

THE A Comprehensive Budget & Policy Document Created by Veterans for Veterans
INDEPENDENT
for the Department of Veterans Affairs **BUDGET**



25 Years

Fiscal Year

2012

Prologue

As the United States closes out a decade of sending service members into harm's way as part of the war on terrorism, and with service members continuing to deploy on a regular basis to Iraq, Afghanistan, and other foreign theaters, the Department of Veterans Affairs (VA) faces growing pressure to address their needs for health care, compensation for injuries, and other earned benefits, while meeting the needs of the men and women who served in prior conflicts. Since the beginning of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), and now continuing with Operation New Dawn, more than 2 million service members have been deployed to combat theaters. Despite recent troop drawdowns in Iraq, thousands more personnel are still being sent into hostile environments. The physical and psychological traumas they face are immense. The sacrifices these brave soldiers, sailors, airmen, marines, and coastguardsmen have made will leave many of them dealing with a lifetime of physical and psychological wounds. It is for these men and women and the millions who came before them that we set out each year to assess the state of the one federal department whose sole task it is to care for them and their families: the Department of Veterans Affairs (VA).

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

The Independent Budget will be released in February 2011 concurrent with the release of the President's proposed budget for VA, but this document is designed to alert the Administration, Congress, VA, and the public to the issues concerning VA health care, benefits, and benefit delivery that we believe deserve early scrutiny and attention. *The Independent Budget* veterans service organizations are releasing this report as a guide to policymakers so that they can enact an adequate health-care budget for fiscal year (FY) 2011 and make necessary adjustments to the advance appropriation for the Medical Care accounts of VA for FY 2012. Likewise, *The Independent Budget* presents a detailed funding analysis and recommendations for FY 2012. Through these efforts we believe VA will be better positioned to successfully meet the challenges of the future. We also hope this document will provide direction and guidance for the Administration and Congress.

As the war on terrorism continues with no end date certain, this country's obligation to the men and women who have served and sacrificed continues to grow. Additionally, we must be cognizant of current fiscal realities in a time of turbulent and rapidly fluctuating economic conditions that may compel veterans of past service to seek VA care and benefits for the first time. In fact, this occurrence has already begun to manifest, as VA Secretary Eric Shinseki outlined in a letter to Congress July 30, 2010. He explained that the advance appropriations levels provided for FY 2011, which virtually match the Administration's request and the appropriations

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levels provided in the FY 2011 Military Construction and Veterans Affairs Appropriations bills, may not be sufficient to meet the health-care demand the Department of Veterans Affairs will face this fiscal year. Secretary Shinseki also emphasized that the passage of P.L. 111-163, the “Caregivers and Veterans Omnibus Health Services Act,” and P.L. 111-148, the “Patient Protection and Affordable Care Act,” will increase the workload for VA, thereby requiring supplemental funding.

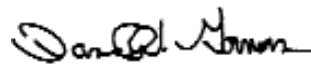
Additionally, this nation faces a harsh reality when it comes to our fiscal future. Rapid growth in federal spending, coupled with an economic downturn that has had a secondary impact on federal revenues, has set us on a course that needs to be corrected. Yet continued investment in the critical programs administered by VA is imperative. The ongoing cost of caring for the men and women who have honorably served this nation does not diminish simply because financial times become challenging.

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 on the frontiers of freedom need to know that they come home to a nation that respects and honors them for their service. Part of this obligation must provide for the best possible 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 accurate compensation, education, and survivors’ benefits—to anyone harmed in service to our nation and to all who earn benefits by serving.

We are proud that this marks a historic 25th year for *The Independent Budget*. We are equally proud of the respect and influence that it has gained during that time. The coauthors—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States—endeavor each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are founded on facts, rigorous analysis, and sound reasoning. We hope that each reader approaches this document with an open mind and a clear understanding that America’s veterans should not be treated as the refuse of war, but as patriots.



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

AMVETS

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

DISABLED AMERICAN VETERANS

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

PARALYZED VETERANS OF AMERICA

Paralyzed Veterans of America (Paralyzed Veterans), founded in 1946, is the only Congressionally chartered veterans service organization dedicated solely to serving the needs of veterans with spinal cord injury or dysfunction (SCI/D). Paralyzed Veterans' mission is to maximize the quality of life for its members and all people with disabilities. Paralyzed Veterans is a leading advocate for health care, SCI/D research and education, veterans' benefits, sports and recreational rehabilitation opportunities, accessibility and the removal of architectural barriers, and disability rights. Paralyzed Veterans of America is composed of 34 chapters that work to create an America where all veterans and people with disabilities, and their families, can achieve their independence and thrive. Paralyzed Veterans represents more than 19,000 veterans in all 50 states, the District of Columbia, and Puerto Rico.

VETERANS OF FOREIGN WARS OF THE U.S.

The Veterans of Foreign Wars of the U.S. (VFW), founded in 1899 and chartered by Congress in 1936, is the nation's largest organization of combat veterans and its oldest major veterans

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service organization. Its 1.5 million members include veterans of past wars and conflicts, as well as those who currently serve in the active, Guard and Reserve forces. Located in 7,900 VFW Posts worldwide, the VFW and the 600,000 members of its Auxiliaries are dedicated to “honoring the dead by helping the living.” They accomplish this mission by advocating for veterans, service members, and their families on Capitol Hill as well as state governments; through local community and national military service programs; and by operating a nationwide network of service officers who help veterans recoup more than \$1 billion annually in earned compensation and pension.

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

Supporters

African American Post Traumatic Stress Disorder Association
Air Force Association
American Association of People with Disabilities
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Military Retirees Association
American Military Society
American Psychological Association
American Veterans Alliance
American Veterans for Equal Rights
Armed Forces Top Enlisted Association
Association for Service Disabled Veterans
Association of American Medical Colleges
Association of the United States Navy
Blinded Veterans Association
Brain Injury Association of America
Catholic War Veterans, USA, Inc.
Combined Korea and US Veterans Association
Enlisted Association of the National Guard of the United States
Fleet Reserve Association
Forty and Eight
Gold Star Wives of America
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the USA
Kansas Commission on Veterans' Affairs
Lung Cancer Alliance
Mental Health America

(Continued)

Military Officers Association of America
Military Order of the Purple Heart of the USA, Inc.
Minnesota Department of Veterans Affairs
National Alliance on Mental Illness
National Association for Uniformed Services
National Association of American Veterans, Inc.
National Association of Disability Representatives
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Disability Rights Network
National Gulf War Resource Center
National Society of Military Spouses
Non Commissioned Officers Association of the USA
Nurses Organization of Veterans Affairs
Oklahoma Department of Veterans Affairs
Society of Cuban American Veterans
Society of Hispanic Veterans
Tennessee Department of Veterans Affairs
United Spinal Association
United States Coast Guard CPOA/CGEA
United States Federation of Korea Veterans Associations
U.S. Korea Allies Council
Veterans Affairs Physician Assistant Association
Veterans of Modern Warfare
Vietnam Veterans of America
Washington State, Office of the Governor

Guiding Principles

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

Acknowledgments

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Introduction

With America having been engaged in conflicts in Afghanistan for nearly 10 years and Iraq nearly 8 years, the numbers of new veterans and disabled veterans entering the Department of Veterans Affairs (VA) health-care and benefits systems shows no signs of declining. Tens of thousands of soldiers, sailors, airmen, marines, and coastguardsmen have experienced injury or illness associated with their service during the global war on terrorism; meanwhile, the responsibility that this country has to take care of those men and women continues to grow.

It is under this dramatic backdrop of dire current military events that the four coauthors of *The Independent Budget (IB)*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—offer our budget and program recommendations based upon our unique expertise and experience concerning the resources that will be necessary to meet the needs of America’s veterans in fiscal year (FY) 2012. These recommendations are designed to meet the needs of the thousands of young veterans currently serving in America’s armed services who have earned and may soon require VA health care and financial benefits and to meet the needs of the millions of veterans from previous conflicts and service who currently depend on the Department of Veterans Affairs.

We are particularly proud of the fact that the fiscal year 2012 edition of *The Independent Budget* represents the 25th consecutive year that our partnership of veterans service organizations has joined together to produce a comprehensive budget document that highlights the needs of elderly veterans and those of younger men and women who join their ranks each year as they return from active duty. During that time, the *IB* has improved significantly while gaining much more respect and recognition.

The Veterans Health Administration, similar to private sector health-care providers and other federal health-care programs, including Medicare, Medicaid, and TRICARE, is facing growing demand for services as America ages and as medical treatment and administrative costs spiral upward. We believe that this growing demand may even have accelerated the passage of comprehensive health-care reform during the 111th Congress, particularly as more veterans may turn to VA as acceptable coverage for their health-care needs. Meanwhile, the influx of new, and often severely disabled, veterans entering the VA system each month bring new demands for sophisticated medical care each year. Moreover, we anticipate greater demand on the resources of the VA health-care system as VA begins implementation of Public Law 111-163, the “Caregivers and Veterans Omnibus Health Services Act of 2010.” These considerations make accurate financial and personnel resource forecasting difficult but even more important each year.

Year after year, the coauthors of *The Independent Budget* conduct comparative analysis of VA workload information and carefully review medical and administrative cost data that form the foundation of the *IB*’s recommendations. *The Independent Budget* veterans service organizations (IBVSOs) then call upon Congress and the Administration to provide sufficient

funding to meet the health-care and financial benefit needs of veterans in a timely and predictable manner. This has proved to be a difficult, but welcome, challenge, particularly in light of recent economic conditions, as we seek to ensure that the needs of all veterans are properly met.

Fortunately, enactment of advance appropriations legislation during the 111th Congress has provided a more stable foundation for funding for the VA health-care system. However, now it is imperative that constant oversight and analysis of the VA's health-care budget be conducted to ensure that the resource needs of the VA health-care system are properly met. With this in mind, we look forward to working with the Administration, Congress, and the Government Accountability Office to follow through on the advance appropriations requirements for FY 2013, specifically to ensure that the GAO finally provides the detailed analysis that is required of the President's budget request.

With regard to veterans' benefits, the IBVSOs believe VA must fast-track real steps that will help ameliorate nagging claims-processing barriers. Studies to find solutions must be replaced by real action plans that produce positive results. Veterans and their families deserve prompt decisions regarding the benefits they have earned and deserve. These benefits are part of a covenant between our nation and the men and women who have defended it. Veterans have fulfilled their part of the covenant. Now VA must avoid further delay and move forward to meet its obligations in a timely manner.

The Independent Budget for Fiscal Year 2012 provides recommendations for consideration by our nation's elected leadership that are based upon rigorous and rational methodology designed to support the Congressionally authorized programs that serve our nation's veterans. *The Independent Budget* coauthors are proud that more than 60 veterans, military, medical service, and disability organizations have endorsed the FY 2012 edition of this historic document. Our primary purpose is to inform and encourage the United States Government to provide the necessary resources to care for the men and women who have answered the call of our country and taken up arms to protect and defend our way of life.

Table 1. VA Accounts FY 2012 (Dollars in Thousands)

	FY 2011* Appropriation	FY 2012** Administration	FY 2012 IB***	FY 2013** Advance Approp.
Veterans Health Administration (VHA)				
Medical Services	37,136,000	40,051,000	43,780,136	41,354,000
Medical Support and Compliance	5,307,000	5,424,000	5,354,985	5,746,000
Medical Facilities	5,740,000	5,376,000	5,904,437	5,441,000
Subtotal Medical Care, Discretionary	48,183,000	50,851,000	55,039,558	52,541,000
Medical Care Collections	3,393,000	3,078,000		3,300,000
Total, Medical Care Budget Authority (including Collections)	51,576,000	53,929,000	55,039,558	55,841,000
Medical and Prosthetic Research	581,000	508,774	620,000	
Total, Veterans Health Administration	52,157,000	54,437,774	55,659,558	
General Operating Expenses (GOE)				
Veterans Benefits Administration	2,148,776	2,018,764	2,321,439	
General Administration	397,500	448,225	406,214	
Total, General Operating Expenses (GOE)	2,546,276	2,466,989	2,727,653	
Departmental Admin. and Misc. Programs				
Information Technology	3,146,898	3,161,376	3,383,202	
National Cemetery Administration	250,000	250,934	274,500	
Office of Inspector General	109,000	109,391	112,020	
Total, Dept. Admin. and Misc. Programs	3,505,898	3,521,701	3,769,722	
Construction Programs				
Construction, Major	1,151,036	589,604	2,201,000	
Construction, Minor	467,700	550,091	585,000	
Grants for State Extended Care Facilities	85,000	85,000	200,000	
Grants for Construct of State Vets cemeteries	46,000	46,000	51,000	
Total, Construction Programs	1,749,736	1,270,695	3,037,000	
Other Discretionary	166,000	156,000	170,482	
Total, Discretionary Budget Authority (including Medical Collections)	60,124,910	61,853,159	65,364,415	

*FY 2011 appropriations levels reflect the amounts included in H.R. 1, the "Continuing Resolution for FY 2011," introduced by the House Committee on Appropriations on February 11, 2011.

**Adjustments to FY 2012 Medical Services, Medical Support and Compliance, and Medical Facilities accounts reflects a decrease of \$713 million in appropriations below the levels provided by H.R. 1, the "Continuing Resolution for FY 2012" due to the freeze in federal pay. However, the Administration's FY 2012 request reflects a \$953 million contingency fund that seems to be factored into the needed appropriations total for Medical Services for FY 2012.

***The recommendations of *The Independent Budget (IB)* for FY 2012 reflect the expectation for a 0 percent pay increase for all VA employees. If Congress chooses to provide a cost-of-living increase or pay raise, sufficient funding must then be provided over and above the recommendations of the *IB*.

Benefit Programs

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

Disability compensation payments seek to make up for some of the economic and other losses veterans experience from the effects of service-connected diseases and injuries. When veterans' lives are cut short as a result of a service-connected cause or following a substantial period of total serviced-connected disability, eligible family members receive dependency and indemnity compensation. Veterans' pensions provide some measure of financial assistance for disadvantaged veterans of wartime service who are totally disabled as a result of nonservice-connected causes, or who have reached the age of 65. Death pensions are paid to underprivileged 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 select groups of veterans and dependents. Because of an apparent correlation between veterans who served in Vietnam and chronic illnesses, such as spina bifida and other genetic illnesses in their children, Congress authorized special programs to provide a monthly allowance, medical treatment, and vocational rehabilitation to help assist in improving the quality of life for these children.

In recognition of the disadvantages that result from the interruption of civilian life to perform military service, Congress authorized various benefits to aid veterans in their readjustment back to civilian life. These readjustment benefits provide monetary assistance to veterans who choose to participate 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 die as a result of a service-connected disability.

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

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

Through continual scrutiny by the authors of *The Independent Budget*, and our work with Congress and the Administration, these carefully crafted benefits programs have provided for the needs of many. However, we have identified areas in which adjustments are needed to

make the programs better serve veterans or meet changing circumstances.

Our continued efforts contributed to the passage of Public Law 111-275, the “Veterans Benefits Act of 2010.” This omnibus benefits and health bill contained a number of important provisions to disabled veterans and their families, including:

- Increase in the automobile grant, which now extends eligibility to veterans with severe burn injuries, from \$11,000 to \$18,900 effective October 2011, to be indexed to the Consumer Price Index to allow for annual adjustment;
- Enhancement of disability compensation for severely disabled veterans who have difficulty using prostheses (criteria change more favorable to amputees—prior language “so near the [joint of the affected limb(s)]” preventing use of prosthesis is changed to “with factors” preventing use of prosthesis, such as a painful neuroma);
- Eligibility for Aid and Attendance benefits for veterans suffering from traumatic brain injury (TBI) (veterans with service-connected TBI may not meet the eligibility criteria for SMC “R-2” [special aid and attendance], so this change allows them to receive additional compensation at the maximum level);
- Increase in Supplemental Service-Disabled Veterans’ Insurance (SDVI or “RH”) on October 1, 2011, from \$20,000 to \$30,000 for totally disabled veterans;

- Increase in Veterans Mortgage Life Insurance (VMLI) for disabled veterans from \$90,000 to \$150,000 effective October 1, 2011, with a 2012 increase to \$200,000;
- Increase in the number of veterans who can participate in VA’s independent living services and assistance program from 2,600 to 2,700;
- Increase in the amount of burial/funeral expense benefits from \$300 to \$700, and increase in the amount of plot or internment allowance from \$300 to \$700; both to be indexed to the Consumer Price Index to allow for annual adjustment.

Unfortunately, inaction by government to regularly adjust benefit rates, or to tie them to cost-of-living increases so they automatically adjust, and inability to meet other needed changes, threatens the effectiveness of other veterans’ benefits.

Veterans’ programs must remain a national priority. Additionally, they must be maintained, protected, and improved as necessary. In order to maintain or increase their effectiveness, we offer the following recommendations in this section of *The Independent Budget*.

Compensation and Pensions

Compensation

COMPENSATION FOR QUALITY OF LIFE AND NONECONOMIC LOSS:

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

The Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation published a report, “A 21st Century System for Evaluating Veterans for Disability Benefits,” in 2007 recommending that the current VA disability compensation system be expanded to include compensation for nonwork disability (also referred to as “noneconomic loss”) and loss of quality of life.¹ The report touches upon several systems that could be used to measure and compensate for loss of quality of life, including the World Health Organization–devised International Classification of Functioning, Disability, and Health, the Canadian Veterans’ Affairs disability compensation program, and the Australian Department of Veterans’ Affairs disability compensation program.²

In its report the IOM distinguished between the purpose of disability benefits and the operational basis for those benefits.³ The report grouped the operational measures used for compensating disabilities into seven categories and subcategories:

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

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

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

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

IIIB. Work disability: actual loss of earnings refers

to the actual loss of earnings resulting from the impairment and limitations in the activities of daily living.

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

V. Loss of quality of life refers to the loss of physical, psychological, social, and economic well-being in one’s life.⁴

The report organized these categories into the relationship shown in Figure 1, page 8:

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

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

The congressionally mandated Veterans Disability Benefits Commission (VDBC), established by the National Defense Authorization Act of 2004 (P.L. 108-136),

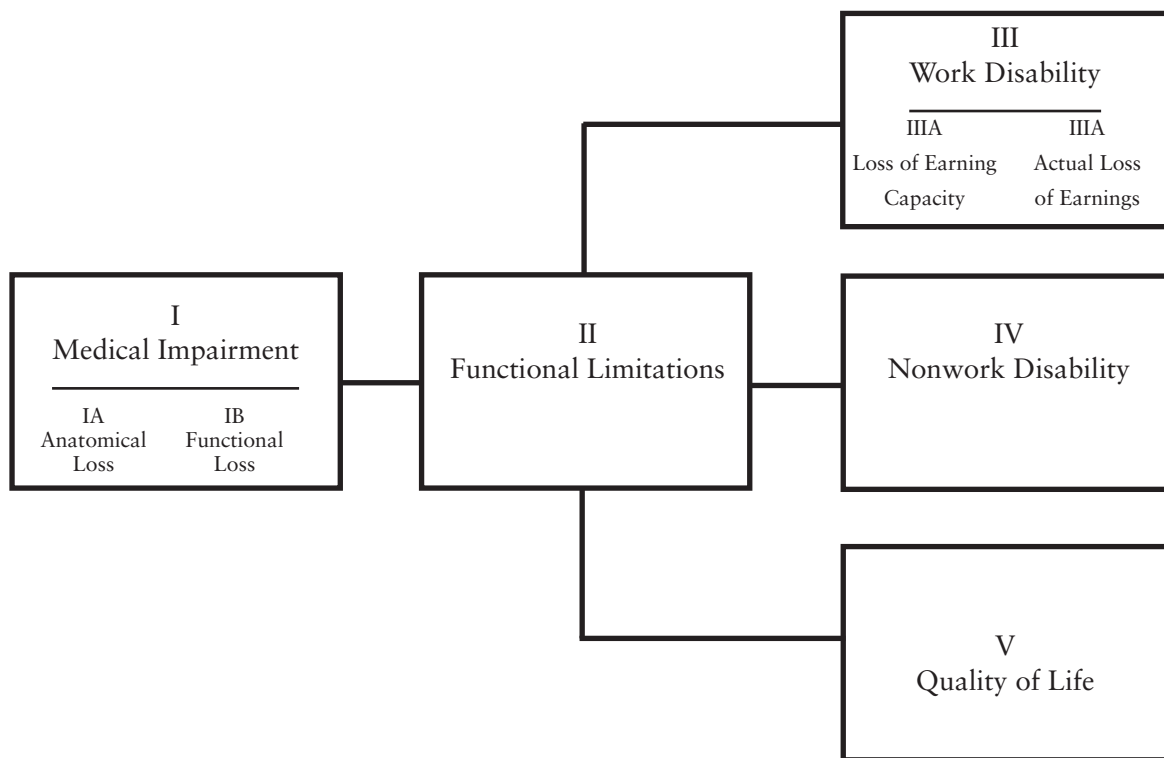


Figure 1: IOM Disability Model

spent more than two years examining how the rating schedule might be modernized and updated. Reflecting the recommendations of a comprehensive study of the disability rating system by the IOM, the VDBC in its final report issued in 2007 recommended:

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

The IOM Report, the VDBC (and an associated Center for Naval Analysis study), and the Dole-Shalala Commission (President's Commission on Care for America's Returning Wounded Warriors) all agreed that the current benefits system should be reformed to include noneconomic loss and quality of life as a factor in compensation. Once this principle is established in statute, only then shall Congress and VA be able to fully and accurately address the question of whether such compensation should be provided through immediate changes to the rating schedule that would modify or include additional compensation paid for average loss of earnings capacity or whether it should come from a separate compensation program, such as SMC.

Recommendations:

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

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

¹ Committee on Medical Evaluation of Veterans for Disability Compensation, Institute of Medicine of the National Academies, *A 21st Century System for Evaluating Veterans for Disability Benefits* (2007) [hereinafter IOM Report].

² *Ibid.*, 78–81.

³ *Ibid.*, 116.

⁴ *Ibid.*, 116–17 (emphasis in original).

⁵ *Ibid.*, 117 fig.4-1.

⁶ *Ibid.*, 117–18.

⁷ *Ibid.*, 3.

⁸ Veterans' Disability Benefits Commission, *Honoring The Call To Duty: Veterans' Disability Benefits in the 21st Century* (2007), 76.

UPDATING AND REVISING THE RATING SCHEDULE:

The Veterans Benefits Administration must work in an open and collaborative manner with all stakeholders, especially veterans service organizations, as it updates and revises the VA Schedule for Rating Disabilities.

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

In line with these recommendations, the Veterans Benefits Administration (VBA) is currently engaged in the process of updating the first 2 of the 15 body systems (mental disorders and musculoskeletal). Additionally, it has committed to regularly updating the entire VA *Schedule for Rating Disabilities* every five years.

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

In January 2010, the VBA held a Mental Health Forum jointly with the Veterans Health Administration (VHA), which included a veterans service organization (VSO) panel. In August 2010, the VBA and VHA held a Musculoskeletal Forum, which also included a VSO panel. While *The Independent Budget* veterans service organizations (IBVSOs) were appreciative of these outreach

efforts, there has been no additional outreach from the VBA on either body system update since the initial public meeting. Because these public forums were conducted at the very beginning of the rating schedule review process, veterans service organizations were not able to provide informed comment, as the VBA had not yet undertaken review or research activities.

Since the initial public meetings, the VBA has not indicated it has any plans to involve VSOs at any other stage of the rating schedule update process other than what is required once the final rule is published, at which time they are required by law to open the proposed rule to all public comment. The IBVSOs believe strongly that the VBA would benefit from VSO input throughout the process of revising the various body systems in the rating schedule. In addition, since the VBA is committed to a continuing review and revision of the rating schedule, it would also be beneficial to conduct reviews of the revision process so that future body system rating schedule updates can benefit from “lessons learned” during prior body system updates.

Recommendations:

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

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

ANNUAL COST-OF-LIVING ADJUSTMENT:

Congress should provide a cost-of-living adjustment for compensation and dependency and indemnity compensation benefits without rounding down such increases to the next whole dollar.

Cost-of-Living Adjustment

In September 2010, the President signed Public Law 111-247, which decreed that the rate of compensation paid to service-connected veterans and recipients of dependency and indemnity compensation should be increased by the same percentage as Social Security is increased, as of November 30, 2010. Increases in Social Security benefits are based on the Consumer Price Index.

Passage of this legislation is a ritual, scripted and performed each year by Congress to ensure that veterans and the surviving spouses of deceased veterans receive benefits in the following year, which are adjusted for inflation.

Disability compensation is paid to the men and women who returned home from military service with the residuals of disease or injury incurred coincident with that service. Compensation was designed to replace the earnings capacity lost because of service-connected disabilities. However, inflation can erode these benefits and, without timely adjustment, can have a material impact on the value of these payments and the quality of life of veterans and their families. While dependency and indemnity compensation is not designed to replace lost earnings capacity, it does provide surviving spouses a modicum of assistance in the absence of a service member who died while in service or a veteran who died as a result of service-connected disabilities. As with compensation, Congress periodically adjusts dependency and indemnity compensation for inflation.

Veterans' and Survivors' Benefits Payment Rounded Down

In government, "temporary" programs often become permanent. In 1990, Congress, in an omnibus reconciliation act, mandated that veterans and survivors benefit payments be rounded down to the next lower whole dollar. Initially, this policy was limited to a few years, but Congress periodically extended this measure, and it is now law.

Rounding down veterans' and survivors' benefits payments to the next lower whole dollar reduces the payments to veterans and their survivors by up to \$12 per year. Each year's cost-of-living adjustment is calculated on the rounded down amount of the previous year's payments. Over time, the cumulative effect of this maneuver has resulted in a significant loss to veterans. For example, a totally disabled service-connected veteran received \$809 per month in 1994. Today, that benefit is worth \$2,673 per month. However, had that veteran received the full cost-of-living adjustment each year as shown in the Consumer Price Index, that benefit would now be \$2,710.⁹ A reduction of \$37 per month means an additional tax of \$444 on this veteran each year.

Recommendations:

To offset cost-of-living increases, Congress should enact legislation that automatically adjusts disability compensation and dependency and indemnity compensation in the same manner as for Social Security benefits.

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

⁹ This amount was calculated using the Bureau of Labor Statistics CPI calculator found at <http://data.bls.gov/cgi-bin/cpicalc.pl>.

STANDARD FOR SERVICE CONNECTION:

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

Disability compensation. (1) Basic entitlement for a veteran exists if the veteran is disabled as the result of a personal injury or disease (including aggravation of a condition existing prior to service) while in active service if the injury or the disease was incurred or aggravated in line of duty.¹⁰

Every so often a commission, committee, government agency (e.g., Government Accountability Office, Office of Management and Budget) or Member of Congress offers the proposition that military service should be treated as if it were a day job: if service members happen to get sick or injured while working a shift they may be eligible, after discharge, for medical treatment and perhaps compensation from the Department of Veterans Affairs. Conversely, if service members are injured before or after work, or become ill from a disease that isn't obviously related to military service, they would not be eligible for service connection at all. Further, medical care would be completely their responsibility.

This idea is offered as a way to “reform and improve” the VA compensation program. In the view of *The Independent Budget* veterans service organizations, it is nothing short of dialing the clock back several hundred years in order to shift the cost of military service to the very men and women who volunteer to serve our nation in both peace and war.

In the military there is no real distinction between “on duty” and “off duty.” A service member on active duty is always at the disposal of military authority and is, essentially, on call 24 hours a day, seven days a week. At any given time a soldier can be placed on alert and assigned to a specific location for as long as his or her superior desires. Sailors can be ordered to sea with minimal notice, where they work their “day job” when they are not standing watch. When the Pentagon wants to send a show of force to a potential adversary somewhere in the world, airmen prepare the planes that aircrews fly, not just from 9 to 5, but anytime day or night.

No one asks them if they can work a little overtime; they are ordered to report and work as long as required to get the job done. Unlike a “day job,” they can't quit. They are there when needed, every day. And far too often they are put at risk of injury, disease, or death in defense of all Americans.

Congress created the Veterans' Disability Benefits Commission to carry out a study of “the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service....” After more than 30 months of meetings, study, analysis, and debate, the commission, in October 2007, unanimously endorsed the current standard for determining service connection.¹¹

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

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

Recommendation:

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

¹⁰ Title 38 CFR 3.4(b)(1).

¹¹ *Ibid.*, note 8, 100.

STANDARD FOR DETERMINING COMBAT-VETERAN STATUS:

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

In the past several years *The Independent Budget* veterans service organizations (IBVSOs) have asked Congress to extend title 38, United States Code, section 1154 to any veteran who served in a combat zone in order to ease the evidentiary burden, and reduce time-consuming development by the Department of Veterans Affairs, so that veterans could more readily obtain service connection for disabilities related to service, especially post-traumatic stress disorder (PTSD).

Relying on medical studies and research, VA amended 38, Code of Federal Regulations, section 3.304 effective July 12, 2010. This change:

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

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

The Independent Budget veterans service organizations congratulate VA for taking the initiative to correct this problem. VA's action in response to our concerns and those of others will demonstrably ease the evidentiary hurdles placed before veterans while ensuring that the integrity of the compensation program is maintained.

Unfortunately, this regulation is not without a major flaw. In section 3.304(f)(3), VA requires that the claimed stressor can only be confirmed by either a "VA psychiatrist or psychologist, or a psychologist with whom VA has contracted." While we recognize that VA mental health professionals have, by necessity, developed an expertise in treating veterans with PTSD, the requirement that only they have the capability to confirm that a veteran suffers from PTSD and that the

stressor is related to military service is both wrong and incredibly wasteful of scarce medical resources.

VA is the largest trainer of health-care professionals in the United States. These interns and residents are exposed to and trained on myriad medical issues that afflict America's veterans. Each year thousands who receive training by VA leave and begin practices in the private sector. They take their training and experience with them and apply it daily. For Veterans Benefits Administration (VBA) officials to assume that psychiatrists and psychologists who receive training in PTSD while at VA would somehow lose that skill once they leave is unreasonable.

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

Finally, refusing to accept a diagnosis and confirmation from a private psychologist or psychiatrist is wasteful of scarce government resources. The savings to VA would be substantial if the acceptance of information from private health-care professionals allowed the VBA to avoid scheduling compensation examinations.

Recommendation:

VA should amend title, 38 Code of Federal Regulations, section 3.304 to allow veterans to submit, and VA to accept, the diagnosis of post-traumatic stress disorder by an outside qualified clinician along with a confirmation that the stressor is directly related to post-traumatic stress disorder and military service.

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

CONCURRENT RECEIPT OF COMPENSATION AND MILITARY LONGEVITY RETIRED PAY:

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

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

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

To put longevity retirees disabled from service on equal footing with nondisabled retirees, VA should provide full military retired pay and compensation to account for reduction of the earning capacity of all those with disability ratings of less than 50 percent. To the extent that military retired pay and VA disability compensation now offset each other, the disabled retiree is treated less fairly than is a nondisabled military retiree. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing a service obligation can receive full VA compensation and full civilian retired pay—including retirement from any federal civil service. A veteran who honorably served and retired after 20 or more years who suffers from service-connected disabilities should have that same right.

A longevity-retired disabled veteran should not suffer a financial penalty for choosing a military career over a civilian career, especially when, in all likelihood, a civilian career would have involved fewer sacrifices and greater rewards. Disability compensation to a disabled veteran should not be offset against military longevity retired pay. While Congress has made progress in recent years in correcting this injustice, current law still provides that service-connected veterans rated less than 50 percent who retire from the armed forces on length of service may not receive disability compensation from VA in addition to full military retired pay. *The Independent Budget* veterans service organizations believe the time has come to finally remove this prohibition completely.

Recommendation:

Congress should enact legislation to totally repeal the inequitable requirement that veterans’ military longevity retired pay be offset by an amount equal to their rightfully earned VA disability compensation if rated less than 50 percent. To do otherwise results in the government compensating disabled retirees with nothing for their service-connected disabilities. *The Independent Budget* veterans service organizations urge Congress to correct this continuing inequity.

MENTAL HEALTH RATING CRITERIA:

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

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

Studies published in 2007 and 2008, the first by the Center for Naval Analysis, Inc.¹⁴ (commissioned by the Veterans Disability Benefits Commission)¹⁵ and the second by Economic Systems, Inc.¹⁶ (commissioned by the Department of Veterans Affairs)¹⁷ found that veterans suffering from service-connected psychiatric disabilities were undercompensated by VA for lost earnings at all levels of disability percentages.

In early 2010, VA began a process that should lead to a rewriting of the entire section of the *Schedule for Rating Disabilities* that deals with mental disorders. VA must ensure that veterans with psychiatric problems

related to service are equitably and appropriately evaluated and compensated.

Recommendation:

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

¹³ 38 U.S.C. 1155.

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

¹⁵ *Ibid.*

¹⁶ EconSys., *A Study of Compensation Payments for Service-Connected Disabilities*, Vol. III (2008), 162–69, 180.

¹⁷ *Ibid.*, 162–69.

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

Hearing loss and tinnitus should be granted service connection if found to a compensable degree in veterans who participated in combat or in those whose military occupations typically involved exposure to acoustic trauma.

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

The Institute of Medicine (IOM) issued a report in September 2005 titled *Noise and Military Service: Implications for Hearing Loss and Tinnitus*.¹⁸ The IOM found that patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel. Because large numbers of people have served in the military since World War II, the total number who experienced noise-induced hearing loss by the time their military service ended may be substantial.

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

Recent medical literature indicates that audiometric testing at high kilohertz levels (10–20 kHz) is more

likely to provide early detection of noise-induced high frequency loss than tests at levels currently used by the Departments of Veterans Affairs and Defense. Although changing testing to higher frequencies for discharging service members would identify those with noise-induced hearing loss while still in service, providing early detection and opportunities for increased education in hearing conservation and the necessary link of hearing loss to military service, this would not result in any changes for veterans who experienced acoustic trauma in service years ago.

Previous audiometric testing in service was insufficient, and testing records were lacking for a variety of reasons. Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control. Congress should do the same for veterans exposed to acoustic trauma, including combat

veterans. Congress should instruct VA, in collaboration with the Department of Defense, to develop a list of military occupations with a high probability of acoustic trauma. VA should be required to presume that any veteran with a military occupational specialty that exposed that veteran to acoustic trauma should be granted service connection for documented hearing loss or tinnitus.

Recommendation:

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

¹⁸ Institute of Medicine, *Noise and Military Service: Implications for Hearing Loss and Tinnitus* (2005).



COMPENSABLE DISABILITY RATING FOR HEARING LOSS NECESSITATING A HEARING AID:

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

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

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

For example, a veteran receives full compensation for amputation of a lower extremity although he or she may be able to ambulate with a prosthetic limb. Additionally, a review of the *Schedule for Rating Disabili-*

ties shows that disabilities for which treatment warrants an appliance, device, implant, or prosthetic, other than hearing loss with hearing aids receive a compensable rating.

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

Recommendation:

VA should amend title 38, Code of Federal Regulations, part 4, *Schedule for Rating Disabilities* to provide a minimum of 10 percent disability rating for any hearing loss medically requiring a hearing aid.

TEMPORARY TOTAL COMPENSATION AWARDS:

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

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

The effective date of temporary total disability ratings corresponds to the beginning date of hospitalization or treatment. Title 38, United States Code, section 5111(c)(2) provides that, in cases where the hospitalization or treatment commences and terminates within the same calendar month, the increase shall commence on the first day of that month. However, in cases where the hospitalization or treatment commences in one month and terminates in a subsequent month, section 5111 delays the effective date for payment purposes

until the first day of the month following the effective date of the increased rating. In many cases this delay in payment causes undue financial hardship on veterans and their families. Disabled veterans, especially those who are unable to work as a result of hospitalization or period of convalescence, rely heavily on this temporary total compensation to replace the lost income. Veterans whose hospitalization or convalescence begins in one month and ends in a different month are left with their temporary total compensation being unnecessarily delayed by at least one month. This practice is unfair in comparison to veterans whose hospitalization or convalescence begins and ends within the same month.

Recommendation:

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

**AGENT ORANGE IN KOREA:**

Differing criteria have been established for Korean War Veterans exposed to herbicides during that conflict.

The delineating dates for presumptive service connection due to exposure to herbicides (Agent Orange) in Korea are not the same for Korean War veterans as they are for Vietnam veterans. If a veteran served in Korea, north of the Imjin River at any time after Agent Orange was applied, presumptive service connection should be granted for the presumptive conditions contained in title 38, Code of Federal Regulations, section 3.309(e).

The current law provides that a veteran who served in Vietnam at anytime during the Vietnam War is presumed to have been exposed to herbicides. If that individual later develops any of the recognized conditions,

service connection is conceded. Service connection opens the door to medical care and compensation.

The same is true if a veteran served in Korea from April 1968 up through July 1969 and was in a unit that rotated to the Korean demilitarized zone (DMZ). Department of Defense records show that herbicides were used extensively in sections of the DMZ during this period.

Korean DMZ veterans must have been stationed there when Agent Orange was applied from April 1968 through July 1969. If a veteran was rotated into the Korean DMZ on 1 August 1969 or later, presumption of

exposure is not conceded and service connection is not granted. Although the Department of Veterans Affairs may still grant service connection if the veteran proves exposure to herbicides and has a listed disability, the evidentiary burden of proving exposure is difficult because the Department of Defense denied for decades the use of Agent Orange anywhere other than in Vietnam. This inequity has created a new class of underserved veterans.

Research has shown that the dioxin in Agent Orange has a half-life of one to three years in surface soil and up to seven years in interior soil.¹⁹ “The toxicity of dioxin is such that it is capable of killing newborn mammals and fish at levels as small as 5 parts per trillion (or one ounce in 6 million tons). Its toxic properties are enhanced by the fact that it can enter the body through the skin, the lungs, or through the mouth.”²⁰

The dioxin on the Korean DMZ did not lose its efficacy on August 1, 1969. It continued to be absorbed into the bodies of the troops who were operating north of the Imjin River and wreaks havoc on those veterans today just as it does to veterans from the Vietnam War.

Recommendation:

Congress should change the eligibility requirements for Korean War Veterans who served north of the Imjin River on the Korean demilitarized zone starting from April 1, 1968, to April 30, 1975.

¹⁹ <http://www.agentorangecanada.com/dioxin.php>.

²⁰ <http://www.vn-agentorange.org/newsletters.html>.



Pensions

PENSION FOR NONSERVICE-CONNECTED DISABILITY:

Congress should extend basic eligibility for nonservice-connected pension benefits to veterans who serve in combat environments regardless of whether a period of war has been established.

Pension is payable to a veteran who is 65 years of age or older or who is permanently and totally disabled as a result of nonservice-connected disabilities, and who has at least one day’s service during a period of war and who has a low income.²¹ The amount of pension awarded is modest at best and is reduced, dollar for dollar, based on countable income. It is designed to ensure that wartime veterans do not become charges on the public welfare.

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

It is quite apparent that the sole service criteria for eligibility to pension, at least one day of service during a period of war, too narrowly defines military activity in the last century. Expeditionary medals, combat badges, and

the like can better serve the purpose of defining combat or warlike conditions when Congress fails to declare war and when the President neglects to proclaim a period of war for veterans’ benefits purposes. Congress should change the law to allow that receipt of an expeditionary medal, campaign medal, combat action ribbon, or similar military service decoration, or service that qualifies the service member for receipt of hostile fire pay, will qualify an individual for pension benefits. This action would ensure that veterans who served during periods of peace but who were placed in hostile situations are eligible for nonservice-connected pension.

Recommendation:

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

²¹ The requirements for pension, along with applicable definitions, are found throughout 38 U.S.C. (e.g., sections 101(15), 1521, 1501).

Dependency and Indemnity Compensation

DEPENDENCY AND INDEMNITY COMPENSATION FOR SURVIVING SPOUSES OF SERVICE MEMBERS:

Congress should increase rates of dependency and indemnity compensation for surviving spouses of service members.

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

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

Recommendation:

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



REPEAL OF OFFSET AGAINST SURVIVOR BENEFIT PLAN:

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

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

Career members of the armed forces earn entitlement to retired pay after 20 or more years' service. Unlike many retirement plans in the private sector, survivors have no entitlement to any portion of the member's retired pay after his or her death. Under the survivor ben-

efit plan (SBP), deductions are made from the member's retired pay to purchase a survivors' annuity. This is not a gratuitous benefit.

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

The Independent Budget veterans service organizations believe this offset is inequitable because no duplication of benefits is involved. Payments under the SBP and DIC programs are made for different purposes. Under the SBP, a dependent purchases coverage that would be paid in the event of the death of the service member. On the other hand, DIC is a special indemnity compensation paid to the survivor of a service member who dies while serving or a veteran who dies from service-connected disabilities. In such cases VA indemnity compensation should be added to the SBP, not substituted for it. We note that surviving spouses of federal civilian retirees who are veterans are eligible for DIC with-

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

Recommendation:

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



RETENTION OF REMARRIED SURVIVORS' BENEFITS AT AGE 55:

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

Current law permits the Department of Veterans Affairs to reinstate DIC benefits to remarried survivors of veterans if the remarriage occurs at age 57 or older or if survivors who have already remarried apply for reinstatement of dependency and indemnity compensation at age 57. Although *The Independent Budget* veterans service organizations appreciate the action Congress took to allow this restoration of rightful benefits, the current age threshold of 57 years is arbitrary. Remarried survivors of retirees of the Civil Service Retirement System, for example, obtain a similar benefit at age 55.²² 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 from 57 to 55 for reinstatement of disability and indemnity compensation to remarried survivors of service-connected veterans.

²² <http://www.opm.gov/retire/pubs/pamphlets/R125-26.pdf>.

Readjustment Benefits

Housing Grants

GRANT FOR ADAPTATION OF A NEW 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 change with time and circumstances. An initial home may become too small when the family grows or become too large when children leave home. Likewise, changes in the nature of a veteran's disability(ies) may necessitate a home configured differently and/or changes to the special adaptations. In addition, technological changes occur rapidly and additional modifications, after the initial housing grant, may maximize the veteran's independence as well as improve the ability for caregivers to provide medically necessary care. These evolving requirements merit a second grant to cover the costs of adaptations to a new home.

Recommendation:

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



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

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

The Department of Veterans Affairs may provide Temporary Residence Allowance (TRA) Grants for veterans who have service-connected disabilities for certain combinations of loss or loss of use of extremities and blindness or other organic diseases or injuries when those veterans reside in but do not intend to permanently reside in a residence owned by a family member. Specifically, the assistance for the first group may not exceed \$14,000 for veterans who have a permanent and total service-connected disability as a result of the loss or loss of the use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair.

For the second group, the assistance may not exceed \$2,000 for veterans who have a permanent and total service-connected disability rating due to blindness in both eyes with 5/200 visual acuity or less and the dis-

ability includes the anatomical loss or loss of use of both hands. Unless the amounts of these grants are periodically adjusted, inflation erodes these benefits that are payable to a select few, albeit among the most seriously disabled service-connected veterans.

A 2009 Government Accountability Office report²³ indicated that only nine veterans had taken advantage of this grant. The report examines several reasons for the low usage. It concluded that because the TRA grant amount counts against the amount of the overall amount of the Specially Adapted Housing Grant, eligible veterans may choose to wait until they want to adapt their own home.

Finally, the current authorization for the TRA expires on December 31, 2011. *The Independent Budget* veterans service organizations believe the grant should be-

come a permanent benefit with implementation of these recommendations.

Recommendations:

Congress should increase the allowance from \$14,000 to \$28,000 for veterans with permanent and total service-connected disabilities as a result of loss or loss of use of both lower extremities that preclude locomotion without the aid of braces, crutches, canes, or wheelchairs.

Congress should increase the allowance from \$2,000 to \$5,000 for veterans who have permanent and total service-connected disabilities due to blindness in both eyes with 5/200 visual acuity or lower and the disabil-

ity includes the anatomical loss or loss of use of both hands. Congress should provide for automatic annual adjustments to keep pace with inflation.

Congress should separate the Temporary Residence Adaptation Grant as a stand-alone program so that the grant amount would not count against the overall grant for permanent housing and eliminate the expiration date of grant eligibility upon implementation of the previous recommendations.

²³ GAO-09-637R.



Insurance

Government Life Insurance

VALUE OF POLICIES EXCLUDED FROM CONSIDERATION AS INCOME OR ASSETS:

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

For nursing home care under Medicaid, the government forces veterans to surrender their government life insurance policies and apply the amount received from the surrender for cash value toward nursing home care as a condition for Medicaid coverage of the related expenses of needy veterans. It is unconscionable to require veterans to surrender their life insurance to receive nursing home care.²⁴ Life insurance is intended to provide for survivors after the veteran's death. It is not a savings method that should be garnered to pay for one's 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.

²⁴ <http://www.insurance.va.gov/gli/glihandbook/glibooklet2010.pdf>, pg12.

LOWER PREMIUM SCHEDULE FOR SERVICE-DISABLED VETERANS' INSURANCE:

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

Because of service-connected disabilities, disabled veterans often have difficulty obtaining life insurance in the commercial market. Even when they can purchase life insurance, premiums are higher than for nondisabled individuals. As a consequence, Congress created the Service-Disabled Veterans' Insurance (SDVI) program to furnish life insurance for disabled veterans at standard rates.

When the SDVI program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. However, the Department of Veterans Affairs is required to base its rates on the mortality tables from 1941.

Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer pro-

vide the intended benefit for eligible veterans. In addition, Public Law 111-275, the "Veterans Benefits Act of 2010," authorized an increase from \$20,000 to \$30,000 in the supplemental amount of insurance available. Eligible veterans must pay for this additional coverage and may not have premiums waived for any reason. Unfortunately, Congressional intent will not be met because the premiums under the current schedule are not affordable for many service disabled veterans.

Recommendation:

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

**INCREASE IN MAXIMUM SERVICE-DISABLED VETERANS' INSURANCE COVERAGE:**

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

Life insurance for veterans was first made available to members of the armed forces in October 1917 because life insurance issued by commercial life insurers either excluded protection against the extra hazards of war, or if such protection was included, the premium rates were much higher than the normal rate. The War Risk Insurance Act was amended on June 12, 1917, to cover merchant marine personnel. The act was again amended on October 6, 1917, authorizing for the first-time issuance of government life insurance to members of the armed forces. More than 4 million policies were issued during World War I.²⁵ Coverage was available in increments of \$1,000 up to \$10,000.²⁶ At that time the law authorized an annual salary of \$5,000 for the director of the Bureau of War Risk Insurance.²⁷ Obviously, the average annual wages of service members in 1917

were considerably less than \$5,000. A \$10,000 life insurance policy provided sufficiently for the loss of income from the death of the insured in 1917.

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

A May 2001 report from an SDVI program evaluation conducted for the Department of Veterans Affairs²⁸ 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 in increments of \$10,000 with a review every five years to determine if the amount remains adequate.

Recommendation:

Congress should enact legislation to increase the maximum protection under base Service Disabled Veterans' Insurance policies to \$50,000 with a review every five years to determine if the amount remains adequate.

²⁵ <http://www.insurance.va.gov/gli/glihandbook/glibooklet2010.pdf>,pg12.

²⁶ <http://www.archive.org/stream/allotmentsfamily00unitrich#page/42/mode/2up>,pg42.

²⁷ *Chicago Daily News, Almanac and Year-Book for 1918*, 248.

²⁸ Department of Veterans Affairs, "Program Evaluation of Benefits for Survivors of Veterans with Service-Connected Disabilities, Volume IV, page 127" by Systems Flow, Inc., Economic Systems, Inc., Macro International, Inc., and Hay Group, (May 2001).

General Operating Expenses

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

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

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

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

Veterans Benefits Administration

CULTURAL CHANGE NEEDED TO FIX THE CLAIMS-PROCESSING SYSTEM:

Fixing longstanding, systemic problems in the VA claims-processing system will require leadership and accountability at all levels and a shift from focusing on “reducing the backlog” to “getting claims done right the first time.”

The Veterans Benefits Administration (VBA) is at a critical juncture in its efforts to reform an outdated, inefficient, and overwhelmed claims-processing system. After struggling for decades to provide timely and accurate decisions on claims for veterans benefits, the VBA over the past year has started down a path that may finally lead to essential transformation and modernization, but only if it has the leadership necessary to undergo a cultural shift in how it approaches the work of adjudicating claims for veterans benefits.

For a number of reasons, including the recent wars in Iraq and Afghanistan, the addition of new presumptive conditions for Vietnam and Gulf War veterans, and the economic recession, the number of new claims for disability compensation, including both first-time claims for benefits and claims for increases or additional benefits, has risen to more than 1 million per year. In addition, both the average number of issues per claim and the complexity of claims have increased as complicated new medical conditions, such as traumatic brain injury, have become more prevalent.

To meet rising workload demands, *The Independent Budget* veterans service organizations (IBVSOs) have recommended, and Congress has provided, significant new resources to the VBA over the past several years in order to increase its personnel levels. Yet despite the hiring of thousands of new employees, the number of pending claims for benefits, often referred to as the backlog, continues to grow. As of January 31, 2011, there were 775,552 pending claims for disability compensation and pensions awaiting rating decisions by the VBA, an increase of 289,081 from one year ago.¹ About 41 percent of that increase is the result of the Secretary’s decision to add three new presumptive conditions for Agent Orange (AO) exposure: ischemic heart disease, B-cell leukemia, and Parkinson’s disease.

Even discounting those new AO-related claims, the number of claims pending rose by 171,522, a 37 percent increase of pending claims over just the past year.² Overall, there are 331,299 claims that have been pending greater than VA’s target of 125 days, which is an increase of 147,930, up more than 80 percent in the past

year.³ Not counting the new AO-related, over 50 percent of all pending claims for compensation or pension are now past the 125-day target set by the VBA.

Worse, by the VBA’s own measurement, the accuracy of disability compensation rating decisions continues to trend downward, with its quality assurance program, known as the Systematic Technical Accuracy Review (STAR), reporting only an 83 percent accuracy rating for the 12-month period ending May 31, 2010.⁴ Moreover, the VA Office of Inspector General (OIG) found that even those numbers were inaccurate, citing additional undetected or unreported errors that increased the error rate for the cases reviewed to 22 percent.⁵ Complicating VA’s problems is its reliance on an outdated, paper-centric processing system, which now includes more than 4.2 million claims folders. In fact, a 2009 VA OIG report found that more than 300,000 claims files had been misplaced and more than 140,000 were lost outright.

Faced with all of these problems, Secretary Eric Shinseki in 2010 set an extremely ambitious long-term goal of zero claims pending more than 125 days and all claims completed to a 98 percent accuracy standard. Throughout the year he forcefully and repeatedly made clear his intention to “break the back of the backlog” as his top priority. While the IBVSOs welcome his intention and applaud his ambition, we would caution that eliminating the backlog is not necessarily the same goal as reforming the claims-processing system, nor does it guarantee that veterans are better served.

The backlog is not the problem, nor even the cause of the problem; rather, it is only one symptom, albeit a very severe one, of a much larger problem: too many veterans waiting too long to get decisions on claims for benefits that are too often wrong.

For example, while a person with a fever can take an aspirin to reduce that symptom, the aspirin will not address the cause of the fever, nor prevent the fever from recurring in the future. So, too, with the backlog: if the VBA focuses simply on getting the backlog number down, it can certainly achieve numeric success in the near term, but it will not necessarily have addressed

the underlying problems nor taken steps to prevent the backlog from eventually returning.

To achieve real success, the VBA must focus on creating a veterans' benefits claims-processing system designed to "get each claim done right the first time." Such a system would be based upon a modern, paperless information technology and workflow system focused on quality, accuracy, efficiency, and accountability. The foundation of this new system must be continuous improvement; the VBA must evolve its corporate culture to focus on information gathering, systems analysis, identification of problems, creative solutions, and rapid adjustments. This process must be a circle, not a series of lines with stoplights. If the VBA stresses quality control and training, and continues to receive sufficient resources, timeliness will improve and production will increase, and then and only then can the backlog be reduced and eventually eliminated.

Recognizing all of these problems and challenges, the IBVSOs do see some positive and hopeful signs of change. VBA leadership has been refreshingly open and candid in recent statements on the problems and need for reform. Over the past year, dozens of new pilots and initiatives have been launched, including a major new information technology system that is now being field-tested. The VBA has shared information with the veterans service organizations (VSOs) about its ongoing initiatives and sought feedback on these initiatives. These are all positive developments.

Yet, despite the VBA's new openness and outreach to the VSO community, we remain deeply concerned about its failure to fully integrate service organizations in reforming the claims process. The VBA has not and does not solicit our input at the beginning of the process, a critical mistake for a number of reasons. First, VSOs not only bring vast experience and expertise about claims processing, but our local and national service officers hold power of attorney for hundreds of thousands of veterans and their families. In this capacity veterans service organizations are an integral component of the claims process. The IBVSOs make the VBA's job easier by helping veterans prepare and submit better claims, thereby requiring less time and resources to develop and adjudicate them. VBA leadership must commit to a true partnership with service organizations and infuse this new attitude throughout the VBA from central office down to each of the 57 regional offices. Partnership with VSOs requires more than "checking a box" after holding pro forma meetings and informing the VSOs of actions after the fact. Similarly, VBA management must work more closely with employees and

employee representatives throughout the transformation process.

In order to make cultural changes at the VBA, there must be steady and consistent leadership and accountability at all levels of the organization. Although Secretary Shinseki has personally focused a significant amount of his time on the problems at the VBA, unfortunately, as 2010 drew to a close—nearly two years into this Administration—there was still no permanent under secretary for benefits in place. Although the VBA has completed some other management changes, the time is long overdue for a new under secretary to provide leadership and stability as it seeks to modernize and optimize its claims-processing system. No large organization can be expected to operate at peak efficiency, much less dramatically transform itself, without a chief executive in place to lead that change.

The VBA must also change how it measures and rewards performance in a manner designed to achieve the goal of "getting it right the first time." Unfortunately, most of the measures that the VBA employs today, whether for the organization as a whole or for regional offices or employees, are based primarily on measures of production, which reinforces the goal of ending the backlog. For example, the most common way to measure the VBA's progress is through its Monday Morning Workload Reports, which contain measures of production, but not accuracy or quality.⁶ Another major tool used to review the VBA's status is its "Dashboard," which provides current performance statistics for each VA regional office (VARO). Like the Monday Morning Reports, Dashboard measures are primarily related to pending work inventory and production times, with just a few measures of accuracy included. Since the primary measures used to hold the VBA and VAROs accountable are focused on the size of the backlog and cycle times, it is not surprising that VARO management focuses so heavily on production, rather than accuracy or quality.

Given leadership and management's focus on production, therefore, it is not surprising that employees—veterans service representatives (VSRs) and rating veterans service representatives (RVSRs)—feel tremendous pressure to meet production goals first and foremost. While accuracy has been and remains one of the performance standards that must be met by employees, the new performance standards may have created new incentives to sacrifice quality for production. The prior performance standards for VSRs included 63 categories of weighted work activities; the new standards have only five production categories now called "outputs." Es-

sentially, a VSR will receive one “output” credit for completing each stage of the work process: initial rating development, initial nonrating development, ready for decision, process award/decision, and authorize award. It appears that this system is designed to emphasize moving claims quickly toward completion by eliminating the piecemeal work credits that were based upon each activity related to development that was completed. The new system provides no work credit for Congressional inquiries, Freedom of Information Act requests, or conducting personal interviews. It also appears to eliminate work credit for appeals related activities, such as supplemental statements of case.

While the former work credit system may have created opportunities for “gaming” the system, such as delaying requests for routine future exams, in order to gain additional work credits, the new system may inadvertently create new incentives for “cutting corners” in order to complete a case, since more complex multi-issue cases get no more credit than simple one-issue cases.

There have been reports that a very high percentage of VSRs have failed to meet the new performance standards in the first few months of implementation, causing the VBA to reexamine the standards in conjunction with employee representatives. The VBA is also continuing to discuss proposed new performance standards for RVSRs and decision review officers with employee representatives. It is imperative that employee and management performance standards and other incentives be directed toward the goal of deciding claims accurately.

Over the past year, under the Secretary’s leadership, the VBA has established an aggressive strategy and schedule for reforming the benefits claims-processing system. In order to achieve lasting success, the VBA must first and foremost focus on quality and accuracy ahead of simply reducing the backlog. As the VBA seeks to modernize its IT infrastructure and optimize business processes, it will require strong and effective leadership, something it cannot fully realize until there is a new under secretary in place. In addition, veterans service organizations firmly believe that the VBA cannot be completely successful unless it truly seeks and realizes a mutually beneficial partnership with the VSO community.

Recommendations:

The Veterans Benefits Administration should develop regular and ongoing roles for veterans service organizations’ participation in reforming the claims process, particularly in the planning, development, implementation, evaluation, and integration of pilots and initiatives, including the Veterans Benefit Management System.

The VBA must have a permanent under secretary for benefits to provide steady and consistent leadership, and the Administration and Congress must ensure that future transitions fill the position of under secretary for benefits in a timely manner.

The VBA and Congress must shift their approach for reforming the claims-processing system so that the goal is not just reducing the backlog, but, first and foremost, creating a system that provides accurate decisions in a timely manner.

The VBA should change its measurement and reporting of progress so that there are more and better indicators of the quality and accuracy of work, thereby demonstrating its commitment to “getting claims done right,” not just “getting claims done quickly.”

The VBA should continue to review employee performance standards and its work credit system to ensure that it creates sufficient and proper incentives and accountability to achieve quality and accuracy, not just increased speed or production.

¹ <http://www.vba.va.gov/REPORTS/mmwr/index.asp>.

² Ibid.

³ Ibid.

⁴ Department of Veterans Affairs, *FY 2010 Performance and Accountability Report Part II*, 107.

⁵ <http://www4.va.gov/OIG/pubs/VAOIG-statement-20100324-Finn.pdf>.

⁶ <http://www.vba.va.gov/REPORTS/mmwr/index.asp>.

REFORMING AND MODERNIZING THE CLAIMS PROCESS:

As the Veterans Benefits Administration moves forward with dozens of pilots and initiatives designed to modernize and streamline the claims-processing system, it is imperative that the VBA have a systematic method for analyzing and integrating “best practices” that improve quality and accuracy, rather than just those that may increase production.

Recognizing that the current claims-processing system is irretrievably broken, the Veterans Benefits Administration (VBA) last year undertook a comprehensive new effort to reform and modernize the claims process. There are currently dozens of initiatives under way that could potentially lead to new ways of establishing, developing, rating, and awarding claims for benefits.

Over the past year, representatives of *The Independent Budget* veterans service organizations (IBVSOs) visited or were briefed on many of the more prominent pilot programs, including ones at Little Rock, Arkansas; Providence, Rhode Island; and Pittsburgh. While the pilots in Little Rock and Providence, as well as the Fully Developed Claim and Individual Claimant Checklist, were Congressionally mandated in Public Law 110-389, many others, such as the Quick Pay Disabilities pilot in St. Petersburg, Florida; the Rapid Evaluation of Veterans’ Claims pilot in Atlanta; and the Case Management pilot in Pittsburgh, were initiated by VBA regional offices with central office approval. Other ideas come from the VBA’s “Innovation Initiative,” which produced 10 winners from hundreds of submissions by regional offices, 8 of which are actively being implemented.⁷ In addition, the VBA also approved eight “quick hit” ideas at the Regional Directors Workshop in spring 2010, including pilots that are testing phone development and a walk-in claims rating program. Many other ideas that the IBVSOs and others have been promoting, including the increased use of private medical evidence and interim ratings, are also currently being tested in the field. The challenge the VBA faces in the coming year will be analyzing and synthesizing the results of all this experimentation into a new claims-processing system.

The Little Rock pilot, developed under contract with Booz Allen Hamilton, sought to infuse Lean Six Sigma⁸ principles of continuous improvement and reduction of waste into the current claims-processing system. This pilot reorganized a portion of the VA regional office (VARO) workforce into integrated teams called “pods,” which included both veterans service representatives (VSRs) and rating veterans service representatives (RVSRs), working as one integrated unit on claims. The pilot also developed new changes to the mailroom operations as well as physical layout changes to improve

oversight of workload. Although the contract is complete, the Little Rock “pod” pilot continues and is being expanded to two additional VA regional offices in New York and Montgomery, Alabama. In addition, a number of other VAROs have begun limited experiments with the lean processing and “pod” concepts.

Since moving to the current Claims Process Improvement (CPI) model of processing claims, based upon specialization of function, the VBA has lost some of the benefits inherent in a team-based approach. For example, by mixing together more experienced RVSRs and VSRs in Little Rock with those less experienced, there has been a natural increase in mentoring and unofficial “on-the-job” training of newer employees. Over time the IBVSOs would expect a measureable improvement in the quality of decision making. While we do not advocate that the VBA simply replace the current model with the “pod” model, we believe that the VBA should continue to explore greater use of team approaches, whether in particular locations, or for specific types of claims.

The Providence pilot begun in October 2009 was designated as the VBA’s Business Transformation Laboratory to provide a testing capability for future paperless processes in a live environment. In addition, they also have been testing a new phone development program. After the regional office sends a veteran claimant a notification letter explaining the veteran’s rights and what he or she needs to do in order to prove the claim, a VSR calls the veteran to answer any questions he or she may have about that letter as well as to assist with fulfilling the veteran’s required burden of development. In essence, VA employees help distill the boilerplate in development letters into something more understandable for veterans. As a result, Providence has been able to shorten development time and the average number of days to complete claims.

The telephone development program has shown promising results, and we support the continued exploration of this concept. It is imperative, however, that the VBA develop and implement proper methods to notify and involve service officers and other power of attorney holders for claimants who are represented.

The Pittsburgh Regional Office has two major initiatives under way: one establishing distinct case-management teams and the other developing templates for private medical evidence that was borne out of the VBA's Innovation Initiative. The IBVSOs have long advocated for the expanded use of private medical evidence, which has too often been discounted because it was submitted in a multitude of nonstandard formats, not always appropriate or sufficient for rating a disability under the rating schedule. These templates, constructed to solicit the information needed to address specific criteria in the rating schedule could, if given proper weight during the rating process, save the VBA time and resources by eliminating unnecessary and redundant VA medical exams for claimants.

Late last year a joint task force with experts from both the VBA and the Veterans Health Administration (VHA) began developing these templates, which are now called Disability Benefits Questionnaires (DBQs).⁹ The first three DBQs completed, which have been approved and are now in use, are for the three new presumptive conditions associated with Agent Orange exposure: ischemic heart disease, Parkinson's disease, and B-cell leukemia. Currently, the joint task force is working on 76 additional DBQs. The DBQs will be used by the VHA and its contract examiners, and will also be available for veterans who would like to have a private physician examine them. While the DBQs are not yet able to be electronically completed and submitted, the VBA is working with the new IT development team to ensure that DBQs can be seamlessly made a part of a veteran's electronic claims file when such a system exists.

The IBVSOs have been provided the opportunity to offer comment on some of the draft DBQs. We believe the VBA will produce better and more useful DBQs if it continues to actively solicit and incorporate the input of veterans service organizations at the earliest stage possible.

We support the development and use of DBQs as a method to streamline and improve the quality and timeliness of decisions, but with one caveat. It is crucial that VSRs and RVSRs be trained and understand that DBQs are but one piece of evidence that must be considered in the development and decision-making process. In many instances, claimants will have other medical evidence that is related to the issue at hand. If so, decision makers must properly consider the evidentiary weight and value of all evidence related to the claim and address it adequately in the reason and bases of the subsequent decision.

