combat veterans without a strategic plan?

■ Long-Term-Care Strategic Plan Mandated by Congress

In the waning days of the 109th Congress, the House of Representatives and the Senate bundled a broad array of veterans' issues and passed Public Law 109-461, the "Veterans Benefits, Health Care, and Information Technology Act of 2006." Section 206 of the bill mandates the Secretary of Veterans Affairs to publish a strategic plan for the provision of long-term care within 180 days of the bill's enactment. VA's strategic plan must include cost and quality comparison analysis for all of VA's different levels of long-term care, detailed information about geographic distribution of services and gaps in care, and specific plans for working with Medicare, Medicaid, and private insurance companies to expand the availability of such care.

Additionally, Section 211 of the bill mandates VA to pay the cost of nursing home care provided by state veterans' homes to any veteran who has a service-connected disability rated 70 percent or more and is in need of such care and to any veteran for a service-connected condition that requires such care. The payment rate for this care will be governed by the prevailing rate in the geographic area.

The authors of *The Independent Budget* welcome this Congressional action, which requires VA to move forward in planning for the increasing needs of an aging veteran population. It is hoped that the 110th Congress will hold appropriate hearings to gather additional information from veterans about their long-term-care needs and desires.

■ The Aging of America's Veteran Population

VA has widely published data that describe an aging veteran population. VA's FY 2006–2011 Strategic Plan points out that the median age of all living veterans is 60 years. Other VA data say in the year 2000, approximately 10 million veterans were age 65 and older. Of that 10 million, approximately 5.4 million veterans were between 65 and 75 years of age, approximately 4 million were between 75 and 85, and approximately 540, 000 were 85 or older.

VA projections say that the veteran population age "85 or older" will increase by 110 percent between 2000 and 2020 and that this group of elderly veterans will peak in 2012 at 1.3 million, representing an increase of 143 percent over the total in 2000. VA's FY 2006–2011 Strategic Plan goes on to say that this large increase in the oldest segment of the veteran population has had, and will continue to have, significant ramifications on the demand for health-care services, particularly in the areas of long-term care.

Despite this VA data, VA's FY 2006–2011 Strategic Plan does not identify the needs of an aging veteran population as one of the Secretary's priorities. *VA's plan has no specific objectives or performance measures directly related to long-term care.* Regarding long-term care, Dr. Michael J. Kussman, Acting Under Secretary for Health says only, "The Veterans Health Administration (VHA) will expand its offerings of non-institutional alternatives to nursing home care and the capabilities of home-based care programs." Yet VA's 2006 Average Daily Census (ADC) data for noninstitutional care show a reduction in veterans served.

■ Disturbing VA Long-Term-Care Program Trend

Despite clear VA data that highlights the aging of the U.S. veteran population, VA's 2006 ADC data for its institutional care programs and its ADC data for its noninstitutional care programs show a reduction in the number of veterans served.

VA says little about the future direction of its nursing home care program, but VA is working to shift more of its long-term-care workload toward its noninstitutional care programs. For many veterans this is a positive policy, but for many other elderly veterans it is not. VA must be judicial in its decisions that guide veterans to home and community-based options for care. *The Independent Budget* authors are concerned that a constrained VA budget is forcing VA to downsize it nursing home capacity and turn to less expensive noninstitutional care in order to meet the growing demand for services. *VA must not substitute noninstitutional care for institutional (nursing home) care just because it is less expensive to do so in order to serve a greater number of veterans.*

■ VA Institutional Care

VA Nursing Home Expenditures/Venues of Care

VA's reported overall nursing home care expenditures in its three settings—VA-operated nursing homes, community nursing homes, and state veterans' nursing homes—increased from $2.3 billion in 2003 to nearly $3.2 billion in 2005 (GAO testimony 1/9/06). The percentage of patient workload provided in VA-operated nursing homes declined from 37 to 35 percent from 2003 to 2005. The percentage of workload in community nursing homes stayed about the same at 13 percent and the percentage of workload in state veterans' homes increased from 50 to 52 percent. (See table 1. LTC)

VA's Nursing Home Care Program

VA is a nationally recognized leader in providing quality nursing home care, but its ADC is being reduced each year. Congress has mandated that VA must maintain its nursing home ADC at the 1998 level of 13,391, but VA has not done so. VA's nursing home average daily census has continued to trend downward. VA has chosen to ignore the Congressional ADC mandate, and Congress has chosen to look the other way. Once again VA has failed to meet the Congressional ADC mandate.

Today, VA's long-term-care program focus is concentrated on expanding noninstitutional care programs. It seems that VA is hoping the financial stress of providing nursing home care will simply go away. However, demand for nursing home care will continue to increase because of expanding life expectancies. Plus, many elderly veterans who are safely utilizing noninstitutional

TABLE 1. LTC—NURSING HOME COMPARISON

(Dollars in Millions)

Nursing home setting	FY 2003	FY 2005	Change 2003–2005
VA-operated nursing homes	$ 1,697	$ 2,441	$ 743
Community nursing homes	$ 272	$ 352	$ 80
State veterans' nursing homes	$ 352	$ 382	$ 30
Total	**$ 2,321**	**$ 3,175**	**$ 853**

(NOTE: Data from GAO testimony 1/9/06.)

services today may not be able to tomorrow. VA must maintain a safe margin of nursing home beds that will meet the needs of America's oldest veterans and be capable of meeting the needs of other elderly veterans who can be expected to transition from VA noninstitutional care programs to nursing home care.

TABLE 2. LTC—AVERAGE DAILY CENSUS (ADC) VA'S NURSING HOME CARE PROGRAM

1998	13,391
2004	12,354
2005	11,548
2006	11,434
Increase/(Decrease)	(114)

(NOTE: ADC for 2006 is an unaudited number at this time.)

Special Program for Young Combat-Injured Veterans

VA must move forward in the development of institutional care programming for young Operation Iraqi Freedom and Operation Enduring Freedom veterans whose combat injuries are so severe that they are forced to depend on VA nursing home care. VA's current nursing home capacity is designed to serve elderly veterans, not young ones. VA must make every effort to create an environment for these veterans that recognizes they have different needs. VA leadership and VA planners must work to bring a new type of long-term-care program forward to meet these needs.

Young veterans must be surrounded by forward-thinking administrators and staff that can adapt to youthful needs and interests. The entire environment must be changed for these individuals, not just modified. For example, therapy programs, surroundings, meals, recreation, and policy must be changed to adapt to a younger, more vibrant resident.

Culture Change

VA has made a positive step forward by embracing the philosophy of "culture change" in the operation of its nursing home care program. The culture change movement for nursing home care is centered around such core concepts as autonomy, privacy, dignity, flexibility, and individualized services. Culture change is a departure from the medical model for nursing home care. VA's challenge to implement culture change throughout its nursing home care program is to develop and implement guidelines for management practices that make it possible for nursing home staff to truly understand and act on the personal care needs and lifestyle preferences of residents.

The culture change movement supports new thinking. It changes an old philosophy that operates in a medical model of service delivery where the veteran is seen as a patient. Instead, the new model called "culture change" refers to veterans as residents and works to create an environment that preserves dignity and promotes self respect. Culture change creates a homelike atmosphere with sufficient space and access to personal living space. The resident is involved in care planning, has a say in room and roommate selection, develops his or her own daily routine, and makes menu choices.

VA's Community Nursing Home Care Program

VA has contracts with more than 2,500 private community nursing homes located across the country. In 2005, the ADC for VA's community nursing home (CNH) program represented 13 percent of VA's total nursing home workload. VA's CNH program often brings care closer to where the veteran actually lives, closer to his or her family and personal friends. Since 1965, VA has provided nursing home care under contracts or basic ordering agreements. The CNH Program has maintained two cornerstones: some level of veteran choice in choosing a nursing home and a unique approach to local oversight of CNHs.

Veterans Health Administration Handbook 1143.2 provides instructions for initial and annual reviews of Community Nursing Homes and for ongoing monitoring and follow-up services for veterans placed in these facilities. The handbook updates new approaches to CNH oversight, first introduced in 2002, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

TABLE 3. LTC—ADC VA'S COMMUNITY NURSING HOME PROGRAM

2004	4,302
2005	4,254
2006	4,395
Increase/(Decrease)	141

(NOTE: ADC for 2006 is an unaudited number at this time.)

TABLE 4. LTC— ADC STATE VETERANS' HOMES

2004	17,328
2005	17,794
2006	17,747
Increase/(Decrease)	(47)

(NOTE: ADC for 2006 is an unaudited number at this time.)

State Veterans' Homes

The state veterans' home program currently encompasses 130 nursing homes in 50 states and Puerto Rico. According to the GAO, half of VA's total nursing home workload in FY 2003 was provided in state veterans' homes. Dramatic reductions in the state veterans' home ADC were prevented when Congress refused to enact dramatic cuts to this program's budget as proposed by VA in its 2006 budget request. VA's projected ADC for state veterans' homes, under its proposed 2006 budget, would have fallen to 7,217 in 2006. VA now projects a state veterans' home ADC rate of 17,747 for 2006. VA's proposed 2006 long-term-care budget cuts would have decreased the state veterans' home ADC in 2006 by 10,530.

Fortunately, Congress realized the ramifications of VA's proposed 2006 long-term-care budget and its negative impact upon elderly veterans. VA's proposed 2006 long-term-care budget would have hurt veterans. The proposed 2006 VA budget also reflected little VA business acumen in light of GAO findings (GAO-05-65) that reported VA pays about one-third the cost of care in state veterans' nursing homes.

In 2005 the ADC for state veterans' homes represented 52 percent of VA's total nursing home workload. Veterans are concerned about VA's desire and ability to meet increasing demand for nursing home care because of previous proposed cuts to the state veterans' home program and because of the downward VA nursing home average daily census spiral.

The GAO is similarly concerned about VA's nursing home program. In its November 2004 report (GAO-05-65) the GAO pointed out several problems that prevent VA from having a clear understanding of its programs effectiveness. The GAO recommended that VA collect and report data for community nursing homes and state veterans' nursing homes on the numbers of veterans that have long and short stays. GAO also recommended that VA collect data on the number of veterans in these homes that VA is required to serve based on the requirements of the Veterans Millennium Health Care and Benefits Act, P.L. 106-117. The GAO believed that this information would assist VA to conduct adequate monitoring and planning for its nursing home care program.

Congress has shown its concern about VA's long-term-care planning as evidenced by its rejection of VA's proposals to halt construction and reduce per diem funding to state veterans' homes and to repeal nursing home capacity mandate under P.L. 106-117. Also, in July of 2005, Congress was asked to provide VA with an additional $1.997 billion for higher that expected health-care needs. Of this amount, $600 million was to be used to correct for the estimated cost of long-term care (VA press release July 14, 2005). Most recently, Congress has directed VA to develop a strategic plan for long-term care.

VA's lack of appropriate workload information gathering and data analysis has placed it in a weak position to do effective planning for the immediate and future long-term-care needs of America's veterans. While VA can only advise Congress about the program requirements necessary to meet these needs, it is its duty to do so. The Department of Veterans Affairs should be the advocate for veterans' long-term-care needs, not just the provider.

VA Noninstitutional Care

VA offers a spectrum of noninstitutional long-term-care services to veterans enrolled in its health-care system. In fiscal year 2003, 50 percent of VA's total long-term-care patient population received care in noninstitutional care settings. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, home respite care, home hospice care, and community residential care.

In recent years VA has been increasing its noninstitutional (home and community-based) budget and services. However, more needs to be done in this area. VA must take action to ensure that these programs, mandated by the P.L. 106-117, are available in each VA network. In May of 2003, the GAO (GAO 03-487) reported: "VA service gaps and facility restrictions limit veterans' access to VA non-institutional care." The report stated that of the 139 VA facilities reviewed, 126 do not offer all of the six services mandated by the P.L. 106-117. In order to eliminate these service gaps, VA must survey each VA network to determine that all of its noninstitutional services are operational and readily available.

The Independent Budget supports the expansion of VA's noninstitutional long-term-care services and also supports the adoption of innovative approaches to expand this type of care. Noninstitutional long-term-care programs can sometimes obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost effective and extremely popular. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

TABLE 5. LTC— ADC FOR VA NONINSTITUTIONAL CARE PROGRAMS PREVIOUSLY REPORTED BY VA

	2004	2005	2006	Increase/ (Decrease)
Home-based Primary Care	9,825	11,594	12,641	1,047
Contract Skill Home Care	2,606	3,075	2,490	(585)
VA/Contract Adult Daycare	1,493	1,762	1,304	(458)
Homemaker Health Aid Services	5,580	6,584	5,867	(717)
Community Residential Care	5,771	6,810	3,692	(3,118)
Home Respite	84	99	118	19
Home Hospice	164	194	427	233
Total Noninstitutional Care Programs	**25,523**	**30,118**	**26,539**	**(3,579)**

(NOTE: ADC for 2006 is an unaudited number at this time.)