We are also concerned that the burdensome review process for approvals of or modifications to DBQs could delay their use. The VBA has indicated that it must re-

ceive Office of Management and Budget approval in order to release or modify any of the DBQs, a process that can take months or years in some cases. The IBVSOs urge VA to work with the OMB to ensure that approval or modification of DBQs are done in a timely manner.

The VBA has also launched another new pilot program designed to improve the collection of private medical evidence. The VBA is contracting with private vendors who will seek to retrieve medical records from private physicians when such records have been identified during the development process, thereby relieving the VBA of that function, which consumes significant VBA resources and delays processing of the claim. This pilot is expected to be operated at six VA regional offices until sufficient information is available to determine whether this approach could reduce the time and resources required for obtaining private medical records.

One of the major new claims-process reform initiatives is the Fully Developed Claims (FDC) program, which began as a pilot program mandated by P.L. 110-389, and was rolled out to all VAROs last year.¹⁰ In response to concerns expressed by the IBVSOs, the VBA has modified the FDC application process so that a veteran can make an informal notification to the VBA of their intention to file a FDC claim, thereby protecting his or her earliest establishment date. This change ensures that veterans who do the work necessary to file a fully developed claim not only get a quicker decision, but also can be assured of their earliest establishment date.

Although the FDC program is fully operational at all VAROs, the VBA reports that the participation level of veterans remains low. In addition, there have been reports that a significant number of claims filed under the FDC program are being removed from the program, often because the veteran (usually those unrepresented) sends in additional information or evidence related to his or her claims after the initial FDC filing. The VBA must work with veterans service organizations, as well as make direct outreach efforts, to better inform veterans of the advantages of, as well as the rules governing, the FDC program.

The VBA has recently stood up an Office of Strategic Planning, charged with managing and implementing the VBA's transformation plan. This new office will be responsible for overseeing the pilots and initiatives and developing plans to integrate them into a new 21st century claims-processing system. In order to develop that new claims process, the VBA will operate an "integration lab" at the Indianapolis Regional Office to consider which of the "best practices" from the many pilots will work best together.

The IBVSOs, however, do have concerns about whether the VBA will successfully extract and then integrate the best practices from so many ongoing initiatives, while simultaneously meeting the Secretary's ambitious goals with regard to "breaking the back of the backlog." Given the enormous pressure to reduce the backlog, we are concerned that there could be a bias toward process improvements that result in greater production over those that lead to greater quality and accuracy. In addition to these many pilots and other initiatives, there are also legislative and regulatory changes that could be made to streamline and modernize the claims process.

The IBVSOs have always encouraged VA to use private medical evidence when making its decisions, as it saves the veteran time in development and VA the cost of unnecessary examinations. While recent court decisions have indicated that VA should accept private medical opinions that are credible and acceptable for rating purposes, we have seen no evident reduction in remands to obtain medical opinions.

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

Modifying regional office jurisdiction regarding supplemental statements of the case (SSOCs) will improve the timeliness of the appeals process. In the current process, when an appeal is not resolved, the VARO will issue a statement of the case along with a VA Form 9 to the claimant, who concludes, based on the title of the Form 9 (Appeal to the Board of Veterans' Appeals) that the case is now going to the BVA. Consequently, the veteran may feel compelled to submit additional or repetitive evidence in the mistaken belief that his or her appeal will be reviewed immediately by the BVA. But the VARO instead issues an SSOC each time new evidence is submitted. This continues until VA finally issues a VAF-8, Certification of Appeal, which actually transfers the case to the BVA.

The IBVSOs propose an amendment to this process that will explain that evidence submitted after the appeal has been certified to the BVA will be forwarded directly to the BVA and not considered by the regional office unless the appellant or his or her representative elects to have additional evidence considered by the regional office. This opt-out clause merely reverses the standard process without removing any rights from an appellant. In implementing such a change, VA must provide sufficient notice to a veteran that new evidence may be considered at the regional office level, should the veteran so desire, and should allow the veteran to provide electronic notice of his or her decision, rather than adding the time and expense of mailing a response. We believe this change should result in reduced waiting times for the appellant and much less appellant confusion, and could potentially save tens of thousands of VA work hours by eliminating, in many cases, the requirement to issue SSOCs.

Recommendations:

Congress must provide sufficient oversight of the Veterans Benefits Administration's myriad ongoing pilots and initiatives to ensure that best practices are adopted and integrated into a cohesive new claims process and that each pilot or initiative is judged first and foremost on its ability to help VA get claims "done right the first time."

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

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

⁷ <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1852>.

⁸ Lean Six Sigma is a business management strategy originally used in many sectors of industry that seeks to improve the quality of process outputs by identifying and removing the causes of defects (errors) and minimizing variability in manufacturing and business processes.

⁹ <http://www.vba.va.gov/disabilityexams/>.

¹⁰ <http://www.vba.va.gov/fastclaims/>.

TRAINING AND QUALITY CONTROL:

Training and quality control are necessarily interrelated and must be given the highest priority by the Veterans Benefits Administration in order to successfully reform the claims-processing system.

Training and quality control are interrelated and must be part of a continuous improvement program, both for employees and for the claims process itself. Quality control programs should identify areas and subjects that require new or additional training for Veterans Benefits Administration (VBA) employees; better training programs for employees and managers should improve the overall quality of the VBA's work.

The VBA's primary quality assurance program is the Systematic Technical Accuracy Review (STAR) program. The STAR program can identify three types of errors—benefit entitlement, decision documentation and notification, and administrative. STAR looks at actions such as whether a proper Veterans Claims Assistance Act predecision “notice” was provided and whether the rating decision was merited based on the available evidence. Under the STAR program, VA reviews a sampling of decisions from regional offices and bases its national accuracy measures on the percentage with errors that affect entitlement, benefit amount, and effective date. The STAR program was also intended to identify major national error trends so that the Compensation and Pension (C&P) program could initiate corrective measures. Such corrective measures could include training, improved procedural guidance, or automated system improvements.

The STAR program was last evaluated by the VA Office of Inspector General (OIG) as part of its review of compensation rating accuracy in March 2009 in the report *Audit of Veterans Benefits Administration Compensation Rating Accuracy and Consistency Views*.¹¹ The OIG determined that the VBA STAR program does not provide a complete assessment of rating accuracy. During the 12-month period ending in February 2008, the VBA STAR process did not effectively identify and report all errors in compensation claim rating decisions. The VBA identified a national compensation claim rating accuracy of 87 percent. Of the approximately 882,000 compensation claims measured by STAR reviewers, the VBA estimated that about 87 percent were technically accurate. The OIG, on the other hand, reviewed a random sampling of cases that had also been reviewed by STAR reviewers and found additional errors. They projected an accuracy rate of only 78 percent. They also audited brokered cases. Of that sampling, they found an accu-

racy rate of 69 percent. Combining the audit of brokered claims with those STAR-reviewed claims results in a projected accuracy rate of about 77 percent of claims. The OIG determined that this equates to approximately 203,000 claims in that one year alone where veterans' monthly benefits may be incorrect.

The Independent Budget veterans service organizations (IBVSOs) agree with the VA OIG that the Veterans Benefits Administration could improve the STAR program by establishing a mechanism to ensure STAR reviewers evaluate all documentation related to the claim selected for review; a requirement that all STAR reviewer comments receive a second review to make sure the reviewer appropriately recorded the comment instead of a benefit entitlement error; procedures to review brokered claims as part of the STAR program; and minimum annual training requirements for each STAR reviewer that are comparable to regional office rating staff training requirements.

In addition, the IBVSOs recommend that the VBA establish a quality control program that looks at claims in process in order to determine not just whether a proper decision was made, but how it was arrived at in order to identify ways to improve the system. The data from all such reviews could be incorporated into the VBA's new IT system (VBMS) so that analysis can provide management and employees important insights into processes and decisions. This, in turn, would lead to quicker and more accurate decisions on benefits claims, and, most important, the delivery of all earned benefits to veterans, particularly disabled veterans, in a timely manner.

The VBA has mountains of data about the quality and accuracy of work performed under the current system that comes from the STAR program, “coaches” reviews of employees, Inter-Rater Reliability reviews, employee certification testing, and data from remands from the Board of Veterans' Appeals and the Court of Appeals for Veterans Claims. However, there is currently no process or system to aggregate or analyze the data to spot error trends or breakdowns in the claims process that need improvement or additional training of employees or managers. The new VBMS system should include this capability and be used to modify training programs.

Training is essential to the professional development of individuals and tied directly to the quality of work they produce, as well as the quantity they can accurately produce. The IBVSOs remain concerned that the VBA has historically emphasized production over training. Veterans service organization officers have been told by many VBA employees that meeting production goals is the primary focus of management, whereas fulfilling training requirements and increasing quality is perceived as being secondary. An overemphasis on productivity must not interfere with the training of new employees who are still learning their jobs.

The training program in the VBA is basically a three-stage system, which requires new veterans service representatives (VSRs) and rating veterans service representatives (RVSRs) to complete orientation training at their respective VA regional office (VARO). Next, they participate in a two- to three-week centralized or “Challenge” training course at the VA training academy, which provides a basic introduction to job responsibilities. When each returns to his or her respective VARO, new VSRs and RVSRs spend several more months in training, which includes completing a required curriculum by way of online learning known as the Training and Performance Support System, as well as on-the-job training and/or instructor-led classroom training. VBA training consists of approximately 11 training modules in the Training and Performance Support System, each consisting of multiple sections and each with some testing requirements. Subjects range from very general orientation to more in-depth subjects, such as medical terminology, how to utilize the VBA’s computer-based programs, how to review and interpret medical evidence, and how to understand and apply the law and regulations when evaluating evidence and rendering decisions.

Once these individuals have successfully completed their initial training, they begin their on-the-job-training phase, in which they will be moved into productive roles in developing and rating cases with supervision. They will continue this on-the-job training phase with mentoring and supervision, slowly increasing the number and complexity of cases until they are assigned a full case load approximately two years from their hire date. Some VBA employees have reported that trainees are being rushed into production in an effort to assist with the reduction of the backlog. It must be understood that increasing the number of claims processors will not immediately translate into greater productivity. The benefit of new claims processors will not be realized for more than two years after they have completed their on-the-job training. This must be taken into consideration during the training phase, and em-

ployees must be allowed adequate time to complete their training, allowing them to move slowly into a productive capacity focused on the quality of decisions they render versus the quantity of work produced. From that point forward, they will have the same training requirements as all other experienced VSRs and RVSRs, which requires all employees to complete 80 hours of training annually, along with an additional 5 hours on VA’s online Learning Management System for cybersecurity and ethics. VBA training is broken down to 40 hours of standardized training on VBA selected subjects and 40 hours of training on subjects selected by the VARO from the Core Technical Training Requirements and other subjects of their choosing.

The Government Accountability Office (GAO) recently conducted a study to determine the appropriateness of training for experienced claims processors and the adequacy of VBA’s monitoring and assessment of such training.¹² Of particular interest are GAO findings that experienced claims processors had concerns with the training received—specifically the hours, amount, helpfulness, methods, and timing of training. Likewise, as the GAO report pointed out, there is very little done by the VBA to ensure the required training is completed or to assess the adequacy and consistency of the training, nor to properly ascertain the total number of VSRs and RVSRs who have met the annual training requirement. In fact, only one VARO met the annual training requirement, and nine VAROs had less than half their employees meet the annual training requirement. It is simply unacceptable to have only one VARO meet the simple requirement of ensuring that all employees complete 80 hours of training. The VBA must place greater emphasis on training by implementing stricter monitoring mechanisms for all VAROs and ensure that they are held accountable for failure to meet this minimal standard.

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

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

In 2008, Congress approved Public Law 110-389, the “Veterans’ Benefits Improvement Act of 2008,” which required the VBA to develop and implement a certification examination for claims processors and managers; however, today there are still gaps in the implementation of these provisions. While tests have been developed and piloted for VSRs and RVSRs, additional tests need to be developed and deployed for decision review officers and supervisory personnel. None of these certification tests are mandatory for all employees, nor are they done on a continuing basis. The VBA has begun administering certification examinations for some employees; however, the examination is primarily being used for grade level increases, not for proficiency purposes. For example, if a VSR wants to raise his or her pay grade level from a GS-10 to GS-11, the VSR must pass a certification examination; however, the VSR may opt out of the examination and remain at his or her current level. Conversely, if that same VSR fails the certification examination, there is no penalty and the VSR may remain in his or her current position. Moreover, the VBA has no remedial training programs for employees that fail certification tests, nor are these employees required to retake the test to show that they have mastered the skills and knowledge required to do their job.

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

- It could be used to measure the proficiency and knowledge required for promotion or be used as a factor in determining other incentives.

- It could be used to identify subject matters or competencies that need required additional training of the test-taker.
- It could help evaluate the effectiveness of the training programs.
- It could help identify weaknesses in the claims process that may require systemic improvements.

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

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

Successful completion of training must be an absolute requirement for every VARO and must be a shared responsibility of both employees and management. Managers must be held responsible for ensuring that training is offered and completed by all of its employees. However it is also the responsibility, as well as part of the performance standard, for employees to complete their training requirements. Managers must provide employees with the time to take training, and employees must fully and faithfully complete their training as offered. Neither should be able or pressured to just “check the box” when it comes to training.

The only way that the VBA can make any tangible and lasting gains toward decreasing the backlog will be by producing better quality decisions the first time. The VBA must undergo a cultural change that focuses on the accountability of managers and employees to ensure the training is being accomplished on time and with consistency.

Recommendations:

The Veterans Benefits Administration must ensure that its existing quality assurance programs, particularly the Systematic Technical Accuracy Review (STAR) program, are sufficiently funded and staffed to allow it to adequately measure accuracy.

The VBA should ensure that the new IT system is able to systematically aggregate and analyze the information that comes from the STAR program, “coaches” reviews of employees, Inter-Rater Reliability reviews, employee certification testing, and data from remands from the Board of Veterans’ Appeals and the Court of Appeals for Veterans Claims to identify error trends and emerging issues that call for process improvements or additional training of employees or managers.

The VBA should develop real-time, in-process quality control mechanisms utilizing the new information technology system once it is fully implemented.

The VBA should consider designating a quality control officer at each VA regional office and look for ways to

strengthen the relationship between training and quality control at each station.

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

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

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

¹¹ <http://www4.va.gov/oig/52/reports/2009/VAOIG-0802073-96.pdf>.

¹² <http://www.gao.gov/new.items/d10445.pdf>.



NEW VBA INFORMATION TECHNOLOGY SYSTEM:

The Veterans Benefits Administration must ensure that the new Veterans Benefits Management System is provided with sufficient time and resources to develop into a comprehensive, paperless, and rules-based platform for processing veterans’ claims for benefits.

Undoubtedly the most important new initiative under way at the Veterans Benefits Administration (VBA) is the Veterans Benefits Management System (VBMS), which is designed to provide a comprehensive, paperless, and ultimately rules-based method of processing and awarding claims for VA benefits, particularly disability compensation and pension.¹³ The VBMS would replace the current suite of applications known as the Veterans Service Network (VETSNET), including Share, MAP-D, RBA-2000, Awards, and FAS.¹⁴ VETSNET itself was designed to replace the Benefits Delivery Network.

Following initial design work, the VBMS had its first phase of development in Baltimore in 2010 where a pro-

totype information technology system was tested in a virtual regional office environment. The main purpose of the virtual regional office was to develop the business requirements for the VBMS system. Although the VBA provided several briefings to *The Independent Budget* veterans service organizations (IBVSOs) about the VBMS prior to the virtual regional office pilot, the phase of the VBMS development in Baltimore was completed without any significant veterans service organization observation, participation, or input.

The first actual pilot of the VBMS system was begun in November 2010 at the Providence Regional Office. The six-month pilot began by working with simulated claims

but was scheduled to begin actual “live” claims in January of this year. Over the course of the Providence pilot, the VBMS will take over functions currently being performed by the VETSNET application, beginning with intake and claims establishment (Share), then development (MAP-D), and finally the rating function (RBA 2000).

The entitlement and awarding of claims (awards) will likely not be performed by VBMS at the Providence pilot. A second six-month pilot is expected to begin in May 2011 at the Salt Lake City Regional Office, which will build on the work begun at Providence. A third pilot is scheduled to begin in November 2011 at an undesignated location, and the final national rollout of the VBMS is scheduled to take place in 2012.

Although the development and deployment of a modern information technology system to process claims in a paperless environment is long overdue, the IBVSOs also have concerns about whether the VBMS is being rushed to meet self-imposed deadlines in order to show progress toward “breaking the back of the backlog.” While we have long believed that the VBA’s IT infrastructure was insufficient, outdated, and constantly falling further behind modern software, web, and cloud-based technology standards, we would be equally concerned about a rushed solution that ultimately produces an insufficiently robust IT system.

In initial discussions about the VBMS with VBA officials early last year, the IBVSOs were told that rules-based decision support might not be a core component of the VBMS, but that it could be treated as a component to be added later, perhaps years later, after rollout. We questioned whether the VBA could achieve significant improvements in quality, accuracy, and efficiency without taking full advantage of the processing capabilities offered by modern IT, such as the use of rules-based decision support. In more recent discussions with VBA officials, there seemed to be a greater emphasis on using rules-based capabilities; however, the IBVSOs remain concerned on this point. In addition, the VBMS must be designed to provide comprehensive quality control to ensure that there is real-time, in-process quality control and robust data collection and analysis in order to support continuous process improvements.

Given the highly technical nature of modern IT development, the IBVSOs urge Congress to fully explore these issues with the VBA and suggest that it could be helpful to have an independent, outside, expert review of the VBMS system while it is still early enough in the development phase to make course corrections, should they be necessary.

The IBVSOs are also concerned about VBA plans for transitioning legacy paper claims into the new VBMS environment. While the VBA is committed to moving forward with a paperless system for new claims, it has not yet determined how it intends to handle reopened paper claims; specifically whether, when, or how they will be converted to digital files. Since a majority of claims processed each year are for reopened or appealed claims and files can remain active for decades, until legacy claims are converted to digital data files the VBA would be forced to continue paper processing, perhaps for decades. Requiring VBA employees to learn and master two different claims-processing systems—one that is paper-based and the other digital—would add even greater complexity and could negatively affect quality, accuracy, and consistency.

There are very difficult technical questions to be answered about the most efficient manner of transitioning to all-digital processing, particularly involving legacy paper files. One way forward would be to leave paper files as they are in their current format unless or until there is new activity. At the time a paper file is pulled, it could then be sent to a conversion center which would scan and enter data into the new VBMS system. The important element would be that it be completely converted into usable digital data, not flat images. Whether this is technically, logistically, or financially feasible in the near term remains to be fully explored and reviewed by experts. However, the IBVSOs believe that the VBA should do all it can to shorten the length of time this transition takes to complete and that it should provide a clear roadmap for eliminating legacy paper files, one that includes timelines and resource requirements.

It remains imperative that input from veterans service organizations be regularly and comprehensively integrated throughout the further development of the VBMS, as well as other new IT initiatives, including the Veterans Relationship Manager.¹⁵ As the IBVSOs have stated elsewhere in this *Independent Budget*, veterans service organizations not only have relevant expertise and perspectives that will benefit the development of these IT systems, we are also direct participants in the claims-processing system and therefore must be integrated into their initial planning. The IBVSOs encourage the VBA to develop regular and ongoing roles for veterans service organization participation and input into future VBMS development. We understand that the VBMS is regularly reviewed by internal panels of subject matter experts and we urge the VBA to include a veterans service organization representative on those panels. Inclusion of even a single service officer or claims expert selected from one of the

IBVSOs could provide important perspective from the veterans service community and our considerable experience in claims processing without slowing down the important development work of the new IT system.

Recommendations:

Congress and VA must ensure that the new Veterans Benefits Management System (VBMS) system is provided sufficient time and resources so that it will develop into a comprehensive, paperless, and rules-based platform for processing veterans' claims for benefits.

The Veterans Benefits Administration must include the maximum level of rules-based decision support feasible at the earliest stages of development of the VBMS in order to build a system capable of providing accurate and timely decisions, as well as include real-time, quality control as a core component of the system.

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

Congress should consider having an independent, outside, expert review the VBMS system while it is still early enough in the development phase to make course corrections, should they be necessary.

The VBA should develop regular and ongoing roles for veterans service organizations' participation in future VBMS development.

¹³ http://www1.va.gov/oamm/docs/business/TAC-APBI_BpeoInitiatives.pdf.

¹⁴ <http://www.virec.research.va.gov/DataSourcesName/VETSNET/VETSNET.htm>.

¹⁵ <https://www.ebenefits.va.gov/ebenefits-portal/appmanager/eb/veterans>.



Compensation and Pension Service

SUFFICIENT STAFFING LEVELS:

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

As a result of the generous support of Congress, the Veterans Benefits Administration Compensation and Pension (C&P) Service hired more than 1,500 new personnel between fiscal years 2008 and 2009 and projected hiring another 1,600-plus full-time employees (FTEs) in FY 2010. This planned staffing increase, as well as those projected for the next couple of years, are essential to the C&P's ability to effectively adjudicate an increasing disability claims workload with cases of even greater complexity than in years past. In FY 2008, the C&P had 10,266 FTEs on board. At the end of FY 2009, its FTE level increased by 1,591 and the VBA projects that in FY 2010 and 2011 staffing will increase by 1,620 and 1,750, respectively. In the near term this increase in claims processors actually can result in a net decrease in productivity, since experienced personnel

are taken out of production to conduct extensive training and mentoring of the new hires. This can be seen in the VBA's projected increase in the average number of days necessary to complete a claim rising from 179 days in FY 2008 to a projected 190 days in FY 2011. Historically, it takes at least two years for new nonrating claims processors to acquire sufficient knowledge and experience to be able to work independently with both speed and quality. Those selected to make rating decisions require a separate period of at least two years of training before they have the skills to accurately complete most rating claims.

Congress has come to recognize that staffing reductions in the VBA in the previous decades contributed to the VBA's claims-processing breakdowns, leading to less

accurate and timely decisions and thus creating the backlogs of the present. Congressional actions to dramatically increase staffing in recent years have provided the VBA a major tool in its efforts to reform the claims process, better manage the pending claims backlog, and begin the process of regaining control of the growing claims for benefits. It is vital, however, that Congress recognize that the backlog will not go away overnight: it developed through years of increasing complexity of the claims development process with an overlay of judicial review. Neither of these causes is inherently bad; in fact, both development safeguards and judicial oversight were deemed necessary to help ensure that veterans and other claimants receive every benefit to which they are entitled under the law. Congress should recognize that it will be several years before the full impact of recent hiring initiatives is felt.

The VBA is faced with challenges that must be addressed by increased resources. For example, the number of veterans receiving benefits has significantly increased in whole numbers and as a percent of that population. While this veteran population demonstrates similar disability profiles to older veterans in terms of the body systems affected, newer veterans are claiming eight or more disabilities with orthopedic, mental health, cardiovascular, endocrine, and hearing problems being the most frequent. Also, the average disability rating has increased steadily from 30 percent in 2001 to 40 percent through 2009, reflecting both the existence of large, unique disability cohorts, such as traumatic brain injury, mental disorders, diabetes, and cancers, as well as the general aging of the earlier service population.¹⁶ In fact, the number of original claims for eight or more disabilities increased from 43,655 in FY 2005 to 67,175 in 2009, an increase of 54 percent.¹⁷

Recommendations:

Congress should provide the Veterans Benefits Administration the appropriate level of resources and staff at or above the FY 2011 request to facilitate its ability to adjudicate disability compensation claims under anticipated workload requirements so that veterans' claims are "done right the first time."

Congress should require the VBA to conduct a study on how to determine the number of full-time employees necessary to manage its growing claims inventory so that claims are decided accurately and in a timely manner.

¹⁶ <http://veterans.house.gov/news/PRArticl.aspx?NewsID=635>.

¹⁷ Department of Veterans Affairs, *FY 2011 Budget Submission—Benefits and Burial Programs and Departmental Administration*, Vol. 3 of 4 (February 2010) 4A-4.

Vocational Rehabilitation and Employment

ADEQUATE STAFFING LEVELS:

Congressional funding for the VA Vocational Rehabilitation and Employment Service must keep pace with veterans' demand for VR&E services.

VA's Vocational Rehabilitation and Employment (VR&E) program, also known as chapter 31 benefits, is authorized by Congress under title 38, United States Code. The program provides the critical counseling and other adjunct services necessary to enable service-disabled veterans to overcome employment barriers as they prepare for, find, and maintain gainful employment. In FY 2010, there were 117,130 individuals receiving VR&E benefits. Of that, 11,000 eligible recipients were successfully rehabilitated, according to the Department of Veterans Affairs.

Tens of thousands of regular military personnel, guardsmen, and reservists are returning home from the global war on terrorism and transitioning to veteran status. In FY 2009, VR&E's continued outreach to newly transitioning personnel and service members on medical hold resulted in more than 78,000 applications, an increase of more than 13 percent from FY 2008.¹⁸ At the end of FY 2009, VR&E was assisting 106,841 veterans and service members.¹⁹ Given the protracted nature of the current conflicts, combined with an aging veterans community and the slow recovery of the economy, the demand for services may well outpace the present funding levels for VR&E programs and overtax current staffing levels as they work diligently to deliver these important benefits.

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

While VR&E Service funding has improved in recent years, the IBVSOs encourage Congress to continue to provide the necessary funding in FY 2012; otherwise, VR&E's ability to meet a rising demand for services may prove inadequate to the task.

Case Manager Workload

VR&E's VetSuccess program is a five-track employment process, which aims to advance employment opportunities for disabled veterans. This is an essential program, providing participants comprehensive reha-

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

The Government Accountability Office (GAO) conducted a 2009 study to assess VR&E's ability to meet its core mission functions. It noted that the implementation of the five-track employment process has "strengthened its focus on employment but veterans' incentives have not been updated to reflect this emphasis."²⁰ A GAO survey of VA regional office staff found that "54 percent of all 57 regional offices reported they had fewer counselors than they need and 40 percent said they have fewer employment coordinators than they need"²¹ and "90 percent of the regional offices we surveyed reported that their caseloads have become more complex since veterans began returning from Afghanistan and Iraq."²²

VR&E officials indicated that the current caseload target, which is 1 counselor for every 125 veterans, is based on a study of the state vocational rehabilitation programs, not VR&E's own workloads. Feedback received by the IBVSOs from counselors in the field found a workload ranging as high as 1 to 160.

To ensure that staff size and skill mix are adequate to the task of serving the eligible population, an accurate assessment of the workload and full spectrum of daily

tasks contributing to that workload must be undertaken. According to the FY 2011 Congressional Budget Submission, in June 2009, VR&E contracted with the Millennium Corporation to conduct a work measurement study. The final report was due for delivery in June 2010. It also worked with the VBA's Employment Development and Training staff to design and contract for a national survey to identify the skills training needed from both management's and the professional staff's perspective. According to the FY 2011 Congressional Budget Submission, the work measurement study and skills assessment study was funded in FY 2009 and, once complete, "funding may be necessary to adjust staffing levels and to provide training targeted toward any core competency gaps identified."²³

Given its increased reliance on contract services, VR&E needs approximately 100 new staff counselors and 50 additional full-time employees 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 the creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

Last year the IBVSOs noted that the VA pilot program at the University of Southern Florida, called "Veteran Success on Campus," placed a qualified vocational rehabilitation counselor and a Veterans Health Administration outreach coordinator who works with the cohort counselor on the campus to assist veterans in vocational rehabilitation as well as veterans enrolled in the Post-9/11 or other VA educational programs. The pilot has garnered praise from the university, the American Council on Education, the press, and veterans service organizations. Given its success on one campus, the IBVSOs recommend that VA be authorized to expand the program significantly in the next fiscal year. We are pleased to note that this is the case. In January 2010, Veteran Success on Campus was activated at Cleveland State University, Ohio, and San Diego State College, California. It will expand further to Rhode Island Community College, Texas A&M, Arizona State University in Tempe, and Salt Lake City Community College. VR&E requested at least 10 full-time employees in FY 2012 to manage expanding campus programs and the IBVSOs support this request.

Recommendations:

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

Congress should authorize at least 150 additional full-time employees for the VR&E Service for FY 2012 to reduce current case manager workload and allow for additional one-on-one dialogue for all veterans generally and for our most severely disabled veterans particularly.

Congress should authorize at least 10 new full-time employees in FY 2012 to manage VR&E's expanding campus program.

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

¹⁸ Ibid., 4E-5.

¹⁹ Ibid.

²⁰ Government Accountability Office, *VA Vocational Rehabilitation and Employment: Better Incentives, Workforce Planning, and Performance Reporting Could Improve Program*, GAO-09-34, January 26, 2009, 6.

²¹ Ibid.

²² Ibid.

²³ Department of Veterans Affairs, *Benefits and Burial Programs and Department Administration*, Congressional Submission, FY 2011, Volume 1, 4B-5.

Board of Veterans' Appeals

BOARD OF VETERANS' APPEALS BUDGET GAP:

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

The Board of Veterans' Appeals (Board) makes final decisions on behalf of the Secretary on appeals from decisions of local VA offices. It reviews all appeals for benefit entitlement to include claims for service connection, increased disability ratings, total disability ratings, pension, insurance benefits, educational benefits, home loan guaranties, vocational rehabilitation, dependency and indemnity compensation, and health-care delivery (medical reimbursement and fee-basis claims).²⁴ The Board's mission is to conduct hearings and issue timely, understandable, and quality decisions for veterans and other appellants in compliance with the requirements of law.

While the Board has jurisdiction over a range of issues, 95 percent of appeals considered involve claims for disability compensation or survivor benefits. Other types of claims that are addressed by the Board include fee-basis medical care, waiver of recovery of overpayments, reimbursements for emergency medical treatment expenses, education assistance benefits, vocational rehabilitation training, burial benefits, and insurance benefits.²⁵

While the number of claims has increased over the past several years, so, too, has the number of appeals to the Board. On average the Board receives appeals on 5 percent of all claims. The chairman's report notes:

In Fiscal Year 2009, the Board issued 48,804 decisions and conducted 11,629 hearings with a cycle time of 100 days. Cycle time measures the time from the date an appeal is physically received at the Board until a decision is dispatched, excluding the time the case is with a Veterans Service Organization (VSO) representative. The cycle time of 100 days was 55 days faster than in 2008 and the lowest since 2004. The Board physically received 49,783 appeals in Fiscal Year 2009 and expects to receive at least that many appeals in Fiscal Year 2010....

...The Board issued 48,804 decisions in Fiscal Year 2009, an increase of 5,047 over the 43,757 decisions issued in Fiscal Year 2008. The Board's productivity in Fiscal Year 2009 represents the greatest number of decisions is-

sued by the BVA in any year since the beginning of judicial review of Board decisions in 1990. VLJs [veteran law judges] conducted 11,629 hearings, which is an increase of 977 hearings over Fiscal Year 2008 and the most hearings ever held by the Board in a year. All of the line VLJs exceeded their productivity goals and most traveled to at least three ROs to conduct one week of Travel Board hearings at each site. This productivity was possible because of the extraordinary efforts of the VLJs, staff counsel, and administrative support staff.

In addition to dispatching the 48,804 decisions issued by the Board in Fiscal Year 2009, the Board's administrative support staff reviewed 67,411 pieces of mail, determined the nature of the correspondence, and associated them with claims files. The administrative staff also answered over 88,000 inquiries from Veterans or their representatives."²⁶

A review of the budget allocations finds only a minimal increase in funding, however, in 2012.

The Board has effectively executed its budget each year so that when funds were available they have been allocated toward bringing on board additional personnel. Nevertheless, as the BVA budget table on page 42 reflects, the Board's overall budget increase has been slight, particularly in 2012, given the cost-of-living increase allowance.

The Board has demonstrated over time that its rate of appeals averages approximately 5 percent of all claims received. An examination of table 3 on page 42, titled "VBA/BVA Workload Correlation," in the block "Actual/Expected BVA Case Receipts" graphically displays the continued growth in appeals.

Given this increasing workload, *The Independent Budget* veterans service organizations are concerned that the Board will have to operate under a constrained budget. The Veterans Benefits Administration has received significant increases in resources over the past several years with a goal of reducing the backlog to an

TABLE 2. BVA BUDGET (DOLLARS IN MILLIONS)

FY	2009	2010	2011	2012	2009 to 2012 Increase
Funding	\$69	\$74	\$79	\$80	\$11
Funding Increase	–	7.2%	6.7%	1.3%	15.9%
Workload	49,783	52,526	60,000	66,000	16,817
Workload Increase	–	5.5%	14%	11%	33.8%

TABLE 3. VBA/BVA WORKLOAD CORRELATION

VBA Projected Workload and FTE Requirements	2008	2009	2010	2011	2012 (estimated)	2013 (estimated)	2014 (estimated)	2015 (estimated)	2016 (estimated)
C&P Direct Labor FTE	10,277	11,868	13,479	15,299	15,300	15,300	15,300	15,300	15,300
Receipts*	888,112	1,013,712	1,332,347	1,318,753	1,516,500	1,744,000	2,005,600	2,306,500	2,652,500
		14%	31%	-1%					
Year-end Inventory	379,842	416,335	700,669	804,460					
Production**	899,863	977,219	1,048,013	1,214,962	1,348,600	1,496,955	1,661,600	1,844,400	2,047,300
		9%	7%	14%					
Average Days to Complete Compensation and Pension Rating Related Claims	179	161	165	190					
Actual/Expected BVA Case Receipts***	40,916	49,783	52,526	60,000	66,600	73,926	82,058	91,084	101,103
Percentage of VBA Production	4.55%	5.09%	5.01%	4.94%	4.94%	4.94%	4.94%	4.94%	4.94%
Appeals Decided	43,757	48,804	49,127	49,500	49,500	49,500	49,500	49,500	49,500

* Assumes 15% growth ** Assumes 11% growth *** Assumes 11% increase

acceptable claims inventory level. According to a Government Accountability Office report, “VA increased claims processing staff about 58 percent from fiscal years 2005 to 2009, which has helped to increase the total number of decisions VA issues annually.”²⁷ New claims continue to rise, many of which are of a more complex nature than before. “The number of compensation claims VA decided with 8 or more disabili-

ties increased from 11 to 16 percent from fiscal years 2006 to 2008.”²⁸ As claims rise, the number of appeals to the Board will likely increase in a corresponding fashion. Therefore, increased funding to meet the needs of the Board is essential.

Recommendations:

Funding for the Board of Veterans' Appeals must rise at a rate commensurate with its increasing workload so it is properly staffed to decide veterans' cases in an accurate and timely manner.

The increased funding recommended above should be contingent upon Board of Veterans' Appeals development of an acceptable plan that will focus on the performance of mission critical activities, reduce the processing time for appeals, and improve the quality of Board decision making, as measured by the consis-

tently high error rate found in those decisions on appeal to the U.S. Court of Appeals for Veterans Claims. Given these criteria, *The Independent Budget* recommends a staffing increase of 28 new personnel for FY 2012 to address the continuing growth in appeals at the BVA.

²⁴ Board of Veterans' Appeals, *Fiscal Year 2009 Report of the Chairman*, 1.

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ Veterans' Disability Benefits, Preliminary Findings on Claims Processing Trends and Improvement Efforts, Statement of Daniel Bertoni, Director, Education, Workforce, and Income Security, GAO-09-910T (July 29, 2009), 2.

²⁸ *Ibid.*, 10.

Judicial Review

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

For the most part, VA worked well. Over the course of the next 50 years, VA made benefit decisions in millions of claims, providing monetary benefits and medical care to millions of veterans. Most veterans received the benefits to which they were entitled.

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

Congress eventually came to realize that without judicial review the only remedy available to correct VA's misinterpretation of laws, or the misapplication of laws to veterans' claims, was through the unwieldy hammer of new legislation.

Thus, in 1988, Congress enacted legislation to authorize judicial review and created the United States Court of Appeals for Veterans Claims (Court) to hear appeals from VA's Board of Veterans' Appeals (BVA).

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

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

Court of Appeals for Veterans Claims

Scope of Review: Enforce Fairness in the Appeals Process

ENFORCE THE BENEFIT-OF-THE-DOUBT RULE:

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

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

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

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

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

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

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

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

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

With the foregoing statutory requirements, the Court should no longer uphold a factual finding by the BVA solely because it has a plausible basis, inasmuch as that would clearly contradict the requirement that the

Court's decision must take due account of whether the factual finding adheres to the benefit-of-the-doubt rule. Yet such Court decisions upholding BVA denials because of the "plausible basis" standard continue as if Congress never acted.

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

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

Recommendations:

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

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

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

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

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

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

⁴ 38 U.S.C. § 7261(b)(1).

⁵ 38 U.S.C. § 5107(b).

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



THE COURT'S BACKLOG:

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

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

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

later seeks a remand, thus utilizing more of the Court's resources and defeating the purpose of the program.

In this practice, the Department of Veterans Affairs usually commits to defend the BVA's decision at the early stage in the process. Subsequently, when VA general counsel reviews the appellant's brief, the Department then changes its position, admits to error, and agrees to or requests a remand. Likewise, VA agrees to settle many cases in which the Court requests oral argument, suggesting acknowledgment of an indefensible VA error through the Court proceedings. VA's failure to admit error, to agree to remand, or to settle

cases at an earlier stage of the Court's proceedings do not assist the Court or the veteran. This failure merely adds to the Court's backlog; therefore, Congress should enact legislation to preserve the Court's resources. Such an act could be codified in a note to section 7264. For example, the new section could state:

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

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

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

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

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

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

Recommendation:

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



EQUITABLE TOLLING:

Congress should authorize the Court of Appeals for Veterans Claims to toll the time for filing a notice of appeal when good cause exists.

Congress has created a benevolent system for the administration of veterans' benefits and services, and under this benevolent system veterans currently have one year to initiate appeals of adverse decisions within the Department of Veterans Affairs.

In 1988, Congress enacted legislation to authorize judicial review and created the United States Court of Appeals for Veterans Claims (Court) to hear appeals from VA's Board of Veterans' Appeals (BVA). Today, VA's 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. Judicial review of VA decisions has, in large part, lived up to the positive expectations.

Under title 38, United States Code, section 7266, claimants have 120 days to file an appeal to the Court after an adverse decision by the BVA.⁷ For more than a decade, however, "equitable tolling" was available if a veteran either misfiled his appeal with VA or filed late because of a disability. That changed when the Court decided *Henderson v. Shinseki*. Now, there is no equitable tolling of the appeal period, no matter whether VA mishandles the appeal or the veteran is physically or mentally incapacitated and unable to file the appeal within the allotted time period. It is often overlooked that many veterans with severe or catastrophic disabilities can be prevented by those disabilities from participating in the normal activities of daily

life for long periods of time. A severely or catastrophically disabled veteran or a veteran suffering from acute illnesses may be hospitalized and rehabilitating for more than 120 days without normal access to mail and may unknowingly lose appeal rights to the United States Court of Appeals for Veterans Claims as a result.

The *Henderson* case is currently before the Supreme Court, but, if that Court does not overturn this detrimental case, amending section 7266 to authorize the Court of Appeals for Veterans Claims to toll the time for filing a notice of appeal when good cause exists will assist disabled veterans in obtaining the benefits they deserve.

The Independent Budget veterans service organizations support legislation to provide for equitable tolling when good cause exists to ensure that all veterans are not prevented from timely filing appeals for adverse decisions of the BVA due to physical or mental incapacity other cause.

Recommendation:

Congress should amend title 38, United States Code, section 7266 to authorize the Court of Appeals for Veterans Claims to toll the time for filing a notice of appeal when good cause exists.

⁷ 38 U.S.C. § 7266 (2006).



Court Facilities

COURTHOUSE AND ADJUNCT OFFICES:

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

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

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

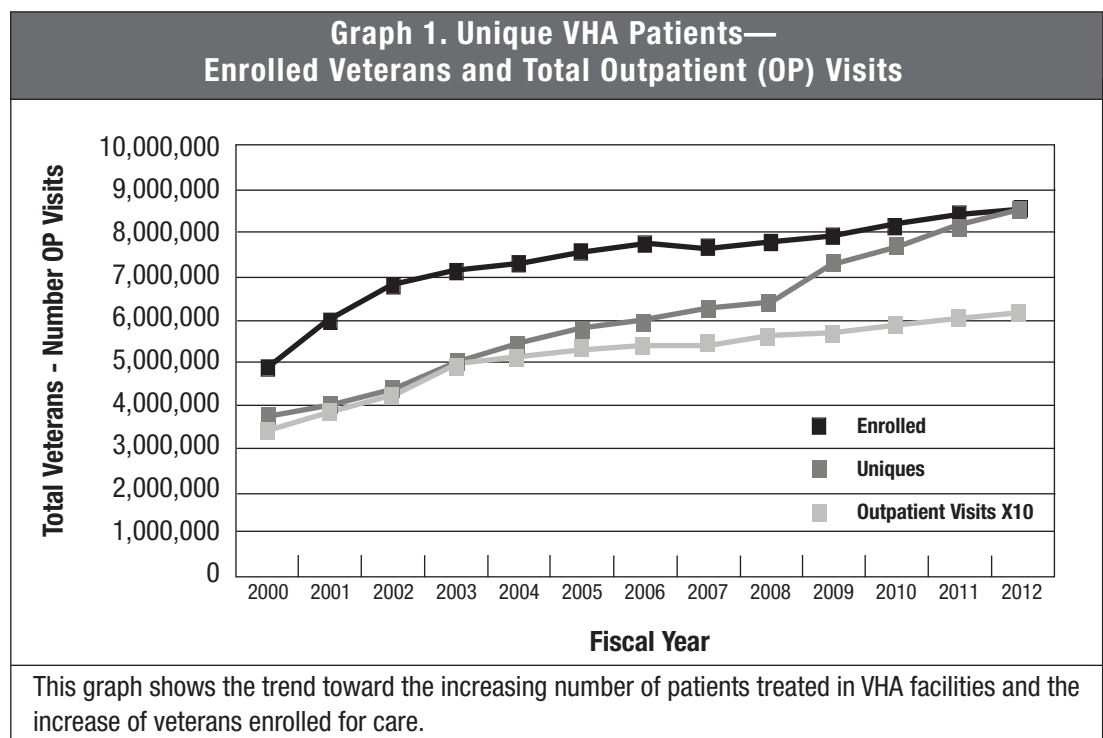
Recommendation:

Congress should provide all funding as necessary to construct a courthouse and justice center in a location befitting the Court of Appeals for Veterans Claims.

Medical Care

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

In fiscal year 2011, the Department of Veterans Affairs anticipates enrolling nearly 8.5 million veterans. Additionally, VA projects enrollment growing to nearly 9 million veterans by FY 2012. Of the more than 9 million veterans that VA projects for enrollment, it plans to provide health-care services to more than 6 million unique patients in fiscal years 2011 and 2012. The VHA also projects more than 80 million unique outpatient visits during the course of the fiscal year. It is a well-established fact that the quality of VHA care is at least equivalent to, and in most cases better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any other system in the United States or worldwide. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors.



Because 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.

While historically VA has faced inadequate appropriations, the enactment of advance appropriations in 2009 allowed VA to better plan and deal with the inability of Congress to complete its work. The fact that the “Military Construction and Veterans Affairs Appropriations bill for FY 2011” was not completed on time further validates the need for advance appropriations for VA health care.

Nevertheless, the process seems to be working as intended. By the middle of 2010, the Secretary of Veterans Affairs identified shortfalls in the advance appropriations levels provided last year for FY 2011, allowing Congress the opportunity to revisit the funding levels that it had enacted last year. Moreover, the advance appropriations process has given VA the ability to react to the ever-changing health-care environment, as was the case with the passage of Public Law 111-163, the “Caregivers and Veterans Omnibus Health Services Act,” and Public Law 111-148, the “Patient Protection and Affordable Care Act.”

Ultimately, the policy proposals and funding recommendations made herein serve to enhance and strengthen the VA health-care system. It is the responsibility of *The Independent Budget*, along with Congress and the Administration, to vigorously defend a system that has set itself above all other major health-care systems in this country. Similar to all health-care systems, VA receives its share of criticism; however, it continues to outperform, both in quality of care and patient satisfaction, every other health-care system in America.

Finance Issues

SUFFICIENT, TIMELY, AND PREDICTABLE FUNDING FOR VA HEALTH CARE: *The Department of Veterans Affairs must receive sufficient funding for veterans' health care, and Congress must fully and faithfully implement the advance appropriations process to ensure sufficient, timely, and predictable VA health-care funding.*

With the newly elected 112th Congress just beginning to conduct business, it is important to once again review and assess the efforts of the 111th Congress to provide sufficient, timely, and predictable funding for the Department of Veterans Affairs, particularly the VA health-care system. The first session of the 111th Congress laid the groundwork for a historic year in 2010. In 2009 the President signed Public Law 111-81, the “Veterans Health Care Budget Reform and Transparency Act,” which required the President’s budget submission to include estimates of appropriations for the Medical Care accounts for FY 2012 and thereafter (advance appropriations) and the VA Secretary to provide detailed estimates of the funds necessary for these accounts in budget documents submitted to Congress. Consistent with advocacy by *The Independent Budget*, the law also required a thorough analysis and public report by the Government Accountability Office (GAO) of the Administration’s advance appropriations projections to determine whether that information is sound and accurately reflects expected demand and costs to be incurred in FY 2012 and subsequent years.

The Independent Budget veterans service organizations (IBVSOs) were pleased to see that in February 2010 the Administration released a detailed estimation of its FY 2011 funding needs as well as a blueprint for the advance funding needed for the Medical Care accounts of VA for FY 2012. It is important to note that last year was the first year that the budget documents included advance appropriations estimates. Unfortunately, due to differences in interpretation of the language of P. L. 111-81, the GAO did not provide an examination of the budget submission to analyze its consistency with VA’s Enrollee Health Care Projection Model. The IBVSOs were informed that the GAO was not obligated to report on the advance appropriations projections of VA until 2011. We look forward to working with Congress to ensure that the GAO fulfills its responsibility this year.

For FY 2011, Congress provided historic funding levels for VA in the House and Senate versions of the Military Construction and Veterans Affairs Appropriations bill that matched, and in some cases exceeded, the recommendations of *The Independent Budget*. Unfortunately,

as has become the disappointing and recurring process, the Military Construction and Veterans Affairs Appropriations bill was not completed even as the new fiscal year began October 1, 2010. Although the House passed the bill in the summer, the Senate failed to enact the bill in a timely manner. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past few years, the larger appropriations process continues to break down over matters unrelated to VA’s budget due to partisan political gridlock.

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

In February 2010, the President released a preliminary budget submission for VA for FY 2011. The Administration recommended an overall discretionary funding authority of \$60.3 billion for VA, approximately \$4.3 billion above the FY 2010 appropriated level but approximately \$1.2 billion less than *The Independent Budget* recommended. The Administration’s recommendation included approximately \$51.5 billion in total medical care funding for FY 2011. This amount included \$48.1 billion in appropriated funding and nearly \$3.4 billion in medical care collections. The budget also included \$590 million in funding for Medical and Prosthetic Research, an increase of \$9 million over the FY 2010 appropriated level.

For FY 2011, *The Independent Budget* recommended that the Administration and Congress provide \$61.5 billion in discretionary funding to VA, an increase of \$5.5 billion above the FY 2010 operating budget level, to adequately meet veterans’ health-care and benefits needs. Our recommendations included \$52 billion for health care and \$700 million for medical and prosthetic research.

The Administration also included an initial estimate for the VA health-care accounts for FY 2012. Specifically,

the budget request calls for \$54.3 billion in total budget authority, with \$50.6 billion in discretionary funding and approximately \$3.7 billion for medical care collections. Unfortunately, because work on the FY 2011 appropriations bill was not completed, advance appropriations funding for FY 2012 remains in limbo.

Moreover, recent actions by VA suggest that the FY 2011 advance appropriations funding levels (which were affirmed in the President's budget request) may not be sufficient to support the health-care programs managed by VA. In a letter sent to Congress on July 30, 2010, VA Secretary Eric Shinseki explained that he believes the advance appropriations levels provided for FY 2011—that virtually match the Administration's request for FY 2011—will be insufficient to meet the health-care demand that VA will face this year. He also emphasized that the passage of P. L. 111-163, the "Caregivers and Veterans Omnibus Health Services Act," and P. L. 111-148, the "Patient Protection and Affordable Care Act," will increase workloads for VA. Unfortunately, the House version of the FY 2011 Military Construction and Veterans Affairs appropriations bill did not fully address this projected current year demand. Likewise, the Senate version of the appropriations bill is apparently insufficient to meet the new demand the Secretary projects.

While we appreciate the funding levels that are provided by the appropriations bills, we believe that the Secretary's letter sends a clear message that, absent some unclear "management action" by VA, more funding will be needed for FY 2011 for VA Medical Care accounts. We hope that as the House and Senate finally complete work on the FY 2011 Military Construction and Veterans' Affairs Appropriations bill, proper consideration must be given to this concern.

Funding for FY 2012

For FY 2012, *The Independent Budget* recommends approximately \$55 billion for total medical care, an increase of \$3.4 billion over the FY 2011 operating budget level currently provided by P. L. 111-322, the Continuing Resolution. Additionally, the Administration recommended an advance appropriation for FY 2012 of approximately \$50.6 billion in discretionary funding for VA medical care. When combined with the \$3.7 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2012 is approximately \$54.3 billion. For FY 2012, *The Independent Budget* recommends a total medical care operating budget of approximately \$55 billion.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2012, *The Independent Budget* recommends approximately \$43.8 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Table 2. Medical Services Recommendation

Current Services Estimate	\$41,274,505,000
Increase in Patient Workload	\$1,495,631,000
Additional Medical Care Program Costs	\$1,010,000,000
Total FY 2012 Medical Services	\$43,780,136,000

Growth in patient workload is based on a projected increase of approximately 126,000 new unique patients—priority group 1–8 veterans and covered nonveterans. *The Independent Budget* estimates the cost of these new unique patients to be approximately \$1 billion. The increase in patient workload also includes a projected increase of 87,500 new Operation Enduring Freedom and Operation Iraqi Freedom veterans at a cost of approximately \$306 million.

Finally, our increase in workload includes the projected enrollment of new priority group 8 veterans who will use the VA health-care system as a result of the Administration's continued efforts to incrementally increase the enrollment of priority group 8 veterans by 500,000 enrollments by FY 2013. We estimate that as a result of this policy decision, the number of new priority group 8 veterans who will enroll in the VA should increase by 125,000 between FY 2010 and FY 2013. Based on the priority group 8 empirical utilization rate of 25 percent, we estimate that approximately 31,250 of these new enrollees will become users of the system. This translates to a cost of approximately \$148 million.

Last, the IBVSOs believe that there are additional projected funding needs for VA. Specifically, we believe there is real funding needed to restore the VA's long-term-care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of VA), to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service), and to meet the new projected demand associated with the provisions of P. L. 111-163, the "Caregivers and Veterans Omnibus Health Services Act." In order to restore VA's long-term-care average daily census to the level mandated by P. L. 106-117, the "Veterans Millennium Health Care Act," we recommend \$375 million. In

order to meet the increase in demand for prosthetics, the IB recommends an additional \$250 million. This increase in prosthetics funding reflects the significant increase in expenditures from FY 2010 to FY 2011 (explained in the section on Centralized Prosthetics Funding) and the expected continued growth in expenditures for FY 2012.

Finally, we believe there will be a significant funding need in order for the VA to address the provisions of P. L. 111-163, specifically as it relates to the caregiver provisions of the law. During consideration of the legislation, the costs were estimated to be approximately \$1.5 billion between FY 2010 and FY 2015. This included approximately \$60 million identified for FY 2010 and approximately \$1.54 billion between FY 2011 and FY 2015. However, no funding was provided in FY 2011 to address this need. As a result, the VA will have an even greater need for funding to support P. L. 111-163 between FY 2012 and FY 2015 in order to fully implement these provisions. With this in mind, *The Independent Budget* recommends approximately \$385 million to fund the provisions of P. L. 111-163 in FY 2012.

For Medical Support and Compliance, *The Independent Budget* recommends approximately \$5.4 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately \$5.9 billion. While our recommendation does not include an additional increase for nonrecurring maintenance (NRM), it does reflect a FY 2012 baseline of approximately \$1.1 billion. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended 2–4 percent of plant replacement value. In fact, VA should actually be receiving at least \$1.7 billion annually for NRM (Refer to Construction section article “Increased Spending on Nonrecurring Maintenance”).

Advance Appropriations for FY 2013

As explained previously, P. L. 111-81 required the President’s budget submission to include estimates of appropriations for the Medical Care accounts for FY 2012 and subsequent fiscal years. With this in mind, the VA Secretary is required to update the advance appropriations projections for the upcoming fiscal year (2012) and provide detailed estimates of the funds necessary for the medical care accounts for FY 2013. Moreover, the law also requires a thorough analysis and public report of the Administration’s advance appropriations projections by the GAO to determine if that information is sound and accurately reflects expected demand and costs.

It is important to note that this is the first year that the GAO will examine the budget submission to analyze its consistency with VA’s Enrollee Health Care Projection Model. The IBVSOs look forward to examining all of this new information and incorporating it into future budget estimates.

Recommendations:

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

Congress and the Administration must work together to ensure that advance appropriations estimates for FY 2012 are sufficient to meet the projected demand for veterans health care, and authorize those amounts in the FY 2011 appropriations act.

Congress must complete work on the FY 2011 Military Construction and Veterans Affairs Appropriations bill as soon as practicable to ensure that VA is not hampered further in providing services and making reforms, and to ensure that advance appropriations for FY 2012 are provided for VA Medical Care accounts, in accordance with Public Law 111-81.

Congress must ensure that supplemental funding is included in FY 2011 and in subsequent years to meet new demand projected as a result of the “Caregivers and Veterans Omnibus Health Services Act” and the “Patient Protection and Affordable Care Act.”

The Administration, Congress, and the Government Accountability Office must fully and faithfully implement all provisions of P. L., the “Veterans Health Care Budget Reform and Transparency Act,” in order to ensure sufficient, timely, and predictable funding for VA health care.

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

INAPPROPRIATE BILLING:

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

The Department of Veterans Affairs has the authority to retain in the Medical Care Collections Fund (MCCF) all collections from health insurers of veterans who receive VA care for nonservice-connected conditions, as well as other revenues, such as veterans' copayments and deductibles.¹ However, the funds collected may be used only for providing VA medical care and services and for paying departmental expenses associated with the collections program. The Medical Care Collections Fund is transferred to a no-year Medical Care service account² and allocated to the medical centers that collect the funds one month in arrears. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that ever-increasing budget estimates for medical care collections and local facilities' need to meet estimates to ensure they have adequate resources may encourage or contribute to inappropriate billing.

The Veterans Health Administration (VHA) continues to bill veterans and their insurers for VA care provided for conditions directly related to their service-connected disabilities. Reports continue to surface of veterans with service-connected disabilities, including amputations, being billed for the treatment of associated pain, and veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers, two ubiquitous problems of the spinal cord injured. Inappropriate billing for such secondary conditions forces service-connected veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden to both veterans and an already backlogged claims system.

Service-Connected Veterans

Service-connected veterans face the scenario of being billed for treatment of a service-connected condition (first-party billing) or having their insurance company billed (third-party billing). The VA Office of Inspector General (OIG) issued a report in 2004 evaluating first-party billings and collections for veterans service-connected at 50 percent or higher or in receipt of a VA pension.³ Four recommendations were made as a consequence of the report. VA's action plan included developing information-sharing initiatives targeted at improving billing practices and addressing inappropriate billing, such as the timely sharing of information across the VHA and with the Veterans Benefits Ad-

ministration (VBA). Specifically, VA medical centers are to have the proper tools to ensure first-party debts are determined appropriately before bills are issued and to identify inappropriate bills that have been sent to veterans for cancellation or reimbursement. In addition, the Office of Compliance and Business Integrity would monitor copayment charges issued to certain veterans⁴ and would monitor facility revenue and the associated business office staff to take corrective action when inappropriate bills were identified.

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

However, these corrective measures do not cover all adversely affected veterans—only those veterans in priority groups 1 and 5 that have been referred to the VA Debt Management Center for collection action. Current law requires VA to collect copayments for medical care and medications provided certain veterans for nonservice-connected conditions. While the VA OIG report focused on the appropriateness of debts, for veterans receiving compensation for service-connected disabilities rated 50 percent or higher or those receiving VA pensions, the IBVSOs do not believe VA responsibility should be limited to the OIG's focus.

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

Prior to these most recent initiatives, inappropriate billing of veterans for VA medical care was a result of a lack of controls, such as oversight on billing and coding, or adequate reviews of whether the medical care provided was for a service-connected disability or not. Other causes of inappropriate billing include incorrect compensation and pension status information, such as the incomplete listing in the information system of service-connected disabilities that can be viewed by MCCF staff or when the system shows an incorrect effective date of claims for service connection, which may have been pending when the veteran sought treatment, making the veteran subject to copayments. Clearly, information management is crucial if inappropriate first-party billing is to be avoided. Although such simple information is readily available in the VBA information system, it may not be easily accessible by MCCF staff in a VHA facility. The VHA has certainly made progress linking these two systems to provide more accurate and up-to-date information; however, the IBVSOs continue to receive recurring reports from our members that inappropriate billing continues.

Nonservice-Connected Veterans

Nonservice-connected disabled veterans are often billed multiple times for the same treatment episode or have difficulty getting their insurance companies to pay for treatment provided by VA. In addition, nonservice-connected veterans experience inappropriate charging for copayments. These billing practices are becoming the norm rather than the exception.

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

These discussions and subsequent entries into a veteran's medical record trigger additional billing. In other instances, simple phone calls from VA health-care professionals to individual veterans to discuss their treatment plan or medication usage can also result in copayment

charges when no actual medical visit has even occurred.

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

Last, while Public Law 111-163, the "Caregivers and Veterans Omnibus Health Services Act," which became law on May 5, 2010, prohibits VA from collecting copayments for medical services from catastrophically disabled nonservice-connected veterans, this may not remove all the problems nonservice-connected veterans face. The IBVSOs are pleased to see that VA has implemented a well-developed plan to ensure that this population of veterans does not continue to be billed for treatment now exempt from charges. However, VA must remain vigilant and Congress must continue to provide effective oversight to ensure that mistakes are not made that could be detrimental to catastrophically disabled nonservice-connected veterans.

Third-Party Billing

Although VA implemented more effective billing practices and systems, only recently has the Department been able to meet its collection goals.⁵ Equal to the need for accurate information on the compensation and pension status of veterans, third-party insurance information is also needed to avert inappropriate third-party billing. The types of policies and services covered by the insurers, patient copayments and deductibles, and preadmission certification requirements are vital to VA's Medical Care Collections Fund program.

The Department's ability to accurately document the nonservice-connected care provided to insured veterans and assign the appropriate codes for billing purposes is essential in improving the accuracy of third-party collections. Failure to properly document care can lead to missed opportunities to bill for care, billing backlogs, overpayments by insurers, or denials of VA invoices. More important, although VA is authorized to bill third parties only for nonservice-connected care, the IBVSOs continue to hear reports from service-connected

disabled veterans, their spouses, or caregivers that VA is billing their insurance companies for treatment of service-connected conditions. At times, notification of the billing departments of their local VA medical centers is sufficient to halt the practice. In other instances, however, the inappropriate third-party billing continues for the same condition or treatment.

A Government Accountability Office (GAO) report issued June 10, 2008, reveals weaknesses in policy, procedures, compliance, and oversight of billing and collections that limit revenue generated from third-party insurance carriers.⁶ VA has responded to each recommendation made by the GAO and holds the chief of the VHA Office of Compliance and Business Integrity responsible for overseeing implementation. The mission of Compliance and Business Integrity is to provide internal oversight of VHA revenue and purchased care business operations to uphold compliance with applicable laws, regulations, and standards; foster a culture of business integrity and quality; and support the early detection, mitigation, and prevention of non-compliant practices.

The IBVSOs look forward to continued oversight by Congress and the GAO to ensure third-party revenue is maximized. However, we also believe the burden to avoid and correct inappropriate billing should rest on VA—not the veteran. This undue burden is particularly egregious when placed on veterans whose disabilities are rated permanent and total, who suffer from conditions reasonably certain to continue throughout their lifetimes and render them unable to maintain substantial gainful employment.

Recommendations:

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

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

Given the rescission of *VHA Handbook 1030.03, First Party Co-Payment Monitoring Policy*, the Under Secretary for Health should establish and enforce a national policy describing the required action(s) a VA facility must take when a veteran identifies inappropriate billing as having occurred. When such actions are taken, their resolution(s) must be reported to a central database for oversight purposes.

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

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

The Government Accountability Office should conduct a follow-up evaluation to ensure that all amounts that should be billed to third-party health insurers are billed in an accurate and timely manner.

¹ The “Consolidated Omnibus Budget Reconciliation Act of 1985,” P. L. 99-272; the “Omnibus Budget Reconciliation Act of 1990,” P. L. 101-508; the “Veterans’ Health Care Eligibility Reform Act of 1996,” P. L. No. 104-262; the “Veterans Reconciliation Act of 1997,” P. L. No. 105-33; and the “Veterans Millennium Health Care and Benefits Act,” P. L. 106-117.

² P. L. 105-65.

³ Office of Inspector General, Department of Veterans Affairs, *Evaluation of Selected Medical Care Collection Fund First Party Billings and Collections*, Report Number 03-00940-38 (December 1, 2004) <http://www.va.gov/oig/52/reports/2005/VAOIG-03-00940-38.pdf>.

⁴ Department of Veterans Affairs, *VHA Handbook 1030.03* (October 16, 2006).

⁵ Fiscal year 2008 budget estimate of \$2.352 billion with actual collections of \$2.442 billion.

⁶ GAO 08-675.

HOMELAND SECURITY/FUNDING FOR THE FOURTH MISSION:

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

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

VA has statutory authority 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[.]”⁷ On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed Public Law 107-40, “Authorization for Use of Military Force,” which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. P. L. 107-40 satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the DOD.

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

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

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

In 2002, Congress also enacted P. L. 107-287, the “Department of Veterans Affairs Emergency Preparedness Act.” 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. Although authorized by law, these centers have not received any funding and have not been established.

The disasters caused by Hurricanes Katrina and Rita in 2005 more than met the criteria for the fourth mission. VA proved to be fully prepared to care for veterans in the Gulf Coast region affected by the hurricanes. Nearly 10,000 VA employees around the country received recognition for their actions during the hurricanes. This included 73 Valor Awards, presented for risking personal safety to prevent the loss of human life or government property, and 3,000 official commendations.

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

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

The Independent Budget veterans service organizations believe that the Administration must request and Congress must appropriate sufficient funds in order for VA to meet these responsibilities in FY 2012. These funds should be appropriated outside the Medical Services appropriation. Without additional funding and resources, VA may encounter difficulties in becoming a resource in a time of national crisis. VA has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not received any designated funding

for the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. Homeland security funding is simply taken from the Medical Services appropriation. This arrangement diverts resources needed to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, resources will continue to be diverted from direct health-care programs.

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

Recommendations:

Congress should provide funds necessary in the Veterans Health Administration's FY 2012 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, funding for the fourth mission should be appropriated separately from the Medical Services appropriation.