Future Directions

The face of long-term care is changing, and VA continues to work within resource limitations to provide variations in programming that meets veterans' needs and choices. VA can be expected to modify existing programs and develop new alternatives as financial resources allow. New horizons for VA long-term care include the following:

- Continue "culture change" transformation to make nursing homes more homelike.
- Continued expansion of hospice and palliative care so VA can care for veterans and respect their choices for care at the end of life.
- Integration of young combat injured veterans into appropriately suited VA's long-term-care programs.
- Implementation, nationally, of a medical foster home program, that would provide veterans who can no longer safely reside in their own homes a homelike environment in their communities.
- Continued expansion of access to noninstitutional home and community-based care. VA's intent is to provide care in the least restrictive setting that is appropriate for the veteran's medical condition and personal circumstances.
- Further collaboration between the Geriatrics and Extended Care programs and those of the Office of Care Coordination/Home Telehealth to provide services that are tailored to an individual veteran's needs.

VA's Care Coordination Program

VA has been investing in a national care coordination program for the past three years. The program applies care and case management principles to the delivery of health care services with the intent of providing veterans the right care in the right place at the right time. Veteran patients with chronic diseases, such as diabetes, heart failure, post-traumatic stress disorder, and chronic pulmonary disease, are now being monitored at home using telehealth technologies.

Care coordination takes place in three ways: in veterans' homes, using home telehealth technologies; between hospitals and clinics, using videoconferencing technologies; and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2 to 3 percent of patients who are frequent clinic users and require urgent hospital admissions. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse or a social worker but other practitioners can provide the support necessary. There are also physicians who care-coordinate complex patients.

As veterans age and need treatment for chronic diseases VA's care coordination program has the ability to monitor a veteran's condition on a daily basis and provide early intervention when necessary. This early medical treatment can frequently reduce the incidence of acute medical episodes and in some cases prevent or delay the need for institutional or long-term nursing home care.

As America's aging veteran population grows older and older, care coordination will be a useful tool in VA's long-term-care arsenal that can enable aging veterans to remain at home or close to home as long as possible. Congress must assist VA in expanding this valuable program across the entire VA health-care system.

VA Long-Term Care for Veterans with Spinal Cord Injury/Disease (SCI/D)

Both institutional and noninstitutional VA long-term-care services designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with SCI/D are especially vulnerable and require a high degree of long-term and acute care coordination.

A major issue of concern is the fact that a recent VA survey indicated that in FY 2003 there were 990 veterans with SCI/D residing in non-SCI/D designated VA nursing homes. However, VA cannot identify the exact locations of these veterans. The special needs of these veterans often go unnoticed and are only discovered when the patient requires admission to a VA medical center for treatment.

VA must develop a program to locate and identify veterans with SCI/D who are receiving care in non-SCI/D designated long-term-care facilities and ensure that their unique needs are met. In addition, these veterans must be followed by the nearest VA SCI center to ensure they receive the specialized medical care they require. Veterans with SCI/D who receive VA institutional long-term-care services require specialized care from specifically trained professional long-term-care providers in an environment that meets their accessibility needs.

Currently, VA operates only four designated long-term-care facilities for patients with spinal cord injury or disease, and none of these facilities are located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility, Chicago, Illinois (28 staffed beds); and Castle Point, New Jersey (16 staffed beds). Unfortunately, these limited staffed (121 total) beds are usually filled, and there are waiting lists for admittance. These four VA SCI/D long-term-care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA Capital Assets Realignment for Enhanced Services (CARES) initiative has called for the creation of additional long-term-care beds in four new locations (30 in Tampa, Florida; 20 in Cleveland, Ohio; 20 in Memphis, Tennessee; and 30 in Long Beach, California), these additional services are not yet available and would provide only 30 beds west of the Mississippi River. These new CARES long-term-care beds present an opportunity for VA to refine the paradigm for SCI/D long-term-care facility design and to develop a new SCI/D long-term-care staff training program. Additionally, VA is currently working with the Paralyzed Veterans of America to create an SCI/D long-term-care handbook that will identify the operational policies of SCI/D long-term care.

RECOMMENDATIONS:

VA must develop a strategic plan for long-term care that meets the current and future needs of America's veterans.

Congress must hold appropriate long-term-care hearings to learn the specific issues of concern for aging veterans. The information gleaned from these hearings must be used by VA as it moves forward in the development of a comprehensive strategic plan for long-term care.

Congress must provide the financial resources for VA to implement its long-term-care strategic plan.

VA must abide by P.L. 106-117's ADC capacity mandate for VA nursing home care and Congress must enforce its own requirement.

VA and Congress must continue to provide the construction/repair and per diem funding necessary to support state veterans' homes. Even though Congress has approved full long-term-care funding for eligibles in state veterans' homes under P.L. 106-117, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure.

VA must do a better job of tracking the quality of care provided in VA contract community nursing homes.

VA must increase its capacity for noninstitutional, home, and community-based care, including assisted living.

VA must ensure that each noninstitutional program mandated by P.L. 106-117 is operational and available across the entire VA health-care system.

Serious geographical gaps exist in specialized long-term-care services for veterans with spinal cord injury or spinal cord disease. As VA develops its strategic plan for long-term care, it must include provisions to provide specialized nursing home capacity throughout the entire country. VA must start by implementing the CARES SCI/D long-term-care recommendations.

VA must develop a mechanism to locate and identify veterans with SCI/D residing in non–SCI/D long-term-care facilities.

VA should develop a VA nursing home care staff training program for all VA long-term-care employees who treat veterans with SCI/D.

VA must move forward in modifying its nursing home programs to meet the needs of younger combat-injured veterans.

ASSISTED LIVING

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living (ADLs) or the instrumental activities of daily living (IADLs). Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, Secretary Principi forwarded a VA report to Congress concerning the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by the Mill Bill. The Assisted Living Pilot Program (ALPP) was carried out in VA's Veterans Integrated Service Network (VISN) 20. VISN-20 includes Alaska, Washington, Oregon, and the western part of Idaho.

VA's ALPP was implemented in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Oregon; Roseburg, Oregon; White City, Oregon; Spokane, Washington; and Puget Sound Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

VA's report on the overall assessment of the ALPP stated: *"The ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."*

Some of the main findings of the ALPP report include:

- *ALPP veterans showed very little change in health status over the 12 months post-enrollment.* As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that the ALPP may have helped maintain veterans' health over time.

- *The mean cost per day for the first 515 veterans discharged from the ALPP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.*

- *The mean cost to VA for a veteran's stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.*

- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.

- *The average ALPP veteran was a 70-year-old unmarried white male who was not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.*

- *ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment:* 22 percent received assistance with between four and six ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with one to three ADLs; while 35 percent received no assistance.

- *Case managers helped ALPP veterans apply for VA Aid and Attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.*

- *Veterans were very satisfied with ALPP care.* The highest overall scores were given to VA case managers (mean: 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82).

- *Vendors are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).*

- *Case managers were very satisfied with ALPP.* Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall in between the cracks."

Secretary Principi's cover letter that conveyed the ALPP report to Congress stated that VA is not seeking authority to provide assisted living services, believing this is primarily a housing function. The authors of *The*

Independent Budget (IB) disagree and believe that housing is just one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is just part of the mix. VA already provides housing in its domiciliary and nursing home programs, and an assisted living benefit should not be prohibited by VA on the basis of its housing component.

■ CARES and Assisted Living

Secretary Principi's final CARES decision document and the VA's CARES Commission recommended utilizing VA's enhanced-use leasing authority as a tool to attract assisted living providers. The enhanced-use lease program can be leveraged to make sites available for community organizations to provide assisted living in close proximity to VA medical resources. The Fort Howard, Maryland, project is a good example of a partnership between a private developer and VA.

The authors of *The Independent Budget* concur with this CARES recommendation and the application of VA's enhanced-use lease program in this area. However, the IB authors believe that any type of VA enhanced-use lease agreement for assisted living, or any other projects must be accompanied with the understanding that veterans have first priority for care or other use.

RECOMMENDATIONS:

While assisted living is not currently a benefit that is available to veterans, even though some veterans have eligibility for nursing home care, the authors of *The Independent Budget* believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care.

VA's ALPP report seems most favorable and appears to be an unqualified success. However, *The Independent Budget* authors believe that to gain further understanding of how the ALPP program can benefit veterans, it should be replicated in at least three VISNs with a high percentage of elderly veterans.

▼ ▼ ▼

VA MEDICAL AND PROSTHETIC RESEARCH

Funding for Medical and Prosthetic Research:

Funding for Department of Veterans Affairs (VA) Medical and Prosthetic Research is inadequate to support the full range of programs needed to meet current and future health challenges facing veterans. Additionally, VA's aging research facilities are in urgent need of renovations and repairs.

VA medical care is touted as an industry leader—its dynamic transformation to this position validated by consistent scores higher than the private sector in patient satisfaction surveys, a cost efficiency with better health outcomes, and cutting-edge information technology. But this success could not have been realized without the premier research program that the VA administers. VA medical and prosthetic research is a national asset that attracts high-caliber clinicians to practice medicine and conduct research in VA healthcare facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately benefits all Americans.

VA research is patient oriented, focusing entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population. More than three-quarters of VA researchers are clinicians that provide direct patient care to veterans. As a result, the Veterans Health Administration, as the largest integrated medical care system in the world, has a unique ability to translate progress in medical science directly to improvements in clinical care.

VA leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other federal research funding agencies, for-profit industry partners, nonprofit organizations, and academic affiliates. This highly successful enterprise demonstrates the best in public-private cooperation. However, a commitment to steady and sustainable growth in the annual research and development appropriation is necessary for maximum productivity.

For decades, VA has failed to request—and Congress has failed to mandate—construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in need of minor and major construction funding and researchers are often stymied by the lack of state-of-the-art facilities. Cutting-edge research demands cutting-edge facilities. Congress and VA must work together to establish a funding mechanism designated for research facility maintenance and improvements until this backlog is addressed.

MEDICAL AND PROSTHETIC RESEARCH

(In Thousands)

FY 2007	$412,000
FY 2008 Administration Request	$411,000
FY 2008 *Independent Budget* Recommendation	$480,000

Medical and Prosthetic Research Account:

Inadequate funding has jeopardized VA Research and Development's status as a national leader. Significant growth in the annual Research and Development appropriation is necessary to continue to achieve breakthroughs in health care for its current population and to develop new solutions for its most recent veterans.

The Department of Veterans Affairs (VA) strives for improvements in treatments for conditions long prevalent among veterans such as diabetes, spinal cord injury, substance abuse, mental illnesses, heart diseases, infectious diseases, and prostate cancer. VA is equally obliged to develop better responses to the grievous conditions suffered by veterans of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF), such as extensive burns, multiple amputations, compression injuries, and mental stress disorders. These returning OEF/OIF veterans have high expectations for returning to their active lifestyles and combat. The seamless mental and physical reintegration of these soldiers is a high priority, but still a difficult challenge that the VA Research program can address.

Despite high productivity and success, funding for VA medical and prosthetic research has not kept pace with other federal research programs or with funding for VA medical care. The VA research program has done an extraordinary job leveraging its modest $412 million appropriation into a $1.7 billion research enterprise that hosts multiple Nobel laureates and produces an exceedingly competitive number of scientific papers annually. VA research awards are currently capped at $125,000, significantly lower than comparable federal research programs. However, VA investigators would be unable to compete for additional funding from other federal sources without the initial awards from the Medical and Prosthetic Research Account.

VA has a distinctive opportunity to recreate its health-care system and provide progressive and cutting-edge care for veterans through genomic medicine. As the largest integrated health-care system in the world with an advanced and industry-leading electronic health record system and a dedicated population for sustained research, ethical review, and standard processing, VA is the obvious choice to lead advances in genomic medicine. Innovations in genomic medicine will allow VA:

- to reduce drug trial failure by identifying genetic disqualifiers and allowing treatment of eligible populations;
- to track genetic susceptibility for disease and develop preventative measures;

- to predict response to medication; and
- to modify drugs and treatment to match an individual's unique genetic structure.

Additional increases are necessary for continued support of new initiatives in neurotraumas, including head and cervical spine injuries; wound and pressure sore care; pre- and post-deployment health issues with a particular focus on post-traumatic stress disorder; and the development of improved prosthetics and strategies for rehabilitation from polytraumatic injuries.

The projected biomedical research and development inflation index (BRDPI) for FY 2007 is 3.4 percent, which necessitates a $14.008 million increase over FY 2007 funding. To ensure that VA Research continues to attract high-caliber investigators, annual award amounts must be reevaluated and adequately increased to compete with other federal research programs. The IBVSOs recommend a phased increase to accommodate the significant costs associated with updating this cap. In FY 2008, Congressional direction to increase the award limit accompanied by adequate funding so as not to reduce awards will demonstrate our nation's commitment to researchers working to help veterans.

The new VA genomic medicine project represents a monumental advancement in the future of the VA Medical and Prosthetic Research program and in the future of America's health-care system. This endeavor will require sustained increases for VA research funding in the coming years. A VA pilot program involving 20,000 individuals and 30,000 specimens provides estimates that approximately $1,000 will be necessary for each specimen. The estimated costs for VA's genomic pilot program and support for current research endeavors complete the additional funding request of *The Independent Budget* recommendations.