⁷Title 38, U.S.C., § 8111A.

Mental Health Issues

MENTAL HEALTH SERVICES:

The Department of Veterans Affairs must deliver on its commitment to transform and improve its mental health programs and rise to the challenge of ensuring that all enrolled veterans, whether new combat veterans or those living with chronic mental illness, have access to needed and high-quality VA mental health services.

The Independent Budget veterans service organizations (IBVSOs) recognize the recent efforts made by the Department of Veterans Affairs to meet the mental health needs of our nation's veterans. Over the past five years VA has dedicated its efforts to improve consistency and effectiveness of, and access to, mental health programs by veterans with serious mental illness and post-deployment mental health readjustment challenges. We are pleased that, through its national Mental Health Strategic Plan, VA has committed to reform its mental health programs by moving from the traditional treatment of psychiatric symptoms to embracing recovery potential in every veteran under VA care. We also applaud Congress for continuing to insist that VA allocate sufficient resources in pursuit of comprehensive mental health services to meet the needs of all veterans using VA services.

VA provides a wide range of mental health services throughout its health-care system, including care for veterans with serious mental illness, depression, anxiety, post-traumatic stress disorder (PTSD), and substance-use disorders. Due to the ongoing conflicts in Iraq and Afghanistan and the multiple deployments for many service members (especially those serving in National Guard and reserve components of the service branches) VA has experienced an increased demand for its mental health services. However, according to VA the majority of veterans receiving mental health services served in conflicts prior to our current ones. To meet this growing demand, VA has increased mental health staff at a rate comparable to workload growth, from 14,207 full-time employee equivalents (FTEEs) in FY 2006 to 20,673 as of July 2010.⁸ Despite the Department's obvious efforts and progress, the IBVSOs believe much still needs to be accomplished to fulfill the nation's obligations to veterans who have serious mental illness, and post-deployment mental health challenges. The IBVSOs believe that all enrolled veterans, and particularly service members, guardsmen, and reservists returning from current conflicts, should have maximal opportunities to recover and successfully readjust to life following military deployments and wartime service. They must have user-friendly and

timely access to VA mental health services that have been demonstrated by current research evidence to offer them the best opportunity for full recovery.

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

Tracking Progress

The development of the VA Mental Health Strategic Plan and the Uniformed Mental Health Services (UMHS) policy (detailed in *VHA Handbook 1160.01*, dated September 11, 2008) provide an impressive and ambitious roadmap for VHA's transformation of mental health services. However, the IBVSOs have expressed continued concern about the timeliness of progress and the need for improved oversight of the implementation phase of these critical initiatives.

Historically, VA has been plagued with wide variations among VA medical centers and their community-based outpatient clinics (CBOCs) related to the adequacy and availability of the continuum of mental health services needed. To address these concerns, over the past several budget cycles VA has provided facilities with targeted mental health funds to augment their services. This funding was intended to address widely recognized gaps in access to and availability of mental health and substance-use disorder services, to address the unique and increased needs of veterans who served in Operations

Enduring and Iraqi Freedom (OEF/OIF), and to create a comprehensive mental health and substance-use disorders system of care within the Veterans Health Administration (VHA) that is focused on recovery—a hallmark goal of the 2003 President’s New Freedom Commission on Mental Health. Experts note that timely, early intervention services can improve veterans’ quality of life, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems.

In May of 2010, the VA Office of Inspector General (OIG) issued its most current report, *Progress in Implementing the Veterans Health Administration’s Uniform Mental Health Services Handbook*. The report focused on several relevant issues: an assessment of the metrics developed by VA to ensure implementation of the handbook and identification of any barriers to full implementation of the handbook’s requirements; an assessment of the system established to track the use of evidence-based therapies for PTSD; and a determination if VA had sufficient inpatient capability for substance-use disorder treatment. The OIG selected 15 handbook items for evaluation of their status across the VA system.

The OIG found that VA was systemically providing individualized and group therapies for PTSD; psychotherapy and pharmacotherapy for patients with depression and major depression; round-the-clock, on-call emergency mental health services; and evening clinics to expand access to mental health services. According to the OIG report, areas where uniform services implementation was not fully achieved across the system included integration of mental health services into primary care; alternative residential treatment options for homeless veterans with mental illness; telemental health; treatment for opioid dependence; and providing secure sleeping quarters for women veterans on acute inpatient psychiatric units. The OIG expressed concern about the provision of intensive substance-use disorder treatment (intensive outpatient and residential) and cognitive testing for patients with traumatic brain injury. The OIG also noted that implementation of specialized PTSD clinics, the availability of evening clinic hours, and integration of mental health services into primary care was lagging in the largest of CBOCs as compared to VA medical centers (VAMCs).⁹

According to that same OIG report, the VA Office of Mental Health Services (OMHS) utilizes an electronic implementation checklist to survey facilities’ implementation progress. The OIG noted that this system of oversight was a reasonable approach given the overall size of the health-care system and variation in charac-

teristics and size of facilities across the system. The respondents to the OMHS checklist indicated that 85.6 percent of requirements had been implemented at more than 80 percent of the VAMCs and 71.1 percent had been implemented at more than 90 percent of VAMCs. Respondents also reported that 85 percent of the requirements on the checklist had been implemented at more than 80 percent of very large CBOCs and 74 percent had been implemented at more than 90 percent of very large CBOCs.

The IBVSOs note that the report predominantly relies on self-reports from leadership at each of the VA medical facilities as to whether they have established a particular program, generally without any clear criteria as to what minimal services the program must offer, the intensity at which services are offered, or facility capacity to provide services at required levels of intensity.

We were pleased to see in the OIG report that VHA clinical leaders have made progress in developing electronic medical record-based templates to facilitate tracking and utilization of evidenced-based therapies for PTSD. The OIG noted that the OMHS has undertaken a large-scale effort to train mental health practitioners at VAMCs and CBOCs. We concur that the VHA should ensure that sufficient numbers of trained clinicians based on workload are available to provide evidence-based therapies for patients with PTSD at all VA locations.

The OIG found that, given the significant rates of primary or comorbid substance disorders in the VA patient population, the Department’s overall capability to provide residential substance-use disorder services was in line with VA projection models. However, at the local and Veterans Integrated Service Network levels, potential gaps exist.

Finally, the May 2010 OIG report addressed barriers to full implementation of the mandates listed in the mental health handbook. Based on interviews with facility mental health leaders, the OIG reported the most commonly identified barriers across the Veterans Integrated Service Networks were the need for additional space and staff, and deficits in recruitment of staff. A withdrawal of Veterans Equitable Resource Allocation (VERA)–designated funding for full-time mental health staff was reported to be occurring simultaneously with a hiring initiative for new mental health staff and was also noted by the OIG as another barrier to full implementation of specialized mental health programs and services.

The OIG report does not specifically focus on the availability and accessibility of early intervention services.

When combat veterans return from war, it seems there is a tendency to underestimate or downplay the early signs of psychological distress. According to mental health experts, these problems often first surface and come to the attention of the veteran or family members and friends and manifest as relationship and marital problems, problems at work or school, or newly uncharacteristic and hazardous use of alcohol or abuse of other substances. A number of research studies underscore this point.¹⁰ These symptoms often indicate broader problems needing attention. When a veteran approaches the VHA with one of these early signs, VA must have available a user-friendly, accessible early intervention program that provides the services needed (e.g. early substance-use disorder services or relationship counseling). Also, the IBVSOs believe VA should be able to use such opportunities to further assess these veterans for other health problems needing VA's attention. When a veteran encounters a complicated, bureaucratic system, where services are fragmented, confusing, delayed, or not available, he or she will likely reject VA. Thereby, VA may lose the opportunity to address such problems early on, when early interventions can have a long-term and even life-saving impact. At minimum, later interventions in chronic illness will be more expensive and even more complicated. Data from a published study of 1,530 users of VHA outpatient services underscore the challenge. While 40 percent of the sample screened positive for potentially hazardous alcohol use and 22 percent screened positive for full alcohol abuse, only 31 percent of those who screened positive reported being counseled about their hazardous alcohol use.¹¹

VA Mental Health Budget

Of the more than 8 million veterans enrolled in VA health care, 5.2 million are active users of the system. According to VA, approximately 1.6 million of its users present a mental health diagnosis, and of that number 31 percent are being treated primarily for these conditions.¹²

In May 2010, the Government Accountability Office (GAO) issued *VA Health Care—Reporting of Spending and Workload for Mental Health Services Could Be Improved* (GAO-10-570). The GAO was asked to examine VA spending and workload for all mental health services, and for this purpose used VA data from FY 2009 that supported VA's FY 2011 Congressional budget justification. In FY 2009, VA reported it had provided mental health services in VA settings primarily used for these services to about 1.22 million unique patients and had spent \$4.4 billion on these services. VA reported that separately it had spent \$269 million on mental health services provided to veterans by non-

VA providers and for outpatient mental health services provided to veterans in VA settings that were not used primarily for VA mental health care. The GAO observed that VA did not report spending information for inpatient hospital mental health services provided in VA settings not primarily used for mental health care, nor for the readjustment counseling services that Vet Centers provided in FY 2009. Data on this additional spending and the number of unique patients were not made publicly available by VA.¹³ The GAO made recommendations that VA should report additional workload, daily census, and spending information for mental health services in all noted settings, either in its annual Congressional budget justification or in a separate annual report that is made publicly available. VA concurred with three recommendations related to these gaps in reporting but did not agree with the recommendation regarding Vet Centers and the need for VA to track the number of counseling visits or the types of services provided.

In response, the GAO recommended that the VA Secretary direct the Under Secretary for Health to identify ways of incorporating spending information and workloads for Vet Center readjustment counseling services that address mental health issues into the VA annual Congressional budget request. VA opposed this idea, attesting that Vet Centers already report data on the numbers of visits and veterans seen in the Readjustment Counseling Service's annual report to the Secretary and Congress, and that the VHA is planning to publish this information on VA's public website and in other designated venues. VA claimed that separate reporting about veterans' mental health problems seen in Vet Centers would fail to capture and thus would underreport the full scope of activities occurring in the Vet Center mission. VA also responded that readjustment counseling should not be "lumped in" with traditional mental health-care services and that doing so would detract from the structure that attracts many combat veterans and military sexual trauma (MST) victims to seek Vet Center services. VA pointed out that traditional VA mental health programs and readjustment counseling services are authorized by separate statutes and employ different eligibility criteria, and VA stressed as important that services provided by Vet Centers not be confused with, or be subsumed within, traditional VA mental health care. The GAO responded to this objection by claiming that the GAO's Vet Center reporting recommendations could be implemented without disturbing the intended separation of these programs.

Although the IBVSOs agree that the Vet Center has a unique mission and culture within VA that should be preserved and protected, we ask the Department to address the GAO's position that more clarity of reporting

is in order for the Vet Center program's workloads and costs. On that basis we urge VA to consider finding ways to compromise with the GAO on these reporting requirements.

Mental Health Services for a New Generation of War Veterans

Since the start of the conflicts in Iraq and Afghanistan, VA has faced a number of specific challenges in providing care to a new generation of war veterans—particularly in treating post-deployment mental health issues. Initially the needs and expectations of OEF/OIF veterans and their families proved to be different from those of previous generations of veterans. Veterans and their families wanted a transformation in DOD and VA approaches to post-deployment mental health services—one that stressed family-centered treatment—a paradigm shift for VA, which for decades has focused primarily on the single veteran-patient to the exclusion of family. But this new generation of veterans is younger, technologically savvy, and demands improved access to information via the Web, access to state-of-the-art prosthetic items and expertise in trauma care, and advanced rehabilitation. They also expect support for their caregivers and better transition and collaboration between the DOD and VA. Likewise, Congress, advocacy groups, and community stakeholders, including groups in the private sector offering specialized services, have been very active in pressing for change in how VA relates to community providers and furnishes care in its mental health and rehabilitative services.

In July of 2010, the VA Office of Mental Health Services held a comprehensive mental health conference titled “Implementing a Public Health Model for Meeting the Mental Health Needs of Veterans.” The purpose of the conference was to focus on developing a public health model for VA mental health, on outcomes of the implementation of the *UMHS Handbook* in VA medical facilities, and on the use of evidence-based mental health treatments in VA programs nationwide. The conference focused on key initiatives in VA mental health, including ending homelessness, preventing suicide, moving to a new paradigm for treating substance use (especially alcohol) disorders, advancing new treatment guidelines for PTSD, implementing the *UMHS Handbook*, and engaging family members of veterans in VA mental health care. The conference goal was to enhance collaboration between Vet Center leaders, VA clinicians, educators, and researchers, as well to promote partnerships with the community.

VA has slowly begun to adjust its model of care delivery. Recently it introduced a public health model for meeting

the mental health needs of veterans with the knowledge that most war veterans will not develop mental illness if proper focus is concentrated on early intervention and efforts to destigmatize their seeking of help and the use of mental health services along with increased outreach efforts to this population. The goal is to promote healthy outcomes and strengthen families with a particular focus on resilience and recovery. This requires VA to shift from its more traditional medical model approach to an approach that would be less focused on obtaining a diagnosis and more on helping veterans and their families retain or regain an overall balance in their physical and mental well-being despite the stress of deployment. Most important, it calls for VA to reach out to veterans in their communities, adjust its message, make access easy and on these veterans' terms, and reformat programs and services to meet the needs of veterans and their families rather than VA expecting veterans to fit into its traditional way of providing services.¹⁴

The “Invisible” Wounds of War: TBI and PTSD

From October 2001 through May 30, 2010, more than 2.1 million military service members have served more than 3 million tours of duty in Operations Enduring and Iraqi Freedom, with multiple deployments that increase risks of exposure to blasts that result in both physical and mental health injuries, often referred to as the “invisible” wounds of war. Since FY 2002, more than 1.2 million individuals, most of whom had combat deployments to these war zones, have left active duty and become eligible for VA health care and other VA benefits. These conflicts have produced a number of polytraumatic or severe injuries in service members, but advancements in military medicine have resulted in a 90 percent survival rate among those who are traumatically wounded. However, the IBVSOs believe gaps remain within the DOD and VA health-care systems in the recognition, diagnosis, treatment, and rehabilitation of the less-visible injuries, such as mild-to-moderate traumatic brain injury (TBI) and PTSD.^{15, 16}

According to VA, in FY 2009, 49,207 patients were seen across VA for inpatient and outpatient services related to TBI; 46,990 patients were treated in outpatient clinics for a total of 83,794 visits. This is a 30 percent increase from FY 2008.¹⁷

In November 2010, VA reported that, altogether, 445,000 OEF/OIF veterans had been screened for possible mild TBI, of whom 83,000 screened positive and consented to additional evaluation. Among that group, 62,000 received completed evaluations, among whom 34,000 were given a confirmed diagnosis of mild TBI. VA also reported in its polytrauma programs that

1,900 active duty service members and veterans have been treated at VA designated polytrauma rehabilitation centers. More than 67 percent of these patients were able to be discharged to home, with functional improvements comparable to private sector rehabilitation discharge rates.¹⁸

An October 9, 2010, letter to the editor, commenting on an October 3, 2010, front-page newspaper article on traumatic brain injuries, “It Changes Who We Are,”¹⁹ relates the sadness and overwhelming feeling of loss that many veterans families experience when their loved ones experience a brain injury.

The military is finally acknowledging that exposure to constant explosions from guns and other weapons damages the sensitive brain tissue that gives our loved ones the ability to think, remember and feel. Our family members may be returning home from the battlefield, but their invisible injuries continually destroy their spirits.

Imagine looking into the eyes of your loved one and being met by an abyss where there was once loving recognition. The pain that we feel cannot be measured by words or soothed by empty promises. Our nation needs a call to action to ensure that everyone who has served our country gets the competent care that he or she deserves.

We must ensure that our brave warriors can defend our nation and can come back and be productive members of our society and our families. If we do not, the casualties from these wars will not be reflected just by those who have died, but by families that have been destroyed.²⁰

Experts note that the effects of TBI are still poorly understood. Within VA, many veterans have a dual diagnosis of TBI and PTSD with overlapping symptoms. Treatment protocols and best treatments plans for this population are still being developed. Unfortunately, we continue to hear complaints from veterans about the fragmentation of care—especially for those that present with behavioral problems. Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, gaps in services are still troubling. The IBVSOs are concerned that VA has not fully addressed the long-term emotional and behavioral problems associated with TBI and its devastating im-

act on veterans and their family members, including their personal caregivers. The IBVSOs urge development of programs and support services to better assist these veterans and their families to manage the tumultuous challenges that accompany brain injury, often attended by other severe physical injuries. We are pleased that in June of 2009 VA convened a special multidisciplinary workgroup conference to address the challenge of treating the increasing numbers of veterans with PTSD and comorbid mild TBI. The conference committee recognized that pain was such a common co-occurring disorder with PTSD and TBI that pain management should be considered in the discussion. Likewise, the committee concurred that, given the toll of PTSD and the additional impacts of mild TBI and pain, it is imperative that clinical guidance for these complex comorbidities be established.

Newly returning veterans’ post-deployment mental health challenges have resulted in a surge for VA mental health services. The VA October 2010 report *OEF/OIF Veterans with Deployment Health Issues* indicates that more than 171,000 veterans have been seen at VHA facilities whose visits were coded for PTSD as of June 30, 2010. Of these veterans, 134,000 were seen only at a VA medical center, 15,000 were only seen at a Readjustment Counseling Service Vet Center, and 23,000 were seen at both.²¹ The most common mental health diagnoses for OEF/OIF veterans were PTSD (53%), depression (36%), and anxiety (29%), as compared to all VA users with depression (52%), PTSD (23%), anxiety (19%).²²

Significantly, VA operates a network of specialized PTSD outpatient treatment programs throughout its system of care, including specialized PTSD clinical teams and/or a PTSD specialist at each VAMC. The VA’s National Center for PTSD oversees a PTSD mentoring program that works with the specialty PTSD programs throughout the system. Care is available for veterans who have substance-use disorder as well as PTSD with substance-use disorder specialists being placed in each PTSD specialty outpatient program.²³

VA also reports it is increasing its justice outreach efforts. It is working in collaboration with a number of state-based “veterans courts” to assist in determining the appropriateness of diversion for treatment rather than incarceration as a consequence of veterans’ troublesome behaviors. Likewise, VA reports it is participating in crisis intervention training with local police departments to help train and provide guidance to officers on approaches to deal effectively with individuals who have mental health problems (including veterans) in crisis situations.

Finally, VA is working with veterans nearing release from prisons and jails to ensure that needed health care and support services are in place at the time of release. The IBVSOs salute VA mental health leaders for taking these proactive steps that not only can prevent recurrence of involvement with the justice system but are cost saving to local and state governments and VA itself. Although this program is in its beginning stages, it has been beneficial for many veterans who have had the opportunity to get needed treatment for PTSD, TBI, and substance-use disorder rather than having been subjected to incarceration.

Mandatory Mental Health Screening

In October 2009, the President signed Public Law 111-84, the “National Defense Authorization Act for Fiscal Year 2010.” The act included a critical provision requiring mandatory, person-to-person, confidential mental health screenings for every returning service member at specified intervals up to 18 months after deployment to a military contingency operation, such as a deployment to Iraq. Put simply, every service member returning from a combat deployment will be screened routinely three times on return, either by a mental health professional or other personnel trained and certified to provide such assessments. According to VA, from February 2008 to September 2009, 119,001 follow-up Post-Deployment Health Reassessments (PDHRAs) were conducted with veterans three to six months after they returned from deployment using the most current version of the form. Although the DOD issued its guidance on this new requirement in July 2010, implementation on the ground level has been slow and limited. Furthermore, the IBVSOs are concerned that the level of training provided to certified screeners is still woefully inadequate and not in keeping with the intent of this new provision. However, we acknowledge that the DOD did incorporate several substantial improvements to the PDHRA in its most recent guidance. Properly implemented, this new requirement will go a long way toward reducing mental health stigma within the military services and in identifying those service members most in need of health care for their psychological injuries and readjustment challenges.

The GAO reported in June 2007 that the DOD was unable to ensure that service members are mentally fit to deploy, nor could DOD accurately assess troops’ mental health conditions when they returned from deployments.²⁴ The single biggest shortfall in the DOD screening process has been the absence of mandatory, person-to-person interviews of all personnel returning from combat deployments and other contingency operations. Experts in the field agree that person-to-per-

son interviews by qualified mental health professionals would be the optimum approach to confirming the PTSD diagnosis, and identifying other mental health challenges in these individuals. Instead, the DOD has relied on an ineffective system of unsupervised and almost primitive self-assessments on paper as the means for obtaining mental health evaluations of these service members. According to the GAO, these paper forms have been routinely misplaced, and such strong disincentives have been reported that returning combat veterans are reluctant to disclose any type of psychological injury or illness, anxiety, depression, or other readjustment problem for fear of being held longer in receiving centers and further delayed from returning to their homes and families.^{25, 26}

The stigma associated with psychological injuries within the military community also presents a serious hurdle to getting service members the mental health care they need. Almost half of the soldiers and marines in Iraq who test positive for a psychological problem are concerned that they will be seen as weak by their fellow service members, and almost one in three of these troops worry about the effect of a mental health diagnosis on their careers. Of deep concern to the IBVSO community is the fact that it remains unclear whether these military personnel, including National Guard and reserve members, who receive referrals to mental health providers through the DOD’s current post-deployment self-assessment process, are actually receiving any mental health care.²⁷

The new mandated person-to-person screening requirement, if implemented correctly, provides a historic opportunity for the DOD and VA to collaborate through this expansive and challenging new mental health screening program. The DOD does not currently have the capacity to ensure that every returning veteran is seen by a licensed mental health professional, and it has yet to develop a training/certification process for nonmental health professionals. On the other hand, for the past several years VA has established numerous new programs and ramped up its hiring of mental health professionals to staff them, with more than 6,000 new providers now on board. Also, according to VA’s Readjustment Counseling Service, by the end of FY 2011, VA will be operating 300 storefront Vet Centers to provide psychological, readjustment, and bereavement counseling, among other services.

The IBVSOs believe this new requirement constitutes a great opportunity for VA and the DOD to share specialized health resources, both in the spirit of P. L. 97-174, the historic VA-DOD health resources sharing

authority Congress established in 1982, and in confirmation of the goals of the 2009 VA-DOD Mental Health Summit, the very purpose of which was to find common ground on addressing the mental health legacy from war service and combat exposure in Iraq and Afghanistan. However, with every new program comes the need for oversight to make sure it operates as smoothly and efficiently as intended. Therefore, *The Independent Budget* recommends that Congress ensure through strong oversight that the new mandatory, person-to-person mental health screening process is conducted by personnel, whether VA or DOD staff, who are effectively trained to identify these hidden wounds and to treat them when found.

According to VA, it has developed with the DOD a strategic integrated mental health plan and together the agencies are currently developing an action plan to implement those strategic elements to ensure that service members are aware of the post-deployment mental services available and how to access them. The goal is for veterans to have a more seamless transition experience between the Departments as they reenter civilian life.²⁸

Readjustment Counseling Service—Vet Centers

VA's Readjustment Counseling Centers, known as Vet Centers, provide readjustment counseling in its community-based centers and in 50 mobile centers. Vet Centers are reporting rapidly growing enrollments in their programs. Although VA has steadily increased the number of Vet Centers to meet workload growth, the IBVSOs believe that Vet Centers should also be provided additional funding to further bolster their staffing to ensure that all the centers can meet their expanding caseloads. In addition to traditional counseling, they also provide outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma. Additional funds would also allow them to expand the current fleet of 50 mobile vet centers (if found cost-effective) to support readjustment counseling for combat veterans and their families throughout the United States in areas where VA facilities may not be nearby.²⁹

It should also be noted that VA readjustment counseling staff are often requested to respond to specific traumas and incidents affecting those in the armed services. For example, after the November 5, 2009, Fort Hood, Texas, shootings the VA Readjustment Counseling Service deployed three mobile Vet Centers with augmented staff to Fort Hood where they provided on-site readjustment counseling to more than 8,200 service members, veterans, and their families.³⁰

Section 401 of P. L. 111-163 authorizes active duty service personnel and serving members of the National Guard and reserve components who have deployed to combat zones to receive psychological and readjustment counseling in VA Vet Centers. The IBVSOs are very encouraged by this new benefit. Given the existence of stigma within the military ranks, we urge VA to make strong outreach efforts to these groups to make them aware of the benefit and to welcome them into Vet Centers. Also, we hope this outreach emphasizes that such counseling is confidential and unreportable to their military line commanders or armories—or even to VA medical authorities. As workloads related to this new authority grow, we urge VA to ensure that Vet Centers maintain proper staffing to carry out the intent of Congress in providing this important service to our newest war generation.

Suicide Prevention and Substance-Use Disorder

Disturbingly, suicide rates in the armed forces are at an all-time high. It is clear that without proper screening, diagnosis, and treatment, post-deployment mental health problems could lead some distressed individuals to attempt to take their own lives. The military suicide rate has steadily increased over the past five years, exceeding the national average of 11.1 suicides per 100,000 people. In 2009, the suicide rate in the Marine Corps was 24 per 100,000; it was 23 in the Army, 15.5 in the Air Force, and 13.3 in the Navy, which are all higher than they were in 2008. VA reports that 18 veterans take their lives each day, which equates to about 6,750 veterans' suicides per year, or almost 60,000 in the nine years since the conflicts in Afghanistan and Iraq began.^{31,32} Ready access to robust VA primary mental health and substance-use disorder treatment programs, emphasizing early interventions and routine screenings for all post-deployed personnel and veterans are critical building blocks of any effective suicide prevention effort. The DOD and VA need to work together to achieve this goal. The IBVSOs are encouraged that VA has developed a comprehensive strategy to address suicide prevention in veterans with its suicide prevention hotline and chat service, and that the DOD has recently joined the Suicide Prevention Alliance in addition to adding more than 2,000 mental health providers at military health-care facilities. Despite this progress, this issue still remains a significant concern to the IBVSOs, and we urge Congress to provide clear oversight to ensure adequate focus and attention remain on this issue.

Similarly, misuse of alcohol and other substances, including prescription drugs, is a recognized problem in many OEF/OIF service members and veterans. Ample evidence documents the severity and chronicity of substance-use

disorder in earlier generations of war veterans, and untreated substance-use disorder can result in emotional decompensation, an increase in health-care and legal costs, additional stress on families, loss of employment, and even homelessness. The GAO noted in a March 2010 report titled *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans* that the three main challenges VA faces are related to (1) accessing substance-use disorder services; (2) meeting the specific treatment needs of veterans with substance-use disorder; and (3) assessing the effectiveness of substance-use disorder treatments. VA has recently begun a number of national efforts to address these challenges including increasing veterans' access to its substance-use disorder services; promoting the use of evidence-based substance-use disorder treatments; and assessing substance-use disorder services and monitoring treatment effectiveness.³³

The IBVSOs urge VA and the DOD to continue research into this critical area and to improve outreach efforts, advance the anti-stigma campaign, and identify and deploy the best, evidence-based treatment strategies for this population. Easy access to mental health services in primary care is essential to addressing and overcoming stigma frequently associated with seeking mental health within the DOD and VA.

Women Veterans

The numbers of women now serving in our military forces are unprecedented in U.S. history, and today women are playing extraordinary roles in the conflicts in Afghanistan and Iraq. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, and military police officers and serve in many military occupational specialties that expose them to the risk of combat, serious injury, and death. To date, more than 100 women have been killed in action, and women service members have suffered grievous injuries, including multiple amputations. The current rate of enrollment of women in VA health care constitutes the second most dramatic growth of any subset of veterans. In fact, VA projects the number of women veterans coming to the Department for health-care services is likely to double in two to four years. According to VA, since 2002, more than 50.6 percent of women who deployed in Operations Enduring and Iraqi Freedom and have since been discharged from military service have enrolled in VA health care.³⁴

As the population of women veterans undergoes exponential growth over the next decade, VA must act now to prepare to meet the specialized mental health

needs of the women who served—especially those who have served in a war zone. Women service members involvement in all-women Lioness teams, and now in Female Engagement Teams, require that VA mental health professionals educate themselves on what the contemporary deployment experience is like for women as well as the novel and unique readjustment challenges they face in the military and upon returning home. VA researchers have been studying the impact of war on physical and mental health of women to determine how to best address their unique needs. The National Center for PTSD has established a number of specialized groups and evidenced based treatments for women with combat-related PTSD, military sexual trauma, or a dual diagnosis of combat-related PTSD and PTSD related to military sexual trauma.

In March 2010, the GAO issued a report based on a performance audit of VA health-care services for women veterans that took place from July 2008 through March 2010 and was centered on the recommendations of the GAO's July 2009 report of preliminary findings, *VA's Provision of Health Care Services to Women Veterans*.³⁵ The GAO found that the availability of specialized gender-specific services and mental health services for women varied by VA facility. Nationally, nine VAMCs have residential mental health programs that are for women only or have dedicated provider groups for women. However, the GAO noted that information about all of these programs was not available on the VA public website.

The GAO also found that most VAMCs offered residential or inpatient mental health services, but few had specialized women's programs, and that information on these programs is not readily available to veterans. The GAO reported that VA community-based outpatient clinics also had limited mental health services compared to VAMCs and Vet Centers. An ongoing issue with internal communications between some leaders of mental health and MST inpatient programs was another issue identified by the GAO. One clinician noted that in the first year of one of VA's specialized trauma programs space was available for additional patients; however, patients in the region were being referred to far-off facilities because area VA providers were not aware of the existence of the local program. Likewise, many veterans are unaware of VA's specialized programs and treatment options. VA has stated that one of its goals is to transform the agency to serve veterans more efficiently, yet its own website does not provide information about the specialized programs available for women and how to access that care. In response to these concerns, VA officials noted its pref-

erence that all women veterans should contact the women veterans program manager (WVPM) or MST coordinator at their local facilities for assistance identifying treatment needs. However, the GAO found that contact information for WVPMs or MST coordinators either was missing or difficult to locate on most of the VA facilities—specific Web pages that the GAO reviewed. The IBVSOs concur that better access to this basic information would empower women veterans to have more informed conversations with VA staff about available treatment options³⁶ (see “Women Veterans Health and Health Care Programs” in this *Independent Budget* for more detailed discussion of this issue).

Military Sexual Trauma— Remaining Challenge for VA

Other challenges uncovered by the GAO were that VA facilities are still having problems hiring providers with the specialized training and experience needed to provide services to women veterans, and that VA lacks clear guidance on the appropriate training for providers who treat survivors of military sexual trauma. While the majority of MST victims are women, male veterans enrolled in VA report a significant incidence of it as well. In the absence of clear guidance from VA clinical leadership, some VA treatment facilities have established their own local criteria to work with this population. Provisions in Title II of P. L. 111-163, the “Caregivers and Veterans Omnibus Health Services Act of 2010,” require VA to train and certify mental health providers on care for veterans suffering from conditions related to sexual trauma and PTSD.

The IBVSOs find it disturbing that VA officials, according to the GAO, indicate that they have no plans to develop policy to mandate the specific training and experience needed for mental health providers who treat survivors of MST. VA maintains that any licensed VA mental health practitioner is qualified to work with these types of patients. However, in a briefing provided to the Women Veterans Advisory Committee by the VA Office of Legislative and Congressional Affairs in October 2010, a VA official stated that program directors plan to establish a one-time mandatory training requirement of only a few hours for all mental health providers currently employed, beginning in the second quarter of FY 2011 to fulfill the MST training provisions mandated by P. L. 111-163. Additionally, VA notes it will develop a short training course on sexual trauma specifically for primary care providers by the end of FY 2011.³⁷

The IBVSOs remain concerned about these reports and feedback from some VA providers who have reported to

us that while they are treating patients for MST-related mental health conditions, they have limited knowledge or specialized training in this particular field. According to mental health experts, a significant period of training and subsequent mentoring by a trained professional are essential for MST therapists to develop and hone skills and develop the understanding of evidence-based therapies and other techniques required to effectively treat this often challenging and complex psychological malady that is consequent to assaultive sexual violence. We urge VA to reconsider its decision to provide a minimal training experience to its therapists and other mental health clinicians who are treating MST survivors. We believe Congress intended VA to conduct rigorous training to satisfy the law’s MST training and certification requirements.

According to the GAO, the VA Readjustment Counseling Service’s Vet Center policy specifies that sexual trauma counselors must satisfactorily receive 120 hours of specialized training followed by 50 supervised hours of treatment experience, dealing with a minimum of five sexual trauma cases under mentored guidance by an experienced counselor, before they may counsel on an independent basis individuals who have experienced military sexual trauma. Mental health experts in this field indicate that MST counseling is a specialized mental health field that requires particular training and experience beyond the basic academic credentialing and licensure required to qualify for employment within the VHA mental health service. We believe that to be fully responsive to the intent of the law, at minimum, a training standard similar to the Readjustment Counseling Service requirement should apply across the VA system to meet the unique needs of veterans who have experienced military sexual trauma.

It is also important to note that 31 percent of women veterans versus 20 percent of men enrolled in VA health care have a diagnosed mental health condition.³⁸ Additionally, 20 percent of women OEF/OIF veterans and 27 percent of women Vietnam veterans have been diagnosed with PTSD.³⁹ Studies show that women present unique symptoms when it comes to PTSD and are more likely to have psychological reactivity to trauma cues, a startle response, restricted affect, depression, and an avoidance of trauma cues. Women may also be more likely to present with the specific comorbidities of depression, panic disorder, eating disorders, and somatic complaints. Studies of treatment of women with PTSD show that they may develop chronic PTSD and may have slower recoveries but women may be more likely than men to seek treatment. The treatments noted for being most successful include cognitive behavioral ther-

apy with a combination of psychotherapy and pharmacotherapy, prolonged exposure, cognitive processing therapy, and family therapy.⁴⁰ However, mental health experts report that these case-intensive treatments are not universally available at VA medical centers nationwide. We believe there is a need to ensure that all VA providers who are treating these patients are appropriately trained in these proven techniques and are certified to provide these effective treatments.

Looking to the Future

VA's transformation for the 21st century includes two relevant initiatives for mental health services. The first of these is the Secretary's stated goal to end veteran homelessness in five years (see "Ending Homelessness among Veterans" in this *Independent Budget* for more detail on this specific issue). The second is VA's announced goal to generally improve veterans' mental health services. VA lists three "workstreams" to accomplish this goal:

- Workstream "A" builds a transformational mental health infrastructure with capacity to better monitor clinical programs and provide feedback to address problems; supports innovation in clinical services that is patient-centered and recovery-oriented; offers veterans alternative treatment choices for care that have been found effective; and supports staffing levels and development of highly skilled mental health staff.
- Workstream "B" focuses on implementation of public health programs in communities to improve the well-being of veterans and to destigmatize their seeking of help and the use of mental health services.
- Workstream "C" calls for implementation of the DOD/VA integrated mental health strategy to provide a comprehensive lifetime of care for service members and veterans throughout their lives after serving in the military services of the nation.

Summary

The IBVSOs applaud the efforts made by VA to improve the safety, consistency, and effectiveness of mental health-care programs for veterans. We also appreciate that Congress is continuing to insist that VA dedicate sufficient resources in pursuit of a comprehensive package of services to meet the mental health needs of veterans, in particular veterans exposed to conditions of war. The IBVSOs are pleased with VA's progress in implementing its Mental Health Strategic Plan, yet we have concerns that these laudable goals may be frustrated unless proper oversight is provided and VA enforces mechanisms to ensure its policies at the top are reflected as results on the ground in VA facilities. In that regard we are deeply concerned that substance-use dis-

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

The development of the Mental Health Strategic Plan and the new Uniform Mental Health Services package provides an excellent roadmap for VHA's transformation of its mental health services. However, gaps remain to be closed, especially in the oversight of mental health programs and in the case management programs for OEF/OIF combat veterans with dual diagnoses of TBI and PTSD.

The IBVSOs also urge closer cooperation and coordination between VA and the DOD as planned and between VAMCs and Vet Centers within their areas of operations. We recognize that the Readjustment Counseling Service is independent from the VHA by statute and conducts its readjustment counseling programs outside the traditional "medical model." We respect that division of activity. However, in addition to having concerns about VA's ability to coordinate with community providers in caring for veterans at VA expense, we believe veterans will be best served if better ties and at least some mutual goals govern the relationship of Vet Center counseling and VA medical center mental health programs.

One overarching concern of the IBVSOs is the lack of clear and unambiguous data to document the rate of change occurring in VA's mental health programs as noted in the May 2010 GAO report *VA Health Care: Reporting Spending and Workload for Mental Health Services Could Be Improved*.⁴¹ We have indicated in a number of discussions, as well as in Congressional testimony, that VA needs more effective measures to validate that progress. Given the enormous additional investment that Congress and the Administration have made in VA mental health, data validation would go a long way toward reinforcing our confidence that VA is moving forcefully to adopt recovery for older veterans suffering from the challenges of chronic mental illnesses, and along the way embracing the transition and readjustment mental health needs of our newest war veteran generation.⁴²

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

Recommendations:

Congress should hold oversight hearings on the implementation strategy of the VA Office of Mental Health Services for the Uniform Mental Health Services (UMHS) package. Congress should require VA to provide an assessment of resource requirements and expenditures, as well as a completion date for full implementation of the UMHS package.

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

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

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

VA should ensure that qualified women mental health counselors with expertise in military sexual trauma are available in all Vet Centers to veterans who request a female counselor, and that all professional staff are provided training on the current roles of women returning from combat theaters and their unique post-deployment mental health challenges.

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

Congress should ensure that the new mandatory, person-to-person mental health screening process for post-deployed combat service members (including guardsmen and reservists) required by the "National Defense Authorization Act for FY 2010" is conducted by personnel who are effectively trained to identify these often difficult to detect service-incurred wounds, and to treat them when found. This responsibility should be jointly embraced by both the DOD and VA mental health-care programs in a shared effort under the authority of Public Law 97-174, the "VA-DOD Health Resources Sharing and Emergency Operations Act."

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

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

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

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⁹ Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection: Progress in Implementing the Veterans Health Administration's Uniform Mental Health Services Handbook*, Report No. 08-02917-145 (May 4, 2010).

¹⁰ J. Scotti, M. Crabtree, and E. Bennett, Presentation at Combat Stress Intervention Program Research Conference on Post Deployment Challenges: What Research Tells Practitioners (Washington and Jefferson College, April 4, 2009).

¹¹ P. S. Calhoun, J. R. Elter, E. R. Jones, H. Kudler, and K. Straits Troster, "Hazardous Alcohol Use and Receipt of Risk Reduction Counseling Among US Veter-

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¹² Ira Katz, Mental Health Services in VA. VA Course on Implementing a Public Health Model for Meeting the Mental Health Needs of Veterans, PowerPoint presentation (Baltimore, MD, July 28, 2010) http://www.nami.org/Content/NavigationMenu/NAMILand/Convention_resources/KatzforNAMI2010.ppt.

¹³ U.S. Government Accountability Office, *VA Health Care: Reporting of Spending and Workload for Mental Health Services Could Be Improved*, Publication No. GAO-10-570 (May 2010).

¹⁴ Harold Kudler, VA/DOD/State and Community Partnerships: Practical Lessons on Implementing a Public Health Model to Meet the Needs of OEF/OIF Veterans and Their Families, VA Course on Implementing a Public Health Model for Meeting the Mental Health Needs of Veterans, PowerPoint presentation (Baltimore, MD, July 28, 2010).

¹⁵ Joseph Stiglitz, Nobel laureate, Columbia University professor, Testimony before the United States House of Representatives, Committee on Veterans Affairs Hearing on the True Cost of War (September 30, 2010).

¹⁶ Department of Veterans Affairs, Office of Public Health and Environmental Hazards, *Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans* (October 2010).

¹⁷ Lucille Beck, chief consultant, Rehabilitation Services, Office of Patient Care Services, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Health, on Caring for Severely Injured OEF/OIF Veterans and Servicemembers (July 22, 2010).

¹⁸ Department of Veterans Affairs, Briefing to Veterans Service Organizations (November 17, 2010).

¹⁹ Christian Davenport, “It Changes Who We Are,” *Washington Post*, Sunday, October 3, 2010, A1.

²⁰ Saralyn Mark, Letter to the Editor, *Washington Post*, Saturday, October 9, 2010.

²¹ Department of Veterans Affairs, A Office of Public Health and Environmental Hazards, *VA Facility Specific OEF and OIF Veterans Coded with Potential PTSD Through 3rd Qtr FY 2010* (October 2010).

²² Katz, *Mental Health Services in VA*, note 12.

²³ Zeiss, *VHA Mental Health Services*, note 8.

²⁴ U.S. Government Accountability Office, *Comprehensive Oversight Framework Needed To Help Insure Effective Implementation of a Deployment Health Quality Assurance Program*, GAO-07-831 (June 2007).

²⁵ Institute of Medicine, *Posttraumatic Stress Disorder: Diagnosis and Assessment* (Washington, DC: The National Academies Press, 2006), 16–17. See also Veter-

ans’ Disability Benefits Commission, *Honoring the Call to Duty: Veterans’ Disability Benefits in the 21st Century* (October 2007).

²⁶ U.S. Government Accountability Office, *Defense Health Care: Post-Deployment Health Reassessment Document Needs Improvement*, GAO-10-56 (November 2009).

²⁷ Mental Health Advisory Team (MHAT) IV, *Final Report: Operation Iraqi Freedom 05-07* (November 17, 2006).

²⁸ Zeiss, *VHA Mental Health Services*, note 8.

²⁹ Department of Veterans Affairs press release, “VA Going to World Series: Department Will Use Mobile Vet Centers for Outreach at Game Four” (October 20, 2010).

³⁰ Ibid.

³¹ American Forces Press Service, “Defense Department Joins Suicide Prevention Alliance” (September 10, 2010) <http://www.defense.gov/news/newsarticle.aspx?id=60801>.

³² Penny Coleman, “Flashback: PTSD, Suicide and the Lessons of War,” Testimony before the U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Oversight and Investigations (July 14, 2010).

³³ U.S. Government Accountability Office, *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans*, GAO-10-249R (2010).

³⁴ Beck, Testimony on Caring for Severely Injured OEF/OIF Veterans and Servicemembers, note 17.

³⁵ United States Government Accountability Office, *Report to Congressional Requestors, VA Health Care: Reporting of Spending and Workload for Mental Health Services Could be Improved*, GAO-10-570, May 2010.

³⁶ Ibid.

³⁷ Joan Evans, *Update on Legislation Related to Women Veterans* (October 26, 2010), 6.

³⁸ Susan Frayne, “VA Women’s Health Evaluation Initiative,” VA Women’s Health Services Research Conference (July 15, 2010) http://www.research.va.gov/programs/womens_health/conference2010/.

³⁹ Garovoy, Natara. “PTSD and Women’s Mental Health Services,” A Forum on Women Veterans (July 28, 2010) http://www1.va.gov/WOMENVET/docs/4_ForumPresentation_Garovoy.pdf.

⁴⁰ Ibid.

⁴¹ U.S. Government Accountability Office, *VA Health Care: Reporting of Spending and Workload for Mental Health Services Could Be Improved*, GAO-10-570 (May 2010).

⁴² Ibid.

OEF/OIF Issues

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

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

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

Polytrauma, TBI, and PTSD

From October 2001 through May 30, 2010, more than 2.1 million military service members served more than 3 million tours of duty in Operations Enduring and Iraqi Freedom (OEF/OIF), with multiple deployments that increase risks of exposure to blasts that result in both physical and mental health injuries, often referred to as the "invisible" wounds of war. Since FY 2002, 1.2 million individuals, most of whom had combat deployments to these war zones, have left active duty and become eligible for VA health care and other VA benefits. Advancements in military medicine have resulted in a 90 percent survival rate among those physically wounded. However, gaps remain within the DOD and VA health-care systems in the recognition, diagnosis, treatment, and rehabilitation of the less-visible injuries, such as mild-to-moderate traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD).^{43,44}

Each VA facility has an OEF/OIF Care Management team in place that consists of a program manager, clinical case manager, VBA service representative and tran-

sition patient advocate. The OEF/OIF Care Management program now serves more than 44,000 service members and veterans, including 5,800 who are severely injured. In FY 2009, 49,207 patients were seen across VA for inpatient and outpatient services related to TBI; 46,990 patients were treated in outpatient clinics for a total of 83,794 visits. This is a 30 percent increase over FY 2008.

In November 2010 VA reported that, altogether, 445,000 OEF/OIF veterans had been screened for possible mild TBI, of whom 83,000 screened positive and consented to additional evaluation. Among that group, 62,000 have received completed evaluations, of whom 34,000 were given a confirmed diagnosis of mild TBI. VA also reported that in its polytrauma programs, 1,900 active duty service members and veterans have been treated at its designated polytrauma rehabilitation centers. More than 67 percent of these patients were able to be discharged to home, with functional improvements comparable to private sector rehabilitation discharge rates.⁴⁵

Experts note that the effects of TBI are still poorly understood. In 2008, the RAND Corporation found high rates of PTSD, major depression, and TBI in OEF/OIF veterans compared to the U.S. civilian population. RAND estimated that 300,000 of the 1.64 million OEF/OIF service members who had been deployed as of late 2007 suffered from PTSD or major depression, and estimated that about 320,000 may have experienced a probable TBI. RAND found that about one-third of those deployed had at least one of these three conditions, with about 5 percent reporting symptoms of all three.^{46,47}

Significantly, VA operates a network of more than 190 specialized PTSD outpatient treatment programs throughout its system of care, including specialized PTSD clinical teams and/or a PTSD specialist at each VA medical center (VAMC).

The VA October 2010 report on *OEF/OIF Veterans with Deployment Health Issues* indicates that more than 171,000 veterans have been seen at Veterans Health Administration (VHA) facilities whose visits were coded for PTSD as of June 30, 2010. Of these veterans, 134,000 were seen only at a VAMC, 15,000 were only seen at a Readjustment Counseling Service Vet Center, and 23,000 were seen at both.⁴⁸

Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, gaps in services are still troubling. The IBVSOs are concerned that VA has not fully addressed the long-term emotional and behavioral problems associated with TBI and its devastating impact on veterans and their family members, including their personal caregivers. The IBVSOs urge development of programs and support services to better assist these veterans and their families to manage the tumultuous challenges that accompany brain injury, often attended by other severe physical injuries.

Vet Centers

VA's Readjustment Counseling Centers, known as Vet Centers, provide readjustment counseling in more than 264 community-based centers and 50 mobile centers. Vet Centers are reporting rapidly growing enrollments in their programs. Although VA has steadily increased the number of Vet Centers to meet workload demands, the IBVSOs believe that Vet Centers should also be provided additional funding to further bolster their staffing to ensure that all the centers can meet the expanding caseloads—now including not only traditional counseling but outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma—and expand the current fleet of 50 mobile Vet Centers (if found cost-effective) to support readjustment counseling for combat veterans and their families throughout the United States where VA facilities may not be nearby.⁴⁹

Section 401 of Public Law 111-163 authorizes active duty service personnel and serving members of the National Guard and Reserve components who have deployed to combat zones to receive psychological and readjustment counseling in VA Vet Centers. We are very encouraged by this new benefit. Given the existence of stigma within the military ranks, we urge VA to make strong outreach efforts to these groups to make them aware of the benefit and to welcome them into Vet Centers. Also, we hope this outreach emphasizes that such counseling is confidential and unreportable to their military line commanders or armories—or even to VA medical authorities. As work-

loads related to this new authority grow, we urge VA to ensure that Vet Centers maintain proper staffing to carry out the intent of Congress in providing this important service to our newest war generation.

Suicide and Substance-Use Disorder

It is disturbing to see suicide rates in the armed forces at an all-time high. It is clear that without proper screening, diagnosis, and treatment, post-deployment mental health problems that are not treated could lead some distressed individuals to attempt to take their own lives. The military suicide rate has steadily increased over the past five years, exceeding the national average of 11.1 suicides per 100,000 people. In 2009, the Marine Corps was 24 per 100,000; it was 23 in the Army, 15.5 in the Air Force, and 13.3 in the Navy, which are all higher than in 2008. From 2005 to 2009, more than 1,100 service members committed suicide—an average of one suicide every 36 hours. Suicide rates in the Air Force and Army have severely increased despite intensive outreach efforts. Since 2001, 252 service members have committed suicide in Iraq and Afghanistan.^{50, 51}

VA estimates that as many as 5,000 veterans kill themselves every year, accounting for one in six of the 30,000 annual suicides in the United States. Veterans commit suicide at a higher rate than the general population, and while this is a long-standing problem, new studies may help guide prevention efforts as they point to risk factors appearing in the months and years before they die. It is thought that many individuals with psychiatric disorders at risk of suicide were not identified by the treatment system possibly because of their fear of the associated stigma. Ready access to robust VA primary mental health and substance-use disorder treatment programs, emphasizing early intervention and routine screening for all post-deployed personnel and veterans are critical building blocks of any effective suicide prevention effort. The DOD and VA need to work together to achieve this goal. The IBVSOs are encouraged that VA has developed a comprehensive strategy to address suicide prevention in veterans, and that the DOD has recently joined the Suicide Prevention Alliance in addition to adding more than 2,000 mental health providers at military health-care facilities, but we urge Congress to provide clear oversight to ensure adequate focus and attention are paid to this issue.^{52, 53}

Similarly, misuse of alcohol and other substances, including prescription drugs, is a recognized problem for many OEF/OIF service members and veterans. Ample evidence documents the severity and chronicity of substance-use disorder in earlier generations of war veterans, and untreated substance-use disorder can result in

decompensation, an increase in health-care and legal costs, additional stress on families, loss of employment, and even homelessness. The Government Accountability Office (GAO) noted in a March 2010 report, *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans*, that the three main challenges VA faces are related to: 1) access to substance-use disorder services; 2) meeting the specific treatment needs of veterans with substance-use disorders; and (3) assessing the effectiveness of substance-use disorder treatments.⁵⁴ VA has recently begun a number of national efforts to address these challenges, including increasing veterans' access to its substance-use disorder services; promoting the use of evidence-based substance-use disorder treatments; and assessing substance-use disorder services and monitoring treatment effectiveness.⁵⁵

The IBVSOs urge VA and the DOD to continue research into this critical area and to improve their outreach efforts, advance the anti-stigma campaign, and identify and deploy the best, evidence-based treatment strategies for this population.

Another potential problem for transitioning veterans, identified in a recent GAO report, is the timely adjudication of nonformulary drug requests in VA. The report *VA Drug Formulary: Drug Review Process Is Standardized at the National Level, but Actions Are Needed to Ensure Timely Adjudication of Nonformulary Drug Requests* deals with drugs prescribed from the national formulary and documents delays in VA medical centers adjudicating nonformulary requests.⁵⁶ Although nearly all drugs that VA providers prescribe are on the VA national formulary, in some cases, providers determine that it is clinically necessary to prescribe nonformulary drugs.⁵⁷ Differences in prescribing practices potentially include drugs that were prescribed by DOD physicians for injured service members.

While the Department of Veterans Affairs requires that medical centers adjudicate nonformulary drug requests within 96 hours, each medical center chief of staff is responsible for establishing a system to address any provider-initiated appeals of denied nonformulary drug requests.⁵⁸ Although VA is unable to determine the total number of nonformulary drug request adjudications that exceed 96 hours, the GAO found that data reported to VA on quarterly average adjudication times for medical centers are sufficient to demonstrate that not all requests are adjudicated within this time frame.⁵⁹ The IBVSOs believe that new veterans should not face problems in quickly obtaining prescribed medication from the DOD. VA and the DOD should coordinate

to ensure that service members leaving active duty have been given prescriptions that will be easily filled in VA pharmacies. In addition, we recommend that individuals leaving active duty with active prescriptions be advised to visit their local VA facilities to verify that their prescribed medications are available or to ensure sufficient time for their nonformulary prescription to be adjudicated and continued.

Better Case Management and Caregiver Support Are Essential

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

The IBVSOs believe that strong case management is necessary to ensure uninterrupted support for severely injured veterans and their family caregivers as these veterans transfer from the DOD to VA care. A veteran's spouse is likely to be young, have dependent children, and reside in a rural area where access to support services is limited. They often fall victim to bureaucratic mishaps as a result of the conflicting pay and compensation systems on which they rely. For many younger, unmarried veterans, their caregivers are their parents, who have limited eligibility for military assistance and historically have had virtually no eligibility for VA benefits or services.

The IBVSOs were pleased that the President signed P. L. 111-163, the "Caregivers and Veterans Omnibus Health Services Act" on May 5, 2010. This law allows VA to create an array of new or enhanced supportive services for family caregivers of disabled veterans from all eras of military service, and will provide a monthly stipend, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) health care, and other benefits to financially burdened family members of the most severely wounded and disabled OEF/OIF veterans.⁶⁰ The law will also improve certain access and health-care issues for our women veterans of all eras.⁶¹ While VA provides limited services to some family members, we hope the new law will spur VA to create a more thorough program in caregiver support, education, training and other assistance.

While this new law responds to some of *The Independent Budget's* most significant legislative goals in recent years, and the IBVSOs are pleased that Congress acted, we remain concerned about the unmet needs of caregivers of disabled veterans of earlier eras of military service, and believe that the services provided to caregivers of veterans serving on or after September 11, 2001, should be authorized to all VA-enrolled veterans on the basis of medical, social, or financial need. We also remain concerned about the current implementation phase of this program, and believe clear, decisive policies and procedures are needed to carefully define the term “severely injured or ill veteran,” explain who qualifies for the new benefits and services afforded by the act, provide instruction on how these caregivers can gain access to them, and provide information on other elements of the new law. We understand that these new or enhanced program elements are complex and difficult to sort out; however, we urge VA to immediately roll out add-ons to established programs (respite, mental health counseling, and CHAMPVA coverage, for example) and make them available as soon as possible to those who qualify. We observe that VA seems to be developing a package of services and while doing so is, in effect, withholding the provision of any expanded service to these caregivers.

Women Veterans

The number of women now serving in our military is unprecedented in U.S. history, and women have played extraordinary roles in OEF/OIF deployments. In OIF, women service members have been commended for their role participating in “Lioness teams” with Marine ground combat patrols. Lioness teams were attached to all-male infantry units. During searches in populated areas, these women (who early on were not trained in weaponry or combat tactics) were assigned to search Iraqi women and children in order to keep intact the social customs of this region while gathering security information and confiscating weapons. Within the past year the Army and Marine Corps began training and developing Female Engagement Teams (FET) for a similar but more formalized program. FET teams are still in their beginning stages, but take women “outside of the wire” and closer to combat, thereby blurring the rules set by federal law that prohibit uniformed American women from participating in direct combat. These women are not combatants but are trained to defend themselves.

Neither the Army nor Marine Corps has a shortage of uniformed women to volunteer to train to be part of the FET program, which also includes humanitarian missions as well as potential combat missions when embedded in traditional all-male military ground units.

The FET is vitally important to the counterinsurgency strategy and to our civil affairs units’ interactions with key leaders and local civilians to learn intelligence. These FET teams also assess the conditions and needs of women and children across Afghanistan’s vast landscape. Due to Islamic cultural taboos, male soldiers and Marines are forbidden to interact, touch, or communicate with civilian women. However, some of our deployed soldiers and marines have been wounded or killed by women suicide bombers in both Iraq and Afghanistan. These security needs were an important justification for establishment of Lioness and Marine FET teams.

In these war zones, before an all-woman team is allowed to enter a home or compound, the members must first introduce themselves to the homeowner, usually male and unaccustomed to interacting with foreign women, and in particular women soldiers or Marines. If they receive an owner’s permission to visit a home, FET members ordinarily set aside their weapons, remove their helmets, and don headscarves. They are trained to do so. These are acts of intended respect but ones that leave them vulnerable to attack. They then communicate with women found on premises on what type of medical care or other assistance might be needed for them and their children and question them on social issues, gathering potential intelligence. They also conduct body searches of women and children if circumstances warrant. Participating on FET teams places women in danger but their contribution to the safety and security of our deployed military in the Islamic world is significant.^{62, 63, 64}

As women transition out of the military today, many are turning to VA for care. The current rate of enrollment of women in VA health care constitutes the largest of any subset of veterans. According to VA, from FY 2002 to the first quarter of FY 2010, approximately 50 percent of 133,000 OEF/OIF women veterans utilized VA health care, with nearly 51 percent who were treated in 11 or more outpatient visits during that time.⁶⁵

The IBVSOs remain concerned about the fragmentation of care and disparities in care that exist for women using the VA health-care system, and we continue to encourage VA to fully address the unique health-care needs of women veterans who have returned from deployments, and to conduct biomedical and health services research initiatives to gain broader understanding of women’s needs in VA health care, including outcomes, quality, satisfaction, barriers to care, and other important challenges.

Occupational Exposures

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

Instead of waiting years or decades to determine what diseases may be linked to these exposures, the IBVSOs strongly urge VA to immediately start identifying, tracking, offering systematic medical monitoring, and, if needed, treating veterans exposed to all known hazards, such as the burn pits. Rather than waiting and then tasking an organization to do a retrospective study, we believe that such a program needs to be instituted immediately. An epidemiological study, survey questions, and other research tools should also be used to improve understanding of veterans’ illnesses and treatments needed, and to compensate those who become disabled as a result of exposure. Having an ongoing monitoring and tracking program of current service members and veterans would provide the data needed.

As an option, the IBVSOs recommend that VA consider basing this program on an existing national, Congressionally mandated program that targets former Department of Energy workers who were likely exposed to toxic fumes and substances during the manufacture of chemical weapons and other hazards. This program has enabled these former workers to receive diagnoses for illnesses that are often not common to the general population as a basis for treatment and potential compensation for their associated illnesses. Starting such a monitoring, tracking, and referral program targeting OEF/OIF veterans would be a proactive way for VA to establish a program that can, and should, be used to test any veterans who may have or believe they may have suffered adverse health effects from hazardous environmental exposures during their military service.

Eye Injuries to New War Veterans: A Rising Concern

Recent data compiled by both the DOD and VA indicate that blindness and eye injury make up 13.9 percent of all sources of injury to service members evacuated from Operation Enduring Freedom and Operation Iraqi

Freedom. Second only to hearing loss, eye injury or trauma is the most common injury from OEF/OIF, according to the VA Office of Research and Development. The November 2008 DOD medical surveillance defense monthly report from the Armed Forces Health Center reported 4,970 moderate-to-severe penetrating eye injuries, with 8,441 retinal and choroidal hemorrhage injuries, 686 optic nerve injuries, along with 4,294 chemical and thermal eye burn injuries occurring between 1998 and 2007. The majority of these injuries occurred during OEF/OIF operations.^{66, 67}

Low-vision clinics at VA polytrauma rehabilitation centers in Palo Alto (California) and Hines (Illinois) VAMCs found that when screening veterans for TBI-related vision problems, 63 percent and 68 percent screened positive for visual system dysfunction in each respective facility. Vision research published by the Palo Alto VAMC Polytrauma Center found that 75 percent have subjective visual complaints, with objective visual diagnostic disorders found of loss of field of vision, accommodation insufficiency, convergence disorder, and ocular-motor dysfunction. More than half of these patients reported inability to interpret print, with 4 percent of those determined to be legally blind.⁶⁸

Research in vision system dysfunction from acquired brain injury is vital to ensuring more treatment options for these neuro-vision complications. Unlike the existing specialized research programs in burns, limb prosthetics, PTSD, and spinal cord injuries, vision research grants consume only a small fraction of Congressional Directed Medical Research Program funding.⁶⁹

The VHA reports that a large number of eye disorders demonstrates the magnitude of OEF/OIF visual injuries entering the system between FY 2002 and FY 2009. During this period, there were 1,304 retinal detachments, 4,787 retinal disorders, 1,525 disorders of the iris, 5,854 cataracts, 1,200 optic nerve injuries, 3,612 corneal disorders, 18,625 visual disturbances, and 6,131 low-vision diagnostic codes. Veterans typically incur multiple eye disorders associated with blast exposures, and complications from eye trauma are more common now. Because they require specialized rehabilitative services, approximately 129 blinded OEF/OIF veterans and 1,089 other veterans with low vision are enrolled in VA Visual Impairment Services Teams (VISTs).^{70, 71}

While blinded veterans are typically referred to VA blind rehabilitation center (BRC) programs, the IBVSOs are concerned that veterans with severe eye injuries are not

being centrally tracked by the eye injury registry while in the DOD system. The BRCs are especially important for returning OEF/OIF service personnel because they often have multiple traumatic injuries that include TBI, amputations, internal injuries, other neurosensory losses, a variety of limb injuries, and mental health challenges. One VA research study found in one population of TBI patients that 44 percent were diagnosed with PTSD, 22 percent suffered depression, and 40 percent had acute and chronic pain management challenges.⁷² Mild TBI was found in 44 percent of 433 patients, with 56 percent diagnosed with moderate to severe TBI, and 12 percent of those had suffered penetrating brain trauma. The Defense and Veterans Brain Injury Center reports that an analysis of the first 433 TBI-wounded veterans found that 19 percent had concomitant amputation of an extremity. In conjunction with other VA specialties, a BRC can deliver the entire array of highly specialized care needed for these veterans to optimize their rehabilitation outcomes and successfully reintegrate within their families and communities.

Private providers often lack all of the highly specialized consultation services, specialties, and prosthetics expertise that BRCs have developed and refined over decades. Few private providers have all the residential specialized surgery, medicine, and mental health professional staff or physical and speech therapists that are needed to adequately care for veterans with combat eye injuries or visual impairments. For these reasons, the IBVSOs strongly discourage the DOD and VA from referring newly injured veterans to private eye care specialists. All BRCs have Commission on Accreditation of Rehabilitation Facilities (CARF) certification, while some private providers do not and cannot produce peer-reviewed, evidence-based study results in their rehabilitative programs. The IBVSOs believe any private blind agencies VA chooses to employ as referral providers should demonstrate peer-reviewed quality outcome measurements that are a standard part of the VHA and must be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped or CARF. Their blind rehabilitation instructors must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals. Also, they should have the specialized medical, surgery, nursing, and psychiatry staffing necessary for complex wounds and mental health disorders common in these newly injured veterans.

The establishment of the Vision Center of Excellence (VCE) for the prevention, diagnosis, mitigation, treat-

ment, and rehabilitation of military eye injuries was authorized in section 1623 of P. L. 110-181, the “FY 2008 National Defense Authorization Act.” This authorization has been poorly managed and has suffered from a lack of clear governance between the Assistant Secretary of Defense Health Affairs and the VA Under Secretary for Health. From November 2008 to November 2009 the VCE had total staff of two physicians without administrative support. A total of four VA staff members are now assigned to the VCE.

This vital legislation established the VCE as a joint DOD and VA program to improve the care of military personnel and veterans affected by combat eye trauma and to aid those suffering from other sources of vision loss and vision anomaly. Despite the legislative mandate, and the inclusion of the implementation of the Vision Center of Excellence as one of the DOD’s top health-care issues in the *Quadrennial Defense Report*, the bureaucratic policy and funding issues have continued and hindered significant progress toward the full establishment of the VCE for the past two years. As we enter into this critical period of funding for FY 2012, the operational and governance management of the VCE needs more oversight by both the joint DOD-VA Health Executive Council and by Congress.⁷³

DOD-VA Information Interoperability

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

The DOD must be positioned to accurately collect medical and environmental exposure data electroni-

cally while personnel are still in theater, and equally important, this information must be provided to VA. Electronic health information should also include an easily transferable electronic DD-214 to allow VA to expedite claims and give service members faster access to their benefits.

To expedite the exchange of electronic health information between the two departments, Section 716 of P. L. 111-84, the “National Defense Authorization Act for Fiscal Year 2010,” required the DOD to report on improvements to the governance and execution of health information management and IT programs within the military health system. Part of the law’s requirement includes an assessment of both DOD’s capability to meet the requirements for joint interoperability with VA as otherwise mandated by law and the progress made by VA and the DOD on the establishment of a joint virtual lifetime electronic record for members of the armed forces.⁷⁴

In conjunction with interoperability capabilities previously achieved through the Federal Health Information Exchange, Biodirectional Health Information Exchange, and the Clinical Data Repository/Health Data Repository, the DOD and VA believed the achievement of six objectives would be sufficient to satisfy the requirement for full interoperability by September 2009: (1) to refine social history data currently captured in the DOD electronic health record; (2) to share physical exam data captured in the DOD electronic health record; (3) to demonstrate initial network gateway operation; (4) to expand questionnaires and self-assessment tools; (5) to expand Essentris⁷⁵ in the DOD to at least one additional site in each military medical department; and (6) to demonstrate initial capability for document scanning into the DOD electronic health record and forwarding those documents electronically to VA.

However, these six objectives were recommended based on defining “full interoperability” as being able to share the necessary information to support the continuum of care between VA and the DOD.⁷⁶ Furthermore, the Departments’ officials, including the cochairs of the group responsible for representing the clinician user community, believe they have satisfied the September 30, 2009, requirement for developing and implementing systems or capabilities that allow for full interoperability.

The IBVSOs are concerned the Departments’ definition falls short of a fully interoperable exchange of health information, which is achieving computable electronic

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

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

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

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

up referrals with VA. At reserve and National Guard locations, DOD contract health-care providers are responsible for administering the PDHRA.

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

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

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

Of greater concern is that of VA mental health providers in the field and active duty service members over the transferability of private and VA mental health treatment records to the DOD. These service members seek care at VA and the private sector because they perceive the barrier, however diminishing, of information sharing as a safeguard against adverse impact on their

security clearances and advancement in military service. The consternation over seeking treatment or not is of great concern to both the patients and providers.

The IBVSOs are pleased that two virtual lifetime electronic record (VLER) pilot programs are operational in San Diego, California, and Hampton Roads, Virginia. The VLER pilot is an Internet-based network enabling web-based, secure exchange of health information for sharing among VA, the DOD, other government entities, and private providers. Other pilots are in development in three more communities: Indianapolis; Spokane, Washington; and the Moab region in Utah. The benefit of these pilot programs is not solely for our veterans but the nation as well. Implementation and operation of VLER tests the complex Nationwide Health Information Network (NHIN), a set of standards, services, and policies that enable secure health information exchange over the Internet. The NHIN will provide a foundation for the exchange of health information across diverse entities, within communities and across the country.

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

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

private health-care providers, and state, local, and other federal agencies.

Because AHLTA has consistently experienced performance problems and has not delivered the full operational capabilities intended, the DOD has initiated plans to develop a new electronic health record system. As with AHLTA, department officials stated that the new electronic health record system is expected to be a comprehensive, real-time health record for active and retired service members, their families, and other eligible beneficiaries. They added that the new system is being planned to address the capability gaps and performance problems of previous iterations and to improve existing information sharing between the DOD and VA and expand information sharing to include private sector providers.

The IBVSOs are concerned over DOD resources allocated to the completion of the Electronic Health Record Way Ahead. The DOD has said it would provide these additional details after the completion of its analysis of alternatives and approval of the FY 2012 Program Objectives Memorandum submission.⁷⁷ We applaud Congress for its continued oversight to determine the reasons for continuing delays toward full interoperability. The IBVSOs urge Congress ensure these additional details are provided by the DOD in order to have a more complete picture on risks and resource needs for achieving the timelines and goals of the Department's health information and information technology programs. Moreover, we urge Congress to ensure the DOD-VA Interagency Program Office reaches the remaining benchmarks and that full electronic sharing of computable health information is achieved.⁷⁸ Additional information on our concerns about VA information technology, and a broader discussion about VA's current and planned use of technology, may be found in "Centralized Information Technology Impact on VA Operations," in this *Independent Budget*.

Federal Recovery Coordinator Program

In 2008, VA and the DOD partnered to create the Federal Recovery Coordinator (FRC) Program to coordinate clinical and nonclinical care for severely injured and ill service members and to also make VA easier to access. Currently 556 clients are enrolled, another 31 are being evaluated for enrollment, and an additional 497 have received assistance through the FRC program.⁷⁹

The IBVSOs remain concerned about the gaps that exist in the FRC program and the accompanying social work case management essential to coordinating complex components of care, particularly for poly-

trauma patients and their families. These gaps were highlighted by disabled veterans and their caregivers in Congressional hearings in 2009 and 2010 and warrant continued oversight and evaluation by Congress, VA, and the DOD.

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

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

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

Although these hearing witnesses all agreed that the FRC program was needed and had the potential to be beneficial, a number of issues must be addressed, including better communication, education, promotion of the program, and streamlining the referral process. Some family members are not aware of their option to request an FRC and are sometimes confused about the roles of the multitude of advocates, program managers, and DOD/VA social workers and case managers assigned to their wounded loved ones. The FRC's level of knowledge about catastrophic injuries and their impact on patients and families—as well as being knowledgeable about the myriad benefits and services available from the DOD and VA—are vitally important to family members and caregivers alike. They also want the FRC to be able to address the need of lifelong care and caregiving for their injured loved ones should these vet-

erans outlive their parents, spouses, or other caregivers, or in cases where caregivers become unable to continuously care for these veterans.

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

For newly injured or ill service members who use outpatient services but do not need the services of the FRC, VA reports it has 33 VA military liaisons for health care stationed at 18 military medical treatment facilities to transition ill and injured service members from the DOD to VA specialized services closer to home. VA military liaisons are social workers or nurses who are colocated with DOD case managers at military treatment facilities. In FY 2010, through June, VA military liaisons coordinated 5,000 referrals for health care and more than 20,000 professional consultations. Each VA facility has an OEF/OIF care management team in place, which consists of a program manager, a clinical case manager, VBA service representatives, and a transition patient advocate. Severely injured OEF/OIF veterans are provided a case manager, and other OEF/OIF veterans may be assigned one based on initial assessment or upon request. A “lead” case manager now serves as a central point of contact for patients and their families.⁸⁰

Under VA’s clinical and nonclinical case management strategy, veterans transitioning from the DOD to VA who are not assisted by the FRC program may be forced to interact with as many as five VA representatives, their primary and specialty care provider or team, and a DOD case manager. The IBVSOs are concerned that so many points of contact impede assistance to veterans and their families at a critical juncture in their lives. Moreover, veterans suffering from cognitive impairment may be overwhelmed by this fragmented and confusing arrangement, and it may hamper their ability to effectively participate in their care and rehabilitation. This is of particular concern as the DOD has expanded its efforts to identify those who may have mild TBI. As greater numbers of these veterans are identified, the need for treatment services will also increase, further challenging the system. We are hopeful VA’s move to patient-aligned care teams or a medical home model of care will provide a more cohesive and empathetic environment for these veterans.

Transition and Disability Evaluation

The IBVSOs support the recommendation of the President’s Commission on Care for America’s Returning Wounded Warriors that “DOD and VA should create a single, comprehensive, standardized medical examination that the DOD administers. It would serve DOD’s purpose of determining fitness and VA’s of determining initial disability level.”⁸¹ We believe this examination must be completed as a prerequisite of promptly completing the military separation process. If a single separation physical becomes the standard practice, VA should be responsible for handling this duty because VA has the expertise to conduct a more thorough and comprehensive examination, given its focus on evaluating veterans for compensation and pension benefits. Moreover, the inconsistencies with the current Physical Evaluation Board process across military service branches can be overcome with a single physical examination administered by VA under its rules, not those of the DOD.

A Disability Evaluation System (DES) pilot project premised on the commission’s recommendation was launched by the DOD and VA in 2007. The DES is managed by the VA-DOD Joint Executive Council. More than 200 service members from Walter Reed Army Medical Center, the Bethesda National Naval Medical Center, and Malcolm Grow Medical Center participated in the first phase of the DES. Using lessons from the pilot, the program expanded to 27 facilities in 2009, with more than 5,400 service members participating. Based on service members’ high satisfaction rates with the revised program, the DOD and VA have designed an integrated disability evaluation system (IDES), with the goal of expediting the delivery of VA benefits to all out-processing service members. The current 27 locations participating in the pilot program examine about 47 percent of service members (12,735 in 2010) who enter the DOD disability evaluation system annually. The impact of each stage of the IDES expansion and cumulative DES population is planned as follows:⁸²

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

While the IBVSOs have been pleased at the progress of the DES to date, we are concerned that service mem-

bers who are participating in the new approach to discharge evaluation are not systematically being encouraged to seek representation from a veterans service organization. Most are relying instead on the advisory services of military counsel. Because most service members undergoing the discharge evaluation process are unaware of the complexities of the disability adjudication and retirement systems, we believe their interests in the DES process would best be served by their being represented by an informed national service officer of a chartered veterans service organization. The IBVSOs believe that all veterans transitioning from military service to civilian life as a result of disability should be afforded the benefit of representation by an advocate before the fact, and we urge the DOD and VA to address this observed gap in IDES. Unfortunately, not all of the IBVSOs are allowed access to military installations in order to be available to provide this representation.

Military Separation Physical Examinations

A mandatory separation physical examination is not required by the DOD for demobilizing National Guard and reserve members. In some cases we believe these personnel are not made aware the option is available to them as they return from deployments. Although the physical examinations of demobilizing personnel have greatly improved in recent years, a number of service members opt out of these examinations even when encouraged by DOD medical personnel to complete them. Although the expense and manpower needed to facilitate these physical examinations might be significant, the separation physical is critical to the future care of demobilizing service members. The mistakes of the first Gulf War should not be repeated for future generations of war veterans, particularly among members of our National Guard and reserve forces. Mandatory separation physical examinations would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by each to recognize, treat, and compensate for illnesses and injuries resulting from military service and, in particular, combat deployments.

Transition Assistance Programs and Disabled Transition Assistance Programs

The DOD Transition Assistance Program (TAP) was developed to assist in the transitioning of military personnel and family members leaving active service. Returning to civilian life is an exciting time for service members, but is also a complex undertaking. TAP was established to meet the needs of separating service members as they transition into civilian life by offering employment assistance and related services.

The law creating TAP established a partnership among

the Departments of Defense, Veterans Affairs, Transportation, and the Department of Labor Veterans' Employment and Training Service (VETS) to give employment and training information to veterans within 180 days of separation or retirement. TAP consists of three-day workshops at military installations throughout the DOD. Facilitators from state employment services, military family support services, DOL contractors, VA, and VETS staff present these workshops.

Workshop attendees learn about job searches, career decision-making, current occupational and labor market conditions, résumé preparation, and interviewing techniques. Participants are provided an evaluation of their employability as it relates to their local labor market conditions; they also receive information on the availability of veterans' benefits, including health care, education, compensation, home loan guaranty, insurance, etc.

Service members leaving the military with service-connected disabilities are offered the Disabled Transition Assistance Program (DTAP). The DTAP program includes the normal three-day TAP workshop, plus additional hours of individual instruction and advice to determine employability and to address their unique needs related to disabilities.

While many veterans generally enjoy favorable employment opportunities in the nation's labor markets, others, in particular young veterans, are challenged to successfully obtain employment. TAP attempts to address many barriers to success and seeks to alleviate many employment-related difficulties.

In the past several years the DOD and VA have made good strides in transitioning our nation's military to civilian lives and employment. Each of the federal agencies involved has recently or plans to award contracts focused on improving and updating their portions of these programs. Local commanders, through the insistence of the DOD, have begun allowing their out-processing personnel to attend TAP workshops well enough in advance to take the greatest advantage of this program. These opportunities are being provided early enough to educate these future veterans on the importance of securing discharge physical examinations and the need for complete documentation of any disabilities incurred during military service. This arrangement has made them better aware of how to seek services from VA and has given them sufficient time to think about their situations and then to seek answers prior to discharge.

TurboTAP.org, a DOD website, is providing information for service members on the transition from military serv-

ice. TurboTAP.org is intended to supplement the services offered by TAP and others. For Army installations, services are provided by Army Career and Alumni Program centers. On Navy and Marine Corps installations, the transition assistance office is typically located at the Family Support Service Center. Air Force TAP services are provided through the Airmen and Family Readiness Flight centers. Coast Guard TAP services are offered through the Work-Life Offices.⁸³

The IBVSOs observe that TAP and DTAP continue to improve, but challenges remain at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service members who wish to file a claim for VA compensation benefits and other ancillary benefits may be dissuaded from doing so by the specter of their being assigned to a military medical holding unit for an indefinite period. Also, in the DTAP program, those with severe disabilities may already be getting health care and rehabilitation from a VA spinal cord injury center or other specialized VA care, while still 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. In this respect DTAP has not scored the level of success that TAP has, and it is critical that coordination be closer between the DOD, VA, and VETS to reduce this disparity for these severely disabled service members.

Many veterans with significant disabilities are turning to state vocational rehabilitation and workforce development systems because of impediments to accessing VA vocational rehabilitation and employment benefits. Almost all state vocational rehabilitation agencies have entered into memoranda of understanding with VA to serve disabled veterans. Disabled Veterans’ Outreach Program and Local Veterans’ Employment Representative Program personnel are often housed in state “One-Stop Career Centers.” These positions are often praised as a model to be emulated in the broader workforce system. However, these state vocational programs are under considerable resource distress, and their ability to serve veterans who are unserved by the Vocational Rehabilitation and Employment Service within VA is hindered by state personnel and budgetary limitations.

The issue of the transition from active duty status to veteran status should also be a subject of future study, and the IBVSOs look forward to participating in such review and research where warranted. The existing programs have proven to be invaluable during the transition period, but they are in need of additional funding. The IBVSOs believe Congress, the DOD, VA, and the DOL should provide increased funding for TAP

and DTAP. Unfortunately, the current level of funding and staffing in these programs is inadequate to support the known and anticipated numbers of discharges in all branches of the armed forces.

While efforts are under way to improve both TAP and DTAP, the recent U.S. Department of Labor Office of Inspector General Office (OIG) audit of VETS found problems with contract compliance and tracking of service delivery.⁸⁴ The OIG found that VETS did not have effective management controls to ensure TAP participants received the employment assistance needed to obtain meaningful employment:

- VETS could not substantiate the 124,700 participants that it reported as having attended TAP workshops with participant attendance documents and monitoring of 117 of 247 (47 percent) domestic and overseas TAP sites. The OIG found a lack of consistent evaluation criteria and resolution tracking in VETS monitoring.
- VETS also did not use measurable performance goals and outcomes to evaluate program effectiveness, and lacked adequate controls over contracting for TAP workshop services.
- These deficiencies resulted in undermining VETS’ ability to ensure it was providing a high-quality program, as required, to meet the assistance needed to ensure veterans succeed in obtaining meaningful employment, and may impact critical program decisions by Congress, VETS, and other stakeholders. In addition, the OIG identified deficiencies that resulted in \$2.3 million in unsupported and other questioned costs and found that \$713,000 spent may have been put to better uses by VETS.

The OIG recommended the following actions by VETS:

- development and implementation of procedures to report and document participant attendance, a monitoring process, and controls for contract activities and administration;
- ensuring that VETS personnel adequately monitor TAP workshops;
- retention of participant information needed to measure and report outcome goals;
- establishment of new memoranda of understanding with its partner agencies;
- revision of methods for contractor cost justification cost comparisons; and
- recovery of unsupported and questioned contract costs.

The IBVSOs fully concur with these recommendations and urge VETS to move forward on its implementation. The IBVSOs also recommend conducting regular audits of TAP to ensure that these recommendations are correctly implemented.

Although the achievements of the DOD and VA have generally been positive with out-processing active duty service members, the IBVSOs remain concerned with the large numbers of reserve and National Guard service members moving through the discharge system without the benefit of the TAP program. Neither the DOD nor VA seems prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life. If service members are uninjured, they may clear the demobilization station in a few days, and little if any of this time is dedicated to informing them about veterans' benefits and services. Additionally, the DOD personnel at these sites are most focused on processing service members through the sites. Lack of space and facilities often restricts contact between demobilizing service personnel and VA representatives. To ensure full participation in this important program, the IBVSOs recommend making participation in the TAP program mandatory for all discharging service members.

In 2008 the DOD released a new version of the *Compensation and Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces*. This handbook is designed to help service members who are wounded, ill, or injured, as well as their family members, navigate the military discharge and veterans' disability systems. The IBVSOs applaud this informative booklet as one more method to help service members understand the transition. Now it will be critical for the DOD to ensure the handbook gets to transitioning service members and incorporates it as an important resource within DTAP. Its availability on the Internet through the DOD website TurboTAP.org and other locations is a strong step toward this goal.

Limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. The IBVSOs believe that a truly seamless transition is imperative for these personnel. Service members 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, VA, and other relevant agencies at the federal and state level improve their coordination and information sharing to provide a seamless transition.⁸⁵

Recommendations:

VA and the DOD should establish a focused campaign to eradicate stigma and provide early intervention services for treatment of war-related mental health problems, including substance-use disorders. In this regard, VA Vet Centers should receive new staffing complements to ensure effective outreach to active duty, guard, and reservist war veterans, and to fully implement section 401 of Public Law 111-163, the "Caregivers and Veterans Omnibus Health Services Act."

Congress should authorize and VA should provide a full range of medical, psychological, financial, and social support services to family caregivers of veterans, especially for those with brain and severe physical and polytraumatic injuries. In that connection, Congress should closely oversee VA's full implementation of caregiver benefits authorized by P. L. 111-163. Congress should expand the benefits afforded by this act to family caregivers of all disabled veteran generations.

The DOD and VA must make participation in the Transition Assistance Program mandatory for all discharging service members. The DOD and VA must invest in traumatic brain injury and post-deployment mental health research to close gaps in care and develop best practices in screening, diagnosis, and treatment of war-related brain injuries.

VA should initiate and conduct surveys and other research to assess the barriers to VA care for veterans of Operations Enduring and Iraqi Freedom (OEF/OIF), with an emphasis on reservists and guardsmen transitioning to veteran status after deployments, women veterans, and veterans who live in rural areas.

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

VA should continue its promotion and expansion of programs for the treatment of the unique needs of women veterans with a focus on OEF/OIF veterans. Congress should provide oversight to ensure VA fully enacts legislation to support improvements in VA women's health programs for all VA-enrolled women veterans.

Congress should provide oversight to ensure that DOD and VA improve the Federal Recovery Coordinator Program in military treatment and VA facilities caring for severely injured service members and veterans. VA should periodically survey the family members of vet-

erans assigned to federal recovery coordinators to determine where improvements might be necessary to the services they provide these veterans and their families.

The DOD and VA must develop clear rehabilitation plans for severely injured service members and veterans and request the necessary resources to accomplish their goals.

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

Congress should consider a joint hearing of the Armed Services and Veterans' Affairs Committees to review the implementation of the Defense-VA Vision Center of Excellence (VCE), as well as provide greater oversight of the joint Health Executive Council and its role monitoring the establishment and operations of the VCE and other centers of excellence that may be established in future law.

Congress should provide sufficient funding to ensure that the VCE meets its expected mandate, and that the Congressionally Directed Medical Research Program be sufficiently funded to provide continuing research into combat eye injuries.

Congress, the President, the DOD, and VA must ensure that specialized programs are sufficiently funded and adapted to meet the needs of our OEF/OIF veterans, while VA continues to address the health needs of veterans from earlier generations of war.

VA and the DOD should coordinate to ensure that service members leaving active duty have prescriptions that will be easily filled by VA. In addition, the DOD should ensure that service members leaving active duty are advised to visit their local VA to verify that their prescription is available or to ensure sufficient time for their prescription to be adjudicated.

In accordance with the recommendation of the "National Defense Authorization Act for FY 2008" and the recommendation of the President's Commission, the DOD and VA must implement a single comprehensive medical examination as a prerequisite of promptly completing the military separation process. Moreover, VA should be made responsible for handling this duty.

The DOD and VA should encourage active duty service members to seek veterans service organization representation during their out-processing and discharge examinations.

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

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

⁴³ Stiglitz, Testimony, note 15.

⁴⁴ VA Office of Public Health and Environmental Hazards, *Analysis of VA Health Care Utilization*, note 16.

⁴⁵ Department of Veterans Affairs, Briefing to Veterans Service Organizations (November 17, 2010).

⁴⁶ Beck, Testimony on Caring for Severely Injured OEF/OIF Veterans and Servicemembers, note 17.

⁴⁷ T. Tanielian and L. Jaycox, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (RAND Center for Military Health Policy Research, 2008).

⁴⁸ VA Office of Public Health and Environmental Hazards, note 21.

⁴⁹ Department of Veterans Affairs press release, "VA Going to World Series," note 29.

⁵⁰ Coleman, Testimony before the U.S. House of Representatives, note 32.

⁵¹ <http://www.health.mil/dhb/downloads>; <http://www.health.mil/dhb/downloads/Suicide%20Prevention%20Task%20final%20report%208-23-10.pdf>.

⁵² Aaron Levin, "Risk Factors for Suicide in Veterans Become Clearer," *Psychiatric News* 46, no. 2 (January 21, 2011), 1.

⁵³ American Forces Press Service, "Defense Department Joins Suicide Prevention Alliance," note 31.

⁵⁴ U.S. Government Accountability Office, *VA Faces Challenges in Providing Substance Use Disorder Services*, note 33.

⁵⁵ *Ibid.*

⁵⁶ *VA Drug Formulary, Drug Review Process Is Standardized at the National Level, but Actions Are Needed to Ensure Timely Adjudication of Nonformulary Drug Requests* (U.S. Government Accountability Office, August 2010), 8.

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*, 22.

⁶⁰ Department of Veterans Affairs Press Release, "VA Celebrates National Family Caregiver Month," (November 8, 2010).

⁶¹ *Ibid.*

⁶² LCPL Dwight Henderson, RCT 7, "Female engagement team helps establish connection between Marines and Afghan women" (December 28, 2010) <http://www.usmc.mil/unit/iimeff/Pages/default.aspx>.

⁶³ Trista Talton, "All-female teams reach out to Afghan women," *Marine Corps Times* (January 10, 2010) http://www.marinecorpstimes.com/news/2010/01/marine_fet_010910w/.

⁶⁴ Capt. Emily Naslund, USMC, Congressional briefing, sponsored by Women's Policy, Inc., Rayburn House Office Building, Washington, DC (November 18, 2010).

⁶⁵ Dr. Patty Hayes, Chief Consultant, Women Veterans Health Strategic Health Care Group, November 9, 2010.

⁶⁶ www.researchva.gov; October 2008

⁶⁷ Armed Forces Health Surveillance Center) *Eye Injuries among Members of Active Components, U.S. Armed Forces, 1998–2007*, MSMR Volume 15, no. 9 (November 2008).

⁶⁸ Greg Goodrich, *Summary of Polytrauma Eye Research and Treatment Study Seen at VA Palo Alto Rehabilitation Network Site, March 2008 Report* (VA Palo Alto Center).

⁶⁹ Diane Cowper Ripley, *Putting Polytrauma Care on the Map*, VA Research Currents R7D (Gainesville FL, October 2008).

⁷⁰ Diane Cowper Ripley, *Putting Polytrauma Care on the Map*, VA Research Currents R7D (Gainesville FL, October 2008).

⁷¹ VHA Blind Rehabilitative Program Data, August 2010 report to BVA.

⁷² "Pain and Combat Injuries in Soldiers from OIF and OEF," *Journal of Rehabilitation Research & Development* 44 (November 2, 2007): 179–94.

⁷³ Department of Defense, Office of the Secretary of Defense, *Quadrennial Defense Review* (February 1, 2010).

⁷⁴ The Wounded Warrior Act (title XVI of P. L. 110 to 181; 10 U.S.C. 1071 note), as amended by section 252 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (P. L. 110-417; 122 Stat. 4400).

⁷⁵ CliniComp's Essentris™ product suite is a customized commercial health infor-

mation system that is the current Inpatient Documentation System (IDS) solution for the DOD to support inpatient treatment at military medical facilities.

⁷⁶ Definition as established by the Interagency Clinical Informatics Board (ICIB). ICIB submitted to VA and the DOD a joint requirements definition schedule (milestones and timelines) for the data elements to achieve interoperability of electronic health systems or capabilities for the provision of clinical care.

⁷⁷ U.S. Government Accountability Office, *Opportunities Exist to Improve Management of DOD's Electronic Health Record Initiative*, GAO-11-50 (Washington, DC: October 6, 2010) <http://www.gao.gov/new.items/d1150.pdf>.

⁷⁸ The DOD/VA Interagency Program Office (IPO) acts as the single point of accountability in the development and implementation of electronic health records systems or capabilities, and is responsible for accelerating the exchange of health care information to support the delivery of health care by both departments, as well as overseeing and managing personnel and benefits electronic data sharing between the departments.

⁷⁹ Beck, Testimony on Caring for Severely Injured OEF/OIF Veterans and Servicemembers, note 17.

⁸⁰ Ibid.

⁸¹ The President's Commission on Care for America's Returning Wounded Warriors (July 2007), 7.

⁸² Statement of John R. Campbell, deputy under secretary of defense (Wounded Warrior Care and Transition Policy), Department of Defense, before the Senate Committee on Veterans' Affairs Hearing on Review of the VA And DOD Integrated Disability Evaluation System (November 18, 2010).

⁸³ http://www.turbotap.org/portal/transition/resources/About_Us.

⁸⁴ Veterans' Employment and Training Service, *Vets Needs To Strengthen Management Controls Over The Transition Assistance Program*, Report No. 06-10-002-02-001 (September 30, 2010).

⁸⁵ Valerie C. Melvin, director, information and human capital issues, U.S. Government Accountability Office, Statement before the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations (July 14, 2009).



Access Issues

TIMELY ACCESS TO VA HEALTH CARE:

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

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

In 2002, VA placed a moratorium on its facilities’ marketing and outreach activities to veterans and determined there was a need to give the most severely service-connected disabled veterans a special priority for care. This was necessitated by VA’s realization that demand was seriously outpacing available funding and other resources and that service-connected veterans were being pushed aside rather than being VA’s highest priority. At its peak in the summer of 2002, VA reported that 310,000 veterans were waiting at least six months for their first appointment for primary care.

On January 17, 2003, the VA Secretary announced a “temporary” exclusion from enrollment of veterans

whose income exceeded geographically determined thresholds and who were not enrolled before that date. This decision denied health-care access to 164,000 priority group 8 veterans in the first year alone. Since 2003, VA notes, more than 565,000 priority group 8 veterans have sought access to VA health care but have been denied.⁸⁶ Although Congress provided \$543 million⁸⁷ in FY 2009⁸⁸ to allow a projected 260,000 priority group 8 veterans to enroll, VA does not have the resources necessary to completely remove the prohibition on all new priority group 8 enrollments.

The question about sufficiency of resources to address waiting time must also include questions about the efficiency of the health-care system. All questions, however, lead to access—a measure of the patient’s ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit.

The Solution: System Change

Several years ago, in an attempt to better manage patient access to care, VA began a process of reengineering its clinic patient flow through the Advanced Clinic Access Initiative developed by the Institute for Healthcare Im-

provement (IHI). The strategy emphasizes managing demand in order to improve patient flow and, thus, access to services. The core principle of Advanced Clinic Access is that patients calling to schedule a physician visit are offered an appointment the same day. Notably, Advanced Clinic Access is not sustainable if patient demand for appointments is permanently greater than physician capacity to offer appointments. Three key concepts supported by 10 elements of advanced access are important in its application: (1) shape the demand (work down the backlog, increasing system ability to reduce demand); (2) match supply and demand (understand supply and demand, reduce appointment types, plan for contingencies); and (3) redesign the system to increase supply (manage the constraint; optimize the care team; synchronize patient, provider, and information; predict and anticipate patient needs at time of appointment; and optimize rooms and equipment).

More specifically, IHI principles identify “bottlenecks,” such as limited clinical staff, care space, clerical staff, and equipment, in order to ensure that the process is optimally efficient. One important element of the IHI strategy is to allow patients to always see the same care provider, which is similar to the Veterans Health Administration’s (VHA’s) new approach to providing primary care (see “Transformation of the Department of Veterans Affairs Health-Care Delivery Model—Patient-Centered Medical Home or Patient-Aligned Care Teams” in this *Independent Budget*). This allows a personal relationship to develop between the patient and provider, thus dispensing with the need to repeat medical background at each visit. The strategy apparently yielded good results in reducing waiting times; however, questions remain about the accuracy of data collected to confirm these reductions. Moreover, although these principles are powerful, they are counter to deeply held beliefs and established practices in health-care organizations. Accordingly, adopting these principles requires strong leadership investment and support.

What to Measure

There is a lot of truth to the adage “you can’t improve what you can’t measure.” Furthermore, the quality of resulting data can influence the ability to improve. The IHI recommends measuring four outcomes in concert with Advanced Clinic Access: (1) third-next available appointment; (2) future capacity (for primary care only), percentage of appointment slots that are open and available for booking patients over the next four weeks; (3) office visit cycle time, the amount of time in minutes that a patient spends at an office visit, where the cycle begins at the time of arrival and ends when the patient leaves the office; and (4) percentage of no-show appointments.

Counting the third-next available appointment is the health-care industry’s standard measure of access to care and indicates how long a patient waits to be seen. According to the Agency for Healthcare Research and Quality, access is a measure of patients’ ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Access to medical care depends greatly on whether the VA health-care system has the capacity to meet the demand. The time to “third-next available” appointment is the preferred measure of overall insufficient capacity. It is used to determine how long patients have to wait for an appointment, whereas the first and second appointments may reflect openings created by patients canceling appointments, working patients into the schedule, or other events, and this does not accurately measure true accessibility.⁸⁹

Tools to Measure

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

Over time, new functionality and enhancements were made to VA’s scheduling software to address findings by VA’s Office of Inspector General (OIG)⁹⁰ and Booz Allen Hamilton⁹¹ on weaknesses in the Department’s outpatient scheduling process.⁹² However, after spending an estimated \$127 million over nine years (from fiscal years 2001 through 2009) on its outpatient scheduling system project to develop a core computer application to schedule patient appointments, VA today is still in need of replacing its archaic scheduling software.^{93, 94} Had the new system been implemented, it would also have been a core piece of VA’s HealthVet electronic health record that includes patient enrollment and scheduling, a pharmacy system, a data repository, a workload management system, and a gateway for patients to manage their own health records and personal information. *The Independent Budget* veterans service organizations (IBVSOs) urge VA to finalize an overall comprehensive development plan for a new scheduling model update. The plan should incorporate critical areas of system development and consider all dependencies and subtasks, including use as a means of determining progress for critical components, such as patient waiting times. Such software can address the validity of data that remain suspect, optimize VHA health-care capacity, and improve access and health outcomes.

VA is now starting over and is in the process of analyzing alternative strategies, which will be the basis for a project plan that is to be developed. In the meantime the VHA is saddled with a workable but less functional scheduling system. The Veterans Information Systems and Technology Architecture (Vista) currently collects waiting time data from 50 high-volume outpatient clinic appointments throughout the system. The VHA also tracks and assesses the utilization and resource needs for specialty care through the use of electronic consult requests in the Computerized Patient Record System. The resulting four reports to track and manage waiting times include the “Missed Opportunities Report” (patients who did not show for their appointments or whose appointments were canceled), “Completed Appointments Report,” “Electronic Waiting List Report” (patients treated without prior appointments), and the “Access Waiting List Report” (patients who have not completed their appointments). The IBVSOs urge the VHA to make public these waiting time reports. Without the ability to compare these waiting time reports to external benchmarks, we cannot accurately evaluate VA’s performance. Greater transparency would allow for clearer accountability, for consistency and performance comparison, across the VA health-care system.

These reports are used in VA’s *Performance and Accountability Reports*, which contain key performance measures to track its progress in accomplishing its overall mission. Under VA’s third strategic goal for fiscal year 2009,⁹⁵ VA has listed performance measures to track all patients based on a 30-day benchmark: the percentage of primary care appointments scheduled within 30 days of a patient’s desired date, the percent of new patient appointments completed within 30 days of the “create” dates, and the percent of unique patients waiting more than 30 days beyond the desired appointment date. The September 2007 OIG report, *Audit of the Veterans Health Administration’s Outpatient Waiting Times*,⁹⁶ challenges the validity of VA’s data and the agency’s assertion that in FY 2006, 96 percent of all veterans seeking primary care and 95 percent of all veterans seeking specialty care were seen within 30 days of their desired appointment times. In subsequent *Accountability Reports*, the VHA claimed even better results for fiscal years 2007, 2008, and 2009: 97.2, 98.7, 99 percent of primary care, and 95, 97.5, and 98 percent of specialty care patients, respectively, falling within the 30-day time frame.

Timely access is crucial to the VHA health-care system’s capacity to provide health care quickly after a need is recognized and is crucial to the quality of care delivered. Significant and recurring delays for appointments result in patient dissatisfaction, higher costs, and possible ad-

verse clinical consequences.⁹⁷ Since the *Independent Budget* first addressed the waiting time issue in its 2002 edition, the IBVSOs have consistently recommended that the VHA “identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide.” In 2002, at the zenith, more than 310,000 veterans were waiting six months or more for care.⁹⁸ In January 2008, 109,970 veterans were waiting more than 30 days to be seen. However, the VHA measurement system for outpatient waiting times continues to lack credibility.

These specific concerns aside, the IBVSOs believe the VHA has made tremendous effort to significantly reduce waiting times over the past several years and should be commended for attempting to measure clinical waiting times for such a vast, national health-care enterprise. Notably, the VHA is moving toward addressing those domains of concern outlined in Booz Allen Hamilton’s report. The report made 52 recommendations (including nine dealing with measurement) to improve the timeliness of care, supported by 78 action items that describe intermediate steps to achieve the goals articulated by the major recommendations. While we agree with many of the recommendations, we disagree with some. For example, we disagree with the report’s recommendation for VA to discontinue the measurement of follow-up waiting times for established patients. The report cited the “desired date” of an appointment to be the main culprit (as indicated by VA’s OIG reports), and that it is aggravated by a lack of compliance despite VA’s training efforts. Another reason for this particular recommendation is that “patient panels effectively match supply to demand, making delays less likely.” This assertion is unproved without data.

We also commend the VHA in issuing a new directive⁹⁹ to address training, compliance, and data validity, such as capturing patients “desired date” for an appointment and also capturing veterans’ experiences in accessing VA health care. However, we recommend that the OIG conduct a follow-up evaluation of VA’s outpatient scheduling processes and procedures, compliance, training, monitoring, and oversight.

Because the Institute of Medicine identified timeliness as one of the six key “aims for improvement” in its major report on the quality of health care,¹⁰⁰ the IBVSOs believe the VHA must take a more aggressive stance to provide greater transparency toward efforts to ensure that veterans are receiving timely access to care. Also, we believe waiting times for all primary and specialty care appointments, regardless of whether these serv-

ices are directly provided or purchased by VA, should be measured. The unprecedented growth of non-VA purchased care, highlighted in the “Coordination of VA Purchased Care” section of this *Independent Budget*, cannot be ignored in performance measurement. So, too, must the VHA track and manage veterans’ access to care in this arena. This advance will bring the Department closer to a more comprehensive measurement of performance in delivering health care to our nation’s disabled veterans. The perception of VHA’s quality is important to its success.

Recommendations:

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

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

The VHA should fully implement complementary aspects of the Institute for Healthcare Improvement’s Advanced Clinic Access principles and measures for primary and specialty care to maximize productivity of clinical care resources by expanding to other clinics that could benefit.

VA should address all recommendations contained in the Booz Allen Hamilton report *Patient Scheduling and Waiting Times Measurement Improvement Study*.

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

VA must ensure that schedulers receive adequate annual training on scheduling policies and practices in accordance with the recommendations of its Office of Inspector General (OIG).

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

VA should finalize an overall comprehensive development plan for HealtheVet to include critical components, such as an outpatient scheduling software.

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

⁸⁶ Personal communication with director, Business Office, VHA.

⁸⁷ Includes \$375 million for medical services, \$100 million for medical support and compliance, and \$68 million for medical facilities.

⁸⁸ P. L. 110-329.

⁸⁹ Thomas Bodenheimer and Kevin Grumbach, *Improving Primary Care: Strategies and Tools for a Better Practice* (New York: Lange Medical Books/McGraw Hill, 2006), 104.

⁹⁰ VA Office of Inspector General, *Audit of the Veterans Health Administration’s Outpatient Scheduling Procedures*, Report No. 04-02887 (Washington, DC: July 8, 2005); *Audit of the Veterans Health Administration’s Outpatient Waiting Times*, Report No. 07-00616-199, (Washington, DC: September 10, 2007); *Review of Alleged Manipulation of Waiting Times, North Florida/South Georgia Veterans Health System*, Report No. 08-03327-35 (Washington, DC: December 4, 2008).

⁹¹ *Executive Summary, Final Report on the Patient Scheduling and Waiting Times Measurement Improvement Study* (Washington, DC: Booz Allen Hamilton, July 22, 2008).

⁹² VHA Directive 2002-068 (November 13, 2002); *Primary Care Management Module Unassign Inactive Patient Primary Care Providers, Release Notes* (December 2006); *Electronic Wait List for Scheduling and Primary Care Management Module User Manual* (November 2002; revised October 2008).

⁹³ Department of Veterans Affairs press release, “Initial 45 Projects Targeted for New Department-wide Management System,” (July 17, 2009) <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1734>. 55; M. Murray and C. Tantau, “Must Patients Wait?” *Journal on Quality Service Improvement* 24, no. 8 (1998): 423–25.

⁹⁴ U.S. Government Accountability Office, *Management Improvements Are Essential to VA’s Second Effort to Replace Its Outpatient Scheduling System*, GAO Report 10-579 (May 27, 2010).

⁹⁵ P. L. 103-62, Government Performance and Results Act of 1993; P. L. 106-531, Reports Consolidation Act of 2000.

⁹⁶ www4.va.gov/oig/52/reports/2007/vaig-07-00616-199.pdf.

⁹⁷ Institute of Medicine, NIH, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press, 2001).

⁹⁸ VHA survey conducted in July 2002. Senate Report 107-222, 107th Cong., 2nd Sess. (2002).

⁹⁹ VHA *Outpatient Scheduling Processes and Procedures*, VHA Directive 2010-027 (June 9, 2010).

¹⁰⁰ Institute of Medicine, NIH, *Crossing the Quality Chasm*, note 97.

TRANSFORMATION OF THE DEPARTMENT OF VETERANS AFFAIRS HEALTH-CARE DELIVERY MODEL—PATIENT-CENTERED MEDICAL HOME OR PATIENT-ALIGNED CARE TEAMS:

The Veterans Health Administration is undergoing a change in the way it plans to deliver health care to the veterans it serves. As the VHA implements a patient-aligned care team model, VA leaders must ensure the unique health-care needs of the veteran population are met while sustaining quality and satisfaction.

Over the past 15 years, VA has been transformed into a nationally recognized, first-rate, and comprehensive health-care system. To maintain its high standards of quality care, VA recently announced its intention to transition into a patient-aligned care team (PACT) approach. *The Independent Budget* veterans service organizations (IBVSOs) believe that such a change has the potential to enhance the delivery of health services for veterans; however, to ensure that the expected positive outcomes are achieved, VA must include three critical factors as fundamental components of the medical home model: (1) the patient-centered care must meet the unique needs of disabled veterans; (2) PACTs must provide consistent communication with veterans and their advocates; and (3) the VHA's infrastructure needs must be aligned with the medical home model delivery of care.

In a VA press release of January 19, 2011, VA announced the creation of the Office of Patient Centered Care and Cultural Transformation. The office is based in Arlington, Virginia, and will have four regional patient-centered care teams located at the medical centers in Birmingham, Alabama; East Orange, New Jersey, Dallas; and Los Angeles. VA research teams are studying the effectiveness of the model in a variety of settings, and VA policymakers have projected that 80 percent of all its outpatient clinics will be participating in the medical home adaptation initiative by 2012, with all VA health-care sites functioning as PACTs by 2015. Although the term "medical home" carries no single and universal definition, a set of accepted principles is common to the concept:

- team-based care that emphasizes continuity of care over the lifespan of the veteran-patient;
- a larger role for nurses, nurse practitioners, and physician assistants in coordinating care;
- use of email, secure messaging, and other alternative forms of communication and telemetry with patients to monitor care;
- greater attention on behavioral and mental health issues; and
- increased focus on what patients want while increasing patient and practitioner satisfaction.

The IBVSOs believe flexibility will be important to foster creation of best practices for the wide variety of health-care options in VA's unique population and geographic diversity—yet it is vital that VA ensures consistency throughout the system. Over the years, VA has established specialized systems of care and primary care teams with specialty-trained practitioners for veterans who have incurred spinal cord injury or disease, blindness, amputations, polytraumatic injuries, and chronic mental health challenges. These specialized systems of care serve as excellent models for patient-centered care. The IBVSOs strongly encourage VA to maintain and enhance these specialized areas of care tailored to the unique needs of these veterans. Particularly, VA must make certain that the specialized systems of care are not replaced or diluted by the advent of PACTs that focus on the basic outpatient model of care and are not trained to adequately meet unique health-care needs of these veteran populations.

Further, because chronic medical issues require interdisciplinary approaches, VA must put in place policies and guidelines that create a structure for a health-care model that will not penalize clinicians for aggressively consulting specialists for coordination of treatment plans. For this reason we believe the numerous emerging versions of the model must be carefully studied, and that consideration must be given to the sensitivities of VA health-care personnel who will actually be making the changes envisioned.

As such studies are being conducted, a comprehensive educational component should be created and shared with veterans and their advocates, including the IBVSOs, during the early stages of PACT implementation. VA must help veterans, family members, and caregivers understand the purpose and goals of this new culture in order for them and their families to become true collaborators in the health-care decisions and care plans formulated to maintain veterans' health. As PACTs are established in VA medical centers, the IBVSOs recommend that VA schedule frequent meetings to reach out to veterans and their advocates for input and feedback, as well as identify tools to monitor quality perform-

ance using measurable indicators to ensure that the intended health-care outcomes are achieved.

The IBVSOs are also interested in the planned methods for implementing this model. Thus far, two large VHA conferences have been conducted that focused on the VHA's intention to transform its health-care system into a patient-centered medical home/patient-aligned care team (PCMH/PACT) model; however, we have not seen any specific details about how the VHA intends to train health-care personnel to ensure consistent, safe, and high-quality care. Also, the results of VA's ongoing research efforts have yet to emerge, and these could be important in guiding implementation.

As PACT implementation moves forward, we are concerned that the changes inherent in this cultural shift in health-care delivery be taken into account in VA's infrastructure and capital investment policies. In "Maintaining VA's Critical Infrastructure," in the Construction section of this *Independent Budget*, the IBVSOs express concerns about VA's adoption of the "Strategic Capital Investment Plan," or SCIP, a new VA policy that seems designed to rely heavily on a health-care facility lease, or "build-to-suit" strategy, with reliance on community providers or academic affiliates for inpatient services rather than VA construction of its own comprehensive facilities. With the advent of PACT, VA would no longer simply be replacing worn-out medical centers and clinics with like, but modernized, facilities; VA's evolution to PACT in all likelihood will result in the need for VA to redesign its thinking for how a 21st century VA health-care system, based on the new PACT model of care, should be configured. Historic academic VA missions in training new generations of American physicians, nurses, and other health-care professionals, plus VA's world-class biomedical research programs, need to be taken into account as the new PACT culture takes hold.

The medical home concept has evolved over several decades, but only recently gained more general acceptance. More than 100 demonstration projects have tested the effectiveness of the PCMH model in the private sector, most with positive results. Currently, VA health-service researchers are conducting a study of selected VA medical home pilot programs in five diverse regions. The teams are collecting data to address a complex array of questions to determine how the national medical home model should be structured and governed to ensure it meets the needs of VA's unique enrolled patient population. The analysis is focused on determining which features of the concept work best for veterans in the VA system; if the program is economically viable and sustainable; if a system with more than 1,400 sites of care

can make this shift in care while maintaining continuity of care for patients; and, finally, if the PCMH increases satisfaction for patients, families, and VA providers. In addition to the goal of better health outcomes and management of chronic diseases, the value of long-term, one-to-one relationships that are established and nurtured between patient and practitioner and the emphasis on enhanced access to care, quality, safety, and coordination of care are also important and beneficial to the results desired.

Today VA benefits from the great advantages of having a number of current programs in place, such as anti-coagulation, hypertension, and diabetes clinics, where nurses and pharmacists lead in providing and monitoring patients' health; availability of an indispensable electronic health record to promote accuracy, safety, and quality of care; use of performance measurements to determine management and clinical effectiveness; reliance on evidence-based treatments; and use of telemedicine and telemetry to manage the system, reach, and treat certain patient populations. Having these programs and policies prepositioned and working enables VA to move beyond the essential building blocks and structural elements of the PCMH model to focus far more on transforming the in-place culture of primary care within the system.

Recommendations:

VA must ensure that the specialized systems of care are not replaced or diluted by standard patient-aligned care teams (PACTs) that are not trained to adequately meet unique health-care needs of the veteran populations needing specialized care.

Because chronic medical issues require interdisciplinary approaches, VA must create new policies to outline a structure for a health-care model that will not penalize clinicians for aggressively consulting specialists for coordination of treatment plans.

VA must implement policies to provide continuity of care throughout the Veterans Health Administration to ensure safe delivery of quality health care.

VA must use the data collected from its research efforts to bring all of the pieces of the PACT puzzle into a cohesive and integrated whole.

VA must communicate clearly with all affected employees the change that is being made with movement to the PACT approach and gain broad "buy-in" by them in making the change.

VA must create and implement a comprehensive educational component for veterans and their advocates during the early stages of PACT implementation to increase the likelihood VA users understand how the new model serves them in an improved way.

VA must include *The Independent Budget* veterans service organizations as an integral part of the transformational process and keep them informed and involved in

the changes to come in order to help serve and educate their memberships and the veterans VA serves.

VA capital investment planning, and its academic missions, must be accommodated as VA shifts its culture to that of PACT.



COMMUNITY-BASED OUTPATIENT CLINICS:

The Department of Veterans Affairs should improve specialty care provided by community-based outpatient clinics and improve oversight regarding contracted CBOC facilities and staff while consolidating contracts at either the medical center or network level.

Since their inception more than 20 years ago, VA community-based outpatient clinics (CBOCs) have steadily grown and are expected to grow well past the 784 clinics that VA uses currently. With such dynamic growth in a relatively short amount of time, oversight of these clinics has been overlooked. This increase has been achieved primarily through separate solicitations and multiple contracts, often with different performance measures and pricing models within an individual catchment area. The result of this is a more complex, less efficient contract administration structure, creating extra work for already overburdened contracting officials and delivering an uneven benefit to veterans who access those CBOCs for their primary care.

A recent audit of CBOCs by the VA Office of the Inspector General found that the Veterans Health Administration (VHA) has not issued adequate guidance to ensure the effective ongoing monitoring and evaluation of CBOCs. Furthermore, the VHA lacks an effective management control system to ensure CBOCs provide consistent care and are in compliance with VA policies and procedures.¹⁰¹ The lack of oversight starts with the delegation of management and oversight to the VA medical facilities or centers in the area. These parent facilities are divided into 21 networks. These networks, however, do not consistently monitor CBOC performance, and few have any form of weekly oversight. This gap leads to many violations of VA policies and procedures due to either a lack of enforcement or knowledge. Screening of traumatic brain injury and

military sexual trauma are in some cases not completed in initial clinic visits as is required. In addition some patients were inaccurately charged copayment fees for such screenings. These are just some of the many instances that highlight the need for a streamlined system of oversight for CBOCs that is consistently enforced and is common knowledge for employees.

Contracted CBOCs exhibit the same problems, yet they are complicated by the lack of enforcement VA exerts over them. VA often states that if a major problem exists, it can terminate the contract with the third-party company and build a VA-managed CBOC in the same area; however, with such a bureaucratic maze to go through and a lack of uniform rules governing CBOC performance and oversight, a major problem may go unnoticed.

Although the establishment of CBOCs by the VHA provides a presence in various communities where veterans reside, the level of care is not as specialized as in the major VA medical facilities. These CBOCs provide an invaluable service to the thousands of veterans currently living considerable distances from their parent VA medical centers. CBOCs however do not offer mental health services, and many diagnostic procedures needed by patients are not currently available in many CBOCs. If a patient is diagnosed with a condition, such as post-traumatic stress disorder, he or she cannot be treated at the local CBOC but must relocate for care or not receive treatment.

Recommendations:

VA should improve specialty care offered at community-based outpatient clinics (CBOCs) and consider adding more mental health services to all CBOCs. This enhancement would increase the level of care provided and availability of specialized care to veterans.

VA must improve oversight for CBOCs to ensure uniform care of the highest degree

VA should improve oversight regarding contract CBOCs and should consider consolidating contracted community-based outpatient clinics at VA medical center or network levels. This would ensure consistent requirements, pricing, and performance measurements, along with simplified contract administration.

The Veterans Health Administration must ensure that CBOCs are staffed by clinically appropriate providers, capable of meeting the needs of veterans.

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

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

¹⁰¹ VA Office of the Inspector General Office of Audits & Evaluations (2010). "Veterans Health Administration Audit of Community Based Outpatient Clinic Management Oversight."



VETERANS' RURAL HEALTH CARE:

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

The *Independent Budget* veterans service organizations (IBVSOs) believe that, after serving their nation, veterans should not experience neglect of their health-care needs by VA because they live in rural and remote areas far from major VA health-care facilities. In *The Independent Budget for Fiscal Year 2011*, we detailed pertinent findings dealing with rural health care, disparities in health, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). Those conditions remain relatively unchanged:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and risks of stress, depression, suicide, and anxiety disorders as major rural health concerns.¹⁰²
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among res-

idents of rural areas.¹⁰³ The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services.¹⁰⁴

- Nearly 22 percent of the elderly live in rural areas where they represent a larger proportion of the population than they do in urban populations. As the elderly population grows, so do the demands on acute care and long-term-care systems. In rural areas, some 7.3 million people need long-term care services, accounting for one in five of those who need long-term care.¹⁰⁵

Given these general conditions of scarcity of resources the following should not be surprising or unusual, with respect to those serving in the U.S. military and to veterans:

- There are disparities and differences in health status between rural and urban veterans. According to the VA Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have worse

physical and mental health related to quality of life scores. Rural/urban differences within some Veterans Integrated Service Networks (VISNs) and U.S. Census regions are substantial.”¹⁰⁶

- More than 44 percent of military recruits and service members deployed to Iraq and Afghanistan come from rural areas.
- More than 60,000 service members have been evacuated from Iraq and Afghanistan as a result of wounds, injuries, or illness, and tens of thousands have reported readjustment or mental health challenges following deployment.¹⁰⁷
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health-care users, 40.1 percent (nearly 2 million) reside in rural areas, including 79,500 from “highly rural” areas, as defined by VA.
- Thirty-five percent of OEF/OIF veterans enrolled in VA are from rural and highly rural areas.¹⁰⁸
- Older enrolled veterans were more likely to reside in rural or highly rural areas, with 77 percent of rural and highly rural veterans being older than the age of 55.
- More than 70 percent of highly rural veterans have to drive more than four hours to receive tertiary care from VA.¹⁰⁹

Currently, VA operates 152 VA medical centers and systems of care, including 784 community-based outpatient clinics (CBOCs). VA staffs more than 550 CBOCs total; contractors manage the remainder of these clinics. At least 333 CBOCs are located in rural or highly rural areas as defined by VA. In addition, VA is expanding its capability to serve rural veterans by establishing rural outreach clinics. Currently, it is our understanding that 12 VA outreach clinics are operational, and VA has reported that more have been planned. However, it is problematic to assess the degree of progress being made in establishing rural outreach clinics because VA data systems do not differentiate rural outreach clinics from its CBOCs. This lack of definition needs to be addressed, and we urge VA to do so.

Rural Veterans

In rural America, veterans and the community entities that work with them are often unaware of VA benefits and how to obtain them. A study commissioned by the Office of Rural Health (ORH) surveyed non-VA providers to identify issues on which health professionals lacked information concerning rural veterans, and among the top areas cited were “general issues in negotiating and managing the VA care system to meet needs of rural veterans.”¹¹⁰

An analysis completed by the ORH in 2008 using FY 2007 VA utilization data¹¹¹ revealed that one in three veterans enrolled in VA health care was defined as rural or highly rural. It also found that, for most health characteristics examined, enrolled rural and highly rural veterans were similar to the general population of enrolled veterans, but this analysis confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately one-quarter of all enrolled veterans fell into this age group. In FY 2007, rural veterans had a median household income of \$19,632, 4 percent lower than the household income of urban veterans (\$20,400). The median income of highly rural veterans showed a larger gap at \$18,528.

Ninety-five percent of rural and highly rural enrolled veterans are men, and approximately 5 percent are women. This proportion corresponds to the overall population of enrolled veterans. Also, approximately 4 percent of enrolled rural and highly rural veterans are veterans of OEF/OIF deployments.¹¹²

Veterans Rural Health Resource Centers Are Key Components of Improvements

VA operates three Veterans Rural Health Resource Centers for the purpose of improving its understanding of rural veterans’ health challenges; identifying their disparities in health care; formulating practices or programs to enhance the delivery of care; and developing special practices and products for implementation VA systemwide. According to VA, these centers serve as satellite offices for the ORH. They are located in VA medical centers in White River Junction, Vermont; Iowa City, Iowa; and Salt Lake City, Utah. The concept underpinning the establishment of these centers was to support a strong ORH presence across the VA health-care system with field-based offices. These offices are charged with engaging in local and regional rural health issues in order to develop potential solutions that could be applied nationally across the Veterans Health Administration (VHA), including building partnerships and collaborations—steps that are imperative in rural America. These offices have made appreciable progress in reaching out to state offices of rural health and their existing or potential collaboration with local rural health providers. The IBVSOs commend that progress and encourage its expansion and continuance, including developing a national-level collaboration, executed via the Rural Health Resource Centers, with Department of Health and Human Services grantee community health centers.

These satellite offices of the ORH and their efforts, along with those of VISN rural health consultants, could validate the importance of the work and extend the reach of the ORH in the VHA, to reinforce the idea that it is moving VA forward using the direct input of the needs and capabilities of rural America, rather than VA trying to move forward alone from a Washington, DC, central office. Nevertheless, we understand that some local VA health-care officials tend to resist these rural resource centers' efforts to bring their collaborations and findings on rural matters into their operations. We believe Congress and the Administration should examine these difficulties and take corrective actions to create incentives to promote better VA coordination with community health centers and other potential resources for the care of rural veterans.

Although some of the work these centers engage in is similar to that of the Mental Illness Research, Education, and Clinical Centers and the similar VA specialized centers in geriatrics, Parkinson's, and multiple sclerosis, the Veterans Rural Health Resource Centers are unique in that, as satellite offices, they have been delegated the appropriate obligation to more directly support the operations of the ORH, in addition to executing demonstration projects and conducting the analytical and scholarly studies required under their charters. The centers should continue to be leveraged to assist and execute the agenda of the ORH. For example, with the significant and recurring funding now flowing to VA from Congress to support improvements in rural health care for veterans, the IBVSOs believe that local, hands-on engagement and technical assistance from the Veterans Rural Health Resource Centers, with oversight by the ORH, is an appropriate direction for VA in rural health.

Despite our recommendation in *The Independent Budget for Fiscal Year 2011*, these resource centers still remain under temporary charters within the VHA, and are the recipients of centralized funding not to exceed five years' duration. The nature of that arrangement has had unintended consequences on the centers, including the problematic recruitment and retention of professional staff. The IBVSOs have been informed that all staff appointments to the Veterans Rural Health Resource Centers remain as temporary or term appointments, rather than career VA positions, primarily because there is reluctance on the part of the host VA medical centers involved to be put in the position of absorbing these personnel costs if their centralized funding from Washington suddenly ends. If the concept of field-based satellite offices for this key function is to be successful and sustained, the centers need to be established permanently, with full-time career staff elements.

Grassroots Rural Health Coordination

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

Beneficiary Travel Should Be Addressed in a Larger Context of Rural Strategy

Over the past two years Congress has provided VA additional funding to supplement the beneficiary travel mileage reimbursement allowance authorized under title 38, United States Code, section 111, a benefit intended for certain service-connected and poor veterans as an access aid to VA health care. Today VA reimburses these veterans at a higher rate, 41.5 cents per mile traveled. While we appreciate this development and applaud both Congress and VA for raising the reimbursement rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by privately owned conveyance, and provides only limited relief to those who have no alternative but to drive or be driven long distances by automobile for VA health care.

According to an analysis completed by one of the ORH rural resource centers in 2009, VA's transportation reimbursement policy represents only one strategy in the need to improve rural veterans' access to VA health care. However, this existing reimbursement policy would be best viewed as an interlocked component of a larger strategy to improve access. According to the analysis, the policy should also consider a greater use of technology (i.e., telehealth, telemental health, and other forms of telemetry to avoid the need to travel) to provide selected services, partnering with local community health resources when rural veterans' personal transportation to VA facilities would be impractical or painful for them, and bringing health resources from VA to rural and highly rural communities (primarily via mobile clinics) when justified by workload volume.

The IBVSOs agree with this analysis. Transportation policy would be most effectively planned and evaluated as one component of an overall strategy to improve ac-

cess to care, since these strategies are not mutually exclusive. For instance, many veterans travel substantial distances to participate in real-time telehealth and telemental health sessions at CBOCs. A successful transportation policy for rural veterans should be comprehensive and include consideration of using alternative means to aid rural veterans in gaining access to services.

To our knowledge, little evaluation of these current policies, including recent significant changes in reimbursement, has been accomplished within VA. We believe evaluating these policies is important to improving rural veterans' access to care. Accordingly, we urge VA to conduct these analyses and report their results.

Telehealth—A Major Opportunity, But Still Lingerin

The IBVSOs believe that the use of technology, including the Internet, telecommunications, and telemetry, offers VA a great but still unfulfilled opportunity to improve rural veterans' access to VA care and services. The IBVSOs understand that VA's intended strategic direction in rural care is a necessity to enhance non-institutional care solutions. VA provides home-based primary care as well as other home-based programs and is using telemedicine and telemental health—but on a rudimentary basis in our judgment—to reach into veterans' homes and community clinics, including Indian Health Service (IHS) facilities and Native American tribal clinics, as well as VA's own CBOCs. It would be a much greater benefit to veterans in highly rural areas if VA installed general telehealth capability directly into a veteran's home or into a local non-VA medical facility that a rural veteran might easily access, versus the need for rural veterans to drive to distant locations for telehealth services that could be delivered in their homes or local communities. This enhanced cyber-access could be made available in the veteran's home via a secure website and inexpensive computer-based video cameras, and private or other public clinics closer to veterans' residences could use general telehealth equipment with a secure Internet line or secure bridge to VA facilities.

Expansion of telehealth would allow VA to directly evaluate and follow veterans without them having to travel great distances to VA medical centers. VA has reported it has begun to use Internet resources to provide limited information to veterans in their homes, including up-to-date research information, access to their personal electronic health records, and the online ability to refill prescription medication. The IBVSOs agree these are positive steps, but we urge VA management to coordinate rural technology efforts among its offices responsible for telehealth, rural health, and

information technology at the department level, in order to continue and promote these advances, but also to overcome privacy, policy, and security barriers that prevent telehealth from being more available in veterans' homes in highly rural areas or into already-established private rural clinics serving as VA's partners in rural areas. We believe advancing telehealth in this manner would be fully consistent with VA's stated intention to move the VA delivery system from its primary care base to that of the patient-aligned care team, also known as the "medical home."

Rural Outreach Needs More Assertiveness

Without question, section 213 of Public Law 109-461 offers a significant mandate to meet the health-care and other needs of veterans living in rural areas, especially those who have served recently in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, the law requires VA to collaborate with employers, state agencies, community health providers, rural health clinics, Critical Access Hospitals (as designated by Medicare), social service agencies, and local units of the National Guard and reserve components to ensure that, after completing their military service, all veterans can have ready access to VA health-care and other benefits they have earned by that service. Given that this mandate is more than four years old now, the IBVSOs urge VA to finally move forward on this mandatory outreach effort to include outreach to all rural veterans—and that outreach under this authorization be closely coordinated with the ORH, or even be managed by the ORH if determined appropriate, to avoid duplication and to maintain consonance with VA's overall mandate on rural health care. To be fully responsive to this legislation, VA should report to Congress the degree of its success in conducting effective outreach and the result of its efforts in public-private and intergovernmental coordination to help rural veterans.

Execution of Congressionally Directed Rural Health Funds

The IBVSOs understand that in allocating these Congressionally directed rural funds (\$250 million in each of fiscal years 2009, 2010, and 2011), some VA offices may have diverted rural funding to underwrite new community-based outpatient clinics, or put those funds to other uses outside the mandate. While we generally support the establishment of new CBOCs, this mandate from the Appropriations Committees in providing these funds specified that they be used for innovative new models of care, given the scarcity of populations involved and the paucity of providers in rural areas.

VA's CBOC business plans are governed by criteria focused on population densities. We do not agree with these decisions, if they occurred, and ask Congress and the Administration to investigate to determine if these rural health funds were in fact diverted to uses other than those intended in this rural health initiative.

While Popular, Privatization Is Not a Preferred Option of the IBVSOs

P. L. 110-387, the "Veterans' Mental Health and Other Care Improvements Act of 2008," directs the Secretary of Veterans Affairs to conduct a three-year pilot program under which a highly rural veteran who is enrolled in the system of patient enrollment of VA and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health-care provider at VA expense. More recently, in section 307 of P. L. 111-163, the "Caregivers and Veterans Omnibus Health Services Act of 2010," Congress clarified eligibility for these services by redefining a "highly rural veteran" as one who resides more than 60 minutes driving time from the nearest VA facility providing primary care services, more than 120 minutes driving time from a VA facility providing acute hospital care, or more than 240 minutes driving time from a VA facility providing tertiary care (depending on which services a veteran needs). The original act allows participation also by a rural veteran who, not meeting these specific mileage criteria, otherwise experiences such hardships or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of that veteran. During the three-year demonstration period the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

While we applaud the sponsors' intentions, unless carefully administered, such measures could result in unintended consequences for VA. Chief among these is the diminution of established quality, safety, and continuity of VA care for rural and highly rural veterans. It is important to note that VA's specialized health-care programs, which are authorized by Congress and designed expressly to meet the specialized needs of combat-wounded and ill veterans—such as the blind rehabilitation centers, prosthetic and sensory aids programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the National Center for Posttraumatic Stress Disorder, as well as several others—could be irreparably affected by the loss of veterans from those programs. Also, VA's medical and prosthetic research program, designed to study and, it is hoped, cure the ills of injury and disease

consequent to military service, could lose focus and purpose if service-connected and other enrolled veterans were no longer physically present in VA health care.

Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when P. L. 104-262, the "Veterans' Health Care Eligibility Reform Act," was enacted in 1996. Unfortunately, some of that capacity has dwindled. The IBVSOs believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with sophisticated health problems, such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health-care programs, such as this rural demonstration program, may only exacerbate the problems currently encountered.