RECOMMENDATION:

The Independent Budget veterans service organizations (IBVSOs) recommend an FY 2008 appropriation of at least $480 million. This appropriation offsets the higher costs of established research resulting from biomedical inflation and wage increases.

▼ ▼ ▼

Research Facilities Consistent with Scientific Opportunity:

Many Department of Veterans Affairs (VA) research facilities are outdated and in need of repair or renovation.

In May 2004, Secretary of Veterans Affairs Anthony J. Principi approved the Capital Asset Realignment for Enhanced Services (CARES) Commission report that called for implementation of the VA Under Secretary of Health's Draft National CARES Plan for VA research. This plan recommended $87 million to renovate existing research space.

In House Report 109-95 providing appropriations for FY 2006, Congress expressed concern that "equipment and facilities to support the research program maybe be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." It noted, "more resources may be required to ensure that research facilities are properly maintained to support the Department's research mission." To assess VA's research facility needs, Congress directed VA to conduct a comprehensive review of its research facilities and report to Congress on the deficiencies found, along with suggestions for correction.

In anticipation of the completion of this report, the House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs proposed $12 million dedicated to renovating and upgrading VA medical research facilities within the Minor Construction budget. *The Independent Budget* veterans service organizations believe Congress should establish and appropriate a funding stream specifically for research facilities, using the VA assessment to ensure that amounts provided are sufficient to meet both

immediate and long-term needs. Congress should also use the VA report as the basis for prioritizing allocation of such funding to ensure that the most urgent needs are addressed first. For these purposes, *The Independent Budget* recommends $45 million.

RECOMMENDATIONS:

Congress should establish and appropriate a funding stream specifically for research facilities, using the VA assessment to ensure that amounts provided are sufficient to meet both immediate and long-term needs.

Congress should also use the VA report as the basis for prioritizing allocation of $45 million to ensure that the most urgent needs are addressed first.

▼ ▼ ▼

Attracting and Retaining a Quality VHA Nursing Workforce:

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis.

NURSING WORKFORCE

The Veterans Health Administration (VHA) has the largest nursing workforce in the country with nearly 61,000 employees in nursing, including registered nurses (RNs), licensed practical nurses (LPNs), and other nursing personnel. Maintaining a strong nursing workforce is essential to providing high-quality health care to our nation's sick and disabled veterans. Unfortunately, the country at large is continuing to experience a shortage of nursing personnel. Likewise, VHA staffing levels are frequently so marginal that any loss of staff can result in a critical staffing shortage and present significant clinical challenges. Staffing shortages can result in the cancellation or delay of surgical procedures and closure of intensive care beds. It also can cause diversions of veterans to private sector facilities at great cost. This situation is complicated by the fact that the Department of Veterans Affairs (VA) has downsized inpatient capacity in an effort to provide more services on an outpatient/ambulatory basis. The remaining inpatient population is generally sicker, has lengthier hospital stays, and requires more skilled nursing care.

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis. Because the VA health-care budget has not kept up with rising health-care costs, the situation grows more critical each fiscal year. Inadequate funding has resulted in sporadic hiring freezes across the country. These hiring freezes have had a negative impact on the VA nursing workforce as nurses have been forced to assume non-nursing duties due to shortages of ward secretaries and other key support personnel. These staffing deficiencies impact both patient programs and VA's ability to retain an adequate nursing workforce.

National Commission on VA Nursing

VHA's Succession Strategic Plan for Fiscal Year (FY) 2006–2010 states, "VHA faces significant challenges in ensuring it has the appropriate workforce to meet current and future needs. These challenges include continuing to compete for talent as the national economy changes over time and recruiting and retaining health care workers in the face of significant anticipated workforce supply and demand gaps in the health care sector in the near future. These challenges are further exacerbated by an aging federal workforce and an increasing percentage of VHA employees who receive retirement eligibility each year."

Like other health-care employers, VHA must actively address those factors known to affect retention of nursing staff: leadership, professional development, work environment, respect and recognition, and fair compensation. In addition, it is essential adequate funds are appropriated for recruitment and retention programs for the nursing workforce.

In 2002, the National Commission on VA Nursing was established through Public Law 107-135 and charged to consider and recommend legislative and organizational policy changes that would enhance the recruitment and retention of nurses and other nursing personnel and address the future of the nursing profession within the Department of Veterans Affairs (VA). The commission developed the desired future state for VHA nursing and recommendations to achieve that vision.

The executive summary of the commission report states:

> Providing high quality nursing care to the nation's veterans is integral to the mission of the Department of Veterans Affairs. The current and emerging gap between the supply of and the demand for nurses may adversely affect the VA's ability to meet the healthcare needs of those who have served our nation. The men and women of the uniformed services who have defended our nation's freedoms in global conflicts deserve the best treatment our nation can provide. Nurses comprise the largest proportion of healthcare providers in the Department of Veterans Affairs. Action is required now to address underlying issues of nursing shortage and retention while simultaneously implementing strategies that assure the availability of a qualified nursing workforce to deliver care and promote the health of America's veterans in the future.

Simultaneously, the Office of Nursing Service developed a strategic plan to guide national efforts to advance nursing practice within VHA and engage nurses across the system to participate in shaping the future of VA nursing practice. This strategic plan embraces six patient-centered goals. These goals encompass and address many of the recommendations of the VA Nursing Commission, as well as the findings in current literature.

1. **Leadership Development:** This goal focuses on supporting and developing new nurse leaders and creating a pipeline to continuously "grow" nursing leaders throughout the organization. The objective is to operationalize the High Performance Development Model for all levels of nursing personnel. This goal also addresses issues related to the nursing Professional Qualification Standards and the Nurse Professional Standards Board as discussed in the commission report.

2. **Technology and System Design:** This goal focuses on creating mechanisms to obtain and manage clinical and administrative data to empower decision making. The objective is to develop and enhance systems and technology to support nursing roles. The commission report highlighted the importance of nursing input in the development stage of new technologies for patient care.

3. **Care Coordination and Patient Self-Management:** This strategic goal focuses on promoting and recognizing innovations in care delivery and facilitating care coordination and patient self-management. The objectives are to strengthen nursing practice for the provision of high-quality, reliable, timely, and efficient care in all settings and to enhance the use of evidence-based nursing practice. This goal also encompasses recommendations from the commission related to the work environment of VA nurses.

4. **Workforce Development:** This goal focuses on improving the recognition of and opportunities for the VA nursing workforce. Areas of emphasis are as follows:

   - utilization: to maximize the effective use of the available workforce;
   - retention: to retain a qualified and highly skilled nursing workforce;
   - recruitment: to recruit a highly qualified and diverse nursing staff into the VHA; and
   - outreach: to improve the image of nursing and promote nursing as a career choice through increased collaboration with external partners.

This goal also includes an emphasis on the importance of striving for the values exhibited by the philosophy of the Magnet Recognition Program of the American Nurses Credentialing Center. The commission report addresses all of these areas as critical to the future of VA nursing.

5. **Collaboration:** This goal focuses on forging relationships with professional partners within VA, across the federal community, and in public and private sectors. The objective is to strengthen collaborations in order to leverage resources, contribute to the knowledge base, offer consultation, and lead the advancement of the profession of nursing for the broader community. The priorities of this goal align with VHA's Vision 2020 and the commission recommendations related to collaboration and professional development.

6. **Evidence-Based Nursing Practice:** This goal focuses on identifying and measuring key indicators to support evidence-based nursing practice. The objective is to develop a standardized methodology to collect data related to nursing-sensitive indicators of quality, workload, and performance within VHA facilities, which will be integrated into a standardized national database. The commission report applauded VA's progress to date related to this goal.

The VHA, in its assessment of current and future workforce needs, identifies RNs as the number one priority in recruitment, with LPNs and nursing assistants also among the top 10 occupations with critical recruitment needs. Recommendations from this workforce assessment include implementing the commission's recommendations, enhanced new employee induction programs, and supervisory training. Additionally, the plan recommends continuing support of employee education programs, implementation of new initiatives for student (including high school outreach) recruitment, and improving the retention of trainees as permanent employees. Finally, the VHA recommends the continuing need to maintain a national recruitment program with innovative approaches and effective outcomes.

The Independent Budget veterans service organizations support the commission's recommendations, the VA's Office of Nursing Service's strategic plan, and the *VHA Workforce Succession Strategic Plan FY 2006–2010 (October 2005)*. We strongly urge Congress to develop a budget for VA health care that will allow the VHA to invest resources—human, fiscal, and technological—for recruiting and retaining nurses and proactively testing new and emerging nursing roles. The commission's legislative and organizational recommendations are a blueprint for the reinvention of VA nursing. The VA model will serve as a foundation for the creation of a care delivery system that meets the needs of our nation's sick and disabled veterans and those providing their care.

In an attempt to address issues impacting registered nurses in the workplace, the Nurses Organization of Veterans Affairs (NOVA), a professional organization of more than 35,000 RNs employed by VA, conducts a biennial survey of its membership. The 2005 membership survey identified an adequate budget for the VHA as the legislative issue most important to NOVA members, followed by patient safety, locality pay, and the nursing shortage.

Members identified their greatest challenges as computerized charting and adequate computers. Respondents noted that problems with bar code medication administration equipment can lead to frustration with this technology, although it has reduced medication errors. NOVA nurses identified salaries competitive with the private sector as having the highest impact on recruitment, followed by flexible work schedules and adequate staffing. Because many VA nurses are eligible to retire now, or will become eligible in the next five years, the top enticement to stay in VHA nursing was flexible working hours. Only 37.5 percent of NOVA members believed VHA nursing salaries to be competitive with the private sector, and even fewer, 20.4 percent, indicated their facility would meet the criteria for Magnet Hospital designation. Last, the survey included several questions about the legislative process. Educating legislators was identified as important for improving the image of VA nursing.

RECOMMENDATIONS:

VA should establish recruitment programs that enable the VHA to remain competitive with private sector marketing strategies.

Congress must provide sufficient funding to support programs to recruit and retain critical nursing staff.

ADMINISTRATIVE ISSUES

Volunteer Programs:

The Veterans Health Administration (VHA) volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

Since its inception in 1946, the Department of Veterans Affairs Voluntary Service (VAVS) has donated in excess of 677.7 million hours of volunteer service to America's veterans in the Department of Veterans Affairs (VA) health-care facilities. As the largest volunteer program in the federal government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee composed of 60 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and seven of their subordinate organizations, which report to the VA Under Secretary for Health.

With the recent expansion of VA health care for patients in a community setting, additional volunteers have become involved. They assist veteran patients by augmenting staff in such settings as hospital wards, nursing homes, community-based volunteer programs, end-of-life care programs, foster care, and veterans' outreach centers.

During FY 2006, VAVS volunteers contributed a total of 12,411,687 hours to VA health-care facilities. This represents 5,967 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $234.8 million if VA had to staff these volunteer positions with FTEEs.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The annual contribution made to VA is estimated to be $50.4 million. These significant contributions allow VA to assist direct patient care programs, as well as support services and activities that may not be fiscal priorities from year to year.

Monetary estimates aside, it is impossible to calculate the amount of caring and sharing that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers is increasing dramatically as additional demands are being placed on VA staff. Health care is changing, which means there is opportunity for new and nontraditional roles for volunteers. New services are also expanding through community-based outpatient clinics that create additional personnel needs. It is vital that the VHA keep pace with utilization of this national resource.

At national cemeteries, volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on graves for Memorial Day and Veterans Day. More than 381,000 hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

RECOMMENDATION:

VHA facilities should designate a staff person with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.

Contract Care Coordination:

The Department of Veterans Affairs (VA) should ensure an integrated program of continuous care and monitoring for veterans who receive at least some of their care from private, community-based providers at VA expense.

Current law authorizes VA to contract for non-VA health care (on a fee or contract basis) and scarce medical specialists only when VA facilities are incapable of providing necessary care to veterans, when VA facilities are geographically inaccessible to veterans, and in certain emergency situations. *The Independent Budget* veterans service organizations (IBVSOs) agree that contract care should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans who are enrolled in VA care. We have consistently opposed proposals seeking to contract for health care provided by non-VA providers on a broader basis than this. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serving larger veteran populations, ultimately only serve to dilute the quality and quantity of VA services for new as well as existing veteran patients.

Currently VA spends approximately $2 billion each year on purchased care outside the walls of VA. Unfortunately, VA is not able to track this care, its related costs, outcomes, or veteran satisfaction levels, and VA has no consistent process for veterans receiving contracted-care services to ensure that:

- effective care is delivered by certified, fully licensed or credentialed providers;
- continuity of care is properly monitored by VA and that patients are directed back to the VA health-care system for follow-up when necessary;
- veterans' medical records are properly updated with contract provider and pharmaceutical information; and
- the process is part of a seamless continuum of services to facilitate improved health status and veterans' access to necessary care.