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

As stated in the "Contract Care Coordination" discussion in this *Independent Budget*, in general, current law places limits on VA's ability to contract for private health-care services in instances where VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has the authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits, there is no general au-

thority in the law (with the exception of the new demonstration project described above) to support broad-based contracting for the care of populations of veterans, whether rural or urban.

The IBVSOs urge Congress and the Administration to closely monitor and oversee the development of the new rural pilot demonstration project from the “Veterans Mental Health and Other Care Improvements Act of 2008,” especially to protect against any erosion or diminution of VA’s specialized medical programs and to ensure participating rural and highly rural veterans receive health-care quality that is comparable to that available within the VA health-care system. We especially ask VA, in implementing this demonstration project, to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state, or other federal agencies) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans’ Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements, outcomes, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. These pilot programs should not become simply another form of unmanaged “fee-basis” care, but should be managed and coordinated carefully by VA, and led by the ORH.

To the greatest extent practicable, VA should coordinate these demonstrations and pilot projects with interested health professions’ academic affiliates of VA. The principles of the recommendations from the “Contract Care Coordination” section should guide VA’s approaches in this demonstration, and we recommend these projects be closely monitored by VA’s Rural Veterans Advisory Committee. Further, the IBVSOs believe the ORH should be designated the overall coordinator of this demonstration project, in collaboration with other pertinent VHA offices and local rural liaison staff in the VHA’s rural VISNs that are selected for this demonstration.

VA’s Readjustment Counseling Service Vet Centers: Key Partners in Rural Care

Given that 44 percent of newly returning veterans from OEF/OIF service live in rural areas, the IBVSOs believe that these veterans, too, should have access to specialized services offered at VA’s Vet Centers. The mission of Vet Centers is to provide nonmedical readjustment services to veterans through psychological and peer-counseling programs (including trained peer counselors who are combat veterans). Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive

to the needs of local veterans. These centers represent the primary access points to VA programs and benefits for nearly 25 percent of veterans who use them. This core group of veteran users primarily receives readjustment and psychological counseling related to their military experiences and recovery from them.

Congress recently passed P. L. 111-163, the “Caregivers and Veterans Omnibus Health Services Act of 2010.” Section 401 of that act authorizes active duty military personnel and members of the National Guard and reserve components who have completed deployment in Iraq and Afghanistan to be counseled at VA’s Vet Centers, hopefully without notification to, or reimbursement by, the Department of Defense for such counseling. The IBVSOs are grateful to Congress for including that helpful and humane provision in this omnibus bill, and urge VA and the DOD to implement this provision as soon as practicable. This novel authority will aid National Guard members and reservists home from deployments in rural, suburban, and urban environments alike to confront any readjustment challenges they and their families may be experiencing, without exposing them to the potential stigma that might well ensue if they identified themselves to their military commanders as challenged by their psychological traumas from combat.

The IBVSOs were pleased that VA took steps to further address rural access concerns by implementing a mobile Vet Centers program. We believe that now is the time to evaluate the effectiveness of these mobile Vet Centers and to determine if and how mobile services contribute to enhanced delivery of care to veterans in rural areas, as well as the relative costs of other approaches to reach rural and remote veterans with psychological counseling. The same logic used in the ORH analysis discussed previously on evaluation of transportation strategies would apply to VA’s decisions in expanding further outreach with mobile Vet Centers.

VA Should Stimulate Rural Health Professions

Health workforce shortages and recruitment and retention of health-care personnel (including clinicians) are a key challenge to rural veterans’ access to VA care and to the quality of that care. The Future of Rural Health report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health-care professionals working in rural areas. To this end, VA’s deeper involvement in education in the health professions for future rural clinical providers seems appropriate in improving these situations in rural VA facilities as well as in the private sector. Through VA’s existing partnerships with 103 schools of medicine, almost 28,000 medical residents

and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health sciences students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners—receive training in VA facilities.

The IBVSOs believe these relationships to health profession schools should be put to work in assisting rural VA facilities with their health personnel staffing needs. Also, evidence shows that providers who train in rural areas are more likely to remain practicing in rural areas. The VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations. The VHA Office of Workforce Recruitment and Retention should execute initiatives targeted at rural areas, in consultation with, and using available funds as appropriate from, the ORH. Different paths to these goals could be pursued, such as the leveraging of an existing model used by the Health Resources and Services Administration to distribute new generations of health-care providers in rural areas. Alternatively, the VHA could target entry-level workers in rural health and facilitate their credentialing, allowing them to work for VA in their rural communities. Also, VA could offer a “virtual university” so future VA employees would not need to relocate from their current environments to more urban sources of education. While VA has made some progress with telehealth in rural areas as a means to provide alternative VA care to veterans in rural America, it has not focused on training future clinicians on best practices in delivering care via telehealth. This initiative could be accomplished by use of the virtual university concept or through collaborations with established collegiate programs with rural health curricula. If properly staffed, the Veterans Rural Health Resource Centers could serve as key “connectors” for VA in such efforts.

Consistent with our Health Resources and Services Administration suggestion, VA should examine and establish creative ways to collaborate with ongoing efforts by other agencies to address the needs of health care for rural veterans. VA has executed agreements with the Department of Health and Human Services (HHS), including the IHS and the HHS Office of Rural Health Policy, to collaborate in the delivery of health care in rural communities, but the IBVSOs believe there are numerous other opportunities for collaboration with Native American tribal organizations, state public health agencies and facilities, and some private practitioners as

well, to enhance access to services for veterans. The ORH should pursue these collaborations and coordinate VA's role in participating in them.

Update on the Rural Veterans Advisory Committee

The Veterans Rural Advisory Committee, established by the Secretary of Veterans Affairs as an advisory committee under the Federal Advisory Committee Act, is fully operational and issued its first annual report in 2010. The IBVSOs appreciate the work of that important committee and commend its most recent recommendations to the VA.

The ORH: A Critical Mission for Rural Veterans Who Need Care

As described by VA, the mission of the Office of Rural Health is to develop policies and identify and disseminate best practices and innovations to improve health-care services to veterans who reside in rural areas. VA maintains that the ORH is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VA also attests that the ORH will conduct, coordinate, promote, and disseminate research on issues important to improving health care for rural veterans. With confirmation of these stated commitments and goals, the IBVSOs believe the VHA would start to incorporate the unique needs of rural veterans as new VA health-care programs are conceived and implemented; however, the ORH is a relatively new function within the VA Central Office, and it is only at the threshold of tangible effectiveness, with many challenges remaining.

Given the lofty goals VA has articulated in rural health, the IBVSOs remain concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning, rather than within the operational arm of the VA health-care system, closer to decision makers in VHA executive management. Having to traverse the multiple layers of the VHA's bureaucratic structure frustrates, delays, and even cancels worthy initiatives established by the ORH. We continue to believe that rural veterans' interests would be best served if the ORH were elevated to a more appropriate level in the VA Central Office, perhaps at the deputy under secretary level.

The IBVSOs appreciate that a new ORH director has been appointed, as well as a new deputy director. We note that both of these individuals transferred to VA from the IHS—an agency with a very different culture as contrasted with veterans' health care. We realize that numerous veterans in fact are members of Indian tribes, or

are Alaska Natives or Pacific Islanders, but not all Indians, Alaska Natives, and Pacific Islanders are veterans. We hope the new ORH director and deputy director will study and adopt VA's culture for delivering rural care rather than attempt to install the IHS culture into VA health care for rural veterans. In that respect, we note that VA and the IHS executed a memorandum of understanding in October 2010 triggering the VHA and IHS to pursue a number of new cooperative ventures at national and local levels, including sharing of programs, equipment, technology (including information technology), reimbursements, referrals, contracts, procurements, and other areas of mutual interest. The IBVSOs will monitor the roll-out of projects from, and products of, the memorandum of understanding to ensure that they are in the best interests of rural veterans.

Finally, we note that ORH staffing is finally improving with a new plan to authorize nine staff members in the VA Central Office. The IBVSOs appreciate that positive change and look forward to growing productivity and effectiveness of that office commensurate with its new leadership and resource investments.

Summary

The IBVSOs believe VA is working in good faith to address its shortcomings in rural areas but still faces major challenges as denoted in this discussion. In the long term, its methods and plans offer rural and highly rural veterans potentially the best opportunities to obtain quality care to meet their specialized health-care and readjustment needs. However, we vigorously disagree with broadly privatizing, vouchering, and contracting out by fee-basis arrangements VA health care for rural veterans: such a development would be destructive to the integrity of the VA system—a system of immense value to sick and disabled veterans and to the IBVSOs. Thus, we remain concerned about VA's demonstration mandate to privatize services in selected rural VISNs without strong coordination of care and will continue to closely monitor these developments.

Recommendations:

VA must ensure that the distance veterans travel, as well as other hardships they face, be considered in VA policies in determining the appropriate location and setting for providing direct VA health-care services and the benefits they have earned by their service to the nation.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural

care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans. In each of the past three fiscal years, Congress has provided VA \$250 million to fund rural health initiatives; this dedicated funding stream should be maintained for FY 2012.

VA should amend its data systems to differentiate rural outreach clinics from their host facilities so that a determination can be made whether VA is expanding its capabilities to reach veterans directly with health-care services in rural and highly rural areas.

The responsible offices in the Veterans Health Administration and at the VA departmental level, collaborating with the Office of Rural Health (ORH), should seek and coordinate the implementation of novel methods and means of communication, including use of the Internet and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health-care services, providers, technologies, and therapies, including greater access to their electronic health records, prescription medications, and primary and specialty appointments.

Although *The Independent Budget* veterans service organizations applaud both Congress and VA for increasing the beneficiary travel reimbursement rate considerably, 41.5 cents per mile of reimbursement is still significantly below the actual cost of travel by private automotive conveyance. Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary automobile travel and should work to develop a transportation strategy in rural and highly rural cases that takes into account alternatives, including greater use of telehealth coordination with available providers and VA mobile services when cost-justified.

The ORH should be organizationally elevated in VA's Central Office to be closer to VA resource allocators and executive decision makers.

The ORH should establish at least one full-time rural staff position in each Veterans Integrated Service Network, and more if appropriate.

The Veterans Rural Health Resource Centers should be established permanently with full-time career staff elements, to properly execute the important function of field-based satellite offices providing operational field support and pertinent rural health analysis.

VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 are closely coordinated with the ORH, or sponsored by ORH directly. One potential method of improving outreach to rural and highly rural veterans might be to create and train a volunteer network of VA-informed individuals to work in local rural communities as a VA “clearinghouse” function—individuals armed with information on all VA services and benefits and how veterans can obtain them. In this connection, veterans service organizations national service officers could be harnessed under a national memorandum of understanding with VA, or VA could contract with, or make grants to, rural organizations or rural state departments of veterans affairs (or equivalent agencies) to accomplish this goal. VA should be required to report to Congress its degree of success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans, also in consultation with, or led by, the ORH.

Congress and the Administration should investigate to determine if Congressionally directed rural health funds for new innovations in rural and highly rural areas were diverted to underwrite new VA community-based outpatient clinics, and if confirmed, should take appropriate action to address those deviations from Congressional intent.

VA should establish additional mobile Vet Centers where needed to provide outreach and readjustment counseling for veterans in rural and highly rural areas, based on analysis and cost-effectiveness of current mobile services deployed by the Readjustment Counseling Service. VA should report the findings of its analysis to the Veterans Rural Advisory Committee and to Congress.

Given VA’s affiliations with schools of health professions, the VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative or initiatives, aimed at taking advantage of VA’s affiliations to meet clinical staffing needs in rural VA locations and to supply addition health manpower to rural America in general. Section 306 of P. L. 111-163 is illustrative of a model for such a policy initiative.

VA should rapidly implement section 401 of P. L. 111-163, which authorizes active duty service members and National Guard and reserve component veterans of Operations Enduring/Iraqi Freedom to be counseled in VA Vet Centers for their readjustment problems.

Recognizing that in some areas of particularly sparse veteran population and absence of VA facilities or travel to them impractical, the ORH and its satellite Veterans

Rural Health Resource Centers should sponsor and establish demonstration projects with available providers of mental health and other health-care services for enrolled veterans, taking care to observe and protect VA’s role as the coordinator of care. The projects should be reviewed and guided by the Rural Veterans Advisory Committee. Funding should be made available by the ORH to conduct these demonstration and pilot projects, and VA should report the results of these projects to *The Independent Budget* veterans service organizations and the Congressional Committees on Veterans’ Affairs.

At rural VA community-based outpatient clinics (CBOCs), VA should establish a staff function of “rural outreach worker” serving to coordinate potentially fragmented care, collaborating with rural and highly rural non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available, or to VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs.

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

¹⁰² L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010*, Vol. 2. College Station, Texas: Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003) www.mentalhealthcommission.gov/reports/FinalReport/downloads/downloads.html.

¹⁰³ President’s New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (July 2003).

¹⁰⁴ Institute of Medicine, NIH, Committee on the Future of Rural Health Care, *Quality through Collaboration: The Future of Rural Health* (The National Academies Press, 2005).

¹⁰⁵ Gamm, Hutchison, et al., *Rural Healthy People 2010*.

¹⁰⁶ Weeks, et. al. *American Journal of Public Health* (2004) 94:1762–1767).

¹⁰⁷ Jack Smith, MD, MMM, acting deputy assistant secretary for clinical and program policy, U.S. Department of Defense, *Caring for Severely Injured OEF/OIF Veterans and Servicemembers*, Testimony before the U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Health (July 22, 2010)

¹⁰⁸ Department of Veterans Affairs, Office of Rural Health, *Demographic Characteristics of Rural Veterans* Issue Brief (Summer 2009).

¹⁰⁹ Department of Veterans Affairs, Office of Rural Health, *Rural Veterans’ Geographic Access to VA Health Services* (2008).

¹¹⁰ A study by Booz Allen Hamilton commissioned by the ORH in February 2008 (*Veterans Rural Health: Perspectives and Opportunities*) surveyed non-VA providers to identify health-care issues on which health professionals required training to serve the health-care needs of rural veterans. The top four among them were: (1) general issues in negotiating and managing the VA care system; (2) cultural sensitivity to the needs of rural veterans; 3–4) training on understanding, identifying, and treating PTSD and TBI.

¹¹¹ Booz Allen Hamilton, Inc., for the Department of Veterans Affairs Office of Rural Health, *Analysis for the Department of Veterans Affairs Fee Basis Program for the Office of Rural Health*, Contract #W74V8H-04-D-0078 (September 28, 2008).

¹¹² Department of Veterans Affairs, Office of Rural Health, *Demographic Characteristics of Rural Veterans*, note 108.

WAIVER OF HEALTH CARE COPAYMENTS AND FEES FOR CATASTROPHICALLY DISABLED VETERANS:

In light of passage of Public Law 111-163, Congress must provide adequate oversight to ensure that the Department of Veterans Affairs does not continue to bill catastrophically disabled veterans for their care.

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

The addition of nonservice-connected catastrophically disabled veterans to priority group 4 was in recognition of the distinct needs of these veterans and the VA's vital role in providing their care. However, access to VA services is only part of the answer to providing quality health care to catastrophically disabled veterans. Exempting these veterans from all health-care copayments and fees completes this quality health-care equation.

Fortunately, Congress recognized this important distinction when it enacted P. L. 111-163, the "Caregiver and Veterans Omnibus Health Services Act of 2010," which, in fact, exempted all veterans determined to have a catastrophic disability from payment of copayments. This included veterans in priority group 4 as well as those enrolled in priority groups 2 and 3 who might also have a nonservice-connected catastrophic disability. The legislation addressed copayments for medical services provided in an inpatient and outpatient setting.

Additionally, in July 2010, VA General Counsel released an opinion addressing questions about the scope of P. L. 111-163. Specifically, the General Counsel was asked to determine if the legislation exempted collections for prescription drug copayments. In its opinion, the General Counsel determined that the legislation does prohibit VA from collecting copayments for prescription drugs for veterans enrolled in priority group 4. Additionally, the opinion emphasizes that the language of the bill essentially prevents VA from collecting any copayments or fees for any type of medical service from catastrophically disabled veterans.

Catastrophically disabled veterans are not casual users of VA health-care services; they require a great deal of care and a lifetime of services because of the nature of their disabilities. Private insurers do not offer the kind of sustaining care for spinal cord injuries found in the VA system even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. The catastrophically disabled most often fall within lower income brackets among veterans, while incurring the highest annual health-care costs. In many instances, fees for medical services equipment and supplies can climb to thousands of dollars per year.

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

Recommendations:

VA must continue to monitor implementation of the provisions of Public Law 111-163, the "Caregiver and Veterans Omnibus Health Services Act of 2010," to ensure that catastrophically disabled veterans are not still being billed for the medical care or prescriptions.

Congress must provide real oversight to ensure that the full intent of Congress to exempt catastrophically disabled veterans from paying medical care and prescription copayments is accomplished throughout implementation of this law.

NON-VA EMERGENCY SERVICES:

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

Many veterans have filed claims for reimbursement for emergency treatment and post-stabilization care that is often necessary in the wake of medical emergencies. However, the strict conditions of eligibility for reimbursement have prohibited VA from paying many veterans who file claims. Moreover, *The Independent Budget* veterans service organizations (IBVSOs) understand that there have also been significant delays in VA reimbursement of approved claims. Delayed reimbursements can damage veterans' credit—by definition of the eligibility criteria,¹¹³ the veteran is liable for these costs—with no means of redress. The IBVSOs believe all enrolled veterans should qualify for reimbursement for non-VA emergency care when necessary, without the caveat of having been seen at VA facilities within the past 24 months.

Section 402 of Public Law 110-387, the “Veterans’ Mental Health and Other Care Improvements Act of 2008,” amended sections 1725 and 1728 of title 38, United States Code, which now requires VA to reimburse for the emergency treatment of VA patients outside VA facilities when these veterans believe a delay in seeking care will seriously jeopardize their lives or health. In addition, VA’s definition of “emergency treatment” under both statutes now conforms to a term commonly known as the “prudent layperson” standard, which has been widely used in the health-care industry.

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

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

Recommendations:

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

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

¹¹³ 62 38 U.S.C. § 1725(b).

Specialized Services

Prosthetics and Sensory Aids

CONTINUATION OF CENTRALIZED PROSTHETICS FUNDING:

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

The protection of Prosthetic and Sensory Aids Service (PSAS) funding by a centralized budget for the PSAS continues to have a major positive impact on meeting the specialized needs of disabled veterans. However, during the past year *The Independent Budget* veterans service organizations (IBVSOs) received reports that the Veterans Health Administration (VHA) was considering moving to a decentralized funding process for the PSAS. The IBVSOs strongly discourage such a policy change as it would significantly hinder the timely delivery of quality prosthetic services. For the past several years the IBVSOs have supported VHA senior leadership's decision to ensure that adequate funding is available through the centralization and protection of the PSAS budget to meet the prosthetic needs of veterans with disabilities. A change to decentralized funding would negatively impact veterans, since centralized funding directly contributes to VA's ability to provide the highest quality prosthetic care of than any other government or civilian medical system in the world. Before the VHA utilized centralized funding, as a result of budget shortfalls, many VA hospitals held down costs by cutting spending for prosthetics. This delayed provision of wheelchairs, artificial limbs, and other prosthetic devices, which was unacceptable. For this reason the IBVSOs strongly encourage the continuation of the centralized funding.

We believe the requirement for increased managerial accountability through extensive oversight of the expenditures of centralized prosthetics funds through data entry and collection, validation, and assessment has had positive results and should be continued. Further, we fully support the decision to distribute FY 2010 prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures, utilization reporting, and expansion of programs, such as surgical implants funding. This decision continues to improve the budget reporting process.

Additionally, the PSAS must ensure that the proper accounting methods are utilized in all VISNs and that VISN prosthetic representatives are held accountable for securing the proper distribution of funds. The Prosthetic Leadership Board is charged with conducting extensive reviews

of prosthetics budget expenditures at all levels, primarily utilizing data generated from the National Prosthetics Patients Database (NPPD).

FY 2010 expenditures were approximately \$1.8 billion, and the 2011 proposed budget allocation for prosthetics is estimated at \$2.1 billion. Funding allocations for FY 2011 were based primarily on FY 2010 NPPD expenditure data, which also included Denver Acquisition and Logistics Center (DALC) billing, the recent approval for increase of Home Improvement Structural Alterations allowances, and expansion of funding for the addition of advancements in new technology. Telehealth continues to be a significant increase in utilization of the prosthetic budget, and PSAS is actively pursuing use of the DALC to reduce the amount of resources required to manage the increased workload. Table 3 on page 106 shows NPPD costs in FY 2010 with projected new and repair equipment costs for FY 2011.

Recommendations:

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

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all enrolled veterans, including the latest advances in technology so that funding shortfalls do not compromise other programs. The Administration must allocate an adequate portion of its appropriations for services and repairs of advanced technological prosthetics.

The VHA should continue to utilize the appropriate oversight to monitor prosthetic expenditures and trends.

The VHA should continue to allocate prosthetic funds based on prosthetic expenditure data derived from the National Prosthetic Patient Database (NPPD), as well as program expansion needs.

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

Table 3. NPPD Recorded Costs

Prosthetic Item	Total Cost Spent in FY 2010	Projected Expenditure in FY 2011
Wheelchairs & Accessories	\$ 171,909,857	\$ 204,991,042
Artificial Legs	\$ 54,691,769	\$ 65,216,288
Artificial Arms	\$ 4,420,459	\$ 5,271,103
Orthosis/Orthotics	\$ 51,791,757	\$ 61,758,217
Shoes/Orthotics	\$ 46,097,212	\$ 54,967,851
Sensori-Neuro Aids	\$ 300,146,304	\$ 357,904,454
Restorations	\$ 5,056,373	\$ 6,029,387
Oxygen & Respiratory	\$ 107,550,183	\$ 128,246,422
Medical Equip & Supplies	\$ 240,343,242	\$ 286,593,290
Medical Supplies	\$ 28,110,269	\$ 33,519,622
Home Dialysis	\$ 2,059,003	\$ 2,455,223
HISA	\$ 9,706,913	\$ 11,574,847
Surgical Implants	\$ 461,959,845	\$ 550,856,311
Biological Implants	\$ 43,106,364	\$ 51,401,464
Other Items	\$ 4,981,453	\$ 5,940,051
	\$ 1,531,931,003	\$ 1,826,725,572
Services and Repairs	\$ 280,359,013	\$ 334,309,428
Total	\$ 1,812,290,016	\$ 2,161,035,000



ENSURING QUALITY AND ACCURACY OF PROSTHETICS PRESCRIPTIONS:

The Department of Veterans Affairs must work to ensure that national contracts for single-source prosthetic devices do not lead to inappropriate standardization of prosthetic devices.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop “best practices” to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA’s Prosthetics Clinical Management Program (PCMP). Specifically, we are concerned that the PCMP could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

In the Department of Veterans Affairs, the PCMP requires a single-source contract for specific prosthetic devices, and 95 percent of such devices purchased by the VHA are expected to be of the make or model covered by the national contract. Therefore, for every 100

devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased “off-contract” (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such a high compliance rate is that inappropriate pressure may be placed on clinicians to meet these goals, and there is no method to ensure that the unique prosthetic needs of patients are properly met. VHA clinicians must be permitted to prescribe devices that are “off-contract” without arduous waiver procedures or fear of repercussions. The IBVSOs believe national contract awards should be multiple-sourced and based on individual patient needs.

Under VHA Directive 1173.1, prosthetic items intended for direct patient issuance are exempted from VHA standardization efforts because a “one-size-fits-all” approach is inappropriate for meeting the medical and personal needs of disabled veterans. 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.

In addition to meeting the unique medical and personal needs of all veterans, the IBVSOs are also concerned with the timely delivery of prosthetic prescriptions. Specifically, VA must continue to ensure that prosthetic orders are processed and delivered to veterans in a timely manner.

VA informed the IBVSOs of its future plans to reorganize the Veterans Health Administration in an effort to create a unified vision for VHA and reduce the variation of health-care delivery across the VA health-care systems.¹¹⁴ While its reorganization plan is in the preliminary phase, we strongly encourage VA to ensure that the timely delivery of prosthetic services remains a priority by keeping the Prosthetic and Sensory Aids Service separate from other acquisition functions throughout VA. VA must also ensure that PSAS personnel have appropriate exclusiveness to complete their critical mission. Confounding prosthetic services with other acquisition challenges within the VHA, or VA, would be detrimental to the timely delivery of prosthetic devices to disabled veterans.

VA must make certain that the issuance and delivery of prosthetic devices and equipment continue to be provided based on the unique needs of veterans and to help veterans maximize their quality of life. As VHA undergoes any reorganization, VA must ensure that prosthetic devices do not become subject to issuance restrictions based solely on cost or internal pressures to control spending.

The Prosthetic and Sensory Aids Service (PSAS) continues to be a strong supporter of addressing the special needs of women veterans. Between fiscal years 2005 and 2010, PSAS experienced an 1,800 percent growth in the number of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) women veterans served by prosthetics staff.

Additionally, the PSAS must compete with all other information technology requests within the VHA for funding. This competition has resulted in delay of numerous critical information technology (IT) projects and inadequate funding for PSAS IT applications and enhancements required to support the ever-changing requirements to

maintain needed health information for this special emphasis group. This stricture has not improved under the national centralization of IT. The VHA health information technology structure is a key component to providing quality and accurate prosthetic devices and related services to disabled veterans. Because IT applications and enhancements are required to support the ever-changing requirements and maintenance of health information for disabled veterans, VA must make a commitment to dedicate the necessary resources to IT systems of the PSAS to ensure these functions are enhanced in a timely manner.

Recommendations:

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

VA must implement safeguards to make certain that the issuance and delivery of prosthetic devices and equipment will continue to be provided based on the unique needs of veterans and to help veterans maximize their quality of life. Such protections will ensure that such principles are not lost during any VHA reorganization. The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

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

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

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

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

The VHA must keep prosthetics standardization separate from other standardization efforts within the VHA since this program deals with items (many uniquely designed) prescribed for individual patients.

VA must make certain that the Prosthetic and Sensory Aids Service (PSAS) is maintained separate from other acquisition functions in VA and ensure appropriate authority and exclusivity are retained by PSAS personnel to ensure timely delivery of prosthetic services to disabled veterans.

The VHA should consider reinstating the PSAS timeliness monitor for FY 2011. This will help ensure that veterans receive their needed equipment in the most efficient and timely manner.

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

VA should provide the necessary resources to PSAS IT systems to ensure these functions are enhanced in a timely manner.

¹¹⁴ Department of Veterans Affairs, *Defining Excellence in the 21st Century: VHA Reorganization, Organizing for Excellence 2010* (November 18, 2010).



CONSISTENT ADMINISTRATION OF THE PROSTHETICS PROGRAM:

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

The VHA must require all Veterans Integrated Service Networks (VISNs) to adopt consistent operational standards in accordance with national prosthetics policies. The current organizational structure has resulted in the VHA national prosthetics staff trying to respond to variable local interpretations of VA policy. This leads to inconsistent administration of prosthetics services throughout the VHA. VISN directors and VHA central office staff should be accountable for implementing a standardized prosthetics program throughout the health-care system. The VHA should set and enforce a five-day written notification for a denial of prosthetics requests to a veteran. Additionally, VA must ensure that its invoice processing procedures allow for prompt payments to prosthetic vendors so as not to adversely affect the timely availability and delivery of veterans' prosthetic devices.

To improve communication and consistency, VA must ensure that every VISN has a qualified prosthetics representative to be the technical expert responsible for ensuring implementation and compliance with national goals. The VISN prosthetics representative must also maintain and disseminate objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetics policies, including administration and oversight

of VHA's Prosthetics and Orthotics Laboratories. With the prosthetics representative serving as the main source of direction and guidance for implementation and interpretation of prosthetics policy and services, prosthetics staff can focus on delivering quality care and services.

Recommendations:

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

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

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

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

FAILURE TO DEVELOP FUTURE PROSTHETICS STAFF:

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

In 2004, the Veterans Health Administration (VHA) developed and requested 12 training slots for the National Prosthetics Representative Training Program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program provides training for prosthetic representatives responsible for management of all prosthetics services within their assigned networks. In 2010 this was increased to 18 training slots due to the number of vacancies of critical staff.

Veterans Integrated Service Networks (VISNs) have also developed their own prosthetics representative training programs. While *The Independent Budget* veterans service organizations support local VISNs conducting such training to enhance the quality of health-care services within the VHA system and increase the number of qualified applicants, we believe local VISNs must also support and strongly encourage participation in the annual National Prosthetics Representative Training Conference, a one-week intensive prosthetics training forum. Local VISN prosthetics training should be a supplement to and consistent with the national training program. The VHA must also revise qualification standards for prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

The VHA must also make certain that veterans are made aware of employment opportunities throughout the Prosthetics and Sensory Aids Service (PSAS). Employing veterans will ensure a balance between the perspective of the clinical professionals and the personal needs of disabled veterans. VA must ensure that the current and future leadership of the PSAS is appropriately diversified to maintain a perspective that is patient-centric and empathetic to the unique needs of veterans with severe disabilities.

Additionally, each prosthetic service within VA must have trained and certified professionals who can advise other medical professionals on appropriate prescription, building/fabrication, maintenance, and repair of prosthetic and orthotic devices. Because VA is currently in the process of implementing a medical home care delivery model, using patient-aligned care teams, we believe additional prosthetic representatives will be needed. This is particularly important as new programs in polytrauma, traumatic brain injury, and amputation systems of care are implemented and expanded in the VHA.

As the conflicts continue in Afghanistan and Iraq, service members are returning home with complex injuries and in need of highly technological prosthetic devices. PSAS leadership must consist of a well-rounded team, including trained and experienced prosthetics representatives, appropriate clinicians and managers, and position-qualified disabled veterans with significant mobility or other impairments requiring the use of prosthetic devices. We believe the future strength and viability of VA's prosthetics program depends on the selection of high-caliber leaders in the PSAS. To do otherwise could lead to grave outcomes due to the complexity of the prosthetics needs of veterans.

Recommendations:

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

With two national training programs in the PSAS, VA must establish a full-time national training coordinator for the PSAS to ensure standardized training and development of personnel for all occupations within the Prosthetics service line. This assignment will ensure successful educational programs and career development.

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

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

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

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

PROSTHETICS AND SENSORY AIDS AND RESEARCH:

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

Many of the wounded veterans returning from the conflicts in Afghanistan and Iraq have sustained polytraumatic injuries requiring extensive rehabilitation periods and the most sophisticated and advanced technologies, such as hearing and vision implants and computerized or robotic prosthetic items, to help them rebuild their lives and gain independence. According to the Department of Veterans Affairs Office of Research and Development (ORD), approximately 6 percent of wounded veterans returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids has increased by more than 70 percent since 2000.¹¹⁵

Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. The Veterans Health Administration is still contributing to this type of research, from funding basic prosthetic research to assisting with clinical trials for new devices. As new technologies and devices become available for wide-scale use, the Veterans Health Administration must ensure that these products prescribed for veterans are made available to them and that funding is made available for timely issuance of such items.

The Independent Budget veterans service organizations are pleased that as part of VA's newly developed Amputation System of Care initiative there is appropriate attention to revolutionizing prosthetics through close

collaboration with the ORD. According to VA, 13 grants directly related to prosthetics and orthotics have been funded by either the ORD or the National Institutes of Health. Additionally, four prosthetic services located in Seattle, New York Harbor, Tampa, and Long Beach, California, are participating in active prosthetic research.¹¹⁶

Recommendation:

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

¹¹⁵ Department of Veterans Affairs, Office of Research and Development, *Operation Enduring Freedom and Operation Iraqi Freedom*, VA Brochure Series (July 2009), 5 <http://www.research.va.gov/resources/pubs/docs/OIF-OEF-brochure.pdf>.

¹¹⁶ J. Czerniecki, MD, J. Randolph, PhD, and C. Poorman, MSPT, *VA Amputation System of Care*, PowerPoint presentation, Department of Veterans Affairs Federal Advisory Committee on Prosthetics and Special Disabilities (November 4, 2009).

VA AMPUTATION SYSTEM OF CARE:

The Independent Budget veterans service organizations strongly support full implementation of the VA new Amputation System of Care and encourage Congress to provide adequate resources for staffing and training of this specialized program.

In September 2006, VA formed an interdisciplinary amputation care working group with the primary objective to rebuild and improve its system of amputation care given the limb loss injuries of veterans from the current conflicts, advances in new prosthetic technologies, and the continuing increasing rates of amputations among previous generations of veterans with complex comorbid health conditions. The working group developed a proposed system of care with four major components: regional amputation centers (RACs), polytrauma amputation network sites, amputation clinic teams, and amputation points of contact. The goal was to create a system of care that would improve access to and the quality of amputation care. While much of the hiring has occurred, RAC prosthetists have not been hired.

RACs will provide expertise in clinical care and prosthetic concepts, and work closely with polytrauma rehabilitation centers and military treatment facilities. The amputation network sites will coordinate amputation care across Veterans Integrated Service Network sites, and provide surgical support, long-term-care needs, and case management. There will be 15 network sites located across the country, and the seven RACs will dually serve as polytrauma/amputation network sites. The proposal includes creation of a veteran amputation registry and utilization of new telehealth technology to monitor the amputation rehabilitation process. For example, the amputation clinic teams will use telehealth technology to coordinate veterans' amputation care with RACs.

The amputation care plan also includes 100 amputation clinic teams that will provide rehabilitation and prosthetic care within network sites with implementation and management of the Amputation System of Care overseen by an amputation rehabilitation coordinator. When facilities do not have expertise or the capacity to provide amputation rehabilitation, amputation points of contact will serve as resource guides to direct veterans to community facilities that can best provide the specific amputation care that is needed. The overall goal of this initiative is to provide consistent quality amputation care to veterans throughout the VA health-care system and ensure that all veterans in need of amputation care have access to the proper services.

The Independent Budget veterans service organizations strongly support full implementation of VA's new Amputation System of Care and encourage Congress to provide adequate resources for staffing and training of this important program. Resources should be dedicated to the immediate hiring of regional amputation care prosthetists/orthotists as these critical roles are still vacant three years after the formation of the system. VA should also implement the proposed system of amputation care, providing proper staffing levels and training to ensure VA provides superior health services for aging and newly injured veterans who need these unique services. The amputee population should be integrated into the Veterans Equitable Resource Allocation model as "complex" patients to ensure facilities providing higher sophisticated levels of care can receive proper funding to continue this important work.

Recommendations:

VA should fully implement its new Amputation System of Care, including the immediate hiring of regional amputation care prosthetists/orthotists. Congress should provide adequate resources for staffing and training of this important program. Resources should be dedicated to the immediate hiring of regional amputation care prosthetists/orthotists.

VA should implement the Amputation System of Care by providing proper staffing levels and training to ensure VA provides superior health services for aging and newly injured veterans who need these unique services.

Hearing Loss

HEARING LOSS AND TINNITUS:

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

Historically, tinnitus, commonly referred to as “ringing in the ears,” has been a leading disability for veterans and in FY 2010 it topped the list as the most prevalent service-connected disability for returning personnel from Operations Enduring and Iraqi Freedom (OEF/OIF).¹¹⁷ Similarly, with regard to veterans who served in previous conflicts, tinnitus has always been one of the top 10 service-connected disabilities for veterans from any period of service (including peacetime).¹¹⁸ With noise exposure and hearing damage being the number-one cause of tinnitus, it is not hard to understand why tinnitus is so prevalent within veteran and active duty military populations. There is currently no cure for tinnitus; treatment options are limited; and efficacy varies depending on the patient.

How Tinnitus Manifests

Acoustic trauma has been part of military life since muskets and cannons were part of the arsenal, and OEF/OIF is no exception. America’s future veterans are exposed to some of the noisiest battlegrounds ever: improvised explosive devices (IEDs)—the signature weapon of the insurgency—regularly hit patrols, which leads to a wealth of problems, including hearing loss and tinnitus. The noise emitted from IEDs is a main source of the disproportionate increases of tinnitus in veterans, but tinnitus can also be caused from head and neck trauma. Traumatic brain injury (TBI), one of the signature wounds of these conflicts, is producing a whole new generation of veterans with both mild and severe head injuries that are often accompanied by tinnitus. Head and neck trauma is the second most frequently reported cause of tinnitus. Blast-related TBI produces significantly greater rates of hearing loss and tinnitus compared with nonblast-related TBI, affecting up to 60 percent of these patients.¹¹⁹

Tinnitus and TBI

In particular, mild traumatic brain injury or mild TBI often includes tinnitus as a manifestation of injury. As defined by the Department of Defense policy for mild traumatic brain injury, TBI is the presence of a documented head trauma or blast exposure event, followed by a change in mental and physical status, which includes multiple symptoms, one of which could be tinnitus. A recent DOD study on Iraq veterans indicated that 70 percent of those exposed to a blast reported tinnitus within the first 72 hours after the incident; 43

percent of those seen one month after exposure to blast continued to report tinnitus. While the rate decreases over time, tinnitus rates exceeded hearing loss rates at all time points. These findings also demonstrate the need for more comprehensive diagnostics and broader range of therapeutic approaches for tinnitus, particularly when it is not accompanied by hearing loss, which can only be achieved by continued and additional research on the condition.

Another research finding on the OEF/OIF veteran population, conducted at the James H. Quillen Veterans Affairs Medical Center Tinnitus Clinic, in Mountain Home, Tennessee, noted the increasing association between tinnitus and post-traumatic stress disorder (PTSD). Of the first 300 patients enrolled at the clinic, 34 percent also carried a diagnosis of PTSD.¹²⁰

These indications of the direct connections between tinnitus and TBI, as well as tinnitus and PTSD, point to the urgent need to address any gaps in research and treatment modalities provided by both the Departments of Defense and Veterans Affairs. Steps to address these conditions and gap areas have begun to be addressed by Congress, VA, and the DOD; however, much more needs to be done to adequately address the growing needs of America’s veterans.

Invisible Injury

Many service members returning from war are physically disabled. Those types of injuries are easily seen, diagnosed, and treated by physicians. Veterans exposed to blasts from roadside bombs often suffer internal injuries that are not as easy to detect and treat. Tinnitus is one of the most prevalent invisible injuries. In September 2010, the Invisible Wounds Caucus held a meeting to specifically address tinnitus. This was the first time a Congressional body had addressed tinnitus in a meeting on veterans’ health and was an excellent step toward better understanding tinnitus. We hope Congress will continue to address tinnitus at future caucus meetings as well as within the VA committees when appropriate to do so.

Tinnitus Prevalence

For millions of Americans, tinnitus becomes more than an annoyance. Chronic tinnitus can leave an individual feeling isolated and impaired in the ability to communicate with others. This isolation can cause anxiety, de-

pression, and feelings of despair. Tinnitus can be so debilitating that some affected individuals cannot work, interact with family and friends, or even sleep. Tinnitus impacts some 50 million Americans to some degree. Sixteen million individuals are chronically afflicted and 2 million are incapacitated by their tinnitus.¹²¹ It is estimated that 250 million people worldwide experience chronic tinnitus.¹²²

Adding to the Rolls Every Year

The number of veterans who are receiving disability compensation for tinnitus has risen steadily over the past 10 years. Since 2005, service-connected disability for tinnitus has increased alarmingly by 15 percent per year. At the end of 2009, nearly 800,000 veterans from all periods of service were service-connected for their tinnitus. A veteran with tinnitus may be awarded up to a 10 percent disability, which currently equals \$123 a month. Although tinnitus is a condition and not a disease, it is considered a “disease of the ear” according to title 38, United States Code.

Translated into financial terms, the government paid out approximately \$1.1 billion in VA disability compensation for tinnitus in 2009. At the current rate of increase, service-connected disability payments to veterans for tinnitus will cost \$2.26 billion annually by 2014.¹²³ While the government will spend increasing amounts to compensate veterans with tinnitus, its investment in research pales in comparison (less than 1 percent of current compensation payments combined).

The scientific community has made groundbreaking discoveries about tinnitus in the past 10 years, such as better understanding of the genesis of tinnitus in the brain and which brain systems are involved with tinnitus perception. We now know that tinnitus originates in the brain and not the ear. Because of these discoveries, and the increases in tinnitus prevalence in both military and civilian populations, it is imperative that we continue to support increased tinnitus research to help expedite further discovery. This support will help to acquire to bet-

ter treatments and an eventual cure for all who suffer from tinnitus. There have been early steps toward collaboration on these research efforts by VA, the DOD, and the National Institutes of Health (NIH), including a two-day workshop in August of 2009 specifically addressing the current state of tinnitus research. *The Independent Budget* encourages continued collaboration by NIH, the DOD, and VA to ensure the best possible outcomes for America’s veterans with tinnitus.

Noise-Induced Hearing Loss and Tinnitus

During present-day combat, a single exposure to the impulse noise of an IED can cause immediate tinnitus and hearing damage. An impulse noise is a short burst of acoustic energy, which can be either a single burst or multiple bursts of energy. According to the National Institute for Occupational Safety and Health, prolonged exposure from sounds at 85+ decibel levels (dBA) can be damaging, depending on the length of exposure. For every three-decibel increase, the time an individual needs to be exposed decreases by half, and the chance of noise-induced hearing loss and tinnitus increases exponentially. At 140+ dBA, the sound pressure level of an IED, damage occurs instantaneously. Table 4 shows a few common military operations and associated noise levels, all exceeding the 140 dBA threshold.¹²⁴

It’s no surprise that service members using weaponry that emits such high decibel levels, in training or combat, are at greater risk of this type of disability than their civilian counterparts.

Hearing Conservation

Hearing conservation programs have been in place since the 1970s to protect and preserve the ears of our military service personnel. However, a study released by the Institute of Medicine in 2005, titled *Noise and Military Service* 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 military personnel develop tinnitus and other hearing impairments prior to active combat as a result of

Table 4. 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

training. If a service member is disabled prior to combat, his or her effectiveness already may be compromised at the beginning of combat exposure. A study in *Tank Gunner Performance and Hearing Impairment* concluded that hearing impairments may delay a service member's ability to identify a target by as much as 50 seconds and be the cause of other inefficiencies and impairments in the line of duty.¹²⁵

The Role of Medical Research

Research has increased our knowledge about hearing loss and how it occurs, while less has been discovered about tinnitus—but that knowledge is growing. So much more is known today about tinnitus and its origins than was known 10 years ago. This knowledge better informs health professionals on how to best treat a patient with a particular subset of symptoms.

Tinnitus is a condition of the auditory system that originates in the brain. This finding reinforces the connection between TBI and tinnitus and may help explain why this population of veterans is experiencing tinnitus in record numbers. Of 692 TBI patients at Walter Reed Army Medical Center between January 2003 and March 2006, nearly 90 percent had nonpenetrating head injuries.¹²⁶ The extent and epidemiology of how tinnitus and TBI are affecting each other will remain unknown unless the federal government funds more medical and prosthetic research as encouraged by *The Independent Budget*.

Even though tinnitus research has come a long way, especially in recent years, much more needs to be learned. With so many veterans being added to the rolls every year for service-connected tinnitus, VA, the DOD, and NIH need to continue working collaboratively to continue as the leaders in tinnitus research. As of July 2009, more than 120,000 OEF/OIF veterans had been awarded service-connected disability for tinnitus. Prior to that, there were approximately 650,000 veterans from previous conflicts already on the rolls for tinnitus. VA estimates show that it is likely that the actual number of veterans who have tinnitus sustained from combat and active duty is closer to 3 to 4 million.¹²⁷

Recommendations:

The Veterans Health Administration must rededicate itself to the excellence of programs for treatment of tinnitus and all associated polytraumatic injuries of war including hearing loss, traumatic brain injury, and post-traumatic stress disorder.

Congress must continue providing funding for VA and the DOD to prevent, treat, and cure tinnitus.

¹¹⁷ Department of Veterans Affairs, Veterans Benefits Administration, *Annual Benefits Report, FY 2010*, 5.

¹¹⁸ Lucille Beck, *Audiology Care in the VA* (Washington, DC: VBA Office of Performance and Analysis, November 2007).

¹¹⁹ Stephen Fausti, Debra J. Wilmington, Frederick J. Gallun, et al., "Auditory and Vestibular Dysfunction Associated with Blast-related Traumatic Brain Injury," *Journal of Rehabilitation Research & Development* 46 (November 6, 2009): 797–8.

¹²⁰ Marc A. Fagelson, "The Association between Tinnitus and Posttraumatic Stress Disorder," *American Journal of Audiology* 16 (2007): 107–17.

¹²¹ G. C. Curhan, W. R. Farwell, and J. Shargorodsky, "Prevalence and Characteristics of Tinnitus among US Adults," *American Journal of Medicine* 123, no. 8 (August 2010): 711–8.

¹²² Munna Vio and Ralph H. Holme, "Hearing Loss and Tinnitus: 250 Million People and a U.S. \$10 Billion Potential Market," *Drug Discovery Today* 10, no. 19 (October 1, 2005): 1263–5.

¹²³ American Tinnitus Association analysis of Department of Veterans Benefits Administration Data (January 2010).

¹²⁴ U.S. Army Center for Health Promotion and Preventative Medicine, <http://chppm-www.apgea.army.mil/>.

¹²⁵ Georges Garinther and Leslie Peters, "Tank Gunner Performance and Hearing Impairment," *Army RD & A Bulletin* (January–February 1990): 1–5.

¹²⁶ Neil Shea, "Iraq War Medicine—The Heroes, The Healing: Military Medicine from the Front Lines to the Home Front," *National Geographic* (December 2006) <http://www.nationalgeographic.com>.

¹²⁷ ncrar.research.va.gov.

Blindness

**THE DEPARTMENT OF VETERANS AFFAIRS
BLIND REHABILITATION SERVICE:**

As the VA Blind Rehabilitation Service expands its blind and low-vision services, the long-term-care needs of blinded veterans and caregiver support services must be improved.

The Department of Veterans Affairs Blind Rehabilitation Service (BRS) has moved forward with its implementation of the continuum of care model, which expands outpatient blind and low-vision services and builds upon VA's well-known reputation of excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. Current VA plans for three new Blind Rehabilitation Centers (BRCs) are in various stages of construction, with the openings of new BRCs expected in Long Beach, California, in June 2011, in Biloxi, Mississippi, November 2011, and Cleveland in 2012. As of September 30, 2010,¹²⁸ the total number of active veterans on the Visual Impairment Service Team (VIST) roster was 50,574. According to the BRS, it is estimated that by 2014 the VA system could sustain a rise to approximately 54,000 enrolled blind or low-vision impaired veterans. It is likely that these projections will increase as a result of the growing number of veterans with visual system dysfunction from traumatic brain injuries. Currently, 1,089 OIF/OEF veterans are requiring specialized low-vision services.¹²⁹

Age-related eye diseases, however, affect more than 35 million Americans who are 40 years of age and older, with the most common eye diseases being macular degeneration, glaucoma, diabetic retinopathy, and cataracts. Further, an estimated 1 million Americans over the age of 40 are legally blind.¹³⁰ While only 4.3 percent of Americans who are 65 years old and older live in nursing homes, 16 percent of Americans are visually impaired, and 40 percent of this population resides in nursing homes. VA rehabilitative low-vision and blind training programs provide veterans with the option of safe independent living environments.

Congress and VA have made many strides toward improving blinded veterans' rehabilitation services. For the past three years, VA has increased funding for new outpatient blind and low-vision programs. The residential BRC programs are still the primary option for many blinded veterans with complex comorbid medical conditions that require a BRC rehabilitation environment with the full complement of medical services. Congress enacted Public Law 111-163, which exempts catastrophically disabled veterans who require residential services at BRCs from copayments for medical care.

Despite these positive advancements, improvements are still needed. *The Independent Budget* veterans service organizations (IBVSOs) have received reports that disabled veterans face many obstacles when trying to arrange travel to regional blind centers. The Veterans Health Administration only provides travel for a direct transfer from one VA medical center to another VA medical center. Veterans who are medically eligible to receive care at a BRC and are not receiving care from another VA medical center are financially responsible for their travel to the BRC. Such travel expenses place financial burdens on veterans who are in need of care. Often these veterans are elderly, catastrophically disabled veterans who cannot absorb such costs on fixed incomes of Social Security. Every year there are blinded veterans who are unable to pay the airfare costs to receive care at a blind center after being told they are accepted for admission. The IBVSOs recommend that Congress Amend title 38, section 111, Beneficiary Travel, to alleviate this out-of-pocket barrier.

The IBVSOs are also concerned that some BRCs are reducing the caregiver three-day training programs that are an essential part of creating support systems for veterans who are returning home and living independently. For many years the BRCs have funded the travel and local hotel costs for family caregivers to attend training with the blinded veteran just before discharge for three days and then return home with the veteran. This gives the caregiver the opportunity to receive proper training and experience with the veteran's orientation, mobility, and living skills, as well as time to learn how to use any specialized vision prosthetics equipment for blindness that have been issued to the veteran. Congress, the Departments of Defense and Veterans Affairs, and veterans service organizations have all worked together to create a supportive atmosphere for the caregivers of disabled veterans through both legislation and new policies; it is counterproductive to now allow BRCs to eliminate these programs from local training budgets.

Congressionally mandated rehabilitation capacity must be maintained, and the BRS must continue to provide for critical full-time employee equivalent personnel within each blind center to maintain current bed capacity and provide comprehensive residential blind rehabilitation

services. Other critical BRS positions, such as the 118 full-time VIST coordinators and the current 75 blind rehabilitation outpatient specialists (BROS), must be sustained. VIST and BROS teams are essential full-time positions that, in addition to conducting comprehensive assessments to determine if a blinded veteran needs to be referred to a blind rehabilitation center, also facilitate blind rehabilitation training support in veterans' homes. VISTs also order new low-vision and adaptive technology when veterans require it and function as key case managers for blinded veterans in most medical centers.

There must be succession training offered for VA employees to move into director and assistant director positions at blind rehabilitation center and VA Blind Rehabilitation Service regional consultant positions. Without adequate training and support, vacant management rehabilitation service positions will negatively impact the operations of these specialized services.

Recommendations:

The Veterans Health Administration must assess the bed capacity and full staffing levels in VA blind rehabilitation centers to ensure they continue to meet the demands

of the new outpatient vision rehabilitation programs being implemented.

The VHA must require the networks to increase the number of full-time Visual Impairment Service Team coordinators and blind rehabilitation outpatient specialists and implement recruitment and retention incentives for employees and increase training opportunities for personnel. The VHA must create and implement succession plans for specialized rehabilitation programs.

Congress must amend title 38, United States Code, section 111, Beneficiary Travel, to mandate that VA must provide airfare for catastrophically disabled veterans traveling to specialized residential rehabilitation programs.

VA must ensure that all blind centers provide continued funding for the training of family caregivers since they are an integral part of many veterans' successful reintegration to independent living.

¹²⁸ Blind Rehabilitative Services, BR Data (VHA, October 14, 2010).

¹²⁹ Blind Rehabilitative Services, BR Data (VHA, August 2010).

¹³⁰ www.silverbook.org/visionloss; Silver Book@agingresearch.org (October 2009).



Spinal Cord Injury/Dysfunction

SPINAL CORD DYSFUNCTION CARE:

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

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

The Independent Budget veterans service organizations (IBVSOs) are concerned about continuing trends toward reduced capacity in VA's Spinal Cord Injury Program. Reductions in beds and staff in both VA's acute and extended care settings continue to be reported. Public Law 104-262, "Veterans' Health Care Eligibility Reform Act of 1996," mandated that VA maintain its capacity to provide for the special treatment and rehabilitative needs of veterans with spinal cord injury, blindness, amputations, and mental illness within distinct programs. This act re-

quired the baseline of capacity for spinal cord injury centers to be measured by the number of staffed beds and the number of full-time employee equivalents (FTEEs) assigned to provide care in such distinct programs.

In addition to the maintenance of capacity mandate, Congress was astute enough to also require that VA provide an annual capacity reporting requirement, to be certified by, or otherwise commented upon by, the inspector general. This reporting requirement was to be in effect from April 1, 1999, through April 1, 2001. Congress later passed an extension of the reporting re-

quirement through 2004. Unfortunately, this basic reporting requirement expired in 2004. Since 2004 the IBVSOs have called upon Congress to reinstate the specialized services capacity-reporting requirement and to make this report an annual requirement without a specific end date. We strongly encourage Congress to reinstate the reporting requirement and prevent a future expiration of this fundamental measure of capacity.

SCI/D Leadership

The continuum of care model for the treatment of veterans with spinal cord injury or dysfunction has evolved over a period of more than 50 years. VA spinal cord injury/dysfunction (SCI/D) care has been established in a “hub-and-spokes” model. This model has been shown to work very well as long as all patients are seen by qualified SCI/D trained staff. Because of staff turnover and a general lack of understanding in outlying “spoke” facilities, not all SCI/D patients have the advantage of referrals, consults, and annual evaluations in an SCI/D center.

This is further complicated by confusion as to where to treat spinal cord diseases, such as multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS). Some SCI/D centers treat these patients, while others deny admission. It is recognized that there is an ongoing effort to create a continuum of care model for MS, and this model should be extended to encompass MS and other diseases involving the spinal cord, such as ALS. However, admission to an SCI/D center may not be appropriate for all SCI/D veterans. In December 2009, VA developed and published *Veterans Health Administration Handbook 1011.06, Multiple Sclerosis System of Care Procedures*, which clearly identifies a model of care and health-care protocols for meeting the individual treatment needs of SCI/D veterans. However, VA has yet to develop and publish a VHA directive to enforce the aforementioned handbook. Without a directive, the continuity and quality of care for SCI/D veterans could be compromised. The issuance of a VHA directive for the handbook is essential to ensuring that all local VA medical centers are aware of and are meeting the health-care needs of SCI/D veterans.

Nursing Staff

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

Historical data have shown that SCI/D units are the most difficult places to recruit and retain nursing staff. Recruitment and retention bonuses have been effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans as well as in the morale of the nursing staff. Unfortunately, facilities are faced with the local budget dilemma when considering a recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus taking away from other needed medical programs. A consistent national policy of salary enhancement should be implemented across the country to ensure qualified staff are recruited. Funding to support this initiative should be made available to the medical facilities from the network or central office to supplement their operating budgets.

Patient Classification

The Department of Veterans Affairs has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of care required during hospitalization, amount of time spent with the patient, technical expertise, and clinical needs of each patient. Acuity category III has been used to define the average acuity/patient classification for the SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of FTEEs needed for continuous coverage.

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

Nurse staffing in SCI/D units has been delineated in *VHA Handbook 1176.1* and VHA Directive 2008-085. It was derived on 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. While VA recognized the IBVSOs' request that administrative nurses should not be included in the nurse staffing numbers for patient classifications, the current nurse staffing numbers still do not reflect an accurate picture of bedside nursing care. VA nurse staffing numbers incorrectly include non-bedside specialty nurses and light-duty staff as part of the total number of nurses providing bedside care for SCI/D patients. When the minimal staffing levels include non-bedside nurses and light-duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in pro-

fessional medical publications that adverse patient outcomes occur with lower levels of nurses.

VHA Directive 2008-085 mandates 1,399 bedside nurses to provide nursing care for 85 percent of the available beds at the 24 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians. SCI/D facilities recruit only to the minimum nurse staffing required by VHA Directive 2008-085. At the end of fiscal year 2010, nurse staffing was 1,318.4. This number is 148.4 FTEEs short of the minimum nursing staff requirement of 1,466.8. The directive calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio of professional nurses to other nursing personnel.

The low percentage of professional RNs providing bedside care and the high acuity of SCI/D patients puts these veterans at increased risk for complications secondary to their injuries. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, 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 been manifested in VA facilities restricting admissions to SCI/D centers. Reports of bed consolidations or closures have been received and attributed to nursing shortages. When veterans are denied admission to SCI/D centers and then beds are consolidated, leadership is not able to capture or report accurate data for the average daily census. The average daily census is not only important for adequate staffing to meet the medical needs of veterans, but is also a vital component of ensuring that SCI/D centers receive adequate funding. Since SCI/D centers are funded based on utilization, refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA's ability to address the needs of new incoming and returning veterans. Such situations create a severe compromise of patient safety and serve as evidence for the need to enhance the nurse recruitment and retention programs.

Recommendations:

Congress should renew legislation to require the annual reporting requirement to measure capacity for VA spinal cord care and other specialized services as originally required by Public Law 104-262.

The Veterans Health Administration should ensure that the spinal cord injury/dysfunction (SCI/D) continuum of care model is available to all SCI/D veterans nationwide. VA must also continue mandatory national training for the SCI/D "spoke" facilities.

VA should develop a directive to enforce *VHA Handbook 1011.06, Multiple Sclerosis System of Care Procedures*.

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

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

Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.

Gulf War Illness

PERSIAN GULF WAR VETERANS:

The Department of Veterans Affairs must aggressively pursue answers to the health consequences of veterans' Gulf War service. VA cannot reduce its commitment to Veterans Health Administration programs that address health care and research or Veterans Benefits Administration programs in order to meet other important and unique needs of Gulf War veterans.

In the first days of August 1990, in response to the Iraqi invasion of Kuwait, U.S. troops were deployed to the Persian Gulf in Operations Desert Shield and Desert Storm. The air assault was initiated on January 16, 1991. On February 24, 1991, the ground assault was launched, and after 100 hours, combat operations were concluded. Approximately 697,000 U.S. military service members served in Operations Desert Shield or Desert Storm. The Gulf War was the first time since World War II in which the reserves and National Guard were activated and deployed to a combat zone. For many of the 106,000 who were mobilized to Southwest Asia, this was a life-changing event.

After their military service, Gulf War veterans reported a wide variety of chronic illnesses and disabilities. Many Gulf War veterans have been diagnosed with chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss, difficulty concentrating, sleep disturbance, and gastrointestinal problems. The multisymptom condition or constellation of symptoms has been referred to as Gulf War syndrome, Gulf War illness (GWI), or Gulf War veterans' illnesses; however, no single unique illness has been definitively identified to explain the complaints of all veterans who have become ill.

According to the VA study "Health of US Veterans of 1991 Gulf War: A Follow-Up Survey in 10 Years," (April 2009), 25 percent to 30 percent of Gulf War veterans suffer from chronic multisymptom illness above the rate of other veterans of the same era who were not deployed. This confirms five earlier studies showing similar rates. Thus, 18 years after the war, approximately 175,000 to 200,000 veterans who served remain seriously ill.

Both the Departments of Defense and Veterans Affairs have invested in conducting research and providing health care and benefits to address the concerns of Gulf War veterans and their families. However, these efforts have lagged in recent months. With the apparent focus of restoring the health of our latest combat veterans of Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND), VA has not maintained a steadfast commitment or adequate ef-

forts to explore the unanswered questions of this previous generation of combat veterans. In addition, because many Gulf War veterans remain ill, *The Independent Budget* veterans service organizations (IBVSOs) stand firm and urge the DOD and VA not to abandon their search for answers to Gulf War veterans' unique health problems and exposure concerns. We should not attempt to serve one veteran cohort at the expense of others.

Building a Base of Evidence

Since the Gulf War, federal agencies have sponsored numerous research projects related to GWI. Although a number of extremely important studies and research breakthroughs received funding support, overall, federal programs were not focused on addressing the Gulf War research issues of greatest importance.

Need for more high-quality evidence

Testimony provided during hearings before the House Committee on Veterans' Affairs pointed to a number of research challenges that have impeded steady progress, including the lack of adequate documentation of exposures, differing case definitions of Gulf War illness, and the weight given to animal and human studies in evaluating research findings for the purpose of determining causation.

The IBVSOs are concerned that, if left unaddressed, GWI research will continue to be hampered and veterans suffering from GWI will not receive proper relief. On April 9, 2010, the Institutes of Medicine (IOM) released *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009*. In this report the IOM expert committee noted virtually all the reports in the Gulf War and Health series have called for improved studies of Gulf War and other veterans. The committee report stated future studies of Gulf War veterans—and indeed any veteran population—need to be adequately designed to:

- provide sufficient statistical power (precision).
- ensure validity, including the avoidance of such bias as response bias and recall bias, which lead deployed and nondeployed veterans to participate unequally,

depending on general health and symptom presence and severity, or to report symptoms differently according to perceived exposures and health status.

- improve disease measurement to avoid misclassification, for example, including information collected from non-DOD hospitals in studies of hospitalization, obtaining cancer incidence data from existing cancer registries, validating self-reports of health outcomes, and using the least error-prone measures of these outcomes.
- characterize deployment and potential related adverse environmental influences better, for example, by collecting information on the length and location of deployment and on jobs and tasks.
- measure and adjust for possible confounding factors by, for example, measuring and adjusting for lifestyle factors (such as smoking and risk-taking behaviors) and predeployment physical and psychologic health status.

The Research Advisory Committee on Gulf War Veterans' Illnesses (RAC-GWVI), appointed by the VA Secretary in 2002, was directed to evaluate the effectiveness of government research in addressing central questions on the nature, causes, and treatments of Gulf War-related illnesses. The RAC-GWVI made specific recommendations for VA's GWI research funding announcements for Biological Laboratory Research and Clinical Science Research.¹³¹ The IBVSOs urge VA to adopt these recommendations that will directly benefit veterans suffering from GWI by, among other things, creating a comprehensive research plan and management structure and answering questions most relevant to their illnesses and injuries. Heightening this concern is a critical need for a comprehensive and well-planned program to address other problems faced by disabled Gulf War veterans.

The Direction of VA Research

The RAC-GWVI notes that studies consistently indicate GWI is not significantly associated with serving in combat or other psychological stressors. Moreover, the IOM committee noted in its *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009*, that “[f]rom several lines of evidence, it can be inferred that the high prevalence of medically unexplained disability in Gulf War veterans cannot be reliably ascribed to any known psychiatric causes or disorders. It is not possible to attribute the high prevalence of medically unexplained disability in Gulf War veterans to somatoform disorder, based on available evidence.” It follows, then, that the Department's research on ill Gulf War veterans should reflect due consideration. Unfortunately, this is not the case.

While the survey instrument for VA's *Follow-Up Study of a National Cohort of Gulf War and Gulf War Era Veterans* does offer some practicality, it requires significant changes to enhance the quality, utility, and clarity of the information to be collected. The RAC-GWVI submitted recommendations that VA suspend current plans to field the large longitudinal survey under development by VA's Office of Public Health and Environmental Hazards, pending extensive revisions of the survey instrument. The RAC-GWVI suggests, as currently designed, the proposed survey fails to collect data on the most pressing health issues related to Gulf War service, while collecting excessive information on more peripheral concerns to include psychiatric disorders.¹³² The IBVSOs believe VA must reassess its survey instrument to collect the most important types of data required to assess priority health issues specific to Gulf War service.

The IBVSOs are also concerned that the diminishing focus of VA GWI research will divert attention to the urgent issues faced by OEF/OIF/OND veterans. As troops in Southwest Asia continue to fight in the same geographic region as did Gulf War veterans, VA's response to this unique situation was to open the Gulf War Registry to OIF veterans,¹³³ and broaden the scope of GWI research to include “deployment-related health research.” While it is unclear whether veterans of the current conflicts, or even OIF veterans specifically, should be categorically grouped with veterans of the first Gulf War for purposes of VA research on GWI, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of another, particularly in light of news reports about an open-air “burn pit” at the largest U.S. base in Balad, Iraq, which has been described as an acute health hazard and may have exposed thousands of service members to cancer-causing dioxin, poison, and hazardous medical waste.¹³⁴ Accordingly, the IBVSOs urge Congress to conduct rigorous oversight on the federal research budget to ensure VA and other federal agencies collaborate to prioritize and coordinate investigations in a progressive manner for both post-deployment groups.