To ensure a full continuum of health-care services, it is critical that VA implement a program of contract care coordination that includes integrated clinical, record, and claims information for veterans referred to community-based providers at VA expense. Preferred pricing allows VA medical facilities to save money when veterans use non-VA medical services by receiving network discounts through a preferred pricing program. However, VA currently has no system in place to direct veteran patients to any participating preferred provider network (PPO) providers so that VA could:

- receive a discounted rate for the services rendered;
- use a mechanism to refer patients to credentialed and certified providers; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VA medical centers (VAMCs), when a veteran inadvertently uses a PPO provider, not all facilities have taken advantage of the cost savings that are available to them. Therefore, in many cases, VA has paid more for contracted medical care than is required. We are pleased that, in response to this realization, the VA made participation in the Preferred Pricing Program mandatory for all VAMCs beginning in October 2005. As a result of mandatory facility participation, VA will likely yield $34.9 million in savings for fiscal year 2007. Despite the significant overall savings achieved through this program (more than $65 million to date), there are several major changes that can be made to improve the access, quality, and cost of contracted VA care.

The Preferred Pricing Program is the foundation upon which a more proactive managed care program should be established that will not only save significantly more money in the purchased care programs, but, more important, will provide VHA a mechanism to fully integrate veterans' community-provided medical care into the VHA health-care system. By partnering with an experienced managed-care contractor, VA can define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value.

Components of the program should include the following:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks should address timeliness, access, and cost-effectiveness. Additionally, the care coordination contractor should require providers to meet specific requirements, such as the timely communication of clinical information to VA, proper and timely submission of electronic claims, meeting VA established access standards, and complying with director's performance standards.

- Customized care management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical needs, the care coordination contractor addresses both appropriateness of care and continuity of care. The result could be a truly integrated seamless health-care delivery system.

- Improved veteran satisfaction through integrated, efficient, and appropriate health-care delivery across VA and non-VA components of the continuum of care.

- Optimized workload for VA facilities and affiliates while costs for non-VA care are better controlled.

Currently, many veterans are disengaged from the VA health-care system when receiving medical services from private nonparticipating physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to medical care through coordination of private contracted community-based care. The IBVSOs believe it is important for VA to develop an effective care coordination model that achieves its health-care and financial objectives. Doing so will improve patient care quality, optimize the use of VA's increasingly limited resources, and prevent overpayment when utilizing community contracted care.

Current law allows VA to contract for non-VA health-care (on a fee basis) and scarce medical specialty contracts only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, and in certain emergency situations. The IBVSOs support a limited VA contract care coordination effort that includes integrated clinical and claims information for veterans referred to community-based providers at VA expense.

However, VA contracted care should be used judiciously in the specific circumstances mentioned so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans. The IBVSOs have consistently opposed proposals seeking to contract out health care provided by non-VA providers on a broad basis. Such proposals, ostensibly seeking to expand VA health-care services into broader areas serving additional veteran populations, in the end only dilute the quality and quantity of VA services for new as well as existing veterans.

Approximately one year ago VA announced "Project HERO," and indicated its goal to be consonant with the ideas expressed by the IBVSOs in improving VA contract care coordination. On closer examination, we concluded this initiative to be ill-considered and potentially dangerous to the continued integrity and availability of specialized health-care services within the VA system. Accordingly we opposed that project, and it was withdrawn. Recent information provided by VA on a new initiative to improve contracting for veterans' care outside VA facilities seems pointed in a direction consistent with our views on this topic. We look forward to further developments in this initiative and will support it to the extent it remains consistent with our goals while neither expanding the gross level of contract care nor eroding the quality of health-care services available within VA facilities for sick and disabled veterans.

RECOMMENDATIONS:

VA should establish a phased-in, contracted care coordination program that incorporates the preferred pricing program discussed above and is based on principles of sound medical management.

Veterans who receive care outside VA, at VA expense and authorization, should be required to participate in the care coordination model. This program should be tailored to VA and veterans' specific needs.

Contract care should be used judiciously and only in specific circumstances when VA facilities are incapable of providing the necessary care, are geographically inaccessible to the veteran, and in certain emergency situations, and should be managed so as

not to endanger VA facilities' ability to maintain a full range of specialized inpatient and outpatient services for all enrolled veterans.

VA should engage an experienced contractor willing to go "at risk" to implement and manage a care coordination program that will deliver improvements in medical management, access, timeliness, and cost efficiencies. VA and the contractor should jointly develop identifiable measures to assess program results and share these results with stakeholders, including the IBVSOs. Care should be taken to ensure inclusion of important affiliates in this program.

The components of a care coordination program should include claims processing, medical records management, and centralized appointment scheduling. VA should also implement a call center or advice line for veterans who are referred outside the VA health-care system for consultations and specialized care.

Federal Supply Schedule for Pharmaceuticals:

The Department of Veterans Affairs (VA) must maintain and protect the ability to achieve pharmaceutical discounts through the Federal Supply Schedule for Pharmaceuticals (FSS-P).

A number of states and the District of Columbia have recently considered legislation that would tie Medicaid drug prices to the discounted prices now contained in the FSS-P. Passage of any legislation mandating that FSS-P pricing be opened to Medicaid programs could threaten VA's ability to receive discounted pricing because vendor contracts contain a clause allowing their cancellation in this event. Legislation considered during recent sessions of Congress that would tie the new Medicare Part D Prescription Drug Benefit to the FSS-P and VA drug discounts by referencing these reduced prices as a target for obtaining Part D drugs, is of even greater concern.

Prior experience, most notably with Medicaid drug provisions contained in the Omnibus Budget Reconciliation Act of 1990 (PL 101-508), has demonstrated that if these types of legislative initiatives are enacted, VA's pharmaceutical discounts could be diluted and costs increased, harming both the VA health-care system and veterans.

Under the FSS-P, VA purchases, on behalf of itself and other federal entities through contracts with responsible vendors, approximately 24,000 pharmaceutical products annually. These purchases are made at discounts ranging from 24 to 60 percent below drug manufacturers' most favored nonfederal, nonretail customer pricing. Since VA's pharmaceutical purchases are now roughly $4 billion annually, the loss of these discounts would dramatically increase the costs of pharmaceuticals, as well as the cost of providing care, to an already underfunded health-care system. These added costs could also be passed on to veterans in the form of dramatically higher copayments.

RECOMMENDATION:

Congress and the Administration need to address pharmaceutical cost-related issues in a manner that does not result in a reduction of veterans' benefits or threaten discounts VA currently receives under the FSS-P.

Fee-Basis Care:

The extent of its decentralized structure, complex legislative authority, and the inadequate funding to local VA facilities for fee-basis care continue to erode the effectiveness of this necessary health-care benefit.

Fee-basis care allows eligible service-connected veterans who live in areas that are geographically inaccessible to Department of Veterans Affairs (VA) medical facilities or who need specific services unavailable at VA to use private sector clinicians at VA expense. Additionally, veterans authorized for fee-basis care generally are required to choose their own medical providers.

Veterans who are approved by VA to utilize fee-basis care are sometimes unable to secure treatment from a community provider because of VA's regulated level of payment for medical services. We are especially concerned that service-connected disabled veterans who are authorized to use fee-basis care are at times required by the only provider in their community to pay for the care up-front. In these instances, veterans must pay for the medical care they need and then seek reimbursement from VA. Furthermore, because VA pays at the Medicare rate or will at times approve only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, veterans who must pay for their care up front and then seek reimbursement from VA end up paying for part of their care.

We applaud VA for addressing existing variability in processing a fee-basis claim, which affects the timeliness to pay a claim, by initiating improvements to its business practice. While software improvements to increase program efficiency and regulatory changes to improve program effectiveness have been delayed, we believe VA leadership must continue to provide the support needed to achieve the goals of these initiatives.

RECOMMENDATIONS:

When VA preauthorizes fee-basis care for a veteran, VA should coordinate with the chosen health-care provider for both the veteran's care and payment of medical services. Service-connected veterans should not be required to negotiate payment terms with private providers for authorized fee-basis care or pay out of pocket for such services.

VA should continue to pursue the regulatory changes needed for its payment methodology to provide equitable payments for care veterans receive in the community.

With support from VA leadership, a standard business practice for efficient and timely processing of claims for fee-based care should be established.

▼ ▼ ▼

VA Physician and Dentist Pay Reform:

The Independent Budget ***veterans service organizations (IBVSOs) are concerned that Department of Veterans Affairs (VA) clinical professional and labor stakeholders were not consulted or permitted to be involved in establishing their new pay system and that the new system may not have achieved its purposes as an effective tool for recruitment and retention.***

In 2004, Congress passed the Department of Veterans Affairs Personnel Enhancement Act, Public Law 108-445. This new law reformed the pay and performance system used by VA in employment of its physicians and dentists. In 2003, in a legislative hearing before the House Committee on Veterans' Affairs, VA testified that the system was "in a critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very noncompetitive position for recruiting the staff we need today and into the future." This legislative proposal was the VA health-care system's top legislative goal for the 108th Congress. Enactment of this proposal was supported by the major veterans organizations, including the

IBVSOs, who expressed their support for VA to be given new pay authority to attract and retain the best physicians and dentists for the care of sick and disabled veterans into the future.

VA worked for more than one year to implement this significant new legislation, whose rules became effective in January 2006. This act is the most significant reform of a pay system for VA employees since the enactment of the Civil Service Reform Act in 1978, and it represents the first real change in physician pay since 1991.

Congress stated its intention for VA to work closely in conjunction with stakeholders in fashioning the new pay system. Senate Report 108-357, supporting the purposes of the act, stated: "Finally, the Committee bill requires that practicing physicians have a significant role in making recommendations to the Secretary or his or her designee as to the appropriate levels of salaries paid to members of their professions. Physicians and dentists are at the front-lines of medicine; they know what is needed to provide care for veterans. This provision advances the tradition of cooperation among labor and management in the Federal sector, particularly within the healthcare environment."

The IBVSOs remain concerned about whether VA met clear Congressional intent in that regard. Stakeholders from the VA medical, dental, and labor sectors have reported that they have not been consulted or involved in establishing the new pay system, which was completed in the summer of 2006 and established new compensation rates for 14,000 VA physicians and 700 VA dentists and oral surgeons. We have been informed that essentially none of those required consultations occurred, that some pay tiers and bands were set arbitrarily, that proposed pay reductions in some disciplines were made in direct contravention of the intent of Congress, and that a number of deserving specialties essentially received no pay adjustment as a result of implementation.

We urge VA to engage labor and professional associations that remain concerned about the new pay and performance system to ensure it gains their continuing cooperation as VA manages this new pay policy. As indicated in the Senate legislative report, VA physicians and dentists are essential caregivers, educators, and researchers in the VA health-care system. This act was intended for their benefit, to attract them to VA careers and to sustain them in providing outstanding care to veterans. We would hope these purposes would have been transparent and that VA would want to involve representatives of professions in establishing and managing their pay system. We urge VA to do so and also to examine whether additional deserving physician and dentist groups should receive additional pay in accordance with this new authority.

RECOMMENDATIONS:

The IBVSOs urge VA to actively engage labor and professional associations that remain concerned about the new pay and performance system, to ensure it gains their cooperation as VA manages and refines this approach to pay the current clinician workforce. We also urge the Secretary and Under Secretary for Health to review this program to ensure its overriding goal was in fact met—to relieve the "critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very noncompetitive position for recruiting the staff we need today and into the future."

Should the Secretary discover that the new pay system lacks essential elements to enable VA to meet its recruitment and retention goals, we recommend the Secretary propose legislation to Congress, or take regulatory action, to remedy this problem.

Challenges in VA Information Technology:

The Independent Budget ***veterans service organizations (IBVSOs) are concerned about the Secretary's decision to centralize all information technology (IT) in the Department of Veterans Affairs (VA) because of a likely deleterious impact on health-care quality.***

In *The Independent Budget for Fiscal Year 2007*, the IBVSOs expressed concern about the status of IT in VA. For years, some of VA's approaches, budgets, policies and initiatives in information technology have been controversial, wasteful, and, ultimately, unworkable. Many fell into disuse and were cancelled (i.e., "HRLinks"). One memorable initiative, "CoreFLS," collapsed amidst its trial implementation in 2003. Over a period of years, Congressional committees applied increasing pressure on VA officials to affix accountability for IT failures and waste. These efforts included demands to centralize IT budget and authority in one chief information officer (CIO) who would report to the Secretary; to apply more acute, detailed and timely reporting requirements; and, in general to provide more acute scrutiny in VA IT practices, initiatives, policies, and expenditures. The CoreFLS catastrophe triggered a number of investigations and resulted in the resignation of several officials, a shakeup of assignments, and cancellation of contracts. The CoreFLS incident brought new energy to the calls for VA IT reform.

In 2006, VA experienced a unique and disastrous event when in May it was discovered that a single laptop computer in the personal residence of a VA data analyst, which contained personal and sensitive information on the entire American veteran population and all currently serving military active duty personnel, was stolen. Although the computer and its data were subsequently recovered, and while the FBI made a determination that the sensitive data in this recovered computer had not been breached by the thieves, this incident generated new concerns about the security of personal information, not only in VA but across the federal government and large private businesses. Several committees of Congress demanded improvements in data security and data management on a large scale to prevent a recurrence in any federal department or agency of such an outrageous breach of personal information held by the government.