Other concerns have also been raised regarding the rates of birth defects in the children of Gulf War veterans and other adverse pregnancy outcomes. These were part of the scope of review in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* report. In its review of existing literature, the committee found there was inadequate or insufficient evidence to determine whether an association exists between deployment to the Gulf War and fertility

problems, specific birth defects, and adverse pregnancy outcomes, such as miscarriage, stillbirth, preterm birth, and low birth weight. VA has the opportunity to gather more information on this matter in its *Follow-Up Study of a National Cohort of Gulf War and Gulf War Era Veterans*. Unfortunately, the VA survey instrument as proposed in the *Federal Register* on September 9, 2010, does not include questions related to the health of veterans' family members, specifically, on children's health—both congenital abnormalities and problems that develop later in life (e.g., childhood cancers, developmental disorders of learning and attention)—and information on birth outcomes and fertility.

The Need for Effective Treatment

The position of the IBVSOs is that in addition to stress and hazards of deployment, all combat environments are hostile and traumatic. Gulf War veterans have suffered the effects of combat and environmental exposures, and their bravery in dealing with the aftermath of service should not be discounted, diminished, or stigmatized. A holistic, comprehensive investigation into the causes and the most effective treatments for all illnesses and injuries suffered by Gulf War veterans is the proper path to restoring the health and well-being of those who served.

It has been eight years since Congress mandated¹³⁵ the Department of Veterans Affairs to commission the IOM to convene a committee¹³⁶ to report¹³⁷ on the primary concern of whether Gulf War veterans are receiving effective treatments for their health problems. In its most recent report,¹³⁸ the RAC-GWVI states, "treatments that are effective in improving the health of veterans with GWI are urgently needed." The DOD's Office of Congressionally Directed Medical Research Programs manages a research program aimed at identifying diagnostic tests and treatments for GWI.

Each year since the dramatic decline in overall research funding for GWI in 2001, the IBVSOs have urged Congress to increase funding for VA and DOD research on GWI. The DOD's Office of Congressionally Directed Medical Research Programs has managed the Gulf War Illness Research Program since fiscal year 2006, but this program did not receive funding in FY 2007. A \$10 million appropriation renewed the Gulf War Illness Research Program in FY 2008, with \$8 million provided in FY 2009 and \$12 million for FY 2010.¹³⁹ The IBVSOs thank the conferees and the Congress for passing the recommended funding level of the Senate for this research program for FY 2010. Such funding will allow our nation to achieve the critical objectives of improving the health and lives of Gulf War veterans.

The IBVSOs also applaud the VA's Office of Research and Development for issuing the 2009 *Clinical Science Request for Applications for New Treatments*. Although application for grants is publicly available through www.grants.gov,¹⁴⁰ we are concerned that the announcement was made internally rather than publicly. Moreover, we urge VA to ensure there is collaboration and strategic planning with the DOD, which currently has two funding mechanisms to study treatments for GWI this year.

Effectiveness of Compensation, Pension, and Ancillary Benefits

Valid data needed

The Gulf War Veterans Information System (GWVIS) report monitors, in part, veterans' use of VA health care and disability benefits. The Veterans Benefits Administration (VBA) indicates that the GWVIS provides the best available current data identifying the 6.5 million Gulf War veterans.

Discrepancies were noted by the Advisory Committee on Gulf War Veterans and identified during a Congressional committee hearing on May 19, 2009, "regarding [a] significant (43%) drop in undiagnosed illness claims processed between the February 2008 and August 2008."¹⁴¹ VA confirmed the GWVIS reports were corrupted and the data discrepancies occurred as a result of data migration from VA's legacy database, the Benefits Delivery Network, to a new corporate database, Veterans Services Network (VETSNET).¹⁴² However, the discrepancy occurred before 2008. The migration of claims data was a 25-month (552-day) process that began on May 21, 2007, and ended on June 30, 2009.¹⁴³ This schedule coincides with the reductions in claims highlighted in the March and June 2007 quarterly reports. The IBVSOs question VA claims information from its August 2009 *Gulf War Review*, which states, "More than 3,400 Gulf War veterans have received service connection for their undiagnosed or difficult-to-diagnose illnesses under this authority."

If this claim is true, less than 1.5 percent of claims for undiagnosed illness have been granted, which suggests that these claims are difficult to prosecute and possibly adjudicate, and that current regulations may be the reason. An equally important question is, if scientific literature suggests 175,000 to 200,000 Gulf War veterans remain seriously ill, how many of them are receiving compensation benefits based on disabilities resulting from military service in the Persian Gulf War? Moreover, as of this writing, the most recent GWVIS reports available data only up to 2008 (March, June, and September) and the issues surrounding the validity of the data remain unresolved.

In addition to compensation and pension benefits, veterans may be eligible for education and training benefits, vocational rehabilitation and employment, home loans, dependents' and survivors' benefits, life insurance, and burial benefits. Unfortunately, information regarding utilization of these benefits by Gulf War veterans is unavailable even on GWVIS reports. Clearly, due to the lack of granularity, the GWVIS quarterly report should be made more comprehensive as many unanswered questions remain that can better describe whether VA benefits are meeting the needs of ill Gulf War veterans and whether such veterans are receiving VA benefits they have earned and deserve.

Presumptive conditions

Under the direction of Congress, VA has a standing responsibility to commission the IOM to assist the Department in making decisions as to whether there is sufficient scientific evidence to warrant a presumption of service connection for the occurrence of a specified condition in Gulf War veterans. On October 16, 2006, the IOM issued a fifth volume of its *Gulf War and Health* series on infectious diseases. On September 29, 2010, more than two years after issuance of the report, VA announced its intention to expand the number of presumed disabilities associated with exposures in the Gulf War. VA has since published the final regulations to include nine additional infectious diseases on VA's list of presumptive conditions of Gulf War veterans that cause compensable disability.

The Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009 was charged to review and update the *Gulf War and Health, Volume 4: Health Effects of Serving in the Gulf War*, which summarized the overall health effects in veterans and noted which health outcomes were more evident in Gulf War veterans than in their nondeployed counterparts irrespective of the specific exposures experienced by the deployed veterans. This most recent report by the IOM committee was limited to reviewing epidemiologic studies of health outcomes noted in the Volume 4 report but used a different approach for reviewing literature in assigning studies as primary or secondary to support committee conclusions.

Specifically, the committee considered studies that used only self-reports by Gulf War veterans to be secondary studies for most health outcomes; the major exception to this rule was multisymptom illness. Some health outcomes however, such as fibromyalgia or irritable bowel syndrome, lack objective diagnostic tests and are diagnosed based on symptom reporting that meet accepted

criteria (e.g., Centers for Disease Control and Prevention criteria for chronic fatigue syndrome and the Rome criteria for irritable bowel syndrome). When the symptom reporting was sufficiently descriptive to meet the diagnostic criteria for that outcome, those studies were considered to be primary if the other evaluation criteria for a primary study were met. Studies that used objective measures to diagnose a health outcome were also considered to be primary if they met the other evaluation criteria.

The 2009 report finds there is sufficient evidence of a causal relationship between deployment to the Gulf War and post-traumatic stress disorder. Furthermore, the committee found sufficient evidence of an association between deployment and other psychiatric disorders, including generalized anxiety disorder, depression, and substance-use disorder, particularly alcohol abuse; gastrointestinal symptoms consistent with gastrointestinal functional disorders, such as irritable bowel syndrome and functional dyspepsia; and multisymptom illness, including chronic fatigue syndrome.

The committee also found limited or suggestive evidence of an association between deployment to the Gulf War and amyotrophic lateral sclerosis (ALS), fibromyalgia and chronic widespread pain, self-reported sexual difficulties, and mortality from external causes (primarily motor vehicle accidents) in the early years after deployment.

Title 38, United States Code, section 1118 provides that whenever the Secretary determines, based on sound medical and scientific evidence, that a positive association (i.e., the credible evidence for the association is equal to or outweighs the credible evidence against the association) exists between exposure of humans or animals to a biological, chemical, or other toxic agent, environmental or wartime hazard, or preventive medicine or vaccine known or presumed to be associated with service in the Southwest Asia theater of operations during the Persian Gulf War and the occurrence of a diagnosed or undiagnosed illness in humans or animals, the Secretary will publish regulations establishing presumptive service connection for that illness. If the Secretary determines that a presumption of service connection is not warranted, the Secretary is to publish a notice of that determination, including an explanation of the scientific basis for that determination. The determination must be based on consideration of National Academy of Science reports and all other sound medical and scientific information and analysis available to the Secretary.

The IBVSOs commend VA for having formed a task force to address the IOM report and make recommendations to the Secretary with respect to presumptions of service connection based on the IOM committee's findings.¹⁴⁴ VA should move with all deliberate speed to include the list of those conditions in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* that were found to have at least met the limited or suggestive evidence criteria as presumptive conditions. Furthermore, these conditions for which the committee considered all possible health effects identified in the studies it reviewed were done so, "[r]egardless of the potential cause of the health effect, with the exception of health effects related to or resulting from infectious and parasitic diseases."¹⁴⁵ We therefore recommend VA amend title 38, Code of Federal Regulations, section 3.317 by adding those conditions.

Expiring authority

Because of what appears to be a dismal record of adjudicating claims based on presumptive service connection for GWI, VA's continuing obligation to conduct research on the health effects of serving in the Persian Gulf War, and the lengthy process by which VA makes final decisions based on findings of IOM reports, the IBVSOs urged Congress to provide ill Gulf War veterans the benefit of the doubt by extending indefinitely the presumptive period for service connection for ill-defined and undiagnosed illnesses and protect such presumptive service connection. We thank Congress for extending to October 1, 2015, the protection of compensation based on presumptive service connection as specified in section 1117(c)(2).¹⁴⁶ However, VA's authority to establish presumptions of service connection for illnesses associated with service in the Persian Gulf under 1118(e) is due to expire on September 30, 2011. The IBVSOs recommend Congress eliminate the sunset date or extend this authority prior to its expiration.

Effectiveness of Health-Care Benefits

Data needed

Similar to the absence of information about compensation, pension, and other ancillary benefits, the GWVIS report lacks any practical information on health-care utilization or diagnostic data of Gulf War veterans' use of VA health care, particularly when compared to the report *Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans*. Issued quarterly by the Veterans Health Administration (VHA) Office of Public Health and Environmental Hazards, this report provides a revealing description of the trends in

health-care utilization and VA workload of OEF/OIF veterans, their diagnostic data, and other helpful information. Such monitoring allows VA to tailor its health-care and disability programs to meet the needs of this newest generation of OEF/OIF war veterans.

Change in VA health-care system to address needs

Veterans suffering from GWI require a holistic approach to the care they receive in order to improve their health status and quality of life. VA must establish a system of post-deployment occupational health care if it is to meet its mission and deliver veteran-centric care to this population.

VA's War Related Illness and Injury Study Centers (WRIISCs) located in Washington, DC; East Orange, New Jersey; and Palo Alto, California, have a central and important role in VA's health-care program for veterans with post-deployment health problems. Funding comes from the VA Office of Research and Development; the DOD's medical research funding program, the CDMRP, which recently met in December 2010 to make its final determination for funding of \$8 million in Gulf War illness research proposals; and the National Institutes of Health's National Institute of Neurological Disorders and Stroke and National Institute of Arthritis and Musculoskeletal and Skin Diseases. WRIISCs conduct clinical treatment trials, such as evaluating a cognitive rehabilitation program for ill Gulf War veterans,¹⁴⁷ a treatment feasibility study of complementary and alternative medicine for sleep disturbances in ill Gulf War Veterans,¹⁴⁸ and a trial in a complementary and alternative medicine treatment program for veterans with pain, fatigue, and PTSD.¹⁴⁹

Despite this important role, VA has not devoted adequate attention or resources to the education of its non-WRIISC staff, or outreach to veterans, to make them aware of these programs. Since the establishment of the Washington and East Orange WRIISCs in 2001, and Palo Alto in 2008, VA's clinical service has seen more than 420 Persian Gulf veterans to date. For veterans of other service eras, the WRIISCs have seen more than 750 to date. Many Gulf War veterans who are ill and their private sector providers are generally unaware of the information, opportunity for consultation, or specialized expertise of the WRIISCs. Thus, the IBVSOs believe this national resource remains largely unrecognized and underutilized. VA should better utilize the expertise of the WRIISCs to ensure that their resources are increased to match the growing demand.

Occupational health is a medical specialty devoted to improving worker health and safety through surveillance,

prevention, and clinical care activities. Physicians and nurses with these skills could provide the foundation for the VHA's post-deployment health clinics and enhanced exposure assessment programs, and improve the quality of disability evaluations for the VBA's Compensation and Pension Service. VA should consider establishing a holistic, multidisciplinary post-deployment health service led by occupational health specialists at every VA medical center. Moreover, these clinics could be linked in a hub-and-spoke pattern with the WRIISCs to deliver enhanced care and disability assessments to veterans with post-deployment health concerns. To achieve this objective, the WRIISCs and post-deployment occupational health clinics could be charged with the following:

- to work collaboratively with the DOD environmental and occupational health programs;
- to identify and assess military and deployment-related workplace hazards;
- to track and investigate patterns of military service members' and veterans' occupational injury and illness patterns;
- to develop training and informational materials for VA and private sector providers on post-deployment health;
- to assist other VA providers to prevent work-related injury and illness; and
- to work collaboratively with DOD partners to reduce service-related illness and injury, develop safer practices, and improve preventive standards.

One of VA's core missions constitutes the comprehensive prevention, diagnosis, treatment, and disability compensation services of veterans who suffer from service-related illnesses and injuries. Service-related illnesses and injuries, by definition, are military occupational conditions and exposures. Accordingly, VA should devise systems, identify expertise, and recruit and train the necessary experts to deliver these high-quality occupational health and benefits services.

Likewise, VA needs to improve the capability of its primary care providers to recognize and evaluate post-deployment health concerns. In approaching this task, VA and the DOD jointly developed the Post-Deployment Health Clinical Practice Guideline to assist VA and DOD primary care clinicians in evaluating and treating individuals with deployment-related health concerns and conditions. This guideline uses an algorithm-based, stepped-care approach that emphasizes systematic diagnosis and evaluation, clinical risk communication, and longitudinal follow-up.

Special treatment authority

Congress provided a "special treatment authority" in 1993, Public Law 103-210, "[a]n Act to amend title 38, United States Code, to provide additional authority for the Secretary of Veterans Affairs to provide health care for veterans of the Persian Gulf War," to empower VA to provide health care to Persian Gulf War veterans who served in the Southwest Asia theater of operations and were therefore presumed to have been exposed to toxic substances or environmental hazards. This special treatment authority is similar to that given to Vietnam veterans who may have been exposed to herbicides in Vietnam. P. L. 105-114, the "Veterans Benefits Act of 1997," eliminated the requirement that the veteran had to be exposed to toxic substances or environmental hazards but only required documented service in the Southwest Asia theater of operations during the Persian Gulf War. In 1998, the authority was extended through 2001, and P. L. 107-135 (115 Stat. 2446) provided another extension through 2002.

Although this special treatment authority lapsed in 2002, VA has continued to treat these veterans within priority group 6. The IBVSOs appreciate the numerous attempts by VA to correct, before and after the expiration, both special treatment authorities. We understand that expiration of the authority will mean that priority group 8 veterans newly applying for enrollment, who claim exposure to Persian Gulf War hazards with no other qualifying eligibility, may be subjected to enrollment restrictions. Also, being recategorized into lower priority groups subjects those Gulf War veterans to pay required copayments, a situation that may serve as a barrier to VA care for some.

A longitudinal study of Gulf War veterans found that prescription drugs and over-the-counter medicines are by far the most common treatments used for the multi-symptom illness of Gulf War veterans.¹⁵⁰ Moreover, established treatment regimens available through VA have been identified that alleviate Gulf War illness symptoms. Section 202 of the House-passed version of H. R. 3219, the "Veterans' Insurance and Health Care Improvements Act of 2009," would have eliminated the sunset provision but it did not advance to final passage. Section 201 of S. 1237, the "Homeless Veterans and Other Veterans Health Care Authorities Act of 2010," includes a provision to extend the sunset date to December 31, 2012. Accordingly, the IBVSOs believe Congress should make permanent or, at the minimum, extend VA's "special treatment authority" for veterans who served in the Persian Gulf War. Given the benefit of the doubt, sick and disabled veterans in

this eligibility category should not face any barrier to VA health care, especially with respect to copayments.

Education and Outreach

Education and outreach are only effective if the information provided is timely and accurate, and if it penetrates and permeates the target audience. The IBVSOs are appreciative of the work done by VA's Office of Public Health and Environmental Hazards' website to make it more user friendly and provide pertinent information that may be useful to ill Gulf War veterans and their health providers.

As of this writing, the Office of Public Health and Environmental Hazards' website for Gulf War veterans' illnesses has but two links for health-care providers who are treating and diagnosing health effects of Gulf War service in veteran patients: the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues* and the *IOM Committee Reports-Gulf War and Health*.¹⁵¹ The Veterans Health Initiative on Gulf War veterans' health is an independent study guide developed to provide a background for VA health-care providers on the Gulf War experience and common symptoms and diagnoses of Gulf War veterans. This guide was released and last revised in 2002. The IBVSOs urge that VA review and revise this guide to include the latest research findings and clinical guidelines.

Effective outreach can be a great tool in ensuring that veterans and their providers are kept informed of any pertinent changes or developments that may occur over the years. However, although passive in nature, tools, such as the *Study Guide*, have not been given the needed attention, necessary updates, or priority by the VHA to improve the health and health care of Gulf War veterans. VA's approach to the needs of this veteran population has become parochial and fragmented.

The IBVSOs believe much work remains to ensure federal benefits and services are adapted to meet the unique needs of veterans suffering from Gulf War illness. VA must meet its obligation to care for the newest and prior generation of disabled veterans without diverting its attention from the actions needed to find the means to diagnose, treat, and cure GWI. We believe the answers lie in medical surveillance, high-quality health care, and research on effective treatments. Where cures remain elusive, VA must provide timely, accessible, responsive, and equitable benefits and compensation for those who suffer from chronic illnesses and disability as consequences of environmental and toxic exposure. Our nation's veterans deserve no less.

Recommendations:

Congress should extend or eliminate the curious expiration date of September 30, 2011, of VA's authority to establish presumptions of service connection for illnesses associated with service in the Persian Gulf under title 38, United States Code, section 1118(e).

Congress should make permanent or, at a minimum, extend VA's "special treatment authority" for veterans who served in the Southwest Asia theater of operations during the Persian Gulf War.

VA and other federal agencies funding Gulf War illness (GWI) research must ensure research proposals are of high quality based on such considerations as the quality of the design, the validity and reliability of measures, the size and diversity of subject samples, and similar considerations of internal and external validity.

VA, in collaboration with other federal agencies funding GWI research, must create a research program with a comprehensive research plan and management structure, prepared to answer questions most relevant and unique to Gulf War illnesses and injuries.

Congress should conduct rigorous oversight of the federal research budget to ensure that VA and other federal agencies collaborate to prioritize and coordinate investigations in a progressive manner.

Congress should maintain its commitment to provide sufficient funding for VA's research program to permit it to resume robust research into the health consequences of Gulf War veterans' service and to conduct research on effective treatments for veterans suffering from Gulf War illnesses. The unique issues faced by Gulf War veterans should not be lost in the urgency to address other issues related to armed forces personnel who are currently deployed and to veterans more recently discharged.

VA should commission the National Academy of Sciences' Institute of Medicine to update the *2001 Gulf War Veterans: Treating Symptoms and Syndromes* report to determine whether treatments are effective in veterans suffering from GWI and whether these veterans are receiving appropriate care.

VA should issue a report containing practical information on utilization and trends of health care and diagnostic data, as well as other helpful information that would allow the Department to tailor its health-care programs to meet the unique needs of ill Gulf War veterans.

VA should review and revise the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues* and the *IOM Committee Reports—Gulf War and Health* to include the latest research findings and clinical guidelines.

To properly assess and tailor existing VA benefits for ill Gulf War veterans, VA should gather more meaningful data that will result in an accurate database than that currently available from the Gulf War Veterans Information System.

VA should move with all deliberate speed to include the list of those conditions in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* that were found to have at least met the limited or suggestive evidence criteria as presumptive conditions. These conditions should also be listed separate and distinct from those disabilities due to undiagnosed illnesses.

The Veterans Health Administration should establish post-deployment health clinics, enhance exposure assessment programs, and improve the quality of disability evaluations for the Veterans Benefits Administration's Compensation & Pension Service. To deliver high-quality occupational health services, VA should consider establishing at every VA medical center a holistic, multi-disciplinary post-deployment health service led by occupational health specialists.

¹³¹ www1.va.gov/RAC-GWVI/docs/Committee_Documents/CommentsAndRecommendations_VA-GWI-research-program_111709.pdf.

¹³² www1.va.gov/RAC-GWVI/docs/Committee_Documents/RACSurveyRecs_Final110210.pdf.

¹³³ As of May 2009, more than 111,000 have participated in VA's Gulf War Veterans' Health Registry Examination, of which more than 7,000 veterans are from the current conflicts.

¹³⁴ Kelly Kennedy, "Burn Pit Fallout; Military Official: Situation Improving; Troops Report Complications from Asthma to Cancer," *Army Times* (November 7, 2008).

¹³⁵ P. L. 105-368 § 105; P. L. 105-277 § 1603.

¹³⁶ Committee on Identifying Effective Treatments for Gulf War Veterans' Health Problems, Board on Health Promotion and Disease Prevention.

¹³⁷ *Gulf War Veterans: Treating Symptoms and Syndromes* (National Academies Press, July 26, 2001).

¹³⁸ *Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations* (U.S. Government Printing Office, November 17, 2008).

¹³⁹ Conference Report 111 to 288 to H.R. 2647, the "National Defense Authorization Act for Fiscal Year 2010," 574, 985.

¹⁴⁰ <https://apply07.grants.gov/apply/UpdateOffer?id=12353&is2006=true>

¹⁴¹ House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, *Gulf War Illness Research: Is Enough Being Done?* Hearing (May 19, 2009). 111th Cong., 1st Sess. (Washington, DC: Government Printing Office, 2009).

¹⁴² Post-hearing response by the Secretary of Veterans Affairs.

¹⁴³ <http://www.privacy.va.gov/docs/SSnApr2008FinE.pdf>.

¹⁴⁴ *Gulf War Review Newsletter* 17, no. 1 (July 2010) <http://www.publichealth.va.gov/docs/gulfwar/gulfwar-newsletter-jul10.pdf>

¹⁴⁵ *Ibid.*, 5

¹⁴⁶ P. L. 111-275, the "Veterans' Benefits Act of 2010."

¹⁴⁷ Proposal submitted to VA Clinical Sciences Research and Development Service

¹⁴⁸ Proposal to be submitted to VA Health Service Research and Development Service.

¹⁴⁹ *Ibid.*

¹⁵⁰ H. Kang, Preliminary findings: Reported unexplained multisymptom illness among veterans who participated in the VA Longitudinal Study of Gulf War Era Veterans. Presentation at Research Advisory Committee on Gulf War Veterans' Illnesses meeting, Washington, DC (September 21, 2005).

¹⁵¹ www.publichealth.va.gov/docs/vhi/gulfwar.pdf.

Lung Disease

LUNG CANCER SCREENING AND EARLY DISEASE-MANAGEMENT PROGRAM:

Lung cancer has a disproportionate impact on veterans, especially those exposed to carcinogens during active duty service. Computed tomography screening has now been proven to reduce lung cancer mortality in a high-risk population. VA can now move expeditiously to develop a safe and effective protocol for the integration of lung cancer screening into the VA health-care system.

On November 4, 2010, the National Cancer Institute (NCI) announced that computed tomography (CT) screening can make a significant reduction in lung cancer deaths in a high-risk population. The National Lung Screening Trial launched by the NCI in 2002 recruited 53,500 people, 55 or older, who were at high risk for lung cancer because of their smoking history (a minimum of 30 pack years) but who were otherwise healthy and had no symptoms of lung cancer. Half of the participants were randomly selected to receive three annual chest X-rays and the other half low-dose CT scans. The participants were then followed for five years. The data collected were so compelling that the NCI terminated the trial early and released the findings to the public. Those receiving the CT scan had 20 percent fewer deaths from lung cancer than those receiving a chest X-ray. In fact, deaths from all other causes were also 7 percent lower in the CT arm, indicating that CT scans may also be of benefit in the early detection of other diseases as well.

The report of the trial indicated that CT screening can save tens of thousands of lives a year. With a longer follow-up period, the mortality impact may prove to be even higher. This tracks the growing body of evidence from other national and international studies, including the International Early Lung Cancer Action Program (I-ELCAP), which pioneered CT screening for lung cancer with a single-arm study that has been ongoing since 1993. The data collected through 60 research sites in the United States and 10 other countries indicate that CT screening for lung cancer, administered with the rigorous protocol I-ELCAP has developed over the years, can achieve a 10-year survival rates of nearly 80 percent. In the early seventies, the overall national five-year survival rate for lung cancer was 13 percent and today remains at 15 percent.

Given that lung cancer causes more deaths each year than breast, prostate, colon, and pancreatic cancers combined, the impact of a 20 percent reduction in lung cancer deaths would be substantial. A recent study (April 2009) published in the *Journal of Clinical Oncology* estimates that the incidence of lung cancer will increase by 52 percent over the next 20 years.

Impact on Veterans

The impact on veterans should be even more significant given the high incidence and rates of lung cancer among veterans. More than one-third of living veterans are from the Vietnam era. The disparate impact of lung cancer among Vietnam veterans was first noted in a study by the Department of Veterans Affairs in 1988.¹⁵² The data indicated that former marine ground troops in Vietnam died of lung cancer at a 58 percent higher rate than marines who did not serve in the war. In 1994, Congress enacted legislation that eventually resulted in VA's recognition of presumptive service connection for diseases consequent to exposure to the herbicide Agent Orange, including lung cancer for in-country Vietnam veterans.

The Department of Defense routinely distributed free cigarettes and included cigarettes in field rations until 1976 and still makes cigarettes readily available at reduced rates in exchanges and commissaries. The 1997 Harris Report to the Department of Veterans Affairs documented a higher prevalence of smoking and carcinogenic exposure among the military, with estimated costs to VA and TRICARE of billions of dollars per year. In that report, more than 70 percent of Vietnam veterans reported a history of smoking, twice the civilian rate.

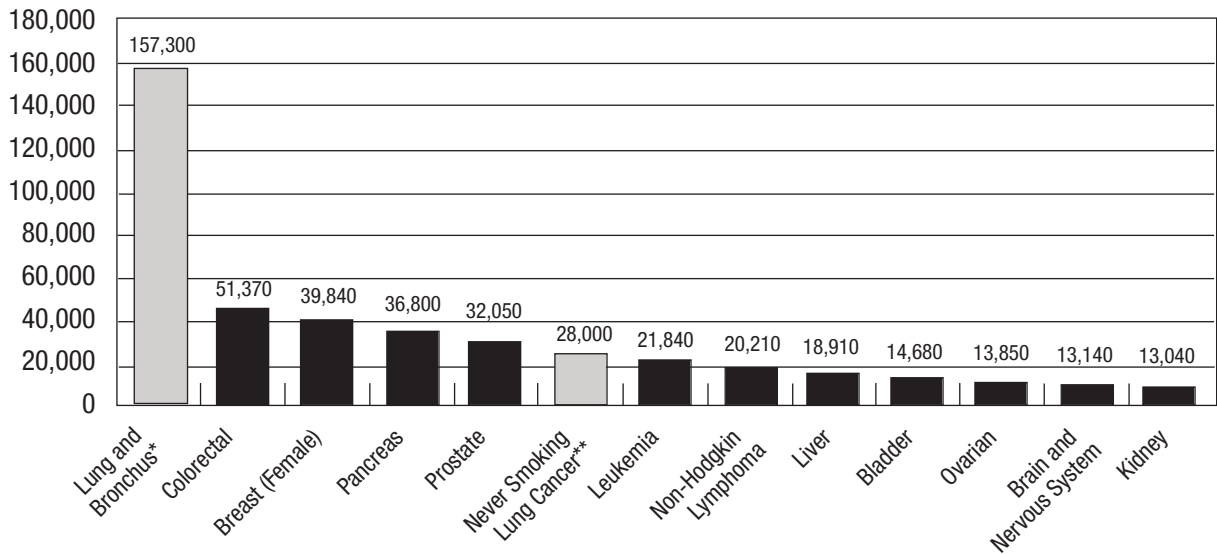
A 2004 report by the Institute of Medicine, *Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer*, concluded that the gestation period for lung cancer could be 50 years or more. The 2004 report confirmed the association with lung cancer, and the updated report in 2008 encouraged "high priority" to continued review.

Impact on VA

Given that lung cancer is an indolent cancer that usually takes decades to develop, the burden of treatment falls heavily on VA. Without screening, more than 70 percent of lung cancer is being diagnosed at late stage when lung cancer is twice as costly to treat as early stage.

Tobacco cessation is still the single most important step in reducing lung cancer mortality and should be integrated into the screening protocol. Studies have shown

Graph 2. Estimated Cancer Deaths in 2010



*Includes current, former and never-smokers

** Estimate of never-smoker lung cancer deaths (15%)

Source: SEER Cancer Statistics Review, 1975-2007, National Cancer Institute

that CT screening can offer current smokers an opportunity for recovery. Half of new lung cancer cases are former smokers, many of whom had quit smoking decades ago. Many veterans who smoke or previously smoked were first enticed to smoke while in the military.

The Department of Veterans Affairs has the opportunity to play a leadership role in developing a model public health protocol that will serve the veteran population and set a standard of excellence for the entire nation. With cancer the leading cause of death and lung cancer the most prevalent type of cancer, VA can influence global public health policy.

Recommendation:

VA should establish pilot CT screening programs based on the findings of the International Early Lung Cancer Action Program to bring the benefits of screening to high-risk veterans.

¹⁵² P. Breslin et al., "Proportionate Mortality Study of U.S. Army and U.S. Marine Corps Veterans of the Vietnam War," *Journal of Occupational Medicine* 30, no. 5 (May 1988).

Women Veterans

WOMEN VETERANS HEALTH AND HEALTH-CARE PROGRAMS:

The number of women veterans seeking VA health-care services is expected to double within two to four years. The Department of Veterans Affairs must reevaluate its programs and services for women veterans to ensure that consistent, comprehensive, quality women's health services are delivered across the continuum of care at all VA facilities.

Women have played a vital part in the military services since the birth of our nation. In the past 50 years their roles and responsibilities have changed and their numbers have significantly increased. According to VA, women are the fastest growing veterans' population cohort, and VA estimates that while the total veterans population will decline by 37 percent by 2033, the number of women veterans will increase by more than 17 percent over the same period.^{153, 154}

Due to the large and growing number of women serving in the military today, with more than 230,000 who have served since 2001, and many of whom are still serving, the percentage of women veterans is projected to rise proportionally from 8 percent of the total veteran population as of July 2010 to 10 percent by 2020.^{155, 156} Additionally, VA notes that women who served in Operations Enduring and Iraqi Freedom (OEF/OIF) utilize VA services at a higher rate than other veterans, including other women veterans and male OEF/OIF veterans—with 50.6 percent of the 133,000 OEF/OIF women veterans having utilized VA health care, nearly 48 percent of whom have been seen for 11 or more outpatient visits.^{157, 158}

Despite the current increasing number of women coming to VA for health care, historically women veterans have been underserved. VA has indicated in the past year that market penetration for men has increased slightly from 22 to 23 percent compared to market penetration for women now at 16 percent nationally, which is up from 11 percent prior to 2005.¹⁵⁹ VA accounts for the significant rise in the women veteran market penetration rates as an effect of the increasing numbers of women veterans from the OEF/OIF population who are seeking care at VA. Although *The Independent Budget* veterans service organizations (IBVSOs) are pleased that more women are choosing VA as their preferred health-care provider, we would like to see market penetration rates for women equal to that of their male counterparts. VA should begin with targeted outreach to women veterans who are receiving VA disability compensation benefits but who are not enrolled in the VA health-care system. Research has shown that women who do not

utilize VA health care report a number of barriers to accessing VA care, the most significant ones being 31 percent who think they are not eligible, 21 percent who did not know how to apply for benefits, and 20 percent who report that the closest VA is too far from their homes.¹⁶⁰ The IBVSOs agree with VA researchers that these results warrant further study to better understand women's reasons for seeking care elsewhere and urge VA to redouble efforts to increase overall market penetration of women veterans.

The IBVSOs believe that while women will still remain a numerical minority in VA, and the overall effect of these increases will be relatively small—the impact on the gender-specific programs and staff who serve the unique needs of women will be profound. The IBVSOs are concerned that, absent significant reforms, VA will be unable to maintain the current level of access for women veterans.

The IBVSOs are pleased that many of the recommendations made regarding this subject in *The Independent Budget for Fiscal Year 2011* have been addressed by VA in its own groundbreaking publication *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, published in November 2008 and released in the spring of 2009. As directed by the VA Under Secretary for Health, the women's primary care workgroup was charged with defining the actions necessary to ensure that every woman veteran has access to a VA primary care provider who can meet all her primary care needs. The workgroup reviewed the current organizational structure of the VHA's women's health-care delivery system, addressed impediments to delivering their care in the Veterans Health Administration (VHA), identified current and projected needs, and proposed a series of recommendations and actions for the most appropriate organizational initiatives to achieve the Under Secretary's goals.

To assist in the implementation of comprehensive health care for women veterans at every VA facility, the Women Veterans Health Strategic Health Care Group developed a Women's Comprehensive Health Imple-

mentation Planning (WCHIP) tool. The tool, which outlines a care gap analysis, market analysis, and needs assessment, was designed to help VA facilities and Veterans Integrated Service Networks assess and make decisions about which services need to be developed and what resources were necessary to carry out those plans. The stated goal was to then have women veterans program managers (WVPMs) work directly with strategic planners at their VA facilities to incorporate the results of the WCHIP into the health-care planning model at their facilities.

The most pressing challenges identified in VA's *Provision of Primary Care to Women Veterans* report include:

- developing the appropriate health-care model for women in a system that is disproportionately male oriented;
- increasing numbers of women coming to VA for care;
- the impact of changing demographics in the women veteran population; and
- the impact of VA health-care delivery as well as the already identified gender disparities in quality of care for women veterans.

The Under Secretary's workgroup concluded that with the significant increase of women veterans turning to VA for care there are now sufficient numbers to support coordinated models of service delivery to meet women's needs. While women will always comprise a minority of veterans in the VA system, they now represent a critical mass as a group and should therefore be factored into plans for focused service delivery and improved quality of care.¹⁶¹

The IBVSOs are pleased with the thoroughness of the review of women's care in the VHA and with the optimism of recommendations to improve women's health and health services. If implemented nationally, the report recommendations would help to ensure:

- that women veterans receive coordinated, comprehensive, primary care at every VA facility from clinical providers who are trained to meet their needs;
- an integration of women's mental health with primary care in each clinic treating women veterans;
- promotion of innovation in women's health delivery;
- enhanced capabilities of all staff interacting with women veterans in VA health-care facilities; and
- an achievement of gender equity in the provision of clinical care within VA facilities.

VA reports that it is conducting two-and-a-half days of case-based learning and hands on training in "mini-residency" training sessions on women's health to enhance the skills of primary care providers. We understand, at the time of this writing, that 800 providers have been trained with an expectation that an internal goal of 1,100 trained will be met by the beginning of 2011. The IBVSOs concur that this type of training is essential to providing comprehensive primary and gender specific care for women veterans and hope that VA will continue to promote its mini-residency training with basic, advanced, and continuing education modules and ensure all clinicians providing care to women in the health-care system are trained as expeditiously as possible.

Today, women veterans using VA are younger—with an average age of 46 compared to male veterans' average age of 60.¹⁶² Among women users from OEF/OIF, 78 percent are under the age of 40 and of child-bearing age, and 47 percent are less than 30.¹⁶³ Women veterans have also been shown to have more complex health needs with a higher rate of comorbid physical health and mental health conditions (i.e., 31 percent of women have such comorbidities versus 24 percent of men). Even with this high rate of comorbidity, women veterans receive their primary and mental health care in a fragmented model of VA health-care delivery that complicates continuity of care. In fact, according to the VHA Plan of Care Survey for fiscal year 2007, 67 percent of sites provide primary care in a multisite/multi-provider model, with only 33 percent of facilities offering care to women in a one-visit model.¹⁶⁴

The IBVSOs remain concerned about the fragmentation of care and disparities in care that exist for women using the VA health-care system. According to VA, 51 percent of women veterans who use the VA system split their care across VA and non-VA systems of care.¹⁶⁵ Additionally, a substantial number of women veterans receive care in the community via fee-basis and contract care, and researchers note that little is known about the quality of that care.¹⁶⁶ For these reasons, we believe studies are needed to evaluate the overall quality of care delivered to women and that VA should focus on developing a model of care that treats women's health as a comprehensive, fully integrated primary care clinic that incorporates specific case management and care coordination programs for women veterans, especially for those who use fee-based or private care and have comorbid mental health conditions. VA also needs better IT tools to track abnormal pap smears, mammogram results, and non-VA care for women veterans. We are pleased to note that VA is

adopting a new model of health-care delivery, PACTs, or patient-aligned care teams, based on the private sector patient-centered medical home model. This integrated model of care, which incorporates mental health providers, pharmacists, case managers, and other health-care professionals into the primary care team, has already been implemented in many VA primary care clinics. We believe the adoption of the PACT model, combined with the concepts in comprehensive primary care for women veterans, has the promise to enhance the provision of integrated primary care, specialty care, and readjustment and mental health services for women veterans. These new models of care are critical to eliminating the fragmentation of care for women veterans and the disparities in care that currently exist.

Unfortunately, availability and the quality of care for women veterans vary widely across the VA health system, creating inequities in quality and service levels. Today's reality is that women veterans cannot be assured that their health-care needs will be consistently met by VA.

Women's health care in the private sector is also somewhat fragmented; however, the IBVSOs applaud VA for its intention and goal to be a national leader in women's health for the country. VA women's health researchers have examined models of care and determined which deliver better quality care and higher patient satisfaction. Results clearly indicate that women veterans are significantly more satisfied with providers who are knowledgeable about women's health, especially when care is provided in a gender-specific clinic, than they are with care in mixed-gender primary care clinics. When examining the question of provider gender as a factor in satisfaction with care, women prefer a provider who has expertise in women's health over a nonexpert, female provider. However, the highest satisfaction ratings are obtained when providers combine the characteristics of primary care/women's health expertise and female gender.¹⁶⁷ Given these findings, the IBVSOs strongly support VA's initiative to provide training to VA clinical staff to increase their expertise in women's health care. VA also needs to increase its efforts to identify, recruit, retain, and educate clinicians who are proficient and interested in treating women veterans. VA should have at least one provider with women's health-care expertise at every VA medical center and clinic and more when warranted by workload demand.

In March 2010, the Government Accountability Office (GAO) issued a report based on its performance audit of VA's health-care services for women veterans, which

took place from July 2008 through March 2010 and was modeled around the recommendations of VA's *Provision of Health Care Services to Women Veterans*.¹⁶⁸ The final report, *VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes*, is a follow-up to the GAO's July 2009 report of preliminary findings.¹⁶⁹ In the most recent study the GAO visited a geographically diverse mix of facilities to include some that provide services to a high volume of women veterans, particularly those who served in OEF/OIF, those that serve a high proportion of National Guard or reserve veterans, and some facilities that serve rural veterans. Seventeen of the 19 medical facilities the GAO visited offered basic gender-specific services, including pelvic exams and cervical cancer screenings on site, and 15 offered access to one or more female providers for gender-specific care.

The GAO found that the availability of specialized gender-specific services and mental health services for women varied by facility. While some VA medical centers (VAMCs) offered a broad array of specialized gender-specific care on site, smaller community-based outpatient clinics (CBOCs) referred women to other VA or non-VA facilities for many or most of these services. Nationally, nine VAMCs have residential mental health programs that are for women only or have dedicated groups for women. However, the GAO noted that information about all of these programs was not available on the VA public website. In general, the GAO found that CBOCs routinely need to refer patients out for gender-specific care; that VA facilities that do provide basic and specialized gender-specific care often do not provide these services on site; and that most medical facilities do not offer evening or weekend hours for basic gender-specific services.¹⁷⁰

The GAO also found that most VAMCs did offer residential or inpatient mental health services, but few had specialized women's programs, and information on these programs is not readily available to veterans. CBOCs also had limited mental health services compared to VAMCs and Vet Centers. The GAO also noted that VA medical facilities had not fully implemented VA policies pertaining to the delivery of health-care services to women. Specifically, the report noted that none of the facilities visited were fully compliant, although all complied with at least some of the policies. Each was in varying stages of implementing the VA initiative to expand access to comprehensive care for women veterans, but it was noted that none of the VAMCs or CBOCs ensured adequate visual and auditory privacy at check-in for all clinical settings, and

only one of the nine VAMCs and two of the eight CBOCs visited had examination tables facing away from doors to ensure a woman's privacy, with two of the CBOCs having no privacy curtains in addition to the gynecological table facing the wrong direction.

An ongoing issue with internal communication between directors of mental health and military sexual trauma (MST) inpatient programs was another issue identified by the GAO. One clinician noted that in the first year of one of VA's specialized trauma programs space was available for additional patients; however, patients in the region were being referred across the country because area VA providers did not know about the local program. Likewise, many veterans are unaware of VA's specialized programs and treatment options. VA has stated that one of its goals is to transform the agency to serve veterans more efficiently, yet its websites are difficult to navigate and do not provide information about the specialized programs available, nor do they provide information on how to access that care. In response to these concerns, VA officials noted that it is preferential for a woman veteran to contact the WVPM or MST coordinator at her local facility to get help in identifying her treatment needs. However, the GAO found that contact information for women veteran program managers or MST coordinators was either missing or hard to find on most of the facility-specific web pages. The IBVSOs also note that many VA facilities do not have prominent posters containing information about programs for women veterans, including how to contact the local WVPM or clinic liaison. We concur that better access to this basic information would empower women veterans to have more informed conversations with VA staff about available services, benefits, and treatment options.¹⁷¹

Other challenges uncovered by the GAO were that VA facilities are still having problems hiring providers with the specialized training and experience needed to provide services to women veterans, and that VA lacks clear guidance on the appropriate training for providers who treat survivors of military sexual trauma. In the absence of clear guidance from VA, some medical facilities have established their own criteria to work with this population. Provisions in title II of Public Law 111-163 require VA to train and certify mental health providers on care for veterans suffering from conditions related to sexual trauma and post-traumatic stress disorder (PTSD). The IBVSOs find it disturbing that VA officials, according to the GAO, indicate they have no plans to develop policy that mandates the specific training and experience needed for mental health providers who treat survivors of military sexual trauma. VA maintains that all licensed providers are qualified to work with

these types of patients. In a briefing provided to the VA Women Veterans Advisory Committee by the Office of Legislative and Congressional Affairs on October 26, 2010, VA officials stated that program directors plan to establish a one-time mandatory training requirement of only a few hours for all mental health providers currently employed beginning in the second quarter of fiscal year 2011 to fulfill the MST training provisions mandated in P. L. 111-163. Additionally, VA notes it will develop a short training course on sexual trauma specifically for primary care providers by the end of FY 2011.¹⁷² As a health-care organization whose mission is to serve veterans, VHA should strive to be a leader in MST treatment and should educate and certify its mental health providers.

The IBVSOs remain concerned about these reports and feedback from providers who state that, while they are treating patients for MST-related mental health conditions, they have limited knowledge or training in this specialized field. According to mental health experts, a significant period of training and subsequently working under a mentor are essential for MST therapists to develop and hone the appropriate skills and understanding of evidence-based therapies and other techniques that are required to effectively treat this often challenging and complex patient cohort. Therefore, we urge VA to review its decision to provide a minimal training experience to its MST therapists and other mental health clinicians who are treating MST survivors. We believe Congress intended VA to conduct rigorous training to satisfy the law's MST training and certification requirements.

According to the GAO, the VA Readjustment Counseling Service's Vet Center policy specifies that sexual trauma counselors must satisfactorily receive 120 hours of specialized training followed by 50 supervised hours of treatment experience, with a minimum of five sexual trauma cases, before they may counsel such individuals independently. Mental health experts in this field indicate that MST counseling is a specialized mental health field that requires training and experience beyond the basic academic credentialing and licensure required to qualify for employment within the VHA mental health service. We believe at minimum a training standard similar to the Readjustment Counseling Service requirement should apply across the VA system to meet the unique needs of veterans who have experienced military sexual trauma, and to meet the intent of the law. Likewise, staff who have MST training should be allocated to adequately meet the workload needs at VAMCs and CBOCs.

Additionally, we encourage the VHA to develop an MST coordinator certification program, guarantee at least 50 percent protected time for MST coordinators to devote their position responsibilities, and improve coordination with the Department of Defense on transition of women veterans to VA, especially those with complex behavioral health needs. These changes are especially important to women who deployed to a combat theater or those who suffered sexual trauma during military service. According to VA, in 2009, 21 percent of women and 1.1 percent of men reported military sexual trauma when screened.¹⁷³ However, the IBVSOs note that the size of each clinical population (men/women) that reports MST within VA is nearly equal: 53,295 women and 46,800 men, respectively.¹⁷⁴

It is also important to note that 31 percent of women veterans versus 20 percent of men have a diagnosed mental health condition.¹⁷⁵ Additionally, 20 percent of women OEF/OIF veterans and 27 percent of women Vietnam veterans have been diagnosed with PTSD.¹⁷⁶ Studies show that women present unique symptoms when it comes to PTSD and are more likely to have psychological reactivity to trauma cues, a startle response, restricted affect, depression, and an avoidance of trauma cues. Women may also be more likely to present with the specific comorbidities of depression, panic, eating disorders, and somatic complaints. When it comes to treating women with PTSD, studies have shown that women may develop chronic PTSD and may have slower recoveries but may be more likely to seek treatment. The treatments noted for being most successful include cognitive behavioral therapy with a combination of psychotherapy and pharmacotherapy, prolonged exposure, cognitive processing therapy, and family therapy.¹⁷⁷ However, mental health experts report that these case-intensive treatments are not universally available at VAMCs nationwide. The IBVSOs believe there is a need to ensure all providers who are treating these patients are appropriately trained in these techniques as well as certified to provide these treatments.

The IBVSOs are pleased the WVPM position was made full time in July 2008. These managers fill a critical role in implementing VHA women's health policy and programs, providing increased outreach to women veterans, improving quality of care, and developing best practices in the delivery of care to women veterans throughout the VA health-care system. However, the GAO has noted that some facilities have not yet implemented the full-time WVPM position as VA envisioned, and some WVPMs told the GAO about situations where their ability to affect changes to improve care for women veterans had been limited by lack of authority to directly

exercise their judgment or report directly to senior facility leadership to discuss key priorities they had identified. One WVPM reported to the GAO that efforts to expand gender-specific services for women at a CBOC were rebuffed by her supervisor and did not move forward until someone else who was committed to addressing the needs of women veterans assumed that supervisory position. Officials from the VA Women Veterans Health Strategic Health Care Group also told the GAO that they have heard from some WVPMs that their supervisors have prevented them from communicating with facility leadership about steps needed to implement necessary changes to improve women's health programs. The IBVSOs believe the GAO findings indicate an ongoing leadership issue and persistence of a VHA culture that fails to value women's health programs.

Additionally, we believe that a full-time WVPM should also be present at every large multispecialty community-based outpatient clinic and an alternate WVPM position formally assigned to cover responsibilities at all facilities when the primary WVPM is on vacation, out of the service area, or unavailable to ensure continuity of services and care. Furthermore, each Veterans Integrated Service Network (VISN) should appoint a lead WVPM who is involved in VISN-level leadership committees and planning. We urge Congress to monitor the maintenance of full-time WVPM positions throughout the system.

The GAO also reported that VA had not updated its official policy to indicate that the WVPM is a full-time assignment in VAMCs and significant CBOCs, or to further clarify the roles and responsibilities of this key position. However, we understand appropriate updates to the policies were completed and the document is being reviewed in the VA Central Office. Given the comments from WVPMs in the GAO report, the IBVSOs urge that the updated policy include guidance to these program managers on how to better collaborate with VISN and facility executives and managers and exert more of a leadership role in conducting women's health programs.

In response to the GAO report, VA agreed to deploy regional inspection teams to assess medical center and outpatient clinic compliance—implying that the current self-reporting practice may not be sufficient. Ongoing objective program assessments are needed to ensure that all aspects of the women's health programs are implemented fully and equitably at each VAMC.

The GAO found that some VA facilities' self-reporting of compliance with existing directives dealing with privacy, safety, and other accommodation of women's

needs did not match conditions the GAO found in its site visits. Therefore, reliance on self-reported, unaudited information does not provide sufficient assurance that facilities are actually in full compliance with these policies. The IBVSOs suggest that VA better address oversight of compliance with these directives incorporating privacy, dignity, sense of security, and safety considerations for women patients, among other factors. Also, significant improvements to facility infrastructure planning need to be made a higher priority in each VISN so that VA can not only better serve women today but also be prepared for the inevitable growth coming in VA women's health workloads in the future.

The GAO's recommendations, to which VA responded and either concurred in, or concurred in principle, are as follows:

- Provide completed information on the VA public website on the specialized residential mental health treatment programs VA offers for women veterans who have experienced military sexual trauma or other trauma.
- Clarify VA policies by describing specifically what constitutes "appropriate and necessary training" for mental health professionals who provide services to veterans who have experienced MST.
- Update VA policies to clarify the roles and responsibilities of the full-time WVPM position, in particular with respect to the level of reporting authority and access to senior facility management.
- Establish a process to independently validate self-reported information by VA medical facilities' on compliance with privacy policies that pertain to women veterans.
- Expedite action to ensure that VA design and construction policies explicitly address the needs of women veterans in all health-care delivery settings in VA medical facilities.¹⁷⁸

The issue of improving quality care for women is a high priority for *The Independent Budget* veterans service organizations. The 2008 congressionally directed "report card" for VA looked at measurements of quality, safety, timeliness, efficiency, and "patient-centeredness" within the VA health-care system. Although the overall report gave the Department high marks, the IBVSOs were distressed to learn that VA performance data revealed that women veterans lag behind their male counterparts in certain quality measures and that disparities in treatment and satisfaction were identified based on gender or ethnic background. Significant gender-based differences in provision of certain clinical prevention measures and mental health screenings were

highlighted. VA indicated that it would work to address these identified health-care disparities faced by women veterans and would devote additional resources and attention to this problem until it was resolved.¹⁷⁹

In the December 2009 report card the same disparities were observed related to the care of women. The VA Office of Quality and Safety reports that several initiatives have been undertaken to better understand and to begin addressing these findings. The IBVSOs are pleased that one of those initiatives is inclusion of women's health outcomes in performance plans of VA medical center executives. Although this is a positive step forward, in order to ensure the highest quality of care, veterans and other stakeholders must have easy access to publicly reported performance measurement data. VA should begin to provide regular quarterly performance reports by facility and VISN. These results should be stratified by gender and reported in an accessible, public, and transparent manner.

Because a significant majority of the women veteran population enrolled in VA is predominantly preretirement and of child-bearing age, potential exposure to teratogenic agents (which cause developmental deformities) and birth defects must also be addressed as critical VA health-care quality and safety issues for women veterans. VA health-care providers should routinely question women about sexual function and reproductive issues and be knowledgeable about health promotion, disease prevention, and current issues related to women's health and treatment regimes. Likewise, VA health-care providers should make every effort to reduce unnecessary exposure to radiation and pharmaceutical teratogens. VA should facilitate providers' ability to identify compounds associated with an increased risk of birth defects (teratogens) and immediately revise VA's automated pharmacy module to provide women's caregivers alerts for potential teratogens prescribed to women veterans younger than 50 years old. The IBVSOs understand that an initiative is moving forward internally, but we urge VA to use interim measures to ensure pharmaceutical safety of younger women veterans during the implementation phase. Equally critical is that every VA facility should have the ability to obtain an urgent beta-HCG pregnancy test so that informed health-care decisions can be made swiftly without endangering the veteran or her fetus. In addition, women veterans should be offered a sexual function and safe-sex practices screening annually.

Women veterans are often the primary caregivers in their families and extended families. Therefore, VA health-care providers need to be sensitized to the sig-

nificant health-care access barriers women face as often unmarried employed heads of households, parents, and caregivers. *The Independent Budget for Fiscal Year 2011* recommended that VA develop a pilot program to provide child care services for veterans who are the primary caregivers of children while they receive intensive health-care services for PTSD, mental health, and other therapeutic programs requiring privacy and confidentiality. We were pleased that provisions in P. L. 111-163 mandate such a pilot program. However, VA officials report they may need to draft and publish regulations that define the scope of services that will be provided and that this may take over one year before the regulatory process is completed.¹⁸⁰ We do not believe that such regulations are necessary and urge VA to move forward swiftly to create this child care pilot program. Numerous prior surveys have clearly documented that the absence of child care is a continuing and significant barrier to access.

With more women serving in combat theaters of operation in OEF/OIF than at any other time in history, it is critical that VA health professionals have a clear understanding of the personal experiences of women in today's armed forces and that specialized programs and services are developed to meet their unique needs post-deployment. These women need help reintegrating back into their "normal" life after coming home from war. Many women have reported feeling isolated, experiencing difficulties in communicating with family and friends, not having enough time to "readjust" when they returned home, and facing unreasonable expectations of family members for them to return to their former, and often more traditional roles, as wife, mother, caretaker, and "old selves." The issues pertaining uniquely to women with dependent children included difficulties reestablishing bonds with children and resuming the role as primary parent or disciplinarian. Women reported they routinely felt "out of sync" with children and partners/family members and felt that they had "missed so much." Employment concerns were expressed equally by women with and without children and included financial issues either due to making less money as a civilian than while in the military or the difficulty finding a civilian job that would pay as well as their military job.

Likewise, researchers found that women experience difficulty finding support systems upon return home and need additional support from the military and VA to assist them with post-deployment reintegration. While progress has been made, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans

readjust and get the health care they need while respecting their privacy and whole person in the process. P. L. 111-63 includes provisions that require VA to conduct a pilot program on group counseling for women veterans newly separated from the armed forces in retreat settings. VA reports that it has developed contract requirements to solicit proposals for this pilot; however, only one proposal was submitted but it did not meet all of the requirements of the solicitation. Therefore, the solicitation has been reopened.^{181, 182, 183}

One final provision in P. L. 111-163 that is extremely important to women veterans requires the Department to furnish payment for health-care services for the newborn of a woman veteran who is receiving maternity care furnished by VA. We are pleased that VA provided initial guidance to field facilities on the change in fee basis authority on August 18, 2010, and submitted a procedural guide to further help staff implement the requirement expeditiously.

According to VA, approximately 8 percent of all polytrauma patients from Operations Enduring and Iraqi Freedom are women. For this reason, the IBVSOs also urge VA to concentrate on improving services for women with serious physical disabilities, such as spinal cord injury, burns, traumatic brain injury, amputations, and blindness. The physical space and size of examination rooms, the need for specialized equipment, overall setting, and safety issues should be evaluated throughout the VA health-care system. Additionally, all VA's specialized services and programs, including those for polytrauma rehabilitation and transitional centers, substance-use disorders, homelessness, domestic violence, and post-deployment readjustment counseling, should be evaluated to ensure women have equal access to these exceptional programs.

Summary

According to VA, when women veterans are asked what they need and want, they respond first and foremost that they would like recognition and respect for their military service. They also need help with employment, suitable housing, access to and receipt of high-quality health care, child care options, and opportunities for social interaction with other women veterans. Most of all, they want to make a difference.¹⁸⁴ Although the most recent GAO report highlights a number of gaps in the system related to women's health issues, the IBVSOs congratulate the Women Veterans Health Strategic Health Care Group for an extraordinarily forthcoming report containing a highly relevant series of goal-oriented recommendations and action items. Likewise, we support the hard work and recommendations of the

VA Advisory Committee on Women Veterans—many which have been reflected in this discussion. VA seems to recognize that the population of women veterans is undergoing exponential growth and that the culture of VA needs to be transformed to value women veterans in all aspects.

We urge the Department of Veterans Affairs to step up its efforts to adapt to the changing demographics of its women veteran patients—taking into account their unique characteristics related to their military experience as war veterans and as young working women, many with both child care and elder care responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care are equal for women and men. We see the need for VA to reevaluate its programs and services for women veterans and to increase attention to a more comprehensive view of women's health beyond reproductive health needs to include cardiac care, breast cancer, osteoporosis, and colorectal cancer. A plan should be established that addresses the increased overall demands on ambulatory care, access to after-hours or urgent care, hospital and long-term care, gender-specific services, and mental health programs recognizing the unique and often complex health needs of women veterans. Mental health integration into primary care is also essential for provision of comprehensive women's health care.

Implementation of full-time WVPs in every VA medical center and large multispecialty community-based outpatient clinic, training to increase staff knowledge of the state-of-the-art in women's health, and mental health care and treatment should be fully realized this year. Women should have access to comprehensive primary care services from competent providers, including gender-specific care, at every VA facility. The IBVSOs also recommend that VA focus on improving services for women with serious physical disabilities and focus its women's health research agenda on a longitudinal health study of women who served in Afghanistan and Iraq as mandated in P. L. 111-163 as well as full implementation of all the other mandates in the law related to women veterans. This particular study could prove invaluable as a source of information to help VA address the unique physical and mental health needs of women who have served in combat theaters and ease the barriers to care for all women who serve.

Recommendations:

VA should ensure that women veterans have access to high-quality comprehensive primary care services (including gender-specific care) at every VA medical facility, including community-based outpatient clinics.

VA should implement the redesign of its care-delivery model for women veterans and establish an integrated system of health-care delivery that covers a comprehensive continuum of care.

VA needs to ensure that every woman veteran has access to a qualified, concerned primary care physician who can provide gender-specific care for all basic physical and mental health conditions.

Using the patient-aligned care team model, collaborative care approaches that incorporate mental health providers and case managers into women veterans' primary care teams should be established. Women's health clinics provide comprehensive primary care and should receive equitable PACT funding and resources.

VA should take action on its reported findings in the November 2008 *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans* and recommendations from the 2010 Government Accountability Office report referred to in this discussion.

Research shows that 51 percent of women veterans using VA are referred for fee-basis care; therefore, VA should take immediate action to improve information technology tools and case management that ensure continuity and coordination of care as highlighted in the "Contract Care Coordination" discussion elsewhere in this *Independent Budget*.

VA should adopt a policy of transparent information sharing and initiate quarterly public reporting of all quality, access, and patient satisfaction data, including a report on quality and performance data stratified by gender.

VA should complete and report to Congress its comprehensive study of the barriers to health care experienced by recently discharged women veterans.

VA should implement a program to educate its leaders about the contributions of women veterans and their health-care needs and preferences. VA efforts to transform the culture of VA to value women veterans should be enhanced and accelerated.

VA should make every effort to reduce women's unnecessary exposure to radiation and pharmaceutical teratogens, identify compounds associated with an increased risk of birth defects, and immediately revise pharmacy software to provide alerts for potential teratogens of prescribing to women veterans under 50 years of age.

VA should enhance its military sexual trauma programs by requiring sufficient and consistent training and certification of health-care personnel across all medical and mental health disciplines on techniques for screening men and women at risk for military sexual trauma, effective care and treatment options, and developing evidence-based clinical practice guidelines for sexual trauma survivors.

VA should expeditiously develop and implement a pilot program to provide child care services for veterans who are the primary caregivers of children while they receive intensive health-care services for post-traumatic stress disorder and mental health and receive other therapeutic treatments requiring privacy and confidentiality.

VA should concentrate on improving services for women with serious physical disabilities and evaluate all VA's specialized services to ensure women have equal access to these programs.

VA should reform its capital investment planning to include criteria and standards to ensure that new construction meets privacy, dignity, and security standards for women. In addition, VA should require that Veterans Integrated Service Networks do annual inspections to verify that all clinic rooms and diagnostic testing areas have examination table orientation and curtains that ensure veterans' privacy.

VA should fund a prospective, longitudinal long-term research study of the health consequences of women veterans' service in Afghanistan and Iraq. The research should include both telephone surveys and periodic health examinations of deployed and nondeployed women veterans.

¹⁵⁷ Beck, Testimony on Caring for Severely Injured OEF/OIF Veterans and Servicemembers, note 17.

¹⁵⁸ Patricia Hayes, *Women Veterans Health*, A Forum on Women Veterans (July 28, 2010) <http://www1.va.gov/WOMENVET/docs/ForumHayes.pdf>.

¹⁵⁹ Patricia Hayes, *Leading the Nation in Women's Health: The Important Role of Research*, VA Women's Health Services Research Conference (July 15, 2010) http://www.research.va.gov/programs/womens_health/conference2010/.

¹⁶⁰ http://www.research.va.gov/programs/womens_health/conference2010/.

¹⁶¹ Department of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans* (Washington, DC: November 2008), 6, 15.

¹⁶² Trowell-Harris, Department of Veterans Affairs, Center for Women Veterans Briefing, note 154.

¹⁶³ Hayes, *Women Veterans Health*, note 158.

¹⁶⁴ Office of Women Veterans Health Strategic Health Care Group, VHA's Plan of Care Survey for FY2007 (SAIC Web Solutions) <http://www.oregon.gov/ODVA/TASKFORCE/women/USHReport.pdf?ga=t>.

¹⁶⁵ D. Washington, *Ambulatory Care Among Women Veterans: Access and Utilization* (VA Office of Research & Development, Health Services R&D Service, November 2008).

¹⁶⁶ E. Yano, *Translating Research Into Practice—Redesigning VA Primary Care for Women Veterans*, PowerPoint presentation, DAV National Convention (Las Vegas, NV: August 2008).

¹⁶⁷ Department of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, *Report of the Under Secretary for Health Workgroup*, note 161, 33.

¹⁶⁸ U.S. Government Accountability Office, *VA Has Taken Steps To Make Services Available to Women Veterans, But Needs to Revise Key Policies and Improve Oversight Policies*, GAO-10-287 (2010) <http://www.gao.gov/new.items/d10287.pdf>.

¹⁶⁹ *Ibid.*

¹⁷⁰ *Ibid.*

¹⁷¹ *Ibid.*

¹⁷² Evans, *Update on Legislation Related to Women Veterans*, note 37.

¹⁷³ Zeiss, *VHA Mental Health Services*, note 8.

¹⁷⁴ Department of Veterans Affairs, Veterans Health Administration, *Women's Mental Health and Military Sexual Trauma* (Office of Family Services, November 2009).

¹⁷⁵ Frayne, "VA Women's Health Evaluation Initiative," note 38.

¹⁷⁶ Garovoy, *PTSD and Women's Mental Health Services*, note 39.

¹⁷⁷ *Ibid.*

¹⁷⁸ U.S. Government Accountability Office, *VA Has Taken Steps to Make Services Available to Women Veterans*, note 153.

¹⁷⁹ Department of Veterans Affairs news release, "Health Care Report Card Gives VA High Marks" (June 13, 2008).

¹⁸⁰ Evans, *Update on Legislation Related to Women Veterans*, note 37.

¹⁸¹ U.S. Department of Veterans Affairs, *Pilot Study of Reintegration and Service Needs for Women Veteran Mothers*, Study No. 08-186 (October 22, 2009) http://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141698773&UnderReview=no.

¹⁸² Trowell-Harris, Department of Veterans Affairs, Center for Women Veterans Briefing, note 154.

¹⁸³ Evans, *Update on Legislation Related to Women Veterans*, note 37.

¹⁸⁴ Trowell-Harris, Department of Veterans Affairs, Center for Women Veterans Briefing, note 154.

¹⁵³ U.S. Government Accountability Office, *VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes*, GAO-10-287 (2010) <http://www.gao.gov/new.items/d10287.pdf>.

¹⁵⁴ Irene Trowell-Harris, Department of Veterans Affairs, Center for Women Veterans Briefing for DAV 89th National Convention, PowerPoint presentation (Atlanta, GA: August 2, 2010).

¹⁵⁵ U.S. Department of Veterans Affairs, *VA Benefits & Health Care Utilization* (July 20, 2010) http://www1.va.gov/VETDATA/PocketCard/4X6_summer10_sharepoint.pdf

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Homelessness

ENDING HOMELESSNESS AMONG VETERANS:

If the trend in reducing the number of homeless veterans is to continue, the Department of Veterans Affairs will need sustained funding for supportive services and housing, improved prevention strategies aimed toward at-risk veterans, continued collaboration with its community partners, and a variety of additional investments.

The Department of Veterans Affairs is the nation's largest single provider of homeless treatment and benefits assistance services to homeless veterans. It provides health-care services to more than 100,000 homeless veterans each year, and associated services to more than 132,000 veterans in its specialized homeless programs. In association with these programs, VA social workers and clinicians work with community and faith-based partners to conduct extensive outreach programs, clinical assessments, medical treatments, alcohol and drug abuse counseling, and employment assistance.¹⁸⁵

The causes of veterans becoming at risk for homelessness—as is the case with all homeless persons—can generally be grouped into three categories: health issues, financial issues, and the lack of affordable housing. According to the National Coalition for Homeless Veterans, veterans face additional hurdles when trying to overcome personal hardships. They often are called upon to leave their families and social support networks for extended periods of time while engaging in highly stressful training and military operations. For half the men and women called to serve in Operations Enduring and Iraqi Freedom (OEF/OIF), the specter of multiple deployments undermines their ability to fully decompress and reintegrate into society after combat deployments. Often, particularly for junior enlisted grades, combat-related skills are not readily transferrable to the civilian workforce, and many young veterans with families must struggle to pursue training and education that will increase their earning potential. Even for those veterans who are able to increase their earning potential and overcome the other stresses of separating from the military, the downturn in the nation's economy and housing markets over the past few years creates added pressure that can have greater impact on younger veterans than their older, more established contemporaries.¹⁸⁶

On November 3, 2009, VA convened a national summit with the goal of developing a comprehensive plan to end homelessness among veterans by combining the resources of government, business, veterans service organizations, and the private sector. At the summit, VA

Secretary Eric Shinseki announced an ambitious five-year plan to end veteran homelessness in the United States. The Department, its federal agency partners, and the community- and faith-based organizations that provide housing and supportive services to the nation's homeless and at-risk veterans all agree that the five-year plan depends on sustained progress on two fronts: the effective, efficient provision of housing and supportive services to homeless veterans and those in recovery programs and increasing the availability of preventive measures that will enable at-risk veterans and their families to remain housed.¹⁸⁷

While there is no exact measure of the number of homeless veterans, the following best estimates help define the scope of the intervention and prevention needs of VA homeless programs:

- Approximately 107,000 veterans are homeless on a typical night, which is a decrease of 18 percent from last year. It is estimated that twice as many veterans experience homelessness at some point during the year.^{188, 189}
- Fifteen percent of homeless adults are veterans.¹⁹⁰
- Women veterans represent 6.8 percent of the homeless veteran population and are the fastest-growing segment of the OEF/OIF homeless population.¹⁹¹
- Just under 95 percent of homeless veterans who receive VA services are male, and most are single, come from urban areas, and suffer from mental illness, alcohol, and/or substance abuse or co-occurring disorders.¹⁹²
- 1.5 million veteran families live at or below the federal poverty level.¹⁹³
- 634,000 veteran families live in extreme poverty, at or below 50 percent of the federal poverty level.¹⁹⁴
- In fiscal year 2010 (through August), 19,856 “new” homeless veterans were treated in a VA specialized homeless program. “New” is defined as a person who has not sought homeless services in the previous two years.¹⁹⁵

According to Secretary Shinseki, VA's strategy to eliminate homelessness among veterans is to implement a "no wrong door" approach, meaning veterans who seek assistance should find it in any number of VA's programs, from community partners or through contract services.¹⁹⁶

The VA five-year plan to end veteran homelessness is built upon six strategic pillars:

- VA will aggressively reach out to and educate veterans—both those who are homeless and those who are at risk of becoming homeless—about VA programs, finding those who are already homeless and those who are at risk for homelessness.
- VA will ensure treatment options are available, whether for primary, specialty, or mental health care, including care for substance abuse disorders.
- VA will bolster efforts to prevent homelessness. Without a prevention strategy, effectively closing the front door into homelessness, VA will only continue responding after veterans become homeless and therefore continue to manage the problem.
- VA will increase housing opportunities and provide appropriate supportive services tailored to the needs of each veteran.
- VA will provide greater financial and employment support to veterans and work to improve benefits delivery for this vulnerable population.
- VA will continue expanding community partnerships because success in this venture is impossible without them.¹⁹⁷

The five-year plan focuses on the prevention of homelessness, permanent supportive housing, mental health, and substance abuse treatment, and education and employment assistance. Full implementation of VA's plan is estimated to significantly impact the lives of an estimated 700,000 homeless and at-risk veterans.¹⁹⁸

VA continues to expand its existing programs and develop new initiatives to prevent veterans from becoming homeless and to aggressively help those who already are by providing housing, offering health care and benefits, enhancing employment opportunities, and creating residential stability for more than 500,000 veterans. This further expansion began in FY 2011 and will continue through FY 2014, subject to the availability of appropriations.¹⁹⁹

According to VA, the agency plans to:

- increase the number and variety of housing options including permanent, transitional, contracted, community-operated, and VA-operated;

- provide more supportive services through partnerships focused on prevention of homelessness, improving employability, and increasing independent living options for veterans;
- improve access to VA and community-based mental health, substance abuse, and support services.²⁰⁰

More than 40,000 homeless veterans receive compensation or pension benefits annually. VA and its community partners have secured nearly 15,000 residential rehabilitative and transitional beds and an additional 30,000 permanent beds for homeless veterans throughout the nation; and in FY 2011 VA expects to spend \$3.4 billion to provide health care for homeless veterans and \$800 million to provide specialized homeless programs.²⁰¹

VA homeless programs, which number more than a dozen, are varied, and many are models for reaching out to the homeless in the general populace. Some of the programs that are noteworthy for their effectiveness in caring for this often hard-to-reach population include:

- *Health Care for Homeless Veterans (HCHV) Program* operates at 132 sites around the country, and participates in active outreach, physical and psychiatric exams, treatment, referrals, and ongoing case management to homeless veterans with mental health and substance abuse problems. In FY 2010 HCHV outreach workers conducted 42,275 intake assessments for veterans referred to the program. Of those, 6.8 percent were women. In February 2010, funding was deployed to the field for an additional 33 HCHV outreach workers to supplement the efforts of the current 340 HCHV outreach workers.^{202, 203}
- *Domiciliary Care for Homeless Veterans (DCHV) Programs* provide residential care for homeless veterans, and operates at 41 sites providing 2,100 beds around the country. The DCHV Programs served approximately 6,350 veterans through August 2010, and more than 8,561 in FY 2009. Of those, 5 percent have been women.^{204, 205}
- *Veterans Industry/Compensated Work-Therapy (CWT) and Compensated Work-Therapy/Transitional Residence (TR) Programs* offer structured work opportunities and supervised therapeutic housing for at-risk and homeless veterans with physical, psychiatric, and substance abuse disorders. VA operates 54 purchased community residences, 9 leased community properties, and utilizes unused space at 15 medical centers on VA grounds. At the end of FY

2009 there were 633 operational beds. Among the 759 veterans discharged from CWT/TR programs during FY 2009, 82 percent were literally homeless upon admission, 96 percent had a substance-use disorder, and 59 percent were diagnosed with a serious mental illness.²⁰⁶

- *HUD-VA Supported Housing (VASH) Program* allocates \$75 million each year to local public housing authorities to provide permanent supportive housing and dedicated VA case managers for an estimated 30,000 homeless veterans and their families. In the past year an additional 10,000 vouchers have been made available. The impact on women and families is evident as 11 percent of veterans receiving vouchers are women (the rate increases to 22 percent among OEF/OIF veterans), and 12 percent of all vouchers issued have been provided to families (43 percent among OEF/OIF recipients are families).^{207, 208}
- *Stand Downs* are one- to three-day outreach events that provide homeless veterans a variety of services and give them a temporary refuge where they can obtain food, shelter, clothing, and community/VA assistance. In 2009, VA and other stakeholders participated in almost 200 events in 46 states, including the District of Columbia and Puerto Rico, reaching more than 42,000 veterans, more than 4,600 spouses, and almost 1,200 children of veterans—the highest totals VA has ever recorded. This represents a 40 percent increase in outreach to veterans from 2008.²⁰⁹
- *Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans* brings together consumers, providers, advocates, local officials, and other concerned citizens to identify the needs of homeless veterans and to work to meet those needs. CHALENG is designed to be an ongoing assessment process that describes the needs of homeless veterans and identifies the barriers they face to successful community reentry. In a 2010 report, data were compiled from 16,512 respondents, including 10,701 survey responses completed by homeless veterans.²¹⁰
- VA's *Homeless Veterans Dental Program* has been managing a funded initiative that provides dental treatment for eligible veterans receiving residential service in five of VA's homeless programs, and VA is working to provide dental care to all eligible veterans within this initiative. For the first time ever, participants in this program who responded to the CHALENG survey did not rank dental care in their top 10 unmet needs.^{211, 212}
- *Supportive Services for Veteran Families (SSVF) Program* is a new VA program that will provide supportive services to very low-income veterans and their families who are in or transitioning to permanent housing. VA will award grants to private non-profit organizations and consumer cooperatives that will assist very low-income veterans and their families by providing a range of supportive services designed to promote housing stability.²¹³
- *National Call Center for Homeless Veterans (NCCHV)*, launched by VA in December 2009, ensures that homeless veterans or veterans at risk for homelessness have free, 24/7 access to trained counselors. The hotline is intended to assist homeless veterans and their families, VA medical centers, federal, state, and local partners, community agencies, service providers, and others in the community. As of August 31, 2010, 10,209 calls had been made to the hotline, 1-877-4AIDVET (877-424-3838).^{214, 215}

On October 1, 2010, Secretary Shinseki announced that more than \$41.9 million in grants to community groups will be distributed among 40 states to provide an additional 2,568 beds for homeless veterans this year under the Homeless Providers Grant and Per Diem Program. This program provides grants and per diem payments to help public and nonprofit organizations establish and operate new transitional housing and service centers for homeless veterans. Of the \$41.9 million, about \$26.9 million will be dedicated to help renovate, rehabilitate, or acquire space for 1,352 transitional housing beds. A second group of awards, valued at \$15 million, will fund 1,216 beds at existing transitional housing programs for homeless veterans this year. The awards are intended to cover daily living costs based upon the number of homeless veterans being served in transitional housing.²¹⁶

The grants and per diem payments are a key component of VA's plan to eliminate homelessness among veterans within five years. VA believes, in part, these funds helped reduce the number of veterans who were homeless on a typical night last year by 18 percent to about 107,000 veterans within one year.²¹⁷

On October 13, 2010, the signed into law H. R. 3219, the "Veterans' Benefits Act of 2010" (P. L. 111-275). The act includes two significant homeless veterans provisions: The first reauthorizes the Homeless Veterans' Reintegration Program (HVRP) through fiscal year 2011. The second authorizes \$1 million annually for fiscal years 2011 through 2015 to provide dedicated services for homeless women veterans and homeless veterans with children.²¹⁸

It should also be noted that the Department of Labor (DOL) Veterans' Employment and Training Service (VETS) supports the VA goal of ending veteran homelessness in five years. A major new undertaking in the DOL's HVRP is a separate grant initiative to serve the needs of homeless women veterans and homeless veterans with families, a population that is on the rise and in need of specialized services. In program year 2010, which began in July 2010, the HVRP dedicated \$5 million of the \$10 million increase appropriated for this program to provide customized employment services. The DOL funded 26 grantees in program year 2010 and requested an additional \$5 million in the FY 2011 budget to provide continued funding for the homeless women veterans initiative.²¹⁹

Additionally, VETS is collaborating with the DOL's Women's Bureau, which has already conducted 28 moderated listening sessions nationwide with formerly and currently homeless women veterans to identify the causes and the solutions for homelessness among this population. The findings from these sessions are available on the Women's Bureau website at <http://www.dol.gov/wb/programs/listeningsessions.htm>. VETS also conducted a national listening session with service providers, VA, the Department of Housing and Urban Development, and other government agencies to begin identifying the best practices for serving homeless women veterans and homeless veterans with families. VETS expects to continue to identify such practices and disseminate them to service providers throughout the nation.²²⁰

The Independent Budget veterans service organizations (IBVSOs) are pleased about VA's goals to end veteran homelessness and its commitment to work in partnership with other agencies and all stakeholders to achieve this laudable goal. We are also pleased that VA officials acknowledge the need to address not only the basic needs of food and shelter for this vulnerable population but underlying mental health issues. Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder (PTSD) or have addictions acquired during or worsened by their military service. According to VA, at least 45 percent of homeless veterans suffer from mental illness, more than 70 percent have substance-use disorders, and nearly 40 percent have both psychiatric and substance-use disorders. As of August 31, 2010 VA has provided residential treatment to more than 31,376 homeless veterans in this fiscal year, and 9.2 percent of the veterans seen in PTSD-specific programs have been women.^{221, 222, 223}

While most homeless veterans served during prior conflicts or in peacetime, significant numbers of men and

women from the newest generation of combat veterans of OEF/OIF are returning home with post-deployment readjustment issues and war-related conditions, including traumatic brain injury and serious wounds, which may put them at a higher risk of becoming homeless. Mental and physical health problems in addition to economic hardships can interrupt veterans' ability to keep a job, find a home, establish savings and, in some cases, maintain family stability. Veterans' family, social, and professional connections may have been strained or broken as a result of their military service.²²⁴

Additionally, the evolving gender mix of the military—with women representing 11 percent of the forces deployed to Iraq and Afghanistan, and of that group more than 30,000 are single parents with dependent children—pose new challenges for the nation's support systems. Some women veterans are reporting serious trauma histories related to combat exposure and episodes of physical harassment and sexual assault while serving in the military. For women veterans in particular, the recent study *Risk Factors for Homelessness Among Women Veterans* notes that characteristics associated with homelessness were sexual assault during military service, being unemployed, being disabled, having worse overall health, and screening positive for an anxiety disorder or PTSD.^{225, 226}

VA reports a total of 14,406 veterans of the approximately 2.1 million personnel deployed to Iraq and Afghanistan have been seen in VA homeless outreach during the past five fiscal years, and as the number of homeless veterans reporting OEF/OIF service is increasing, they constitute 5 percent of the overall homeless population. Poverty, lack of support from traditional social networks, high unemployment rates, and unstable living conditions in overcrowded and substandard housing may also be factors contributing to these veterans' need for assistance. With greater numbers of women serving in combat operations, along with increased identification of and a greater emphasis on care for victims of sexual assault and trauma, better outreach, and availability of new and more comprehensive services, housing, and child care services are needed. Furthermore, in the next 10 years, significant increases in funding will be needed for Vietnam veterans who will be experiencing more age-related illnesses and conditions.²²⁷

According to VA CHALENG reports, three possible factors have been identified to help explain the drop in veteran homelessness in the past three years: (1) VA program interventions, (2) changes in methodology,

and (3) changing demographics.²²⁸ The IBVSOs applaud VA efforts and gains in serving the homeless veteran population, but if the trend in reducing the number of homeless veterans is to continue, more funding is needed for supportive services and housing options to ensure low-income veterans exiting grant and per diem programs can access housing, and veterans who served in Afghanistan and Iraq receive the low-threshold assistance they need to reduce their risks of becoming homeless. Additionally, increased appropriations for VA homeless veteran assistance programs will likely spur development of more local community-based prevention strategies.

The rapid expansion of the Housing and Urban Development-VA Supportive Housing Program (HUD-VASH)—from 1,700 housing vouchers in 2007 to 30,000 vouchers today for veterans with serious mental illness, disabilities and extreme low-income veterans with families—is one of the most important developments in the history of the homeless veteran assistance movement. There were also additional legislative proposals in the 111th Congress that would have provided sustained support for VA’s five-year plan, but, unfortunately, they were not enacted.

In part, these bills would have provided for an expansion of the HUD-VASH program to 60,000 vouchers by 2014; child care assistance for single homeless veteran parents in employment assistance programs; legal aid for credit repair and to address child support issues, and access to and development of affordable permanent housing. In addition, up to \$10 million in grants to community and faith-based organizations would have been funded to provide specialized support for employment assistance for single parents of dependent children through FY 2014. One measure called for \$50 million to be appropriated annually for support services for low-income veterans in order to prevent them from becoming homeless; 20,000 rental vouchers would also be funded, and the VA Homeless Providers Grant and Per Diem Program would be expanded to provide more access to counseling, education, and access to legal aid. Another provision would support VA’s efforts to develop and carry out a national media campaign to better inform homeless and at-risk veterans about the benefits available to help them. The IBVSOs urge Congress to renew its consideration of these measures.

Recommendations:

Congress should ensure sufficient and sustained resources to strengthen the capacity of VA health-care services for homeless veteran programs to enable VA to meet the physical, mental health, and substance-abuse rehabilitation needs of this population, including vision and dental care services.

Congress should reintroduce legislation needed to complement and support VA’s Five-Year Plan to End Homelessness among Veterans and the Federal Strategic Plan to Prevent and End Homelessness.

Congress should increase appropriations for the Homeless Veterans’ Reintegration Program to the authorized level of \$50 million. Funded by the Department of Labor Veterans’ Employment and Training Service, the HVRP is the only federal program wholly dedicated to providing employment assistance to homeless veterans and provides competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers when such services are not available within VA.

Congress should ensure that the Department of Defense assesses all service members separating from the armed forces to determine their risk of homelessness and provide life skills training to help them avoid homelessness.

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

VA should enhance its outreach efforts to help ensure homeless veterans gain access to VA health and benefits programs—including a national media campaign aimed at prevention for at-risk veterans.

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

Congress should require applicants for Department of Housing and Urban Development McKinney-Vento homeless assistance funds to develop specific plans for providing housing assistance and services to homeless veterans. Organizations receiving these funds should screen all participants for military service and make referrals as appropriate to VA and local homeless veteran service providers.

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¹⁸⁶ National Coalition for Homeless Veterans, Facts and Media, *Veteran Homelessness Prevention Platform* (March 26, 2009) http://www.nchv.org/news_article.cfm?id=515.

¹⁸⁷ Department of Veterans Affairs press release, “Secretary Shinseki Details Plan to End Homelessness for Veterans” (November 3, 2009) <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1807>.

¹⁸⁸ John H. Kuhn and John Nakashima, The 16th Annual Progress Report Community Homelessness Assessment, Local Education and Networking Group (CHALENG) for Veterans (FY 2009): Services for Homeless Veterans Assessment and Coordination (March 17, 2010).

¹⁸⁹ The National Coalition for Homeless Veterans, Facts and Media, Background and Statistics <http://nchv.org/background.cfm>.

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¹⁹¹ Department of Veterans Affairs, Advisory Committee on Women Veterans, *Homeless Veterans Program Overview*, PowerPoint presentation (October 27, 2010).

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¹⁹³ United States House of Representatives, *House Report 110-268—Veterans’ Health Care Improvement Act of 2007, Section: Financial Assistance for Supportive Services for Very Low Income Veteran Families in Permanent Housing* (July 27, 2007) <http://thomas.loc.gov/cgi-bin/cpquery/T?&report=hr268&dbname=110&>.

¹⁹⁴ *Ibid.*

¹⁹⁵ Department of Veterans Affairs, Advisory Committee on Women Veterans, “Homeless Veterans Program Overview,” note 191.

¹⁹⁶ Department of Veterans Affairs press release, “Secretary Shinseki Announces \$41.9 Million to Help the Homeless” (October 1, 2010) <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1977>.

¹⁹⁷ Pete Dougherty, director, Homeless Programs, Department of Veterans Affairs, Testimony before the United States Senate, Committee on Veterans Affairs, Hearing on Ending Homelessness Among our Nation’s Veterans (March 24, 2010).

¹⁹⁸ Department of Veterans Affairs, “Homeless Veterans Program Overview,” note 191.

¹⁹⁹ Dougherty, Testimony before the United States Senate, note 197.

²⁰⁰ *Ibid.*

²⁰¹ Department of Veterans Affairs, Office of Public Affairs and Media Relations, *Fact Sheet: VA Programs for Homeless Veterans*, note 185.

²⁰² *Ibid.*

²⁰³ Department of Veterans Affairs. “Homeless Veterans Program Overview,” note 191.

²⁰⁴ Department of Veterans Affairs, Office of Public Affairs and Media Relations, *Fact Sheet: VA Programs for Homeless Veterans*, note 185.

²⁰⁵ Department of Veterans Affairs. “Homeless Veterans Program Overview,” note 191.

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²⁰⁷ *Ibid.*

²⁰⁸ Kuhn and Nakashima, 16th Annual Progress Report, note 188.

²⁰⁹ Dougherty, Testimony before the United States Senate, note 197.

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²¹¹ *Ibid.*

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²¹³ Department of Veterans Affairs, Office of Patient Care Services, Office of Mental Health Services, *Supportive Services for Veteran Families (SSVF) Program Fact Sheet* (2010).

²¹⁴ Department of Veterans Affairs, National Call Center for Homeless Veterans. <http://www1.va.gov/HOMELESS/NationalCallCenter.asp>.

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²¹⁷ *Ibid.*

²¹⁸ The National Coalition for Homeless Veterans, Facts and Media; Background and Statistics, note 189.

²¹⁹ Raymond Jefferson, assistant secretary for veterans’ employment and training, United States Department of Labor, Testimony before the United States Senate, Committee on Veterans Affairs, Hearing on Ending Homelessness Among our Nation’s Veterans (March 24, 2010).

²²⁰ *Ibid.*

²²¹ Department of Veterans Affairs, Homeless Veteran Program, *Overview of Homelessness* <http://www1.va.gov/HOMELESS/Overview.asp>.

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²²⁴ R. Rosenheck, *Homeless Veterans: Epidemiology and Outcomes 1987–2009*, PowerPoint presentation, VA Homeless Veterans Summit (November 3, 2009).

²²⁵ Stiglitz, Testimony before the United States House of Representatives, Committee on Veterans Affairs, note 15.

²²⁶ D. Washington, E. Yano, et al. “Risk Factors for Homelessness Among Women Veterans,” *Journal of Health Care for the Poor and Underserved* 21 (2010): 81–91.

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Long-Term-Care Issues

LONG-TERM-CARE:

The VA Office of Geriatrics and Extended Care is responsible for meeting the diverse long-term-care needs of America's aging veteran population. To fulfill this responsibility, the Department of Veterans Affairs must follow Congressional mandates and be responsive to organizations that represent veterans.

The Aging of America's Veterans

Changes in the age composition and health status of the veteran population that the Department of Veterans Affairs will most likely serve will affect the needs and demand for VA health care. Further, medical care resource needs are not equally distributed among age groups in the population in need of long-term care. Future long-term-care consumption tends to rise sharply with age. According to VA's Information Technology Center (July 30, 2010), veterans 65 or older comprised 39 percent (9.2 million) of the total veteran population (23.1 million) in 2010. Additionally, according to information contained in the VA 2008 Long-Term Care Strategic Plan, 5.5 percent of veterans older than 65 (1.25 million) are 85 years old and older.

VA states in its Geriatrics and Extended Care (GEC) 2008 Strategic Plan, "The Department of Veterans Affairs is challenged as never before by unprecedented increases in the age, number and medical complexity of elderly veterans; the appearance of a younger, more health-savvy cohort of veterans with immediate and future extended care service needs; and increasing awareness that the U.S. healthcare workforce is under-equipped to care for those with chronic diseases and disabling conditions."

Based on a 2007 national survey²²⁹ conducted by the Veterans Health Administration (VHA) on its enrolled veteran population, the median age of enrollees was 63. Though 46 percent of the total enrolled veterans were 65 years and older, the number of veterans in this age group had steadily grown from 1.6 million in 1999 to 3.3 million in 2007. According to the GEC Strategic Plan, veterans ages 65 to 84 in 2011 are projected to reach more than 7.4 million, peak in 2015 at nearly 7.9 million, and gradually decline to 7.2 million in 2020. Furthermore, while an increase is expected in the number of enrolled veterans age 65 or older over the next decade, nearly 60 percent of the increase is projected to be among veterans age 85 or older. Most striking is that the enrollment of all veterans age 85 and older is projected to grow from 20 percent to 51 percent (to more than 1.2 million veterans) by 2013

then gradually decline to 1.1 million in 2020. This oldest segment of the veteran population will continue to demonstrate growth in demand for VA health-care services, including long-term care.

In addition to age, another key element of demand for VA medical care is the degree of reliance and dependence of enrolled veterans on the VA health-care system. Over the past few years, the growth rate of unique veteran patients who seek VA care has slowed and is projected to peak in 2012. However, aging World War II and Korean War veterans (median ages 83 and 76, respectively) are increasing their reliance on VA care, with a corresponding growth in consumption of pharmaceutical products to manage chronic conditions.²³⁰ It is interesting to note that the largest cohort of the VA enrollee population is of Vietnam-era veterans, with a median age of 60. Findings based on the 2001 National Survey of Veterans, published in *Military Medicine*,²³¹ indicate that veterans younger than 60 who served in Vietnam had worse self-reported health and higher rates of stroke than those who served elsewhere during that time. Vietnam veterans 60 years old and older had poor self-rated health and a higher risk for cancer than their peers. To validate those self-reports, many VA facilities are now beginning to absorb Vietnam veterans in need of long-term-care services for the chronic health problems of old age.

Special Innovations Are Needed for New, Severely Injured Veterans

A long-standing goal of VA has been to provide a full spectrum of health-care services to eligible veterans. With the influx of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans with severely disabling conditions, such as traumatic brain injury (TBI), VA is challenged to meet their long-term-care needs, particularly in the area of therapeutic residential rehabilitative care. OEF/OIF veterans place a higher value on their independence, are physically strong, and want resocialization and a return to their previous vigorous lives. They are part of a generation that was socialized differently than were their older veteran counterparts with chronic disabilities. Although these generational differences pose unique challenges to VA in the insti-

tutional care environment, these veteran generations share a natural preference to receive their long-term care in home and community settings where possible, so they can stay connected with their communities and loved ones.

According to the Institute of Medicine (IOM), the array of potential health outcomes associated with TBI suggests that injured service members and veterans will present long-term medical and psychosocial needs from the persistent physical disability as well as cognitive deficits and psychosocial problems that may develop in later life.²³² Access to rehabilitation therapies is essential—including psychological, social, and vocational services.

Although VA has established a comprehensive system of rehabilitation services for polytrauma and severe TBI patients that addresses acute and chronic needs that arise in the initial months and years after injury, protocols and programs to manage the devastating lifetime effects that many of these veterans must live with are not in place and have not been studied for either military or civilian populations. *The Independent Budget* veterans service organizations (IBVSOs) concur with the IOM that, as in other chronic health conditions, long-term management of TBI may be effective in reducing mortality, morbidity, and associated costs of VA's caring for this extraordinary population.²³³

VA testified before Congress that in 2007 it had developed and implemented Transitional Rehabilitation Programs at each polytrauma rehabilitation center (PRC). These facilities consist of 10-bed residential units with a homelike environment to facilitate community reintegration. The average stay in one of these rehabilitation units is approximately three months. Other specialized services developed by VA include the establishment of an “Emerging Consciousness” care path at the four PRCs for severe TBI patients who are slow to recover consciousness, as well as a program to evaluate ocular health and visual function.²³⁴ According to VA, it has also developed policies regarding comprehensive long-term care for post-acute TBI rehabilitation that include residential, community, and home-based components utilizing interdisciplinary treatment teams.²³⁵ However, despite these VA actions, in some cases it may be difficult to find appropriate residential placement options for a subset of severely injured OEF/OIF veterans who are ready for discharge from acute rehabilitation but are unable to return home. For many of these severely disabled individuals, neither medical foster home care nor nursing home placement is an appropriate option. In fact, the IBVSOs are not aware of any age-appropriate,

government-operated facilities for this unique younger patient population with polytraumatic injuries and brain injury. These types of facilities for long-term placement only exist in the private sector, but, again, they may not be appropriate placement options for a variety of reasons.

When we think of long-term care, we assume that these programs are reserved for the oldest veterans, near the end of life. Today, however, we confront a population of new veterans (many who are very young) in need of specialized forms of long-term care—a population that will need comfort and care for decades and that the government must provide. In discussion with VA officials, including facility executives and clinicians now caring for some of these injured veterans, it has become apparent to the IBVSOs and others that VA needs to accelerate its adaptation of existing long-term-care programs to better meet the individualized needs of a small, truly special, and unique population. VA's existing programs will not be satisfactory or sufficient in the long run. In that regard, the Department needs to plan to establish age-appropriate residential facilities, and additional programs to support these facilities, to meet the needs of this new population and those of their families. While the numbers of veterans sustaining these catastrophic injuries are very small, their needs are extraordinary. While today many of them are under the close supervision of the Department of Defense and its health agencies, their family members, and VA, as years go by VA will become the dominant source of their permanent care and social support system. In some cases VA may need to provide their permanent living arrangements in an age-appropriate therapeutic environment. That environment is not available in VA today.

However, it is reported that 85 acres of land are available for a proposed VA “Heroes Ranch” outside Tampa, Florida. If constructed, the Heroes Ranch would serve as a VA post-acute, long-term-care residential brain injury facility for active duty military service members and veterans referred from other treatment facilities. The location of the land for the proposed ranch is approximately 15 miles from the Tampa PRC. This cutting-edge residence would serve the most severely injured—including individuals in a vegetative state, patients with neurobehavioral problems, and individuals who require a structured day program for ongoing recovery after completing acute inpatient rehabilitation for polytrauma with brain injury. According to the proposal, a three-tiered program would include the following:

- post-acute long-term care for patients in a state of emerging consciousness who have completed 12 weeks of acute inpatient TBI rehabilitation and whose families are not ready, or are unavailable, to care for them at home;
- subacute residential rehabilitation in a safe environment to treat patients with residual neurobehavioral issues; and
- outpatient day rehabilitation in a structured environment for brain injured and neurologically and cognitively impaired veterans.

The IBVSOs understand that this proposal is pending consideration within VA but not yet formally approved or funded. Clearly, an off-site VA therapeutic residential facility of this type is needed to ensure the ongoing recovery of this uniquely and catastrophically disabled veteran population and as an aid to their families. It is our duty to ensure that proper lifetime, age-appropriate care centers are established within VA for these men and women who courageously served the nation and nearly made the ultimate sacrifice in that service.

However, we believe the success of such long-term care innovations would be critically dependent on the availability of local services, means of transporting veterans to access these facilities and services, and the ability of veterans' families and friends to assist in their care. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers, unless provided with the proper resources and support networks. The IBVSOs are aware that VA is moving to implement caregiver support services; more discussion can be found in "Family and Caregiver Support Issues Affecting Severely Injured Veterans" in this *Independent Budget*.

VA Community Living Center (Nursing Home Care) Capacity

With the exception of nursing home care, the majority of geriatric and extended-care programs are part of VA's uniform health benefits package and are available to all enrolled veterans as outlined in Public Law 104-262, the "Veterans' Health Care Eligibility Reform Act of 1996," and P. L. 106-117, the "Veterans Millennium Health Care and Benefits Act of 1999" (Millennium Act). The Millennium Act directed VA to expand noninstitutional (home and community-based) long-term care; maintain the "level and staffing of extended care services" that existed in 1998;²³⁶ and provide nursing home care services, as warranted, to a subpopulation of its enrolled veteran population based on medical need.

In its consideration to mandate nursing home care, Congress noted in 1999 that aging veterans' access to primary and acute-care services had expanded significantly since the publication in 1984 of a VA needs assessment titled "Caring for the Older Veteran."²³⁷ In contrast, VA extended-care and long-term-care programs were found not to have experienced comparable growth. Thus, Congress concluded that veterans who enjoyed markedly improved access to primary and hospital care had been put at greater risk with respect to needed nursing home care or alternatives to that care.

Congress also recognized then that the decentralization of decision making in VA on both regional policy and funding priorities conspired to make nursing home care a discretionary program. Congress found that VA's nursing home care units had been subjected to significant bed reductions. The result was marked variability from network to network in veterans' access to VA nursing home care and nursing home care alternatives.²³⁸ Similar issues remain today that existed during passage of the Millennium Act in 1999. These challenges continue to affect VA in its institutional and non-institutional care programs. VA is a supply-constrained health-care system that operates on a global budget. The allocation of these finite resources promotes organizational behaviors of the VA health-care system and ultimately affects the choices of veterans who are enrolled in VA health care. How those resources are allocated, the national policies and directives that affect them, the employment of performance measures, the way workloads are credited, the management of bed capacity, and the availability of services favor the provision of some VA health-care services over others. These factors have pushed to the forefront the problems attributable to the absence of policies regarding VA extended-care programs that meet the patients' preferences and clinical needs versus what services are made available. Because of these often-conflicting variables, the IBVSOs believe that resources and services in VA long-term-care programs are not synchronized, nor are they collaborative, and that veterans' interests are not best served as a consequence.

Certainly, VA has been increasing its capacity to provide noninstitutional long-term care as intended by its performance measure²³⁹ and increasing resources being directed to expand these services. While more needs to be done to stimulate VA extended-care services and ensure such services are tailored to meet patients' needs, the IBVSOs also applaud the Office of Geriatrics and Extended Care for formally recognizing the need for change, clarity, and better coordination in its 2008 Strategic Plan. Notably, the plan recognizes the eligi-

bility mismatch between inpatient and noninstitutional long-term care and possible adverse impact on VA's extended-care program.

The eligibility mismatch is based on which extended-care services are available to the enrolled veteran population. According to the Millennium Act, VA is required to provide nursing home care to a subpopulation of enrolled veterans that includes any veteran in need of such care due to a service-connected disability and to veterans enrolled in priority group 1(a)—any veteran rated 70 percent service-connected disabled or more, or one who is rated unemployable due to service-connected conditions, and who needs institutional nursing home care. Veterans in all other priority groups who need nursing home care, however, are considered by VA to be “discretionary,” where such care would be provided only if resources become available. Unlike nursing home care, VA makes available in its medical benefits package noninstitutional long-term care to all veterans who are enrolled for VA health care based on medical need. Despite VA's recognition of these contravening eligibility policies, the IBVSOs are greatly concerned with the strategic plan's assumptions in crafting the description of the problems created by such policies and VA's apparent lack of assertiveness in solving them with a legislative remedy.

According to VA, the eligibility mismatch “disadvantages those that the policies were written to benefit; both [eligibility policies] inadvertently direct resources imprudently; and both should be critically reassessed and revised.”²⁴⁰ Certainly, the IBVSOs agree that VA extended-care eligibility policies must be addressed, either within VA itself or by Congress. We also note that VA has been continuing to downsize its institutional long-term-care capacity and is not meeting the 1998 average daily census mandate still required by law.

VA suggests that because of its limited resources, the eligibility mismatch in the law forces it to pit institutional care programs against noninstitutional care alternatives. VA has attempted to meet the demand for nursing home care in the most cost-effective manner by favoring the use of non-VA community nursing home providers. This shift in capacity, by intent or accident, is evidenced by a five-year shift from VA-provided nursing home care to care provided by contract community nursing homes and to care provided by state veterans' homes. Despite this shift and even given policy directives^{241, 242} that called for all VA medical centers to provide the full array of noninstitutional services,²⁴³ we are unaware of any VA medical center that has met this requirement to date.

The IBVSOs believe Congress should further investigate this inconsistent eligibility policy and VA's inability to meet mandated capacity levels. We also believe VA has itself contributed significantly to these issues. First, the Department has historically failed to request the appropriate level of resources since enactment of the Millennium Act for its extended-care programs despite knowing that the demand for VA community living center beds by priority group 1(a) veterans would soon outstrip current bed capacity. Second, decentralized decision making across the VHA has turned the capacity mandate from a floor, as Congress legislated it, into a ceiling. Third, VA has not met the Millennium Act's requirement to develop and deploy a practical, user-friendly means for collecting, tracking, and analyzing characteristics of veterans served in VA's extended-care programs. Finally, VA has not created or fostered an environment that would stimulate innovations in long-term care to meet all enrolled veterans' needs and to lower costs and improve the quality of care.

Until such time as the Administration requests and Congress provides the resources necessary for VA to meet the current and projected demand for geriatric and extended-care services, and VA and Congress have addressed the fundamental flaws outlined above, the IBVSOs will continue to oppose any proposal to eliminate the minimum bed capacity for VA community living centers (CLCs). We strongly recommend that Congress enforce its average daily census mandate for VA, provide institutional care, and provide adequate funding to allow VA to expand its noninstitutional care services to meet current and future demand. Without restoration of the bed floor already required by statute, this elderly population of veterans and their growing needs for the full array of VA long-term-care programs will test the Department's ability to meet them in the future.

Continuing Concerns with VA's Inadequate Planning for Long-Term Care

The VHA Office of Geriatrics and Extended Care initiated a process of strategic planning with a national “State of the Art” (SOTA) conference in March 2008. On December 24, 2008, the GEC released its long-awaited strategic plan. The future of VA long-term care (LTC) is centered squarely on its stated mission statement, “VA will be the national leader in providing, improving, evaluating, teaching, and researching excellence in geriatrics and extended care for settings that are patient centered, integrated, and informed by individual preferences for settings that are safe, affordable, and as home-like as possible.”

Such an uncompromising statement begs the question, will VA indeed be the national leader in long-term care

as America moves forward in the 21st century? The IBVSOs believe that VA has the potential to become the national leader in long-term care, but this achievement would be dependent upon the GEC's ability to implement its own strategic plan. The IBVSOs offer their support to this effort, but such a plan requires the involvement and participation of the veteran community, including the IBVSOs.

VA's LTC strategic plan contains 4 goals, 10 strategies for achieving them, and 82 specific recommendations for addressing the strategies. More than 10 recommendations are being implemented as part of VA's current plan to present a cohesive approach, integrated with and dependent upon ongoing activities to address the needs of caregivers as well as mental health issues, dementia care, care in rural settings, and extended-care challenges of OEF/OIF injured veterans.

Additionally, VA's Strategic Plan identified seven most critical "key recommendations" as the first steps necessary to set in motion a series of improvements for more effective services. Full implementation of key recommendation six, "[d]evelop and deploy a practical, user-friendly means of collecting, tracking, and analyzing characteristics of the veterans served in extended care programs, as called for by the "Veterans Health Care and Benefits Act of 1999" and the 2003 VA Long-Term Care State-of-the-Art Conference," would be a giant step in the right direction.

The IBVSOs want to be supportive of the most recent GEC strategic plan. However, when we consider that the Millennium Act, the 2003 SOTA Conference, and the Government Accountability Office (GAO) have made recommendations to improve VA's LTC planning over a 10-year period, without much detectable progress by VA except expansion of nonbed alternatives, we conclude that VA may lack the will to move key recommendation six forward in an expedited manner.

For example, from 2003 to 2006, the GAO examined various aspects of VA long-term-care programs at the direction of both the House and Senate Committees on Veterans' Affairs. The reports, which continued to find limitations with VA long-term-care program data for planning and oversight, remain a cause of great concern. In addition, the reports also describe access to a complete continuum of VA long-term-care services that remains markedly variable from network to network.

In its November 2004 report,²⁴⁴ the GAO pointed out several problems that prevent VA from having a clear understanding of its program's effectiveness. In a follow-

up report²⁴⁵ issued in January 2006, the GAO reiterated the need for VA to estimate who will seek VA nursing home care and what their needs will be, including estimation of the number of veterans that will be eligible for nursing home care, based on law and VA policy, and the extent to which these veterans will be seeking care for long and short stays.

The GAO recommended that VA collect data for community nursing and state veterans' homes that are comparable to data collected on residents in VA community living centers, including their bed residence characteristics. The GAO also recommended that VA collect data on the number of veterans in these homes it is required to serve based on the Millennium Act. VA's position is that data other than eligibility and length of stay, such as age and disability, are "most crucial" for its long-term-care strategic planning and program oversight. To best serve the veteran patient population, the IBVSOs believe Congressional oversight is equally important to VA's need to manage and plan for its long-term-care benefits package, particularly in light of shifting patient workload with 65 percent of that care burden now being met by community nursing and state veterans' homes.

While the IBVSOs applaud the Department's expansion of noninstitutional long-term-care programs, such as home-based primary and home respite care, VA has resisted our call for changing its data collection and reporting conventions to better reflect the distinction in resources required for nonbed versus bed care programs. These are clearly different programs, yet VA seems to suggest its resource and cost implications to be roughly equal, with equal impacts—a suggestion refuted by the GAO. This type of data collection and reporting are not conducive to proper oversight by the IBVSOs and Congress, and produce a distortion of activity, workload, or resources expended. VA's response to the assertion in the GAO's 2004 report²⁴⁶ that VA workload measurement for home-based primary care does not accurately reflect the amount of care received by veterans specifies a combination of workload measures for home-based primary care and other long-term-care programs beginning in fiscal year 2005, including days enrolled in the program, the number of patients treated, and the number of visits veterans receive.

Congress has shown its concern about the weaknesses in VA long-term-care planning by rejecting earlier proposals by VA to establish a moratorium on state extended-care construction grants and to repeal the nursing home capacity mandate under P. L. 106-117. In fact, most recently Congress expanded VA's reliance on

state veterans' homes in passing P. L. 109-461, the "Veterans Benefits, Health Care, and Information Technology Act of 2006."²⁴⁷ The law requires VA to reimburse state veterans' homes for the full cost of nursing home care for a veteran with a 70 percent or greater service-connected disability rating, or for a veteran who is in need of such care primarily for a service-connected condition. It also ensures that veterans with a 50 percent or higher service-connected disability receive, at no cost, medications they need through VA. After a long delay, final regulations²⁴⁸ to implement the new authorities were issued April 29, 2009, but have since been discovered to be problematic for about one-half of the nation's state veterans' homes—those that participate in the Medicaid and Medicare programs. The National Association of State Veterans Homes and other supporters of the state veterans' home system have asked that Congress make technical and conforming amendments to the law to ensure these service-connected veterans receive the benefits intended in state homes. Alternatively, the IBVSOs urge the VA GEC program and representatives of the state home system to reach an accommodation or compromise that would be satisfactory to both parties and enable more service-disabled veterans to choose state veterans' homes for their care.

In light of VA's inability to meet mandated capacity requirements, coupled with its commitment to invest in alternative extended-care services, the IBVSOs are concerned about the delicate balance VA must achieve between institutional and noninstitutional long-term-care services to provide for veterans' health-care needs. We believe the information to be collected and reported should be that needed to support better strategic planning and program management and that would support more consistent policy decisions and justify future budget requests.

The VHA-modeled future enrollee demand for long-term-care services lacks reliability and, thus, was rejected for inclusion in the work of the Capital Asset Realignment for Enhanced Services (CARES) plan from 1999 to 2005. Also, the limitation of this model was evidenced by VA's supplemental request in FY 2005 for \$1.997 billion, of which \$600 million was to be used to correct for the actual cost of long-term care versus VA's earlier estimate. One of the most important underlying assumptions needed for VA's long-term-care planning model relates to understanding which enrollees choose to use VA extended-care services and why they make those choices. Until the necessary programmatic and patient population information is collected, validated, and analyzed, the IBVSOs be-

lieve VA will continue to struggle to effectively plan and provide for the immediate and future long-term-care needs of America's veterans. VA retains a duty to clearly advise Congress about the needs and requirements to provide long-term care. Without clear advice and advocacy by VA, Congress is unable to conduct proper oversight. We believe VA should be the advocate for veterans' long-term-care needs, not simply a provider.

VA's Long-Term-Care Programs

VA provides institutional (nursing home) care in three venues to eligible veterans and others as resources permit. VA provides nursing home care in VA-operated nursing homes (now termed community living centers) under contracts with private community nursing homes and reimburses for veterans' care on a per diem basis in state veterans' homes. Additionally, VA provides an array of noninstitutional (home- and community-based) LTC programs designed to support veterans in their own homes. Additionally, the long-term-care philosophy adopted by VA is to provide services in the "least restrictive setting." According to the VHA,²⁴⁹ the aging veteran patient population will result in a 20–25 percent increase in use for both nursing home and home- and community-based services through FY 2012. The VHA currently concentrates more than 90 percent of its long-term-care resources on providing nursing home care. However, among veterans who receive long-term care from all sources, 56 percent receive care in the community. VHA's experience with providing nursing home care in its CLCs on a mandatory basis to service-connected veterans rated 70 percent or higher suggests that only 60–65 percent will choose VHA-provided care, primarily due to geographical considerations and cost. These findings support the increased projected use for long-term care through home- and community-based services.

VA's current policy to increase noninstitutional services is supported by veterans, their families, and by organizations that represent them, including the IBVSOs. However, the reality is that VA's own data forecast that demand for long-term-care services will continue to grow over the next decade. Inevitably, thousands of veterans who are currently living in community settings, with the support of VA's noninstitutional services today, eventually will need VA institutional services. The IBVSOs believe the demand for VA nursing home care is growing, not only because of the expanding population of veterans 85 years of age and older, but also because of the complications related to the secondary conditions associated with military service that often present later in life. Accordingly, the IBVSOs are greatly concerned about VA's inability to maintain its

CLC capacity at the 1998 level of 13,391 average daily census (ADC) as mandated by P. L. 106-117. In particular, the decline in VA's CLC capacity year after year makes it more difficult to reactivate VA nursing home beds to serve veterans in need of such care.

Other equally disturbing issues exist that are aggravated by the continued reduction in CLC capacity along with the shift to provide institutional long-term care through community nursing homes (CNHs) and state veterans' homes. For example, VA's "partnership" with the State Veterans Home Program is in essence twofold: VA's on-site inspections to ensure quality of care in state veterans' homes and per diem payments to the states as they care for their veterans' long-term-care burdens. While provisions in P. L. 109-461 have enhanced this relationship, the majority of VA facilities continue to deny access to enrollment and to specialized VA care for residents of state veterans' homes on the basis that once these veterans are placed and certified by VA, the homes are responsible for comprehensive care, not VA. Moreover, most VA medical centers do not refer enrolled veterans to state veterans' homes even when one is located close to the veteran's community, family, and friends. The lack of a true partnership between VA and state veterans' homes affects the ability of veterans to receive patient-centric long-term care. In addition, VA has become highly efficient at converting veterans it has placed in CNH to Medicaid status for payment purposes without establishing a formal tie to the Centers for Medicare & Medicaid Services (CMS) or with the states to oversee that unwritten policy.

Clearly, much work remains to be done in VA's long-term-care program; however, Congress should conduct oversight and VA must maintain a safe margin of CLC capacity that will meet the needs of elderly veterans who can be expected to transition from VA noninstitutional care programs to VA nursing home care in the near future.

VA Institutional (Nursing Home) Long-Term-Care Services

Community Living Centers

VA owns and operates 133 CLCs nationwide, ranging in size from 20 beds to 240 beds. As mentioned previously, VA's nursing home average daily census this year is below that of the previous year. VA third quarter 2010 nursing home care workload data reflect an ADC of 10,165 (see table 5).

VA's national recognition as a leader in providing quality nursing home care is being challenged by its own emphasis on post-acute care at the expense of maintaining

Table 5. LTC-ADC VA's Community Living Center (Nursing Home) Care Program

2010 (<i>Third Quarter Data</i>)	10,538
2009 (<i>Third Quarter Data</i>)	10,538
2008 (<i>Projected ADC</i>)	10,538
2007	10,926
2006	11,434
2005	11,548
2004	12,354
1998 (PL 106-117 Mandate)	13,391
ADC Decline from PL 106-117 Mandated level: (3,226)	

CLC capacity. The IBVSOs believe this approach is short-sighted considering the increasing number of veterans most likely to need long-term care. According to VA, approximately 75 percent of priority group 1(a) veterans needing institutional extended care (ranging from 72 to 90 percent by Veterans Integrated Service Networks (VISNs)) received it in VA community living centers in 2008, yet the average census in VA CLCs is approximately 10 percent below capacity. It is widely regarded that much of nonutilization of the nursing home benefit by priority group 1(a) veterans is due to their preference for and ability to pay for assisted living, a form of extended care VA neither currently offers nor is currently authorized to purchase, yet this has not been rigorously established. Further, Congress has mandated that VA must maintain its CLC capacity at the 1998 ADC level of 13,391, but VA has not done so despite testifying in 2007 that it expects to sustain existing capacity in its own CLCs.²⁵⁰

The IBVSOs are concerned that the reduced number of long-stay patients and increase in the number of short-stay patients VA treats in community-living centers will continue to drain needed capacity to treat patients who need longer lengths of stay. However, VA has chosen to ignore the Congressional mandate without adequate justification, and, to date, Congress has not intervened.

VA's Contract Community Nursing Home Care Program

VA has contracts with more than 2,500 private community nursing homes (CNHs) located throughout the nation. In 2005, the average daily census for VA's CNH program represented 13 percent of VA's total nursing home workload. The CNH program often brings care closer to where the veteran actually lives, closer to his or her family and friends. Since 1965, VA has provided nursing home care under contracts or purchase orders. The CNH program has maintained two cornerstones: some level of veteran choice in choosing a nursing home

and a unique approach to local oversight of community nursing homes.

Table 6. LTC-ADC VA's Community Nursing Home Program	
2010 (Third Quarter Data)	7,177
2009 (Third Quarter Data)	5,046
2008 (Projected ADC)	4,787 (projected)
2007	4,439
2006	4,395
2005	4,254
2004	4,302
2010 ADC Increase over 2009: 2,131	

The IBVSOs have ongoing concerns about the quality of VA contract community nursing home care.²⁵¹ Once veterans are placed in CNHs, with exception of annual home inspections, VA is challenged to directly monitor veterans' health status and quality of care or to ensure that these veterans receive their rightful benefits. VA must do more to ensure that the quality of care in these facilities meets the highest standards and that it remains the responsible party to facilitate medical information transfer and coordination of other VA benefits and services. Veterans and their families must be assured that all aspects of care meet the individual veteran's needs. For example, veterans with catastrophic disabilities, such as spinal cord injury/dysfunction (SCI/D), blindness, and PTSD and other mental health challenges, must receive care from specialty trained staff. Their unique medical care needs require access to physicians, nurses, and social workers who are knowledgeable about the specialized care needs of these veteran groups.

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

VA Nursing Home Care Provided in State Veterans' Homes

The State Veterans Home Program currently encompasses 137 nursing homes in 50 states and Puerto Rico, with more than 28,000 nursing home and domiciliary beds for veterans and their dependents. State veterans'

homes provide the bulk of institutional long-term care to the nation's veterans. The GAO has reported that state homes provide 52 percent of VA's overall patient workload in nursing homes, while consuming just 12 percent of VA's long-term-care budget. VA's authorized average daily census for veterans in state veterans' homes was 19,681 as of the third quarter of FY 2010 (see table 7).

VA holds state homes to the same standards it applies to the nursing home care units it operates. State homes are inspected annually by teams of VA examiners, and the VA Office of Inspector General also audits and inspects them when determined necessary. State homes that are authorized to receive Medicaid and Medicare payments also are subject to unannounced inspections by the CMS and to announced and unannounced inspections by the inspector general of the Department of Health and Human Services.

2010 (Third Quarter Data)	19,681
2009 (Third Quarter Data)	19,196
2008 (Projected ADC)	19,208 (projected)
2007	18,349
2006	17,747
2005	17,794
2004	17,328
2010 ADC Increase over 2009: 485	

VA pays a small per diem payment for each veteran residing in a state home, less than one-third of the average cost of that veteran's care. The remaining two-thirds is a mix of funding, including state support, Medicaid, Medicare, and other public and private sources.

By right, service-connected veterans should be the top priority for admission to state veterans' homes, but traditionally they have not considered state homes an option for nursing home services because of the lack of VA financial support and personal liability for cost-sharing. To remedy this disincentive, Congress provided authority for full VA payment in P. L. 109-461.

In addition to per diem support, VA helps cover the cost of construction, rehabilitation, and repair of state veterans' homes, providing up to 65 percent of the cost, with the states providing at least 35 percent. Unfortunately, in FY 2007 the construction grant program was funded at only \$85 million, the same amount Congress had provided in FY 2006. Based on a current backlog of nearly \$1 billion in grant proposals (including hun-

dreds of millions in pending life and safety projects) and with thousands of veterans on waiting lists for state beds, *The Independent Budget for Fiscal Year 2008* recommended no less than \$150 million for this program. The IBVSOs are grateful Congress responded and provided \$165 million for FY 2008. For FY 2009, *The Independent Budget* recommended \$200 million for the state veterans' home construction grant program, and Congress provided \$175 million. In FY 2010, Congress provided \$100 million for this program, and in the American Recovery and Reinvestment Act, Congress provided an additional \$100 million for state home construction grants. We remain grateful for these helpful allocations. VA recently reported that 49 approved construction projects to create new, expand, or renovate and modernize existing state homes are currently under way. For FY 2011, Congress is poised to appropriate \$85 million in additional funds to support this grant program.

For FY 2012, *The Independent Budget* recommends the state extended-care construction grant program be funded at \$200 million to keep pace with the need to make these important facilities safe, modern, and available for veterans who choose them for their long-term care. However, we recognize that, with 49 construction projects under way now and \$85 million more soon available in the appropriations pipeline to fuel more projects, VA and the states—many of which are in budgetary deficit—may not be able to wisely spend any higher level of funding than we recommend for FY 2012.

VA Noninstitutional Long-Term-Care Services

VA offers a wide spectrum of noninstitutional LTC services to veterans enrolled in its health-care system. From 1998 to 2002, VA's ADC in home- and community-based care increased from 11,706 to 17,465. In FY 2003, 50 percent of VA's total long-term-care patient population received care in noninstitutional care settings. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, home respite care, home hospice care, and community residential care.

In recent years VA has been increasing its noninstitutional (home- and community-based) budget and services through the use of key performance measures for an annual percentage increase of noninstitutional long-term-care average daily census, using 2006 as the baseline of 43,325 ADC. As mentioned previously, simply using the percentage increase²⁵² is based on the ADC of veterans enrolled in home- and community-based care

programs (e.g., community residential care, home-based primary care, contract home health care, adult day health care (VA and contract), homemaker/home health aide services, and care coordination/home telehealth) and does not adequately capture the workload for strategic planning, program management, policy decisions, budget formulation, and oversight.

VA must also take action to ensure that these programs, mandated by P. L. 106-117, the "Veterans Millennium Health Care and Benefits Act," are readily available in each VA network. In May of 2003, the GAO reported, "VA service gaps and facility restrictions limit veterans' access to VA noninstitutional care."²⁵³ The report stated that of the 139 VA facilities reviewed, 126 do not offer all of the six services mandated by P. L. 106-117. In order to eliminate these service gaps, VA must survey each VA network to determine that all of its noninstitutional services are operational and readily available. Despite this information, VA's LTC Strategic Plan neglects to provide a clear and specific path to ensure systemwide compliance.

The success of noninstitutional long-term care is critically dependent on the availability of local services and ability of veterans' family and friends to assist in their care. Family caregivers play an important role in health care, but need regular breaks to maintain their own health and well-being. VA respite care is one of the few services broadly available with a primary focus on supporting family caregivers. Caregiver burden (often referred to as "burnout") is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers. The IBVSOs applaud Congress for authorizing VA to conduct a pilot program on improvement of caregiver assistance services,²⁵⁴ and look forward to the lessons learned from these initial pilots, which we hope will inform VA's implementation of the caregiver supports and services Congress more recently authorized in P. L. 111-163. More discussion on the caregiver topic may be found at "Family and Caregiver Support Issues Affecting Severely Injured Veterans," in this *Independent Budget*.

The IBVSOs support the expansion of VA's noninstitutional long-term-care services and the adoption of innovative approaches to expand this type of care. In many cases noninstitutional long-term-care programs can obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost-effective. However,

Table 8. LTC-ADC for VA Noninstitutional Care Programs (Third Quarter 2010 Data)

Programs	2005	2006	2007	2008	2009	2010	I/D Over 2006
HBPC	11,594	12,641	13222	16523	20621	24143	3522
PSHC	3075	2490	2656	3319	4093	4378	285
HHHA	6584	5867	6631	9321	13307	15804	2479
VA ADHC			15	335	327	335	8
CADHC	1762	1304	1884	2019	2544	2806	262
SADHC					21	21	NONE
SCI-H				598	721	749	28
HH	194	427	553	858	949	973	24
HR	99	118	254	418	672	681	9
GEM					52		
CRC	6810	3692	5069	4248	4550		
CCOOR/TH					22539		
Total		26,539	30,284	37,639	50,096	49,980*	

Note: I/Differ = Increase or (Decrease) 2010 over 2009

*The total noninstitutional care workload numbers are lower than the total for 2009 because VA did not provide the workload numbers for the GEM, CRC, CCOOR/TH.

the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

Future Directions for VA Long-Term Care

The face of long-term care is changing, and VA continues to work within resource limitations to provide variations in programming that meet veterans' needs and preferences. The IBVSOs expect VA to modify existing programs and develop new alternatives as financial resources permit. New horizons for VA long-term care include the items discussed in the following subsections.

Culture Change in Community Living Centers

Concerned by the perceived devaluation of the elderly and those who care for them, formal and informal meetings of a small group of health-care providers and administrators led to the creation of a national movement within the VHA. This movement aims to engage staff and veterans across the country in transforming the culture of long-term care to a resident-centered model providing compassionate and comprehensive care to veterans in a homelike environment. The cultural transformation is also expected to ensure increased satisfaction for both nursing home residents and staff at all 134 VA community living centers across the United States. The IBVSOs believe VA should continue this progress; ensure VA medical center executive staffs and the CLC nurse managers and staffs are involved and committed to this initiative; and evaluate the results with a public report measuring the increased

satisfaction of residents and staff with VA community living centers' new approach to care of the elderly.

Hospice and Palliative Care

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings for persons in the terminal phases of disease. Hospice is intended to allow these individuals to live as fully and as comfortably as possible. The program emphasizes managing pain and other physical symptoms, addressing the psychosocial problems, and providing for the spiritual comfort of the patient and the patient's family or significant others. Services are provided by an interdisciplinary team of trained professionals and dedicated volunteers. Bereavement care is also available to the family following the death of the patient. Hospice services are available 24 hours a day, seven days a week, and are provided across multiple VA and community settings and in veterans' private residences.

While hospice and palliative care are part of VA's medical benefits package, only in recent years was hospice made into a formally structured program. Expansion and outreach was greatly assisted through the Hospice-Veteran Partnership, a local coalition of VA facilities, community hospices, veterans service organizations, and volunteers. Community agencies have been made aware of this VA benefit through the Hospice-Veteran Partnership and are actively identifying veterans within the populations they serve.

VA is now providing hospice and palliative care to a growing number of veterans throughout the country. More than 8,000 veterans were treated in designated hospice beds at VA facilities in fiscal year 2010, and thousands of other veterans were referred to community hospices to receive care in their homes. In addition, the number of veterans receiving hospice care in their homes paid for by VA increased by 6 percent this past fiscal year.

The IBVSOs applaud VA for its commitment to make this service available to all veterans who require such compassionate care. Nearly half of all veterans who died in VA facilities received care from a palliative care team prior to their death, although such services are provided at only about one-fourth of all U.S. hospitals. Because of the large number of World War II and Korean War-era veterans and a tripling of the number of veterans over the age of 85, the increase in the need for hospice care and palliative care is expected to continue. Furthermore, we applaud Congress's recent efforts to improve access to VA hospice and palliative care services by prohibiting VA from collecting copayments for hospice care provided to enrolled veterans in all settings.²⁵⁵

However, some gaps remain that are a cause for concern. Through the use of palliative care consultation services at each of its medical centers and inpatient hospice care in many of its nursing homes, VA is providing hospice and palliative care to a growing number of veterans throughout the country. While VA hospice and palliative care is to be available by direct provision or by purchase in the community, VA must ensure all its medical centers have a palliative care consultation team consisting of, at a minimum, a physician, nurse, social worker, chaplain, and administrator.²⁵⁶ Moreover, when a veteran who is dually eligible for VA hospice and Medicare/Medicaid hospice is referred to a community hospice agency, the veteran is given a choice as to which will pay for hospice care.

Although the IBVSOs believe a veteran's preference should be honored, we are concerned that the choice of payer can affect the types of services provided, the quality of care, and financial expenses the veteran and dependents may incur. VA hospice care benefit is a greater benefit since it is part of a VA comprehensive medical care benefits package designed to be patient-centric and to treat the whole patient. For example, when a veteran chooses Medicare as the payer of hospice care, Medicare will not pay for any treatment or medications not directly related to the hospice-related diagnosis. The community hospice would need to tell the veteran and his or her spouse or significant other

which treatments or medications are or are not covered. Further, under the Medicare hospice benefit, all care that veterans receive for their illness must be given by the community hospice. Therefore, the veteran must be discharged out of Medicare hospice before any other treatments or medications can be given to ensure comfort and quality of life. Finally, the IBVSOs believe both the community hospice agency and VA must ensure that when the veteran dies his or her dependents are made aware of all VA survivor benefits to which they may be entitled.

Respite Care

According to VA, respite care is a program in which brief periods of care are provided to veterans by VA in order to give veterans' regular caregivers a period of respite, or rest. Respite care services are primarily a resource for veterans whose caregivers are neither provided respite services through, nor compensated by, a formal care system (i.e., Community Residential Care program agreements, Medicaid waiver programs, hospice programs, and others for which the veteran is dually eligible).