Soon after the theft, the former Chairman of the House Committee on Veterans' Affairs introduced legislation that would centralize information control, flow, security, planning, programming, budgeting, and resources, to a new "Under Secretary for Information Security," an official who would serve as a peer to the two existing VA Under Secretaries (for Health and Benefits). This bill, similar to a bill introduced in 2005 based on prior IT conditions in VA, quickly passed the House unanimously but generated no companion bill in the Senate.

The House and Senate Veterans' Committees approved legislation at the end of the 109th Congress that enacts some of the security and notification provisions in the latest IT bill, but the IBVSOs believe it is important to note that Congress did not agree to statutorily mandate centralization of the management of all IT in VA. Nevertheless, the VA Secretary announced late in 2006 his intention to carry forward his earlier decision to centralize the IT security function by adding to it the IT development function as an additional centrally controlled activity. Thus, as this *Independent Budget* is being presented, IT functions, resources, and personnel are being collected across the three VA administrations and numerous staff offices and are now being consolidated under one official in VA central office, the Assistant Secretary for Information Management—in effect, VA's "chief information officer." Despite the outrage expressed by many veterans service organizations over the theft of veterans' personal data, the IBVSOs remain concerned that centralizing all vital IT functions presents new challenges and may result in unfortunate consequences.

The IBVSOs acknowledge that a number of problems have plagued VA's IT programs and that better means need to be employed to keep VA from wasting resources on frivolous ideas or applications or investing in large-scale initiatives that are unsupported by the field staffs who ultimately must implement them (such as in the HRLinks and CoreFLS failures). We certainly agree that IT security, especially that involving personally identifiable records of veterans, must be paramount in VA's actions. We deplore the theft of VA computers containing sensitive data. Nevertheless, the IBVSOs are convinced that whatever course is taken to reform IT at the departmental "enterprise" level, the Veterans Health Administration's seminal accomplishments that established the world's foremost computerized patient care records system should not be compromised at the expense of central control.

The VA health-care system has been developing a unique VA computerized patient care record system for more than 30 years. The most important and lasting value of the VHA's automated system is that it was conceived and developed by VA clinical, research, and informatics specialists—those who actually deliver VA health care every day in VA facilities. The current version of this system, based on the VHA's self-developed VistA software, sets the standard for electronic medical records in the United States and has been publicly praised by the President as a model for all health-care providers. In fact, VistA, available free of charge in the public domain, is being imported into a number of U.S. and foreign health-care systems. Recently the government of West Virginia contracted with a private company to install VistA in all public hospitals in that state.

The existence of computerized patient care records enables the VHA to provide better and more efficient health care, and VistA empowers VA, uniquely, to avoid medical mistakes that are routinely made by other providers in the private and public sectors. Given that the Institute of Medicine estimates that avoidable medical mistakes cost 90,000 lives annually, it is no exaggeration to say VistA saves veterans' lives.

The VHA's health-care quality improvements over the past decade have been lauded by many independent and outside observers, including the Institute of Medicine of the National Academy of Sciences, the Joint Commission on the Accreditation of Healthcare Organizations, the National Quality Forum and the Agency for Health Care Quality, and Research of the Department of Health and Human Services. For the first time in history, mainstream media and press are reporting VA health care's high quality as news. Reports in 2006 in such publications as *Business Week and Time Magazine* have clearly documented VA's rise in quality and efficiency, in no small measure because of the advent and universal employment of VistA in VA patient care. While the IT accomplishments alone certainly did not improve VA health care, the integration of IT with VA's enrollment, laboratory, radiology, pharmacy, scheduling, personnel, logistics, management, and reporting systems has uniquely enabled VA to deliver and coordinate care as never before—and to do so at a level well beyond existing capabilities of other public and private providers. We believe the VHA's IT system is inseparable from its clinical care system.

Given the degree of success evident in the VHA, the authors of *The Independent Budget* cannot find justification for centralizing VHA IT to a non-VHA environment. One reason VHA IT has been so successful is that the Under Secretary controls and manages the IT programming and budget for the VHA, while thousands of clinical and other personnel involved in delivering direct health care also serve as software developers, subject matter experts on technical evaluation panels, and thus substantive advisors, to achieve an IT system that supports the delivery of coordinated clinical care—care that they themselves largely manage. Without IT integration to this degree, we contend that the VHA would never have been able to double patient enrollment since 1995, nor to significantly reduce the cost of care, while improving quality.

The IBVSOs do not believe a VA "data czar" can manage VHA IT with the same degree of success or with the same sensitivities that the VHA has achieved with its current approach. We feel certain that this will be true with respect to the next generation of VHA software, HealtheVet, a web-enabled system already well into its developmental and planning phase, overseen by VHA clinicians. We acknowledge that centralization of any governmental or business function can be made to save dollars; however, these dollar savings in the case of the VHA may come at a cost of eroded quality of care to sick and disabled veterans with an inevitable overlay of new bureaucracy from centralization. Removing field facility personnel, especially clinical caregivers and management personnel, from the planning and development of clinical IT could doom future developments to mediocrity and ultimate decline. We understand that the current acting Under Secretary for Health has been assigned to lead a task group in examining how to balance VHA's special clinical interests in IT versus the Secretary's decision to centralize management, development, budget, and administration of IT systemwide. We are anxious to learn how the VHA will be able to sustain its excellence in IT development in the bureaucratic environment of Washington, DC.

Dr. Jonathan C. Javitt, former IT advisor to President Bush, testified as follows at a Congressional hearing on September 28, 2005:

> The centralization of VHA's electronic health records program is likely to have a disastrous effect on the continued success of

> that program; which President Bush identified as the only place IT has really shown up in health care, a terrible effect on the morale of VA care providers; and on the system's productivity. Worst, it will damage the health of our nation's Veterans to whom we owe so much.

The IBVSOs believe Dr. Javitt's analysis is still as correct as when he stated it.

Motivated by the computer theft, the Secretary has decided to restructure IT to give a departmental CIO more authority. The Secretary retains authority to empower the current CIO with additional responsibility, including some of the ideas embedded in the arguments that would centralize IT completely. The current CIO exercises authority delegated by the Secretary and mandated by the Chief Information Officer Act codified in Title 40, United States Code. Nevertheless, VHA's relative IT independence from strong central control is a success story. We believe this unique progress should be sustained by enabling the VHA, with the Under Secretary for Health in the lead, to retain its current authority in IT planning, development, programming, operations, and budgeting for computerized patient care records systems.

The IBVSOs are concerned that total centralization would retard the creative elements that so characterize VHA's current IT environment and its future viability. VA clinicians have high motives toward investigation, research, and teaching. VHA's IT environment feeds innovation and creative applications to solve difficult and complex problems in clinical care, particularly in the university-affiliated environment. How long will such an environment be sustained if major development decisions on VHA IT are being made in Washington and managed through a centralized bureaucracy? We believe such potentially opposing forces will be difficult to reconcile.

In summary, the IBVSOs remain highly skeptical of total centralization of IT in VA, particularly for its likely deleterious impacts on the VHA, VistA and HealtheVet, and on veterans served by the VHA. We are concerned that centralization may rupture the strong, vital link that has been established between quality of VA health care and VHA IT programs supporting that quality.

RECOMMENDATIONS:

Given the recent Congressional decision to improve IT security and accountability but to decline to statutorily centralize all control over IT, VA should proceed with great caution in centralizing all aspects of information technology.

To ensure VA remains in the forefront of quality health-care providers, the VHA should be provided the means to continue investing in and refining VistA, while developing the next generation of clinical information technologies that will aid health-care delivery to the nation's veterans.

Veterans Affairs Physician Assistant:

The position of physician assistant advisor to the Under Secretary for Health should be a full-time employee equivalent (FTEE).

The Department of Veterans Affairs (VA) is the largest single federal employer of physician assistants (PAs), with approximately 1,574 PA FTEE positions. Since the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the Under Secretary of Health appoint a PA advisor to his office, VA has continued to assign this duty as a part-time field employee, as collateral administrative duties in addition to their clinical duties. *The Independent Budget* has requested for five years that this position be a FTEE within the Veterans Health Administration. In addition, in Senate Appropriations language in 2002 and again in 2003, it was requested and ignored.

The VA Under Secretary for Health has consistently refused to establish this important FTEE, and despite numerous requests from members of Congress, the veterans service organizations, and professional PA associations, VA has maintained this position as part-time, field-based with a very limited travel budget. This important occupation's representative has not been appointed to any of the major health-care VA strategic planning committees, has been ignored in the entire planning on seamless transition, and was not utilized during the emergency disaster planning and VA response to Hurricane Katrina.

PAs in the VA health-care system were the providers for approximately 8.7 million veteran visits in FY 2004; and PAs work in primary care, ambulatory care clinics, emergency medicine, and in 22 other medical and surgical specialties. PAs are a vital part of VA health-care delivery, and *The Independent Budget* supports the inclusion of a PA advisor in VA headquarters' Patient Care Services, FTEE in very close proximity to Washington, DC, which was the intent of the law. We urge Congress to enact and fund this FTEE within the budget for FY 2008 and to ensure the position is in Washington, DC.

The Independent Budget veterans service organizations fully support Congress legislatively correcting this long-standing problem.

RECOMMENDATION:

Congress should legislatively mandate the Veterans Affairs physician assistant advisor to the Under Secretary for Health as a FTEE within VA, allowing the PA consultant to become fully integrated into VHA policy management and health-care planning.

Construction Programs

The Department of Veterans Affairs (VA) construction budget has, for the past few years, been dominated by the Capital Asset Realignment for Enhanced Services (CARES) process.

CARES is a systemwide, data-driven assessment of VA's capital infrastructure. It aimed to identify the needs of veterans to aid in the planning of future and realignment of current VA facilities to most efficiently meet those needs. It was not just a one-time evaluation, but also the creation of a process and framework to continue to determine veterans' future requirements.

Throughout the entire CARES process, *The Independent Budget* veterans service organizations (IBVSOs) were highly supportive, as long as VA emphasized the "ES"—enhanced services—portion of the acronym.

CARES Timeline

- 2001—CARES pilot study in Network 12 (Chicago, Illinois; Wisconsin; and Upper Michigan) completed.
- 2002—Phase II of CARES began in all other networks of VA individually, to be compiled in the Draft National CARES Plan.
- 2003—August: Draft National CARES Plan submitted to CARES Commission to review and gather public input.
- 2004—February: VA Secretary receives CARES Commission recommendations.
- 2004—May: VA Secretary announces his decision on CARES, but calls for additional "CARES Business Plan Studies" at 18 sites throughout the country.

These CARES Business Plan Studies are available on VA's CARES website, www.va.gov/cares. As of December 2006, only 10 of these studies have been completed, despite VA's stated June 2006 deadline. The IBVSOs look forward to the final results so that implementation of these important plans can go forward.

The IBVSOs believe that all decisions on CARES should be consistent with the CARES decision document and its established priorities, or with the findings of the CARES review commission that largely confirmed those priorities. Proposed changes or deviation from the plan should undergo the same rigorous data validation as the original projects.

CARES was intended to be an apolitical, data-driven process that looked out for the best interest of veterans throughout the entire system. We are certainly pleased that the Secretary and members of Congress are interested in the future of VA capital facilities, but we urge all involved to maintain consistency with the apolitical process that, as agreed to by all parties—stakeholders included—would provide the best way to determine future VA infrastructure needs to sufficiently care for all veterans. This was the hallmark of the CARES plan.

Throughout the CARES process, the IBVSOs were greatly concerned with the underfunding of the construction budget. Congress and the Administration did not devote many resources to VA's infrastructure, preferring to wait for the final results of CARES. In past *Independent Budgets* we warned against this, pointing out that there were a number of legitimate construction needs identified by local manager of VA facilities. A number of facilities were authorized, including House passage of the "Veterans Hospital Emergency Repair Act," but funding was never appropriated, with the ongoing CARES review being used as the primary excuse.

At the time, the IBVSOs argued that a de facto moratorium on construction was unnecessary because of our conviction that a number of these projects needed to go forward and that they would be fully justified in any future plans produced through CARES. Despite this reasonable argument, funding never came, and VA lost progress on hundreds of millions of dollars that otherwise would have been invested to meet the system's critical infrastructure needs.

The IBVSOs continue to believe that this deferral of all major VA construction projects was poor policy. In the five-plus years the process took, construction and maintenance improvements lagged far beyond what the system truly needed. With CARES nearly complete, funding has not yet been proposed by the Administration nor approved by Congress to address the very large project backlog that has grown.

We note that in its final hours in December 2006, the 109th Congress enacted Public Law 109-461, an act that included authorizations for fiscal years 2006 and 2007 for a number of VA major projects and capital leases that had been backlogged, some for a number of years. While relieved by this action, the IBVSOs remain concerned that VA's construction needs are not being fully addressed by Congress or the Administration. Also, while these projects have been approved through the authorizing legislation, it is important to note that, under law, they cannot commence without specific appropriations. Given that the VA is operating on a Continuing Resolution rather than its expected regular appropriation, at the time this *Independent Budget* is being published, VA is unable to proceed with this critically needed construction.

In July 2004, VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans' Affairs. In his testimony, he noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next five years to modernize VA's medical infrastructure and enhance veterans' access to care." Since that statement, however, the amount actually appropriated by Congress for VA major medical facility construction has fallen far short of that goal; in fiscal year 2007, the administration recommended a paltry $399 million for major construction.

After that five-year de facto moratorium and without additional funding coming forth, VA facilities have an even greater need than they did at the start of the CARES process. Accordingly, we urge the Administration and the Congress to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the needs of 21st century veterans.

MAJOR CONSTRUCTION ACCOUNT

For major construction, the IBVSOs recommend $1.602 billion in funding. This includes funding for the projects on VA's priority list, advanced planning, and for construction costs for a number of new national cemeteries in accordance with the NCA strategic plan.

MAJOR CONSTRUCTION ACCOUNT RECOMMENDATIONS

Category	Funding (Dollars in thousands)
CARES	$1,400,000
Master Planning	20,000
Advanced Planning	45,000
Asbestos	5,000
Claims Analyses	3,000
Judgment Fund	2,000
Hazardous Waste	2,000
National Cemetery Administration	95,000
Staff Offices	5,000
Historic Preservation	25,000
TOTAL	**$1,602,000**

▼ ▼ ▼

MINOR CONSTRUCTION ACCOUNT

For minor construction, the IBVSOs recommend a total of $541 million, the bulk of which will go toward the more than 100 minor construction projects identified by VA in its five-year capital plan in fiscal year 2008.

MINOR CONSTRUCTION ACCOUNT RECOMMENDATIONS

Category	Funding (Dollars in thousands)
CARES/Non-CARES	$450,000
National Cemetery Administration	40,000
Veterans Benefits Administration	35,000
Staff	6,000
Advanced Planning	10,000
TOTAL	**$541,000**

▼ ▼ ▼

Inadequate Funding and Declining Capital Asset Value:

The Department of Veterans Affairs (VA) does not have adequate provisions to protect against deterioration and declining capital asset value.

The last decade of underfunded construction budgets has led to a reduction in the recapitalization of VA's facilities. Recapitalization is necessary to protect the value of VA's capital assets by renewing the physical infrastructure to ensure safe and fully functional facilities. Failure to adequately invest in the system will result in its deterioration, creating even greater costs down the road.

As in past years, we continue to cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). The PTF noted that in the period from 1996–2001, VA's recapitalization rate was 0.64 percent, which corresponds to an assumed building life of 155 years. When maintenance and restoration are factored into VA's major construction budget, VA annually invests less than 2 percent of plant replacement value in the system. The PTF observed that a minimum of 5 to 8 percent per year is necessary to maintain a healthy infrastructure and that failure to adequately fund could lead to unsafe, dysfunctional settings.

RECOMMENDATION:

Congress and the Administration must ensure that there are adequate funds for major and minor construction so that VA can properly reinvest in its capital assets to protect their value and ensure that health care can be provided in safe and functional facilities long into the future.

▼ ▼ ▼

Increase Spending on Nonrecurring Maintenance:

The deterioration of many Department of Veterans Affairs (VA) properties requires increased spending on nonrecurring maintenance.

A Pricewaterhouse study looked at VA facilities management and recommended that VA spend at least 2 to 4 percent of its plant replacement value on upkeep. Nonrecurring maintenance (NRM) consists of small projects that are essential to the proper maintenance and to the preservation of the lifespan of VA's facilities. Examples of these projects include maintenance to roofs, replacement of windows, and upgrades to the mechanical or electrical systems.

Each year, VA grades each medical center, creating a facility condition assessment (FCA). These FCAs give a letter grade to various systems at each facility and assign a cost estimate associated with repairs or replacement. The latest FCAs have identified $4.9 billion worth of necessary repairs in projects with a letter grade of "D" or "F." F's must be taken care of immediately, and D's are in need of serious repairs or represent pieces of equipment reaching the end of their usable life. Most of these projects would be reparable using NRM funds.

Another concern with NRM is with how it is allocated. NRM is under Medical Facilities of the Medical Care Account and is distributed to various VISNs through the Veterans Equitable Resource Allocation (VERA) process. While this does move the money toward the areas with the highest demand for health care, it tends to move money away from facilities with the oldest capital structures, which generally need the most maintenance. It also could increase the tendency of some facilities to use maintenance money to address shortfalls in medical care funding.

RECOMMENDATIONS:

VA should spend $1.6 billion on NRM to make up for the lack of proper funding in previous years and to keep VA on the right track with maintenance for the future.

VA must also resist the temptation to dip into NRM funding for health-care needs, as this could lead to far greater expenses down the road.

High-Risk Buildings:

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

The Independent Budget veterans service organizations continue to be concerned with the seismic safety of the Department of Veterans Affairs (VA) facilities. The July 2006 Seismic Design Requirements report noted the existence of 73 critical VA facilities that, based on Federal Emergency Management Agency definitions, are at a "moderately high" or greater risk of seismic incident. Twenty-four of these have been deemed "very high" risk, the highest standard.

To address the safety of veterans and employees, VA includes seismic corrections in its annual list of projects to Congress. In conjunction with the Capital Asset Realignment for Enhanced Services process, progress is being made on eight of these facilities. More is needed, and, accordingly, funding will need to increase.

For efficiency, most seismic correction projects should also include patient care enhancements as part of their total scope. Seismic correction typically includes lengthy and widespread disruption to hospital operations; it would be prudent to make medical care improvements at the same time to minimize disruptions in the future. While this approach is the most practical for the delivery of health care and services as well as for cost-effectiveness, it also results in higher upfront project costs, which would require an increase in the construction budget.

RECOMMENDATIONS:

Congress must appropriate adequate construction funding to correct these critical seismic deficiencies.

VA should schedule facility improvement projects concurrently with seismic corrections

▼ ▼ ▼

Establishing a Program for Architectural Master Plans:

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed master plan.

This year's construction budget should include at least $20 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty and short-sighted construction planning.

The Independent Budget veterans service organizations believe that each VA medical center should develop a facility master plan to serve as a clear roadmap to where the facility is going in the future. It should be an inclusive document that includes multiple projects for the future in a cohesive strategy.

In many cases, VA plans construction in a reactive manner. Projects are funded first and then fitted onto the site. Each project is planned individually and not necessarily with respect to other ongoing projects or ones planned for the future. It is essential that each medical center has a plan that looks at the big picture to efficiently utilize space and funding. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. Master plans would prevent short-sighted construction that restricts, rather than expands, future options.

Every new project in the master plan is a step in achieving the long-range CARES objectives. These plans must be developed so that all future projects can be prioritized, coordinated, and phased. They are essential to efficiently use resources, but also to minimize disruption to VA patients and employees. Medical priorities, for example, must be adjusted for construction sequencing. If infrastructure changes must precede new construction, master plans will identify this so that schedules and budgets can be adjusted. Careful phasing is essential to avoid disrupting the

delivery of medical care, and the correct planning of such will ensure that cost estimates of this phased-construction approach will be more accurate.

There may be cases, too, where master planning will challenge the original CARES decisions, whether due to changing demand, unidentified needs, or other cause. If CARES, for example, calls for the use of renovated space for a relocated program, and a more comprehensive examination, as part of a master plan, later indicates that the site is impractical, different options should be considered. Master plans will help to correct and update invalid planning assumptions.

VA must be mindful that some CARES plans involve projects constructed at more than one medical center. Master plans, as a result, most coordinate the priorities of both medical centers. Construction of a new SCI facility, for example, might be a high priority for the "gaining" facility, but a lower priority for the "donor" facility. It may be best to fund and plan the two actions together, even though they are split between two different facilities.

Another essential role of master planning is its use to account for three critical programs that VA left out of the initial CARES process: long-term care, severe mental illness, and domiciliary care. Because these were omitted, there is a strong need for a comprehensive plan, and a full facility master plan will help serve as a blueprint for each facility's needs in these essential areas.

VA must ensure that each medical center develops and continues to work on long-range master plans to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruptions to patient care.

RECOMMENDATIONS:

Congress must appropriate $20 million to allow each VA medical facility to develop architectural master plans to serve as roadmaps for the future.

Each facility master plan should address long-term care, including plans for those with severe mental illness, and domiciliary care programs, which were omitted from the CARES process.

VA must develop a format for these master plans so that there is standardization throughout the system, even though planning work will be performed by local contractors in each Veterans Integrated Service Network.

▼ ▼ ▼

Plan for Long-Term Care and Mental Health Needs:

The Department of Veterans Affairs (VA) must develop a strategic plan for the infrastructure needs of long-term care and mental health programs.

The initial Capital Asset Realignment for Enhanced Services (CARES) plan did not take long-term care or the mental health considerations of veterans into account when making recommendations. We were pleased that the CARES Review Commission recognized the need for proper accounting of these critical components of care in VA's future infrastructure planning. However, we continue to await VA's development of a long-term care strategic plan to meet the needs of aging veterans. The commission recommended that VA "develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliary, residential treatment facilities and nursing homes, and for older seriously mentally ill veterans."

Moreover, the commission recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible, and identifying freestanding nursing homes as an acceptable care model. In absence of that plan, VA will be unable to determine its future capital investment strategy for long-term care.

VA must take a proactive approach to ensure that the infrastructure and support networks needed by veterans will be there for them in the future.

The Independent Budget veterans service organizations also concur with the CARES Commission's recom-

mendations that VA take action to ensure consistent availability of mental health services across the system to include mental health care at community-based clinics along with the appropriate infrastructure to match demand for these specialized services. This is important in light of the growing demand for these types of services, especially among those returning from overseas in the wars in Iraq and Afghanistan.

RECOMMENDATIONS:

VA must develop a long-term care strategic plan to account for the needs of aging veterans now and into the future. This should include care options for older veterans with serious mental illnesses.

VA must also develop plans to provide for the infrastructure needs associated with mental health-care services, especially with the unprecedented current need for these services, and the likely tremendous long-term needs of our returning service members.

▼ ▼ ▼

Empty or Underutilized Space at Medical Centers:

The Department of Veterans Affairs (VA) must not use empty space inappropriately.

Studies have suggested that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect on everything around it, and these secondary impacts greatly increase construction expense and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs for different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, the renovation can end up costing more and producing a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for more modern needs. Most of these Bradley-style buildings were designed before the widespread use of air-conditioning and the floor-to-floor heights are very low. Accordingly, it's impossible to retrofit them for modern mechanical systems. They also have long,

narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise, it would have been previously renovated or demolished for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

RECOMMENDATION:

VA should develop a plan for addressing its excess space in nonhistoric properties that are not suitable for medical or support functions due to their permanent characteristics or locations.

▼ ▼ ▼

Updating and Expanding VA Design Guides:

The Department of Veterans Affairs (VA) must continue to develop and revise facility design guides for spinal cord injury/spinal cord dysfunction (SCI/D).

With the largest health-care system in the United States, VA has an advantage in its ability to develop, evaluate, and refine the design and operation of its many facilities. Every new clinic's design can benefit from lessons learned from the construction and operation of previous clinics. VA also has the unique opportunity to learn from medical staff, engineers, and from its users—veterans and their families—as to what their needs are, allowing them to generate improvements to future designs.

As part of this, VA provides design guides for certain types of facilities that provide care to veterans. These guides are rough tools used by the designers, clinicians, staff, and management during the design process. These design guides, which are viewable on the Facilities Management web page, cover a variety of types of care.

These design guides, due to modernization of equipment and lessons learned at other facilities, should be revised regularly. Some of the design guides have not been updated in more than a decade, despite the massive transition of the VA health-care system from an inpatient-based system. *The Independent Budget* veterans service organizations (IBVSOs) understand that VA intends to regularly update these guides, and we would urge that increased funding be allocated to the Advanced Planning Fund to revise and update these essential guides.

As in past years, the IBVSOs would note the need for guides for long-term care at SCI/D centers. It is important that these guides be separate from the guides that call for acute care as the needs of the two are dramatically different.

These facilities must be less institutional in their character with a more homelike environment. Rooms and communal space should be designed to accommodate patients who will be living at these facilities for a long time. They must include simple ideas that would improve the daily life of these patients. Corridor length should be limited. They should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyard areas where the climate is temperate and indoor solariums where it is not. We believe that a complete guideline for these facilities would also include a discussion of design philosophies that emphasize the quality of life of these patients, and not just the specific criteria for each space. Because the type of care these patients need is unique, it is essential that this type of design guidance is available to contracted architects.

RECOMMENDATIONS:

VA must revise and update their design guides on a regular basis.

VA should develop a long-term care design guide for SCI/D centers to accommodate the special needs of these unique patients.

Preservation of VA Historic Structures:

The Department of Veterans Affairs (VA) extensive inventory of historic structures must be protected and preserved.

VA has an extensive inventory of historic structures, which highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected, and preserved because of their importance.

Most of these facilities are not suitable for modern patient care, and, as a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services process. As a first step in addressing its responsibility to preserve and protect these buildings, VA must develop a comprehensive program for these historic properties.

VA must make an inventory of these properties, classifying their physical condition and their potential for adaptive reuse. Medical centers, local governments, nonprofit organizations, or private sector businesses could potentially find a use for these important structures that would preserve them into the future.

The Independent Budget veterans service organizations recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. Their expertise would be helpful in creating this new program.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly for preservation's sake. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds. We would point to the partnership between the Department of the Army and the National Trust for Historic Preservation as an example of how VA could successfully manage its historic properties.

P.L. 108-422, the Veterans Health Programs Improvement Act, authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property. We applaud its passage and encourage its use.

RECOMMENDATION:

VA must begin a comprehensive program to preserve and protect its inventory of historic properties.

Career and Occupational Assistance Programs

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to their entry or reentry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties, in turn, contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

In recent years there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, cumbersome, and unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training in their particular fields while on active duty, yet in most cases these learned skills and trades are not recognized by nonmilitary organizations. Efforts to enhance civilian awareness of the quality and depth of military training should be made to reduce or eliminate licensing requirements and employment barriers. We are encouraged by the continued emphasis now being placed on employment and not just the counseling portion of vocational rehabilitation.

In response to criticism of the Vocational Rehabilitation and Employment (VR&E) Service, former Department of Veterans Affairs Secretary Anthony Principi formed the Vocational Rehabilitation and Employment Task Force. The Secretary's intent was to conduct an "unvarnished top to bottom independent examination, evaluation, and analysis." The Secretary asked the task force to recommend "effective, efficient, up-to-date methods, materials, metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment. In March 2004, the task force released its report recommending needed changes to the VR&E service. *The Independent Budget* continues to support the recommendations of the task force, and we look forward to continued implementation of these recommendations.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Vocational Rehabilitation and Employment Funding:

Congressional funding for the Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) services must keep pace with veteran demand for VR&E services.

The VR&E program provides services and counseling necessary to enable service disabled veterans with employment handicaps to prepare for, find, and maintain gainful employment in their communities. The program also provides independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their reentry back to private life. The program further offers educational and vocational counseling to service members and veterans recently separated from active duty. These services are also available to dependents of veterans who meet certain eligibility requirements.

The Office of Management and Budget (OMB) evaluates the average cost of placing a service-connected veteran in employment at $8,000 as calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, OMB calculations do not include a provision for inflation, increased student tuition costs, and the number of veterans who drop out of the VR&E program or enter interrupt status of their rehabilitation plan. Comparisons to other vocational programs are not appropriate since nonfederal dollars are excluded when calculating their cost to place an individual in employment status.

Many veterans are facing significant challenges when they return home from the current global war on terrorism. These large numbers of regular military, National Guard, and Reserves are creating tens of thousands of new veterans, many of whom are eligible for VR&E programs. At present funding levels, VR&E programs cannot keep pace with the current and future demand for VR&E benefits.

RECOMMENDATION:

Congress must provide the funding level to meet veteran demand for VA VR&E programs.

▼ ▼ ▼

VR&E Staffing Levels Inadequate:

Staffing levels of the Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) Service are not sufficient to meet the needs of our nation's veterans in a timely manner.

The VA VR&E Service is charged with the responsibility to prepare disabled veterans for suitable employment and provide independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their entry into the program. However, VR&E must begin to strengthen its program due to the increasing number of service members returning from Afghanistan and Iraq with serious disabilities. These veterans require both vocational rehabilitation and employment services. There is no VA mission more important during or after a time of war than to enable injured military personnel to have a seamless transition from military service to a productive life after serving their country.

Success in the transition of disabled veterans to meaningful employment relies heavily on VA's ability to provide vocational rehabilitation and employment services in a timely and effective manner. Unfortunately, the demands and expectations being placed on the VR&E Service are exceeding the organization's current capacity to effectively deliver a full continuum of comprehensive programs. The service has been experiencing a shortage of staff nationwide because of insufficient

funding, which, as a result, has caused delays in providing VR&E services to disabled veterans, thus reducing the veteran's opportunity to achieve successful rehabilitation and employment.

To increase emphasis on employment, the service has begun an initiative titled "Coming Home To Work" as an early outreach effort to provide VR&E services to eligible service members pending medical separation from active duty at military treatment facilities. This and other new programs will require additional staff to maintain efforts nationwide. It is imperative that VA increase VR&E staffing levels to meet the increasing demand our nation's veterans have for services. The following facts further confirm these problems.

Currently, there are 89,000 veterans in the various phases of VR&E programs compared to 70,000 in FY 2000. This number is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Nineteen-thousand veterans have ended their participation in the VA rehabilitation program. Of these, 63.3 percent successfully completed the program, of which 48.9 percent ended with employment and 14.4 percent ended with achieving their goal of independent living.

For many years, *The Independent Budget* veterans service organizations have criticized VR&E Service programs and complained that veterans were not receiving suitable vocational rehabilitation and employment services in a timely manner. Many of these criticisms remain of concern, including the following:

- inconsistent case management with lack of accountability for poor decision making;
- delays in processing initial applications due to staff shortages and large caseloads;
- declaring veterans rehabilitated before suitable employment is retained for at least six months; and
- inconsistent tracking of electronic case management information systems.

RECOMMENDATION:

VA needs to strengthen its Vocational Rehabilitation and Employment program to meet the demand of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce.

▼ ▼ ▼

Follow-up on Referrals to Other Agencies for Entrepreneur Opportunities:

Department of Veterans Affairs Vocational Rehabilitation and Employment (VR&E) Service staff should follow up with veterans who are referred to other agencies to ensure that the veteran's entrepreneur opportunities have been achieved.

VR&E has expanded its efforts toward fostering awareness and opportunities for self-employment by signing memorandums of understanding with the Department of Labor, the Small Business Administration, and The Veterans Corporation and SCORE. They have also implemented the Five Track Employment Process, which places emphasis on self-employment as a potential for gainful employment. VR&E has further included self-employment in standardized operation materials, online employment sources, and information guides. However, VR&E must follow up with veterans who were referred to other agencies for entrepreneur opportunities and reassess their employment needs if they were not successful.

RECOMMENDATION:

VR&E staff must follow up with veterans after being referred to other agencies for self-employment to ensure that the veteran's entrepreneur opportunities have been successfully achieved.

VR&E Revision of Procedural Manuals:

The Department of Veterans Affairs Vocational Rehabilitation and Employment (VR&E) Service must continue to revise its procedural manuals to keep current with changes in laws and regulations.

VR&E is currently working on revising its procedure manuals, which have been neglected for several years. Four of the seven chapters have been revised leaving three parts still to be updated. In addition to revising the content of the manuals, VR&E must establish an ongoing routine for revising its manuals to be consistent with changes in laws, regulations, and policies.

RECOMMENDATION:

The VR&E manual must be routinely revised to remain current with present as well as future changes in laws, regulations, and policies.

▼ ▼ ▼

VR&E Contract Counselors:

The Department of Veterans Affairs (VA) needs to improve the oversight of contract counselors to ensure that veterans are receiving the full array of Vocational Rehabilitation and Employment (VR&E) programs and services in a timely and compassionate manner.

VA's Strategic Plan for FY 2006–2011 reveals that VA plans to continue the utilization of contractors to supplement and complement services provided by VR&E staff. However, *The Independent Budget* veterans service organizations are concerned about the quality of services provided by contract counselors, which may be contributing to the problem of veterans dropping out of their VR&E program before completion or going into interrupt status in their rehabilitation plan.

A survey conducted by the Veterans Benefit Administration Office of Performance Analysis & Integrity conducted in 2003 supports this concern. The survey concluded that "VA staff counselors were consistently rated higher than contractor counselors on the majority of issues addressed by their survey." VA counselors were viewed to be more concerned about the individual's needs and goals and were likely to be more caring and compassionate.

RECOMMENDATIONS:

VR&E Service staff must improve the oversight of contract counselors to ensure veterans are receiving the full array of services and programs in a timely and compassionate manner.

The VR&E Service should improve case management techniques and use state-of-the-art information technology.

The VR&E Service must increase the success rate of their program above the current 67 percent to meet its goal of 80 percent by 2011.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

VA needs to streamline eligibility and entitlement to VR&E programs to provide earlier intervention and assistance to disabled veterans.

The VR&E Service needs to identify and address why veterans drop out of its VR&E program prior to completion or choose to interrupt their rehabilitation plans.

The VR&E Service must place higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

The VR&E Service should follow up with rehabilitated veterans for at least two years to ensure that the rehabilitation and employment placement plan has been successful.

VA needs to develop resource centers that focus on obtaining and maintaining gainful employment for veterans. The program needs to prepare veterans for interviews, offer assistance creating resumes, and develop proven ways of conducting job searches.

Transition Assistance Programs Inadequate:

The Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) do not adequately serve service members.

The Departments of Defense (DOD), Labor (DOL), and Veterans Affairs (VA) provide transition-assistance workshops to separating military personnel through TAP and DTAP. These programs generally consist of a three-day briefing on employment and related subjects, and veterans' benefits.

DTAP, however, has been largely relegated to a "stand-alone" session. Typically, a DTAP participant does not benefit from other transition services, nor does he or she automatically see a Vocational Rehabilitation and Employment (VR&E) Service representative.

The number of military members being separated annually remains high (more than 200,000 as projected by the DOD). These numbers continue to grow as large numbers of separating service members are returning from the global war on terrorism. Many have been on "stop loss," prevented from leaving military service on their scheduled date, and they depart military service soon after their return. It is imperative that these soon-to-become veterans are not overlooked during their rapid transition to civilian life. Additionally, tens of thousands of National Guardsmen and Reservists have been called to active duty for the current conflict. No coherent program exists for them to receive transition services at demobilization. In some ways, they face even more difficult employment problems after being ripped from their civilian employment to serve the nation. Though protections exist, separating service members need detailed information on these protections and the benefits of service as well as information on other opportunities they may have available. *The Independent Budget* veterans service organizations (IBVSOs) believe TAP/DTAP must continue to provide their important services as recommended by the VR&E Task Force in March 2004 and expand them to Guardsmen and Reservists returning from combat.

The IBVSOs are encouraged that the VR&E Service is in the process of restructuring DTAP. However, we are concerned that too little is still being done for transitioning disabled veterans and we will continue to monitor the changes and progress in DTAP.

RECOMMENDATIONS:

Congress should pass legislation ensuring the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.

VA should assign primary responsibility for DTAP within the Veterans Benefits Administration to the VR&E Service and designate a specific DTAP manager.

The DOD should work closely with the DOL to ensure detailed transition services are provided at the demobilization station or other suitable site for demobilizing National Guardsmen and Reservists.

The DOD should ensure that separating service members with disabilities receive all of the services provided under TAP as well as the separate DTAP session by the VR&E Service.

Whenever practical, the DOD should make preseparation counseling available for members being separated prior to completion of their first 180 days of active

duty unless separation is due to a service-connected disability when these services are mandatory.

The House and Senate Veterans' Affairs Committees should conduct oversight hearings regarding the implementation of P.L. 107-288 to ensure the President's National Hire Veterans Committee fulfills the following purposes:

> Raise employer awareness of the advantages of hiring separating service members and veterans; facilitate the employment of separating service members and veterans through America's Career Kit, the National Electronic Labor Exchange; and direct and coordinate departmental, state, and local marketing initiatives.

Congress should provide the DOL adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act provisions.

▼ ▼ ▼

Licensing and Certification:

Recently separated service members should have the opportunity to take licensing and certification examinations without a period of retraining.

Men and women of the armed forces acquire extensive knowledge and job skills, via military training and work experience, which are transferable to an array of civilian occupations. Along with technical proficiencies, service members offer intangible qualities like leadership skills and strong work ethics that are eagerly sought in the national job market as well as in other branches of government.

Yet an untold number of separating service members miss immediate opportunities to obtain good, high-paying jobs because of civilian licensure and certification requirements. Much of the lengthy and expensive training necessary for such certification is redundant to, and in some cases modeled on, military training.

This inefficient and costly waste of valuable human resources is unfair to veterans, an impediment to businesses that need skilled workers, and ultimately a burden upon the national economy due to delayed job creation, consumer spending, and unnecessary unemployment compensation insurance payments.

RECOMMENDATION:

To eliminate such artificial hurdles to employment in the private sector, the Department of Defense in partnership with the Department of Labor (DOL) should develop programs that track military training requirements and how they compare to those needed for licensing and certification in the civilian workforce. Additionally, the DOL should work with states and local governments and the private sector to enhance civilian awareness of the quality and depth of military training and to eliminate superfluous licensing requirements and employment barriers.

▼ ▼ ▼

Training Institute Inadequately Funded:

The National Veterans Training Institute (NVTI) lacks adequate funding to fulfill its mission.

The NVTI was established to train federal and state veterans' employment and training service providers. Primarily, these service providers are Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) specialists. DVOP/LVER specialists are located throughout the country at various locations, such as state workforce centers, Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) Service offices, VA medical centers, Native American trust territories, military installations, and other areas of known concentrations of veterans or transitioning service members.

DVOP/LVER specialists help veterans make the difficult and uncertain transition from military to civilian life. They help provide jobs and job training opportunities for disabled and other veterans by serving as intermediaries between employers and veterans. They maintain contacts with employers and provide outreach to veterans. They also develop linkages with other agencies to promote maximum employment opportunities for veterans.

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. It is administered by the Department of Labor Veterans Employment and Training Service through a contract with the University of Colorado at Denver. The NVTI curriculum covers an array of topics that are essential to DVOP/LVER specialists' ability to assist veterans in their quest to obtain and maintain meaningful employment. Such topics include courses to develop the following:

- core professional skills,
- media marketing skills,
- case management skills,
- investigative techniques,
- quality management skills, and
- grants management skills.

Certain DVOP/LVER specialists may be required to participate in employment programs involving other state and federal agencies. The NVTI helps prepare DVOP/LVER specialists for their roles in such programs as the VR&E Service and the Transition Assistance Program (TAP). The NVTI curriculum also includes information and training on the Uniformed Services Employment and Reemployment Rights. The NVTI offers Department of Defense employees TAP management training through reimbursable agreements under the Economy Act (at actual cost of training). The NVTI also offers a Resource and Technical Assistance Center, a support center, and repository for training and resource information related to veterans' programs, projects, and activities. *The Independent Budget* veterans service organizations are concerned because, after several years of level funding, appropriations for the NVTI for FY 2005 actually decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

RECOMMENDATION:

Congress must fund the NVTI at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

Performance Standards:

Performance standards in the Veterans Employment and Training Service (VETS) system need to be uniform and consistent.

The enactment of the Jobs for Veterans Act (P.L. 107-288) has resulted in significant improvements in employment services to veterans and is showing a positive impact on veteran employment outcomes. However, while progress is being made, there are still no clear and uniform performance standards that can be used to compare one state to another or even one office to another office within one state.

In 2002, VETS began reporting performance outcomes that measured the "entered employment rate" and "employment retention rate" of veterans by state. However, the report lists percentages only, not actual numbers of veterans hired or served. Federal contractors must also file a "veterans hired" report annually. However, this report does not include all veterans employed and is only applicable to employers with federal contracts exceeding $25,000. The Bureau of Labor Statistics also has a number of reports available on the Department of Labor (DOL) website; however, none of them differentiate between disabled veterans, nondisabled veterans and nonveterans. It is clear that the Department of Labor needs to develop a standardized performance measure system and develop a centralized, national research database with this information.

Furthermore, despite these reporting requirements, the VETS headquarters and regional administrators have almost no authority to reward a good job or impose sanctions for poor performance. The only real authority is the seldom-used power to recapture funds when a state has acted in a way contrary to law. VETS is authorized to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly disabled veterans, find work. However, this recognition is only for individuals and not entities. It would be practical if Congress would amend the Jobs for Veterans Act so entities (such as career one-stops) can be recognized and rewarded for exceeding the standards by providing them with additional funding.

In 2004 the VETS performance measures were applied to veterans served by the Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) staff members as well. For several years, many have expressed a need for qualification standards to be put in place for both DVOP and LVER staff. In 2005 there was draft legislation proposed that would require the Secretary of the Department of Labor to establish such professional qualifications for employment in the two programs. While this concept is certainly welcomed and broadly supported, the legislation did not explain exactly how VETS would implement the new qualification standards.

The heart and soul of VETS efforts is the dedicated DVOPs and LVERs tasked with facing the employment challenges of hard-to-place veterans. For decades, DVOPs and LVERs have been the cornerstone of employment services for veterans. It is important for states to continue to be required to hire veterans for these positions. Part of this reason is that these individuals are veterans advocating for veterans. After all, DVOP and LVER staff are the front-line providers for services to veterans. They are the individuals who provide a smooth transition of service members from the military to the civilian workforce.

We must never lose sight of the fact that veterans continue to need the special job training and services that VETS provides within the Department of Labor. Shifting VETS to VA will not improve the employment and training needs of veterans. The DOL knows the job market and skills required to fill jobs beyond any other executive department. Furthermore, it is unclear as to exactly how VA would effectively run the program that so naturally suits the DOL. VA does not have the capacity or the assets to support employment programs. Therefore, the IBVSOs recommend that VETS remain a function of the Department of Labor.

RECOMMENDATIONS:

VETS should compile, and make available to the public, a state-by-state, standardized performance measure system on the hiring of veterans on all levels.

Congress should amend the Jobs for Veterans Act so that entities (such as career one-stops) can be recognized and rewarded with additional funding.

Congress needs to continue work on crafting legislation that will provide meaningful DVOP and LVER qualification standards, provide the Secretary with the authority and direction to implement the standards, and keep VETS within the Department of Labor.

The National Cemetery Administration

The Department of Veterans Affairs National Cemetery Administration (NCA) honors veterans with final resting places that commemorate their service to our nation. *The Independent Budget* veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families despite funding challenges, aging equipment, and the increasing workload of new cemetery activations.

The NCA currently maintains more than 2.7 million gravesites at 124 national cemeteries in 39 states and Puerto Rico. At the end of 2007, 66 cemeteries will be open to all interments; 16 will accept only cremated remains and family members of those already interred; and 43 will only perform interments of family members in the same gravesite as a previously deceased family member.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the global war on terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 102,000 in 2006 to 117,000 in 2009. It is expected that one in every six of these veterans will request burial in a national cemetery.

NCA ACCOUNT

The Independent Budget recommends an operations budget of **$218 million** for the NCA for fiscal year 2008 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

The NCA is responsible for five primary missions:

1. to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites;

2. to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application;

3. to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries;

4. to award a presidential certificate and furnish a United States flag to deceased veterans; and

5. to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of the national cemeteries.

Therefore, in accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a five-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY 2008 operations budget. Volume 2 of the independent study provides a systemwide comprehensive review of the conditions at 119 national cemeteries. It identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. Headstones and markers must be cleaned, realigned, and set. Stone surfaces of columbaria require cleaning, caulking, and grouting, and the surrounding walkways must be maintained. Grass, shrubbery, and trees in burial areas and other land must receive regular care. Additionally, cemetery infrastructure, i.e., buildings, grounds, walks, and drives must be repaired as needed. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options and maintenance programs.

The IBVSOs were encouraged that the NCA earmarked $28 million for the National Shrine Commitment for fiscal year 2007. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. By enacting a five-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

In addition to the management of national cemeteries, the NCA has responsibility for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

FY 2008 NATIONAL CEMETERY ADMINISTRATION

(Dollars in Thousands)

FY 2007 Administration Request	$160,733
FY 2007 *IB* Recommendation	$213,982
FY 2008 *IB* Recommendation	
Administrative Services	$168,335
Shrine Initiative	$ 50,000
Total FY 2008 *IB* Recommendation	**$218,335**

RECOMMENDATIONS:

Congress should provide **$218 million** for fiscal year 2008 to offset the higher costs related to increased workload, additional staff needs, general inflation and wage increases, and an enhanced national shrine initiative.

Congress should include as part of the NCA appropriation $50 million for the first stage of a $250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

The State Cemetery Grants Program:

Heightened interest in the State Cemetery Grant Program (SCGP) results in stronger state participation and complements the National Cemetery Administration (NCA) mission.

The State Cemetery Grants Program (SCGP) complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

The State Cemetery Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial services to veterans, especially those living in less densely populated areas not currently served by a national cemetery.

States remain, as before enactment of the Veterans Benefits Improvements Act of 1998, totally responsible for operations and maintenance, including additional equipment needs following the initial federal purchase of equipment. The program allows states in concert with the NCA to plan, design, and construct top-notch, first-class, quality cemeteries to honor veterans.

To help provide reasonable access to burial options for veterans and their eligible family members, *The Independent Budget* recommends $37 million for the SCGP for fiscal year 2008. The availability of this funding will help states establish, expand, and improve state-owned veterans cemeteries.

RECOMMENDATIONS:

Congress should fund the SCGP at a level of $37 million and encourage continued state participation in the program.

Congress should recognize the increased program interest by the states and provide adequate funding to meet planning, design, construction, and equipment expenses.

The NCA should continue to effectively market the SCGP.

Veterans' Burial Benefits:

Veterans' families do not receive adequate funeral benefits.

There has been serious erosion in the value of burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they covered in 1973, when the federal government first started paying burial benefits for our veterans.

In 2001 the plot allowance was increased for the first time in more than 28 years, to $300 from $150, which covers approximately 6 percent of funeral costs. *The Independent Budget* recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

In the 108th Congress, the allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. Clearly, it is time this allowance was raised to make a more meaningful contribution to the costs of burial for our veterans. *The Independent Budget* recommends increasing the service-connected benefit from $2,000 to $4,100, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected benefit was last adjusted in 1978, and today it covers just 6 percent of funeral costs. *The Independent Budget* recommends increasing the nonservice-connected benefit from $300 to $1,270.

RECOMMENDATIONS:

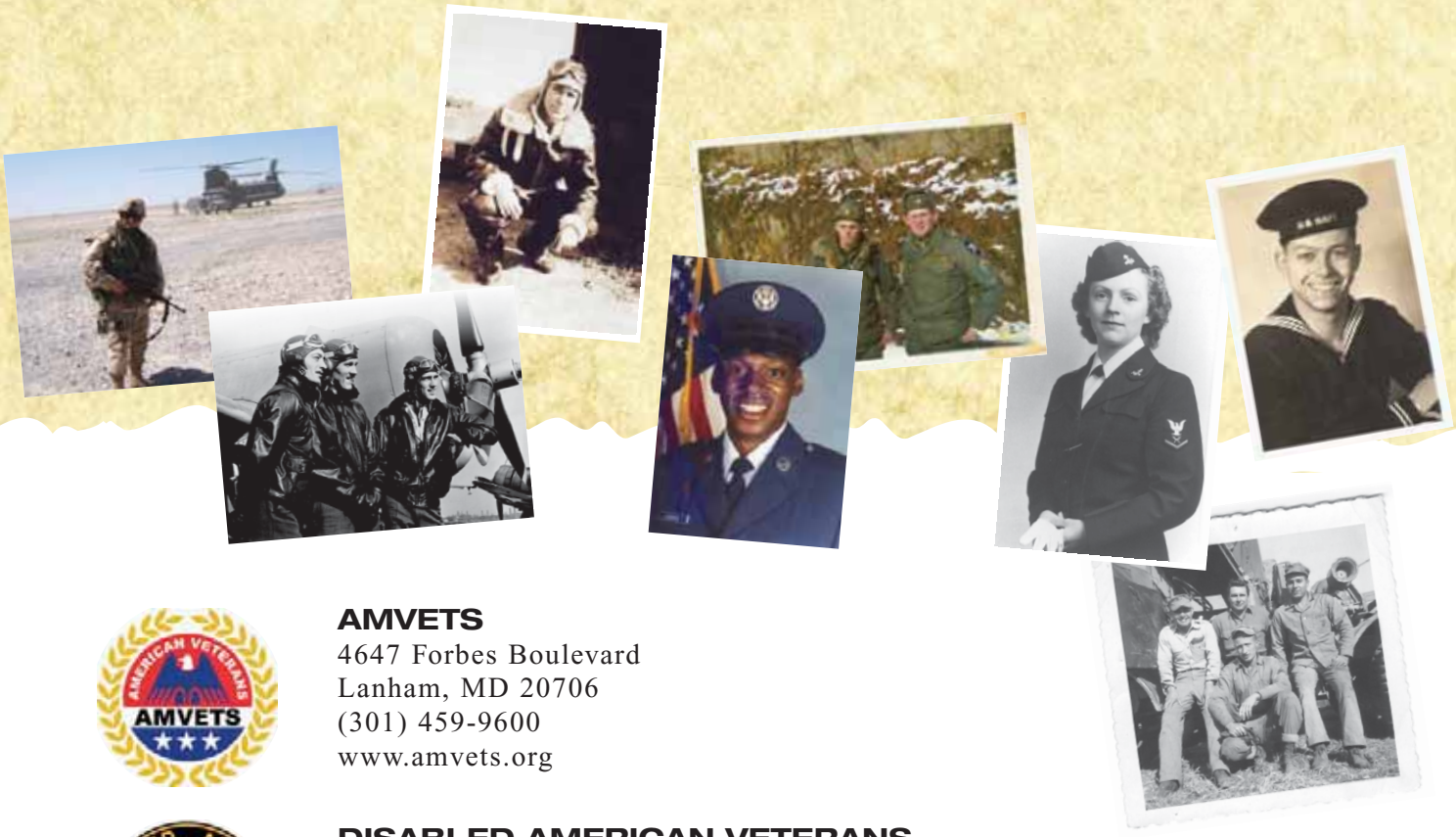
Congress should increase the plot allowance from $300 to $745 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected benefit from $2,000 to $4,100.

Congress should increase the nonservice-connected benefit from $300 to $1,270.

Congress should enact legislation to adjust these burial benefits for inflation annually.


EIGHTH FIELD HOSPITAL



AMVETS
4647 Forbes Boulevard
Lanham, MD 20706
(301) 459-9600
www.amvets.org

DISABLED AMERICAN VETERANS
807 Maine Avenue, SW
Washington, DC 20024-2410
(202) 554-3501
www.dav.org

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, NW
Washington, DC 20006-3517
(202) 872-1300
www.pva.org

VETERANS OF FOREIGN WARS OF THE UNITED STATES
200 Maryland Avenue, NE
Washington, DC 20002
(202) 543-2239
www.vfwdc.org

www.independentbudget.org