The National Family Caregiver Support Program²⁵⁷—along with Aged/Disabled (A/D) Medicaid Home and Community-Based (HCBS) waivers and state-funded respite care and family caregiver support programs that provide the bulk of public financing to support family caregiving, including respite care—defines respite care as a service to provide temporary relief for caregivers from their care responsibilities. Respite care is considered the dominant service strategy to support and strengthen family caregivers under the A/D Medicaid HCBS waiver program. In a survey conducted on A/D Medicaid waiver programs that asked respondents to choose from a list of 20 items of the services their program provides specifically to family caregivers, respite care received a 92 percent positive response, followed by information and assistance, homemaker/chore/personal care, and care management/family consultation at 48 percent each.²⁵⁸

The Department of Defense provides respite services to injured active duty service members, including National Guard/reserve members injured in the line of duty. TRICARE now offers primary caregivers of active duty service members rest, relief, and reprieve, authorized by section 1633 of P. L. 110-181, the "National Defense Authorization Act for Fiscal Year 2008." This respite benefit helps homebound active duty service members who need frequent help from their primary caregivers. If the injured service member's treatment plan requires a caregiver to intervene more than twice in an eight-

hour period, the caregiver can receive respite services for a maximum of eight hours of respite per day, five days a week. Active duty service members or their legal representatives can submit receipts for reimbursement of respite care services that began on or after January 1, 2008, by a TRICARE-authorized home health agency. This benefit serves to mirror other supplementary TRICARE benefits that provide respite services to active duty family members under TRICARE Extended Care Health Option (ECHO)²⁵⁹ and TRICARE ECHO Home Health Care, which are created to better align the DOD's existing unlimited home health agency and skilled nursing facility benefits to mirror the benefits and payment methodology used by Medicare.

VHA Handbook 1140.02, released on November 10, 2008, seeks to address concerns about the availability of respite in both institutional and noninstitutional settings; however, some limitations are still problematic. For example, while VA policy allows respite care services to be provided in excess of 30 days per annum, requested extensions must be justified by unforeseen difficulties and must be approved by the VA medical center director with jurisdiction. Moreover, long-term-care copayments are required for respite care regardless of the setting or source of such care. The IBVSOs believe VA should enhance this service to reduce the variability across the continuum of VA care by, at minimum, enabling attending physicians to approve respite care in excess of the annual limit when medically necessary, adding flexibility and discretion. Also, we recommend eliminating copayments for respite services because they provide a disincentive to the use of this valuable tool that supports caregivers.

Medical Foster Homes

In March 2008, VA testified before the Senate Committee on Veterans' Affairs regarding an initiative to be implemented nationally that includes the Medical Foster Home Program. This program identifies families who are willing to open their homes and care for veterans who need daily assistance and are no longer able to remain safely in their own homes but do not want to move into a nursing home. It is provided as an adult foster home arrangement on a permanent basis, supported by VA's home-based primary care team that provides oversight and regular visitation.

VA considers this is a long-term commitment between the veteran and the caregiver. The veteran may live in foster care the remainder of his or her life, and the partnership between VA's Foster Care Program and Home-Based Primary Care is a safeguard against abuse. The first foster home program was started in Little Rock, Arkansas, in 1999, followed by programs in Tampa,

Florida, and San Juan, Puerto Rico. Using New Clinical Initiative Funding in 2000, VA developed medical care foster homes and provided minimal funding for two years. In 2002 VA had 35 foster homes and 45 patients. Currently, the VHA has 38 facilities in 14 VISNs with medical foster home programs, and in 2008, Congress granted funds for 33 additional sites.

Medical foster homes can be owned or rented by the caregiver, and the home is limited to three or fewer residents (veterans and nonveterans) receiving care. The range of fee payments to medical foster home caregivers has increased from \$1,000 to \$1,800 per month in 2002 to \$1,500 to \$2,500 based upon the level of care needed by the veteran—for example, a cost of \$1,500 for someone with mild cognitive impairment who is independent in activities of daily living but requires supervision, to \$2,500 for someone who is incontinent, bed-bound, and needs to be turned every four hours. This payment is made by the veteran directly to the caregiver monthly and includes room and board, 24-hour supervision, assistance with medications, and whatever personal care is needed.

VA believes medical foster homes to be cost-effective alternatives to nursing home placement because veterans must pay for their medical foster care using Social Security, private pensions, and VA pensions, service-connected disability compensation, or other sources of funds. Under current law, if a veteran receiving a nonservice-connected pension has no dependents, is covered by Medicaid for nursing home care, or occupies a VA nursing home bed, the pension payment exceeding \$90 per month is suspended.²⁶⁰ However, this policy does not apply to veterans in nursing facilities who receive service-connected disability benefits. The IBVSOs are concerned that veterans living in the medical foster home are required to pay for their stays in the homes using personal funds, including their VA compensation payments.

The newest generation of veterans, from the Gulf War to today's OEF/OIF veterans, has different expectations than their counterparts of the past. In general, they are computer literate, well educated, want more involvement in their own care, and want to control their own destinies. As these veterans age and begin to need long-term-care services, this will make VA's and our jobs much more challenging. Younger veterans with catastrophic injuries must be supported by forward-thinking administrators and staff who can adapt services to youthful needs and interests. The entire environment must be changed for these individuals, not just marginally modified. For example, therapy programs, surroundings, meals, recreation, and policy must be

changed to adapt to a younger, more vibrant resident. Unfortunately, VA's Long-Term-Care Strategic Plan does not explain how VA will adjust services to care for younger veterans.

My HealtheVet

VA's Office of Geriatrics and Extended Care should aggressively promote VA's My HealtheVet program. This VA online program can greatly enhance an aging veteran's quality of life and help ensure the quality of medical care he or she receives from VA. My HealtheVet is a veteran-centered proactive website that encourages veterans to be more involved in their own health and the care they receive from VA.

VA's Care Coordination Program

VA's intent is to provide care in the least restrictive setting that is appropriate for the veteran's medical condition and personal circumstances. Further collaboration between programs within Geriatrics and Extended Care and those of the Office of Care Coordination/Home Telehealth can continue to produce positive results by providing services that are tailored to meet individual veterans' needs.

VA has been investing in a national care coordination program for the past three years. The program applies care and case management principles to the delivery of health-care services with the intent of providing veterans the right care in the right place at the right time. Veteran patients with chronic diseases, such as diabetes, heart failure, 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 VA medical centers and clinics, using videoconferencing technologies; and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2 percent to 3 percent of patients who are frequent clinic users and could require urgent hospital admissions if their conditions deteriorate. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse, or a social worker. Sometimes physicians serve as care coordinators in the case of complex patients.

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

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

VA Long-Term Care for Veterans with Spinal Cord Injury/Dysfunction

Both institutional and noninstitutional VA long-term-care services designed to care for veterans with spinal cord injury/dysfunction (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 in 2003 a VA survey indicated that an estimated 990 veterans with SCI/D were residing in non-SCI/D designated VA nursing homes. However, as *The Independent Budget for Fiscal Year 2012* was being developed, VA had not yet identified the exact locations of these veterans in its long-term care strategic plan. The special needs of these veterans often go unnoticed and are only discovered when the patient requires admission to a VA medical center for treatment.

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

Currently, VA operates only five designated LTC facilities for patients with SCI/D, and none of these facilities is located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility, Chicago (28 staffed beds); Castle Point, New York (16 staffed beds); and at the Tampa SCI/D Center (30 beds). Unfortunately, these 151 beds are usually filled, and there are waiting lists for admission. These five VA SCI/D long-term-care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA CARES initiative has called for the creation of additional long-term care beds in three new locations—20 in Cleveland, 20 in Memphis, and 30

in Long Beach, California—these additional services are not yet available and would provide only 30 beds west of the Mississippi River. If established, these new long-term-care beds would present an opportunity for VA to refine the paradigm for SCI/D long-term-care design and to develop a new SCI/D LTC staff training program.

Assisted Living

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

In November of 2004, VA reported to Congress the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by Public Law 106-117. The Assisted Living Pilot Program (ALPP) was carried out in VISN 20. VISN 20 includes Alaska, Washington, Oregon, and the western part of Idaho. It was implemented in seven medical centers in four states: Anchorage; Boise; Portland; Roseburg, Oregon; White City, Oregon; Spokane; and Puget Sound Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

The VA report on the overall assessment of the ALPP stated, "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."

VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority to provide assisted living services, believing this is primarily a housing function. The IBVSOs disagree and believe that housing is only one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is one part. VA already provides housing in its domiciliary and nursing home programs, and is providing housing by definition in all its homeless veterans' assistance programs. An assisted living benefit should not be prohibited by VA on the basis of its housing component.

The IBVSOs acknowledge and appreciate that Congress authorized a new VA assisted living pilot project in Section 1705 of title XVII of the "National Defense Au-

thorization Act for FY 2008." We are hopeful that VA and the DOD will move forward to establish this program, understanding that its intent is aimed at providing alternative therapeutic residential facilities to severely injured OEF/OIF veterans. However, this new program also provides an important new opportunity to further study the feasibility and worth of assisted living as an alternative to traditional institutional services for all veterans, young and old, who may need these valuable services.

Summary

While it has numerous parts and functions as explored above, and provides vital services to hundreds of thousands of veterans at significant cost each year, VA long-term care programs are functioning today in a fractious, discordant manner within the Veterans Health Administration, and therefore they are not operating at an optimal level to serve the best interests of veterans. Veterans with severe service-connected disabilities (those 70 percent disabled or more, or unemployable, and those who need care for service-connected disabilities) are now reported to be saturating the VA's existing community living center bed capacity, in effect blocking other veterans from the in-house VA nursing care CLC option (even for temporary convalescence after hospitalization). Some of those veterans are being referred to community nursing homes initially under VA contract, and ultimately under Medicaid financing for those eligible who need longer term bed stays, while others are referred to VA Home-Based Primary Care (HBPC) for home visits and case management (or to a VA bed in an acute or subacute care bed section). The IBVSOs are concerned that the HBPC program in most VA locales is available only to veterans in need who reside within a reasonable driving distance from the host VAMC. This means that veterans who live any considerable distance away from the HBPC team cannot avail themselves of this important alternative to institutionalization. The HBPC program is clearly a part of long-term care but is not consistently available. Thus, the IBVSOs conclude that care coordination for these patients can be challenging to all concerned.

Also, very few veterans, whether service-connected or not, are referred directly by VA facilities to state veterans' homes as a VA aftercare option, whether for short-term convalescence or longer terms of residency. Although they called their relationship a "partnership," a wall of separation exists between VA and the states on long-term care. Also, for individuals who are service-connected, some of the state homes (those participating in Medicaid—about 63 facilities to date) will not accept these veterans or greatly restrict their admissions

because of the stalemate with VA over implementation of P. L. 109-461 and reimbursement policy from that act. In medical foster homes, all veterans, including service-connected veterans, are being required to defray major parts of the cost. Finally, in respite, strict time limits and copayments serve as a disincentive to the caregivers who might want and need to use that benefit, thus making it unavailable to many who need it.

We sense a friction or tension between and among these efforts that, unless reformed, could impart harm to the very veterans these programs were designed to serve. We believe strong justification exists for Congress to provide intensive oversight of these fractious elements of VA's long-term care programs, in an effort to make them more logical, seamless, and coordinative, for the veterans VA is charged to serve, so that veterans in need of long-term care can be placed in the most appropriate setting to receive these services.

After investigation, Congress may find that legislation is warranted to take corrective action or remove inconsistencies or obstacles in either current statutory language, or in VA's flawed implementation of Congressional intent in establishing and maintaining VA's vital long-term care programs. The IBVSOs invite that attention.

Recommendations:

For the Office of Geriatrics and Extended Care's (GEC's) 2008 Strategic Plan to be successful, VA must implement implementation of many of the plan's recommendations with exception to the recommendation to revise the Congressionally mandated nursing home capacity level.

VA should explore the impact inconsistent eligibility policies may have on its long-term-care programs and veterans access to extended-care services.

VA must develop a more robust long-term-care planning model to ensure that veteran tracking, strategic planning, program management, policy decisions, budget formulation, and oversight are able to meet the growing need of veterans of all ages for long-term care.

VA should develop the Heroes Ranch facility in the Tampa, Florida, area and establish similar long-term, therapeutic residential facilities in other areas of the nation with concentrated populations of severely injured veterans with polytrauma and traumatic brain injury.

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 GEC's 2009 Long-Term Care Strategic Plan. Congress must enforce its average daily census mandate for VA-provided institutional care from Public Law 106-117 and provide adequate funding to allow VA to expand its noninstitutional care services to meet current and future demand.

VA and Congress must sustain the state extended-care construction grant program in state veterans' homes. To that end, Congress should authorize and appropriate \$200 million in such grant funds to be awarded in FY 2012.

Congress must conduct oversight on VA's relationship and use of community nursing homes to provide long-term care to disabled veterans, and VA must do a better job of tracking the quality of care provided in VA contract community nursing homes.

Given the evident growth in demand and to protect traditional VA institutional programs, Congress must provide additional resources and VA must increase its capacity for noninstitutional and home- and community-based care.

The Veterans Health Administration must update its noninstitutional extended-care directive and information letter to ensure that each noninstitutional long-term-care program mandated by P. L. 106-117 is operational and available across the entire VA health-care system.

VA should continue the "culture change" transformation; ensure that VA medical center executive staff and the community living center nurse manager and staff are involved and committed to this initiative; and issue a report measuring the expected increased satisfaction in VA community living centers.

VA should ensure that all veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be provided, at a minimum, all services within the VA medical benefits package regardless of the payer of services.

VA should ensure all dependents of veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be made aware of all ancillary VA benefits to which they may be entitled.

VA should improve the availability of respite services to reduce the variability across the VA continuum of care by, at a minimum, allowing attending physicians to approve respite care in excess of 30 days on a discretionary basis, making more flexible the number of hours or days of respite care provided to veterans' caregivers and eliminating copayments for respite services.

VA should expand the care-coordination program to reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

VA should not require veterans to use personal funds, such as their service-connected disability compensation, to avail themselves of the Medical Foster Home Program.

The VA GEC should encourage veterans to use VA's My HealtheVet website.

Serious geographical gaps exist in specialized nursing home care services for veterans with spinal cord injury or spinal cord dysfunction (SCI/D). As VA advances construction planning for VA nursing homes, it must provide a minimum of 15 percent bed space to accommodate the specialized spinal cord injury nursing home needs nationally.

VA must develop a more detailed facility-by-facility mechanism to locate and identify veterans with SCI/D and other catastrophically injured veterans residing in long-term-care facilities that were not designed for veterans with SCI/D.

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

VA's 2004 Assisted Living Pilot Program report seemed most favorable in its conclusions. To gain further understanding of how the ALPP can benefit veterans, a similar pilot program should be authorized in at least three Veterans Integrated Service Networks with a high percentage of elderly veterans who might benefit from assisted living. VA should use the authority provided in the "National Defense Authorization Act for Fiscal Year 2008" in establishing such pilots to evaluate assisted living as an innovative option for meeting long-term-care needs of elderly veterans.

Congress should consider providing an assisted living benefit to veterans as a new alternative to nursing home care and urge consideration of such a program.

Congress should engage in strong oversight of VA's long-term-care programs in an effort to improve coordination of care and seamless operation of the now-frictional and discordant situation extant in VA that reduces VA's effectiveness in providing the nation a model of delivery in long-term-care services.

²²⁹ Veterans Health Administration, 2007 *Survey of Veteran Enrollees' Health and Reliance Upon VA* (May 2008) <http://www.va.gov/vhaeorg>.

²³⁰ VA Congressional budget submissions for FY 2009 and FY 2010

²³¹ Matthew S. Brooks, Sarah B. Laditka, and James N. Laditka, "Evidence of Greater Health Care Needs Among Older Veterans of the Vietnam War," *Military Medicine* 173(8) (2008): 715-20.

²³² Institute of Medicine, *Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families, Ch. 5* (March 31, 2010).

²³³ *Ibid.*

²³⁴ R. Jesse, MD, PhD, Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs, Testimony before the United States Senate Committee on Armed Services (June 22, 2010).

²³⁵ L. Beck, PhD, chief consultant, Office of Rehabilitation Services, Office of Patient Services, Veterans Health Administration, Department of Veterans Affairs; *Testimony before the United States Senate Committee on Veterans' Affairs*; May 5, 2010.

²³⁶ The average daily census (ADC) at that time of 13,391 for its Nursing Home Care Units (now renamed "Community Living Centers").

²³⁷ Veterans Administration, *Caring for the Older Veteran* (Washington, DC: U.S. Government Printing Office, July 1984).

²³⁸ Conference Report 106-237 (July 16, 1999).

²³⁹ Measure of annual percent increase of noninstitutional long-term care average daily census using FY 2006 as baseline (43,325 ADC), versus the FY 2011 census of 92,567.

²⁴⁰ Department of Veterans Affairs, *Geriatrics and Extended Care Strategic Plan*, (Washington, DC, December 24, 2008), 4.

²⁴¹ IL 10-2004-005, Under Secretary for Health's Information Letter, *Noninstitutional Extended Care* (May 3, 2004).

²⁴² *Noninstitutional Extended Care within VHA*, VHA Directive 2001-061 (October 4, 2001).

²⁴³ Home-based primary care, purchased skilled home health care, homemaker/home health aide, adult day health care, geriatric evaluation, respite care, and hospice and palliative care.

²⁴⁴ GAO-05-65.

²⁴⁵ GAO-06-333T.

²⁴⁶ GAO 04-913.

²⁴⁷ P. L. 109-461 § 211.

²⁴⁸ Per Diem for Nursing Home Care of Veterans in State Homes, Final Rule. *Federal Register* 74(81) (28 April 2009): 19426-51. Print.

²⁴⁹ Bruce Kinoshian, Eric Stallard, and Darryl Wieland, "Projected Use of Long-Term Care Services by Enrolled Veterans," *Gerontologist* 47(3) (2007): 356-64.

²⁵⁰ House Committee on Veterans' Affairs, Subcommittee on Health, *State of the U.S. Department of Veterans Affairs' Long-Term Care Programs*, Hearing, May 9, 2007. 110th Cong., 1st Sess., Washington: Government Printing Office, 2008. Print.

²⁵¹ GAO-01-768.

²⁵² Annual percentage increase from 2006 baseline of 43,325 average daily census of noninstitutional long-term care.

²⁵³ GAO 03-487.

²⁵⁴ P. L. 109-461, Title II, § 214.

²⁵⁵ P. L. 110-387, Title IV, § 409.

²⁵⁶ Additional support may be provided by pharmacists, rehabilitation therapists, recreation therapists, mental health professionals, and other specialists.

²⁵⁷ Enacted under the Older Americans Act Amendments of 2000.

²⁵⁸ L. Feinberg, and S. Newman, *Medicaid and Family Caregiving: Services, Supports, and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S.* (New Brunswick, NJ: Rutgers Center for State Health Policy, May 1, 2005).

²⁵⁹ Formerly Program for Persons With Disabilities. See "National Defense Authorization Act of 2002."

²⁶⁰ 38 U.S.C. § 5503.

Medical and Prosthetic Research

MEDICAL AND PROSTHETIC RESEARCH

The VA Medical and Prosthetic Research program is one of the nation's premier biomedical and behavioral health research endeavors. VA's research program underpins the highest standard of care for veterans in VA treatment and improves care in all human health. This key program also aids the Department in recruitment and retention of the best and brightest clinician-scientists to care for veterans in VA health facilities and influences the quality of care throughout the VA system. To continue its success, VA research must be predictably and sufficiently funded, with a state-of-the-art research environment.

The VA Office of Research and Development's illustrious history of health-improving advances spans across 85 years of research accomplishments.²⁶¹ Since 1925, even before VA's official establishment by presidential executive order, VA's research program has enhanced veterans' lives—improving care and standards of care immeasurably not only for them, but ultimately for all human beings. From early advances in effective therapies for tuberculosis to implantable cardiac pacemakers, the first successful kidney and liver transplants, the development of the nicotine patch and beyond, VA has a rich research history of trailblazing accomplishments, a legacy that fosters continued achievement today.

VA's research accomplishments span the full spectrum of veterans' health needs, from disease prevention to rehabilitation. The wide range of health concerns consistently addressed by VA research includes traumatic brain injury, post-traumatic stress disorder (PTSD) and other mental health conditions, post-deployment transition health, neurological diseases, cardiovascular diseases, exposure-related illnesses, cancers, diabetes, prosthetic inventions, women's health, and health services and policy.

One cutting-edge area of current VA research focus that will transform the future of VA health care is the science of genomics—the study of genetic information tailored toward therapies for individual patients. With the pending launch of VA's "Million Veteran Program," VA is moving ever closer to personalization of care that meets an individual patient's unique care needs. This research shift toward the patient dovetails well with VA's emerging "Medical Home" models of care, discussed in the FY 2012 *Critical Issues* report and described elsewhere in this *Independent Budget*. The Million Veteran Program initiative aims to be the basis for one of the largest studies of genes and health in the United States, with an expected enrollment of 1 million veterans over the next five to seven years.

Other areas of important VA progress include comparative effectiveness studies. This research compares therapeutic options head to head so that clinicians will use those techniques and interventions with the best chance of efficacy. Also, VA is conducting a growing body of research to examine the unique needs of women veterans regarding risks, treatment, and health-care outcomes. It is also engaged in public-private research partnerships leading to significant advances in prosthetics, such as the advanced prosthetic arm. As another leading example, VA researchers are working to find better ways for clinicians to accurately diagnose traumatic brain injury and PTSD—especially in cases where they may overlap in confounding ways. In a small pilot study, a team of VA and University of California–San Diego, investigators found that a combination of two imaging technologies—magnetoencephalography (MEG) and diffusion tensor imaging (DTI)—can show subtle brain injuries that go undetected by conventional CT and MRI scans. MEG picks up the signals that neurons give off when these neurons "fire." DTI picks up abnormalities in the brain's nerve fibers. More VA research using these technologies in tandem is now under way.

Through discovery and innovation, VA Research continues to lead the way in health-care advances.

²⁶¹ Additional information about VA's research programs and numerous current initiatives may be found at <http://www.research.va.gov/news/features/VA-ResearchToday.pdf>.

FUNDING FOR VA MEDICAL AND PROSTHETIC RESEARCH:

Funding for VA research must be sufficient, timely, and predictable to meet current commitments and allow for growth in areas of timely importance.

The VA Medical and Prosthetic Research program leverages the taxpayer's investment via a nationwide array of synergistic relationships with academic affiliates, nonprofit organizations, and for-profit industry participants. Adding to these partnerships is the ability of VA researchers to successfully compete for funding from the National Institutes of Health, the Department of Defense, and other federal agencies. The VA research program successfully leverages its relatively modest annual VA appropriation into a \$1.8 billion national research enterprise that sponsored three Nobel laureates and six Lasker Award (often called the "American Nobel") recipients. The VA research program produces an increasing number of scientific papers annually, many of which are published in the most highly regarded and peer-reviewed scientific journals. Recent examples of VA contributions to innovative technologies include the nicotine patch; an improved prosthetic ankle that better mimics a normal gait; and the "DEKA Arm," a collaborative invention involving VA and Department of Defense scientists and private entrepreneurs, which holds promise for upper extremity amputees to achieve remarkable dexterity using a robotic hand.

The highly successful VA research enterprise demonstrates the best in public-private cooperation, but would not be possible without the VA-funded research opportunities and VA's laboratories. As such, a commitment to steady and sustainable growth in the annual research appropriation, and a significant investment in VA's aging research infrastructure, are necessary for maximum productivity and continued achievement.

Predictable and Sustainable Growth to Meet Current and Emerging Research Needs

The organizations that author this *Independent Budget* applaud Congress for sustaining growth in the Medical and Prosthetic Research and Development program in recent years, and urge Congress and the Administration to continue this positive trend. Predictable funding enables the national VA Office of Research and Development to stabilize its planning, and increases investigator confidence in continuous funding for thousands of important research projects in VA. Should availability of research awards decline as a function of budgetary policy, VA risks having to terminate ongoing research projects. It also risks losing from VA ranks physician-researchers and other clinical investigators who are integral to providing direct

care for our nation's veterans and high-quality programs for veterans' specialized needs.

Table 9. Medical and Prosthetic Research (in millions)

FY 2011	\$590
FY 2012 Administration Request	\$509
FY 2012 <i>Independent Budget</i> Recommendation	\$620

To maintain the current level of VA research activity, inflation in biomedical research and development is assumed at 3.4 percent for FY 2012. The basis for this assumption is the annual change in the Biomedical Research and Development Price Index, which is developed and updated annually by the Bureau of Economic Analysis and the Department of Commerce. It is used by federal research agencies, including the National Institutes for Health, to estimate changes in funding levels necessary to maintain purchasing power.

Beyond anticipated inflation, additional VA research funding is needed to (1) address the critical needs of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and others who were deployed to combat zones in the past; (2) take advantage of opportunities to improve the quality of life for our nation's veterans through "personalized medicine"; and (3) maximize use of VA's expertise in research conducted to evaluate the clinical effectiveness, risks, and benefits of medical treatments.

Funding Growth Will Aid New Discoveries and New Treatments

Additional funding is needed to expand research on strategies for overcoming the devastating injuries suffered by veterans of OEF/OIF. Urgent needs are apparent for improvements in prosthetics technologies and rehabilitation methods, as well as more effective treatments for polytrauma, traumatic brain injury (TBI), significant body burns, damage to the eye, and mental health consequences of war, including post-traumatic stress disorder (PTSD), depression, and suicide risk. In particular, an increasing rate of suicide among military personnel signals the need for more VA research to forestall equally dire consequences among the veteran population. Funding more studies and accelerating ongoing research efforts in all of these critical areas can deliver

results that make a measurable difference in the quality of life of thousands of our newest generation of sick and disabled war veterans and their families.

Through personalized medicine research VA is uniquely positioned to revamp modern health care and to provide progressive and cutting-edge care for veterans. VA is uniquely capable of leading personalized medicine research, including genetics-based research or “genomics.” VA is the largest integrated health system in the world, employs an industry-leading electronic health record, and has an enrolled treatment population of millions of veterans to sustain important research. VA combines these attributes with rigorous ethical standards and standardized practices and policies. Innovations in personalized medicine will allow VA to:

- reduce drug trial failure by identifying genetic disqualifiers and allowable treatment of eligible populations;
- track genetic susceptibility for disease and develop preventative measures;
- predict responses to medications; and
- modify drugs and treatments to match an individual’s unique genetic structure.

In 2006, VA launched the Genomic Medicine Program to examine the potential of emerging genomic technologies, optimize medical care for veterans, and enhance the development of tests and treatments for relevant diseases. One of the main objectives of the Genomic Medicine Program is to create an expanded DNA sample bio-bank of veteran donors, which will be made available for carefully designed research that leads to improved treatments while protecting veteran privacy and safety. To enroll 1 million veteran volunteers over five years as planned, and to set up the necessary infrastructure, VA must be in a position to make a sustained investment in this innovative initiative.

Finally, increased funding would allow VA to conduct additional research to ensure that veterans receive the most effective therapies for their conditions, sometimes at a savings because the less costly treatment is as or more effective, or because the patient receives the right treatment promptly. In addition to the attributes described above, VA already has a fully functional clinical research infrastructure including:

- five data and statistical coordinating centers,
- four epidemiology research centers,
- a pharmacy coordinating center,
- a health economics resource center, and
- a pharmacogenomics analysis laboratory.

VA Research Infrastructure Funding Shortfalls

For decades, VA construction and maintenance appropriations have failed to provide the resources needed by VA to replace, maintain, or upgrade its aging research facilities. Consequently, many VA facilities have run out of adequate research space, or existing space is unable to meet current standards. Ventilation, electrical supply, roofs, and plumbing deficiencies appear frequently on lists of urgently needed upgrades along with significant space reconfiguration.

In House Report 109-95 accompanying FY 2006 VA appropriations, the House Appropriations Committee expressed concern that “equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department’s research facilities remain competitive.” In the same report, the committee directed VA to conduct “a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies.” To comply, VA initiated a comprehensive assessment of VA research infrastructure. According to an October 26, 2009, Office and Research and Development report to the VA National Research Advisory Committee, preliminary results indicated “there is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety.”

To prompt VA to complete and publish its long overdue assessment, House Report 111-564 directed VA to provide its final report to Congress by September 1, 2010, and also to detail any recent renovations or new construction. *The Independent Budget* veterans service organizations urge Congress to hold VA accountable for submission of this report to ensure that the Administration and Congress are well informed of the deteriorating conditions of VA’s research infrastructure and of its funding needs so that these may be fully considered for the FY 2012 budget formulation process. Additionally, for FY 2012 Congress should (1) allocate funding sufficient to address VA’s five highest priority research facility construction needs as identified in the report; and (2) provide a pool of funding for urgently needed maintenance and upgrades at research facilities nationwide.

Research in Newly Constructed VA Medical Centers

An emerging problem is that research facilities often are not an integral component of planning for new VA medical centers (VAMCs). Congress is to be applauded for funding a number of new VAMCs to replace aging facilities, but the IBVSOs are dismayed that in many

cases research has not been appropriately considered during the planning process for these new structures. For example, historically, the Denver VAMC has had vibrant research laboratory and clinical research programs. However, plans for the new Denver VA to be sited at the former Fitzsimons Army Medical Center in Aurora provide for very limited lab space, inadequate to meet even the current needs of the research program, and will include no space designated for clinical research programs, such as the Denver Mental Illness Research, Education and Clinical Center, a specialized program authorized by law that conducts research to address growing needs in mental health, including suicide prevention, PTSD, and TBI. The new Denver facility also excludes space for health services research and development.

Similarly, initial designs for the new facility at Orlando do not incorporate any laboratory research space. These omissions will now need to be addressed in expensive, modified design work. Modern-day research has unique power, safety, privacy, building equipment, and configuration requirements that must be fundamental in VA's new construction planning processes, not an expensive afterthought.

VA Lacks a Mechanism to Ensure that Its Research Facilities Remain Competitive

A significant cause of VA research infrastructure's neglect is that there is no direct funding line for research facilities. Nor does the VA Medical and Prosthetic Research appropriation contain funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with medical facilities' direct patient care infrastructure needs (such as elevator replacement, heating and air conditioning upgrades, and capital equipment upgrades and replacements, including X-ray machines and MRIs) for funds provided under either the VA Medical Facility appropriation account or the VA Major and Minor Construction appropriations accounts. VA investigators' success in obtaining funding from non-VA sources exacerbates VA's research infrastructure problems because non-VA grantors typically provide no funding to VA grant awardees to cover the costs to medical centers of housing extramurally funded projects.

The Uncertain Future

As indicated in "Maintain Critical VA Health Care Infrastructure" in this *Independent Budget* and in the *Critical Issues* associated with this budget, we are con-

cerned about the future direction of the VA health-care system if VA shifts its focus away from inpatient services and relies primarily on affiliates or community hospitals for those services. If such a shift is being contemplated, in effect "closing" many VA hospital beds, the IBVSOs urge VA and Congress to consider the ramifications on VA's historic academic and research missions. Although VA research investigators do not necessarily need to rely on hospital inpatients as clinical subjects for their projects, inpatient services and resources are important components of VA's academic and research missions. Moving VA inpatient care to external providers raises a number of questions about the viability of both missions.

Integrity of the Peer-Review Process

Both *The Independent Budget* veterans service organizations and Friends of VA Medical Care and Health Research strongly support leaving all decisions about the selection of particular research projects, and their funding, to the VA scientific peer-review process. Funding for any potential congressionally mandated VA research, therefore, is neither anticipated nor included in this *Independent Budget* discussion or funding recommendations. We believe any such directed research, if so desired by Congress, should be appropriated separately from the needs we are identifying in this *Independent Budget*.

In addition, it is vitally important that the integrity of the Department's highly regarded peer-review process be protected. Although outside stakeholders' carefully considered views on funding priorities should be a consideration, they must not be allowed to unduly influence research funding deliberations or decisions. Ultimately, scientific merit based on careful peer review must be the determining factor in whether a project is funded, not pressure from interest groups or interference in selection of peer reviewers. We contend that between VA's current peer-review system and the public status of this federally funded activity, sufficient accountability is present and that no further outside interference or influence is warranted. *The Independent Budget* veterans service organizations urge Congress and VA to take assertive steps to preserve the quality and transparency of VA's research funding decisions.

Recommendations:

To keep VA research funding at current-services levels, the VA research program needs at least \$20 million (a 3.4 percent increase over FY 2011) to account for biomedical research inflation. However, *The Independent Budget* veterans service organizations believe an additional \$10 million in FY 2012, beyond infla-

tionary coverage, is necessary for sustained support of the ongoing VA research initiatives discussed herein. Thus, Congress should increase by \$30 million the VA Medical and Prosthetic Research account in fiscal year 2012, for a total of \$620 million.

Congress should require VA to submit its research facilities needs report to the House and Senate Committees on Appropriations and Veterans' Affairs upon completion in 2011. Further, correction of the known infrastructure deficiencies should not be further delayed. Therefore, *The Independent Budget* veterans service organizations recommend (1) a construction appropriation sufficient to address VA's five highest priority research facility construction needs as identified in its facilities assessment report; and (2) a pool of \$50 million dedicated exclusively to renovating existing research facilities to address the current and well-documented shortfalls in research infrastructure. Further, the committee should require that research space must be an integral component of planning for every new medical center and that such space should be designed by architects experienced in research facility requirements.

The Administration and Congress should establish a new appropriations account in FY 2012 and thereafter to independently define and separate VA research infrastructure funding needs from capital and maintenance funding for direct VA medical care programs. The account should be subdivided for major and minor research construction and for maintenance and repair needs of VA's research programs. This revision in appropriations accounts can empower VA to address research facility needs without interfering with direct health-care infrastructure.

In summary, Congress should fund the VA Medical and Prosthetic Research program in FY 2012 as follows:

- for appropriate program growth, and to cover anticipated inflation, \$620 million;
- for capital infrastructure, renovations, and maintenance, \$150 million for five research major construction projects and \$50 million for minor construction and maintenance and repair (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).



Administrative Issues

THE DEPARTMENT OF VETERANS AFFAIRS MUST STRENGTHEN ITS HUMAN RESOURCES MANAGEMENT PROGRAMS:

The Department of Veterans Affairs must update existing personnel programs and develop innovative employment strategies to help human resources staffs, facility program leaders, and executives recruit, train, and retain a qualified workforce.

The Department of Veterans Affairs must improve its human resources management policies and procedures in order to remain a leader in health-care delivery and ensure that America's veterans receive the benefits and services they have earned. Specifically, VA must revamp its hiring system to make the hiring process timely and efficient, update salary and compensation scales to levels that are competitive in the current employment market, and ensure that adequate training and continuing education opportunities are offered and made available to all employees for career progression. Both Congress and VA must continue to

work to strengthen and energize VA human resources management programs and give human resources staffs, facility program leaders, and executives new tools to recruit, train, and retain highly qualified VA employees.

In order for VA to continue to build a reputation as an "employer of choice," it must work to (1) refine and modernize human capital policies and procedures, specifically in the areas of recruitment, retention, and succession planning; and (2) provide and create satisfying work environments that encourage scholarship,

professional development, and career advancement. VA must also work to reach out to the trained and qualified community of veterans that are potential candidates for VA employment, and ensure that veterans hired by VA receive fair treatment and adequate support for successful career development.

As service members return home from the conflicts in Afghanistan and Iraq, and veterans from previous and future service seek VA health care and benefits, VA must make certain that it is adequately staffed with a well-trained workforce committed to providing veterans with high-quality care and services. VA's ability to sustain a full complement of skilled and motivated personnel requires assertive and competitive hiring strategies that enable VA to successfully compete in the local and national labor markets. To be successful, human resources management programs of both the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA), as well as a multiplicity of other VA offices, require attention by the highest levels of VA leadership, the use of effective tools and strategies with measureable outcomes, and strong oversight by an engaged Congress.

Current VA Workforce and Its Future Needs

To meet the needs of America's veterans, it is essential that employee education and development programs, leadership succession planning, and recruitment and retention initiatives be moved forward so that VA can ensure that it has talented people with the right skills, experiences, and competencies in the right jobs at the right time. One of VA's greatest challenges is dealing effectively with succession—especially in the health sciences and technical fields that so characterize contemporary American medicine and health-care delivery. The VHA 2010 Workforces Succession Strategic Plan reports that VHA continues to face a succession challenge unprecedented in its history. The VBA also has an unprecedented backlog of disability claims that it must process, a supremely labor-intensive requirement.

With respect to health care, the VHA reports that between FY 2009 and FY 2015, 94,700 VHA employees, 40 percent of its total workforce, will be eligible for retirement, and predicts that 51,900 of those employees will retire.²⁶² The VHA is facing the challenge of an increasing percentage of workers becoming eligible for retirement, while moving toward an even more diverse, "multigenerational workforce."²⁶³ For the past several years, the VHA has identified registered nurses (RNs) as its top occupational challenge, with nurse anesthetists also identified in the top 10 occupations with critical recruitment needs.

In addition, the average age of VHA employees increased from 45.4 years in FY 1997 to 47.8 years in FY 2008, and the average age of permanent new hires increased from 38.5 years in FY 1998 to 41.9 years in FY 2007. While these data are significant, there is evidence that a growing number of VA personnel are staying beyond their eligible retirement ages. All of this underscores the need for the VHA to market itself vigorously and try to appeal to all age groups as a preferred employer.

Today's health-care professionals need improved benefits, such as competitive salaries and incentives, child care, flexible scheduling, generous continuing educational benefits, and education and training that enhance their upward mobility opportunities.

In a 2008 VA benchmarking study, the VHA analyzed "leading public and private sector organizations to identify best practices in workforce planning."²⁶⁴ The VHA received a score of "low" in the program recruitment area, and ultimately determined from the study that new employee recruitment and employee retention would be two main areas of focus for future improvement.²⁶⁵ Given the VHA's leadership position as a health-care system, it is imperative that VA work aggressively to improve its recruitment strategies for health-care professionals. In a recent health-care inspection report,²⁶⁶ the VA Inspector General found needs for additional staff and recruitment of staff to be two important reasons that accounted for delays in the VHA's implementation of mental health reforms.

Veterans Benefits Administration

With Congressional authorization, over the past three years the VBA has hired a record number of claims adjudication staff. Unfortunately, as a result of senior VBA officials' retirements in the interim, an increase in disability claims received, rising complexity of veterans' claims, and the time required for new employees to become proficient in processing claims accurately, VA has achieved little noticeable improvement in its claims-processing capabilities. The VBA has a major challenge under way in completing the complex training required to gain full productivity of several thousand new staff, many of whom are eager to build careers of service to other veterans.

With the influx of these new benefits personnel, however, the IBVSOs observe that the VBA's challenges can no longer be attributed to staffing shortages. In fact, we realize that, considering the size of the claims backlog and the workload pressures on staff, it would be unrealistic to expect an immediate reduction in the

backlog. Given the time required for new employees to train and gain necessary experience with claims, and the productivity drain on experienced supervisors who provide much of the needed training in the VBA, it is unsurprising to us that the backlog continues to grow. In order to make the best use of new human resources, we believe the VBA must focus on improving training for both new employees learning this complex job and senior employees staying abreast of new laws and technology, and holding supervisors and managers accountable for it while simplifying the claims process itself.

Many of the core human resource systems problems documented primarily for the VHA in this discussion also pertain to the VBA. As VA approaches solutions to its human resource challenges in its health-care system, it should also incorporate those solutions where applicable in the human resource policies and practices of the VBA.

Timely and Efficient Hiring

To ensure that VA is able to hire and retain the most qualified applicants, it must strengthen its employee recruitment and retention programs and increase the timeliness of its hiring processes. In the 2010 VHA Workforce Succession Strategic Plan, human resources management was the fourth-ranked occupation in the top 10 occupational priorities for recruitment and retention. While VA recognizes that human resources managers and specialists provide the support necessary to recruit and retain employees, it must also begin to recognize that competent human resources staff are instrumental to the VA hiring process. VA must improve its hiring process by reducing the amount of time to bring new employees on board, and provide its human resource staff adequate support through updated hiring systems and proficiency training.

The IBVSOs have received recurring reports indicating that appointment of a new employee within the VHA can consume up to 90 days or more. While VA has recognized the need to improve its hiring timelines, it must begin the next phases of identifying the most promising systems, and implementing these programs or pilots to determine new methods to reduce the hiring timeline. In some professional occupations (especially in cases of physicians and nurses), months can pass from the date a position vacancy is announced by VA until the date a newly VA-credentialed and privileged professional caregiver is on board, receiving pay, and providing clinical care to veterans. The seeming lack of ability to make employment offers and confirm them in a timely manner unquestionably affects VA's success in hiring highly qualified employees and has the potential to diminish

the quality of VA health care and VA's overall ability to deliver benefits and services.

In addition to hiring and recruiting new employees as a method for maintaining adequate staff, VA must also put in place programs for future succession. In the VHA alone, between FY 2002 and FY 2006, 108,620 new hires (21,724 per year) were needed to maintain the VA health-care workforce. Between FY 2007 and FY 2017, 163,308 new hires will be needed to maintain that workforce (an average of 23,330 new hires per year). While VA has recognized that the employment market is extremely competitive for some positions and is working to provide more professional development opportunities and programs to attract new employees needed to care for veterans, it must begin to put more effort into creating succession plans, since a large percentage of the VA workforce is eligible for or nearing retirement.

Succession planning would also allow for VA leadership to identify future gaps in personnel for mission-critical positions, and allow management to begin the recruitment process earlier. For instance, it is predicted that by 2013, the VHA will need an approximate 30,000 additional registered nurses; foresight in planning would allow management additional time for recruiting and training of new RNs. In that connection, VA has fostered a "nursing academy" in partnership with a number of major university schools of nursing, and VA is affiliated with schools of medicine at more than 100 universities (see "Attracting and Retaining a Quality Nursing Workforce" in this *Independent Budget*.) Yet VA generally reports continuing shortages of both RNs and physicians. The IBVSOs believe that part of the reason for these shortages is not that new RNs and new graduate physicians and medical fellows are not interested in VA employment; rather, VA is not positioned to offer them immediate employment after graduation but, if at all, many months following graduation. VA must work to harness its human resources function with academic calendars so that coordinated hiring initiatives can be timed to graduation dates. Today, in general, this is not the case, these hiring opportunities are lost, and as a consequence, veterans suffer.

In addition to implementing new hiring strategies to help improve the efficiency of VA human resources, VA must also create performance measures and standards that systematically identify when VA recruitment and retention goals are achieved and when they are not achieved. Specifically, VA must develop and implement specific goals for recruitment and retention (to also include promotions, continuing education, or other op-

portunities within their function) as components of human resources staffs' performance plans. VA human resources management staffs are not accountable to direct services providers because the failure to secure these needed results as planned carries no reward or sanction for human resources staffs.

Performance of human resources personnel is not measured by the degree to which they meet hiring and recruitment goals. As a consequence, failure to fill a critical vacancy in a timely manner carries no adverse effect on the involved human resources management staff, but that failure could directly impact on VA's ability to provide services to veterans in VA programs. VA should adopt performance measures that include evaluation of VA human resources employees meeting VA recruitment, promotion, and similar goals. Such evaluation should then be tied to the receipt of awards, performance bonuses, and performance sanctions. Such a system of connecting their relevant work with results at the direct-service level would allow VA human resources to identify areas in need of improvement and also provide new motivations and incentives for a more responsive VA human resources management program to those who provide direct services to veterans.

Competitive Compensation

Adequate compensation for VA employees is a tool for both recruitment and retention. VA must provide its employees with salaries that are comparable to private sector earnings if it is to become and remain an employer of choice. VA must combine competitive compensation packages with new employee incentives, such as signing bonuses, retention incentives, and scholarships; education loan repayment; and attractive benefits.

Congress and VA must work together to ensure that sufficient resources are available to VA managers to offer competitive salary and employment packages to new employees. For instance, in 2004, Congress passed Public Law 108-445, the "Department of Veterans Affairs Health Care Personnel Enhancement Act." The act was intended to aid VA in recruitment and retention of VA physicians, including scarce subspecialty practitioners, by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. VA has fully implemented the act, but the IBVSOs believe the act may not have provided VA the optimum tools needed to ensure that veterans will have available the variety and number of physicians needed in the VA health-care system. We urge Congress to provide further oversight and to ascertain whether VA has adequately implemented its intent or if VA

needs additional tools to ensure full employment for qualified physicians as it addresses its future staffing needs. Additionally, in an effort to recruit and retain medical subspecialists who provide care in VA's specialized service areas (such as spinal cord injury, blind rehabilitation, physiatry, surgical specialties, etc.) Congress should consider implementing an additional title 38 specialty pay provision to cover these scarce medical specialties.

Another human resources challenge that is rising in importance is pay disparity between top executives at medical centers and Veterans Integrated Service Networks (VISNs) and those whom they supervise. With reforms in nurse executive and physician pay from prior acts of Congress, Medical Center and VISN chief executives now find themselves in a compensation system that pays them significantly less than some of the senior personnel they supervise. Such inequality in pay also contributes to a dampening of interest in these executives to relocate for more challenging positions in the VHA—because essentially there is no pay incentive associated with VA career mobility.

We anticipate that many of these seasoned VA executives will be lured to higher paying positions in private health care because of the enormity of the existing pay disparity with private sector equivalent positions in health care. The loss of this experience in VA at a crucial time, with the advent of health insurance reform likely causing significant expansion of private health care, is of great concern to our organizations. Increasing VA compensation for these individuals now may offset some of these losses to the VA system by dissuading executives from leaving VA service. If increasing their pay can slow the drain of this talent from the VA system, this would be a well-justified investment.

Despite our concerns about whether VA adequately implemented this act, the IBVSOs believe the physician pay reform authorized by P. L. 108-445 could be an effective model of reform for senior health executive compensation in the VHA. Congress and VA should explore this strategic issue with oversight and further investigation, and develop an appropriate statutory response for VA to achieve pay equity for VHA's senior health executive leadership.

Personnel Training and Education

Maintaining a high-caliber professional staff is critical to the successful delivery of quality VA services. VA must make continuing education and training programs and incentives available to all qualified employees. VA leadership must make certain that existing staff

and potential employees are aware of these opportunities and benefits for career development within VA.

Last year VA increased the maximum award amount for its Employee Incentive Scholarship Program to \$37,494, from the earlier limit of \$35,900. This increase will help many existing VA employees who wish to further their education and will, hopefully, serve as a retention tool to keep valuable employees within VA; however, other incentive programs, such as the VA Education Debt Reduction Program (EDRP), are in need of award increases as educational costs continue to rise. A higher EDRP award would also serve as an effective recruitment tool to attract recent graduates and students in all degree programs of VA affiliated institutions to VA employment. For instance, the amount of reimbursement of continuing medical education expenses for physicians and dentists has remained unchanged since 1991 and should be adjusted to remain competitive with other health-care employers.²⁶⁷

Concerns about “Hybrid title 38-title 5”

Appointments

Congress had historically authorized so-called “hybrid” appointment authorities in about two dozen VHA career fields, such as practical nursing, psychologist, blind rehabilitation specialist, and social worker. While the availability of this hybrid appointment authority has been a boon to VA because of the flexibility it provides in setting grade levels and determining qualification and classification standards for these positions, a number of problems had persisted that prevented VA from taking full advantage of its usefulness, and impeded career advancement for individuals involved in VA health care but who were unaffected by this program. However, in section 601 of P. L. 111-163, Congress granted VA the authority to add to these positions additional occupations in the VHA that provide direct health-care services, including nursing assistants. Should VA need these positions to meet its requirements for recruitment and retention, they may be appointed, so long as they provide direct patient care and VA notifies Congress in advance of its intention to bring specific new occupations into this flexible hiring authority. VA must also consult with affected federal labor organizations beforehand. We support this progress and urge VA to move forward forcefully in implementing it.

Veterans and VA Employment

VA has a long tradition of employing veterans, including service-connected disabled veterans who successfully complete VA vocational rehabilitation programs. In establishing the Veterans Employment Coordination Service in 2008, VA reiterated its commitment to “ad-

vance efforts to attract, recruit, and hire veterans into the VA, particularly severely injured veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom,” through a network of regional employment coordinators.

However, VA must take action to ensure that veterans have greater opportunities to enter and remain part of the VA workforce. First, VA should seek out jobless veterans for positions for which they are qualified. Second, Congress should amend either title 38 or title 5, United States Code, to reverse a federal appeals court decision holding that title 38 employees are not covered by the “Veterans Employment Opportunities Act.”²⁶⁸ Third, VA should ensure that veterans’ preference-eligible individuals are properly acknowledged and rated for their military occupational specialties when seeking VA employment (for example, medics or corpsmen applying for licensed vocational or practical nurse positions should receive significant credit for their prior experience). Finally, to ensure that these protections are enforceable, VA human resources management officials should adopt a tracking system, similar to the system used for tracking employment discrimination data, to ensure qualified veterans are an employment priority for VA.

Summary

VA human resource management policies and procedures serve as the foundation of initial employment for all VA employees, and provide the pathway for overall career direction. VA employees rely on human resources management programs and staff for advice on a wide range of issues, such as life and health insurance, retirement options, and other very personal and important matters. VA service officials rely on human resource management offices to support their needs to obtain and retain the best employees to provide direct services to veterans.

Congress and VA must work to strengthen and energize VA’s human resources management programs to recruit, train, educate, and retain qualified employees; to identify new tools to enable VA to gain equality with other employers in attracting a new generation workforce for the care of veterans; and to provide their vital services. VA must strive to provide satisfying work environments that encourage scholarship, professional development and growth, upward mobility, and career advancement throughout the VA enterprise. VA human resources should set the standard of excellence when it comes to providing services for America’s veterans. Ultimately, VA must provide efficient, safe, and productive work environments and conditions of employment that attract and retain high-caliber professional, technical,

administrative, and crafts and trades staffs, in order to successfully execute the VA mission: caring for America's veterans.

Recommendations:

VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process, and avoid recruitment delays that serve as barriers to VA employment.

VA must implement an energized succession plan in VA medical and regional office facilities and other VA offices that utilizes the experience and expertise of current employees, as well as to improve existing human resources policies and procedures that promote succession.

VA should adopt performance measures that tie the results obtained by human resources staffs, managers, and facility executives—to meet service recruitment goals and needs, for elements that provide direct services to veterans—to their own performance evaluations, awards, performance bonuses, and performance sanctions.

VA facilities must fully utilize recruitment and retention tools, such as hiring, relocation, and retention bonuses; equitable locality pay for VA nurses; physician compensation improvements; reimbursement for continuing medical education and scholarship; and educational loan repayment programs, as employment

incentives, in both the Veterans Health Administration and Veterans Benefits Administration.

Congress should implement an additional title 38 specialty pay enhancement for medical professionals who provide care in VA's specialized services areas, such as in spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury programs.

VA must develop more assertive recruitment strategy and tactics that provide employment incentives to attract and encourage affiliated health profession students, as well as new graduates in all relevant degree programs of affiliated institutions, to commit to VA careers.

Congress should enact legislation to reverse a federal appeals court decision holding that title 38 employees are not covered by the "Veterans Employment Opportunities Act." The Administration should take additional actions to ensure VA provides ample opportunities for veterans to secure VA employment.

²⁶² Department of Veterans Affairs, Veterans Health Administration. Workforce Succession Strategic Plan 2010 (HPDM National Program Office [2010]).

²⁶³ Ibid.

²⁶⁴ Ibid.

²⁶⁵ Ibid.

²⁶⁶ VA Office of Inspector General, Report No. 08-02917-145 (May 4, 2010).

²⁶⁷ 38 U.S.C. § 7411.

²⁶⁸ *Scarnati v. Dept of Veterans Affairs*, 344 F.3d 1246 (Fed. Cir. 2003).



ATTRACTING AND RETAINING A QUALITY NURSING WORKFORCE:

The Veterans Health Administration must devote sufficient resources to prevent a national shortage of nurses from creeping into and potentially overwhelming VA's critical health-care missions.

Retention and recruitment of high-caliber health-care professionals and other staff is critical to the mission of the Veterans Health Administration and essential to providing safe, high-quality health-care services to sick and disabled veterans. During the current economic recession and slow recovery, hospital employment of full-time nurses has increased, which has eased the hospital nursing shortage. However, relief is likely to be temporary, and there is a need to focus on how the current workforce is changing and its implications for future im-

balances in the nurse labor market in the years ahead. In the long term, research points to the development of another nursing shortage, one that will be larger than any experienced previously. Given the impact of this impending nationwide nursing shortage and the resulting difficulty in filling nursing and other key positions within the Veterans Health Administration (VHA), this is a continuing challenge for the Department of Veterans Affairs. This section presents key points specific to VHA nursing programs, with recommendations *The Independent*

Budget veterans service organizations (IBVSOs) believe will help VA conquer this challenge.

Addressing the National Nursing Shortage

Recruitment efforts within the VHA focus on strategies to attract and hire registered nurses (RNs) into the organization. The VHA Healthcare Retention & Recruitment Office continues to coordinate systemwide comprehensive programs for recruiting RNs, including high-school outreach nursing programs (“HONOR”), internships for nursing students (“VALOR”), and recruitment and retention incentives, scholarships, and loan repayment programs. The Healthcare Retention & Recruitment Office conducted an analysis of past scholarship programs that demonstrated their positive impact on retention, showing that loss rates for nurse scholarship participants (7.5 percent) are lower than turnover for non-scholarship recipients (10 percent) and that fewer than 1 percent of nurses completing their one- to three-year service obligation ultimately leave VA.

The IBVSOs believe VA recognizes that in the near term the supply of qualified nurses in the nation will be inadequate to meet increasing demand for services. According to the Health Resources and Services Administration, in 2004, 28 percent of RNs were over the age of 50. The aging nursing workforce significantly contributes to the overall nursing shortage. The population of RNs over the age of 50 has expanded 11 percent annually over the past four years. The current recession has induced older nurses to delay retirement and others to rejoin the workforce. Because 70 percent of RNs are married, many had little choice as their spouses lost their jobs or feared that they might be in jeopardy of losing employment. According to a study by Buerhaus and colleagues (2009),²⁶⁹ between 2001 and 2008, RN employment increased by 18 percent; however, 77 percent of that increase was RNs older than 50—the age group that is growing the fastest among professional nursing. Because RNs older than 50 will soon be the largest age group in the nursing workforce, their retirement over the next decade will lead to a projected shortfall developing by 2018 and growing to approximately 260,000 RNs by 2025. The magnitude of the 2025 deficit would be more than twice as large as any nursing shortage experienced since the mid-1960s. These projected shortages will fall upon a much older RN workforce than previous shortages.

Nursing leadership at all levels is critical. A succession plan which incorporates the nurse manager, assistant chief, and chief nurse executive positions will be critical to VA’s future. Support of a VA mentoring program and other opportunities to educate and support our emerging nursing leaders is paramount to VA’s future.

The average age of a new graduate nurse increased from 23.8 years prior to 1984 to 29.6 years during 2000–2004. However, projections by Buerhaus²⁷⁰ conclude that future nurses will enter the workforce at ages 23 to 25. Nursing education programs could experience an increase in demand, as some people who are attracted by the relative job security and earnings offered in nursing seek to become RNs, and the capacity of some education programs could be affected negatively by state budget reductions. Faced with the projected nursing shortage, the ability to expand the long-term supply of RNs is in doubt. Since 2002, nursing enrollments have increased so rapidly that each year approximately 30,000 or more qualified applicants have been turned away from nursing education programs primarily because of shortages of faculty, clinical sites, and classroom space. The American Association of Colleges of Nursing has reported that three-fourths of the nation’s schools of nursing acknowledge faculty shortages along with insufficient clinical practicum sites, lack of classroom space, and budget constraints as reasons schools of nursing deny admission to qualified applicants. Over the past several years the VHA has been trying to attract younger nurses into VA health care and creating incentives to retain them in the VA system. New nursing graduates are currently experiencing difficulty finding jobs. Findings of a 2009 study by the National Student Nurses’ Association²⁷¹ revealed that 51 percent of diploma graduates, 50 percent of associate degree graduates, and 38 percent of baccalaureate graduates were unable to find jobs. In addition, 41 percent of respondents reported that there were no jobs available for new graduates in their areas.

The IBVSOs understand that the Office of Nursing Services in VA Central Office successfully completed a RN residency pilot program and is making plans for full implementation of a RN residency program. An effort to increase consistency in the nursing work environment should include participation in improvement programs, such as the Robert Wood Johnson Foundation’s Transforming Care at the Bedside. This program encourages nurses to develop interventions and design new processes that improve care. The IBVSOs believe that every VA health-care facility should explore similar opportunities to participate in these kinds of programs, which have been shown to improve patient outcomes as well as patient and nurse satisfaction.

A VA “Travel Nurse Corps” program has been initiated. VA established an office to coordinate RNs to serve short-term assignments at VA facilities, and this program, which has completed its third year, offers a valuable service by providing RNs to VA facilities in need on

short notice and at a lower cost than if VA were to employ private nursing agencies. In addition, if they are unfamiliar with VA, these nurses attend an orientation program that prepares them to work in the VA environment before they are given travel assignments. One concern with this program is the need for VA facilities to pay adequate travel and per diem costs for these staff members. VA should reimburse these nurses' expenses appropriately to protect the viability of this important program.

The Office of Nursing Services initiated a nationwide program to support nurses in obtaining certification in their specialty areas. Nurse executives were educated on existing authorities and provided with resources to encourage nurses in their facilities to pursue certification. In addition, the clinical nurse leader position was established in another initiative supported by the Office of Nursing Services, to enhance education for nurses and patients in the clinical arena. The clinical nurse leader role is designed to deliver clinical leadership in all health-care settings and to respond to individuals and families within a microsystem of care. As of August 2007, more than 80 VA medical centers are participating in this initiative.

Recently the Robert Wood Johnson Foundation provided its vision for the future of health care.²⁷² Four key messages were conveyed, as follows:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners with physicians and other health-care professionals in redesigning health care in the United States.
- Effective workforce planning and policy making would be improved with better data collection and an improved information technology infrastructure.

The IBVSOs fully concur with the foundation's vision for the future of health-care and urge VA to instill this vision in its own strategic planning programs.

VA Nursing Academy Expands

In an attempt to attain a more stable nursing corps, VA initiated a "Nursing Academy" pilot program known as "Enhancing Academic Partnerships." VA's pilot program for fiscal years 2007–2012 initially partnered with the University of Florida, San Diego State University, the University of Utah, and Connecticut's Fairfield University, with their respective VA affiliates at Gainesville, San Diego, Salt Lake City, and West Haven.

An additional six sites were selected to begin the program in academic year 2008–2009. They included the Medical University of South Carolina, Loyola University of Chicago, Rhode Island College, the University of South Florida, and the University of Oklahoma, partnering with VA facilities in Charleston, Hines, Providence, Tampa, and Oklahoma City, respectively. The sixth site selected included two institutions, the University of Detroit Mercy and Saginaw Valley State University, partnering with Michigan VA facilities in Detroit, Saginaw, Battle Creek, and Ann Arbor.

Additional VA-nursing school partnerships selected for 2009 included Western Carolina University, University of Alabama at Birmingham, University of Hawaii, Pace University, and Waynesburg University, partnering with VA facilities in Asheville, Birmingham, Honolulu, New York, and Pittsburgh, for a total of 14 sites during the five-year pilot program. Similar to VA's long-standing relationships with schools of medicine nationwide, VA nurses with pertinent expertise and qualifications will be appointed as faculty members at the affiliated schools of nursing. Students accepted for the academy will be offered VA-funded scholarships in exchange for defined periods of VA employment subsequent to graduation and successful state licensure.

VHA research shows that nursing students who perform clinical rotations at a VA facility are more likely to consider VA as an employer. VA is hopeful that the investment made in helping to educate a new generation of nurses, coupled with the requirement that scholarship recipients serve a period of obligated service in VA health care following graduation, will help VA cultivate and retain quality health-care staff, even during a time of looming nationwide nursing shortages. Continued funding beyond the pilot program is needed to provide this benefit to additional VA facilities. We also urge VA to examine the effectiveness of this approach and to make expansionary plans as warranted by the results obtained in that review.

VA Nursing Workplace Issues

VHA staff will need to have new skills and competencies to treat the new generation of veterans, particularly in such areas as rehabilitation, mental health, and primary care. Those working in primary and ambulatory care settings will need to be able to screen combat veterans for post-traumatic stress disorder, depression, substance-use disorder, maladaptive coping, and various other mental health challenges, and will need to know how to refer these veterans for appropriate care and treatment. Those working with veterans with amputations will need to know how to work with the latest technologies in pros-

thetic limbs. Staff will need to be able to provide female-specific health-care services. Also, VA nurses will need better training in assessing veterans for military sexual trauma, and to provide appropriate referrals to ensure they receive adequate care for that highly sensitive problem. New roles for RNs, such as in primary care as care managers, are also critical to the emerging patient-aligned care team model.

As addressed more thoroughly in the discussion of human resources management in this *Independent Budget*, and similar to other health-care employers, the VHA must actively address the factors known to affect recruitment and retention of all health-care providers, including nursing staff, and take proactive measures to stem crises before they occur. While the IBVSOs applaud what VA is trying to do in improving its nursing programs, competitive strategies have yet to be fully developed or deployed in VA. We encourage the VHA to continue its quest to deal with shortages of health manpower in ways that keep it at the top of the standards of care in the nation. The importance of nursing informatics, nursing data, and nurse-sensitive outcomes is critical information for our nursing workforce today. The ability to review data on patient outcomes and to measure efficiency and effectiveness in the area of quality and safety are essential in today's health-care arena. We recommend sustained support of ongoing and additional projects to support the necessary nursing informatics to achieve these results.

We also fully endorse enhanced physician-nurse collaboration to achieve the nation's, and VA's, goals for health care. The impact of collaborative physician-nurse partnerships in clinical, research, academic and leadership areas cannot be understated, and these collaborations are a major part of the blueprint for reform of all health care in the future.

Recommendations:

Congress must provide sufficient funding and strong oversight to support programs to recruit and retain critical nursing staff in VA health care, and in particular, to support enlargement of the Nursing Academy if warranted by expected results in the existing 14-site program.

Congress should support changes in per diem and travel requirements to ensure the viability of the VA Travel Nurse Corps Program.

Congress should provide support to ensure sufficient nurse staffing levels, to regulate, and ultimately reduce to a minimum VA's use of mandatory overtime for nurses.

Congress should provide sufficient funding so that all VA facilities can participate in workforce environmental improvement programs, such as recommended by the Robert Wood Johnson Foundation's "Transforming Care at the Bedside."

Congress should support funding to continue and expand the Office of Nursing Services' registered nurse residency pilot program.

VA should expand information technology efforts in nursing informatics and promote opportunities for VA physician-nurse collaborations in clinical, academic, research, and leadership areas.

²⁶⁹ P. Buerhaus, D. Auerbach, and D. Staiger, "The Recent Surge in Nurse Employment: Causes and Implications," *Health Affairs*, (Project Hope). July–August 2009, 28(4):w657–68.

²⁷⁰ Ibid.

²⁷¹ D. Mancinno, "Entry Level Positions for New Graduates: Real-Time Dilemma Requires Real-Time Solutions." *Dean's Notes*, September/October, 2009, 31(1): 1–4.

²⁷² "The Future of Nursing: Leading Change, Advancing Health," Robert Wood Johnson Foundation, Institute of Medicine (Washington, DC: The National Academies Press, 2010) <http://www.rwjf.org/humancapital/product.jsp?id=69909>.

VOLUNTEER PROGRAMS:

The Department of Veterans Affairs needs to provide sufficient dedicated staff at each VA medical center to promote volunteerism and coordinate and oversee voluntary services programs and manage donations given to the medical center.

Since its inception in 1946, volunteers have donated in excess of 725 million hours of volunteer service to America's veterans in VA health-care facilities and cemeteries through the Veterans Affairs Voluntary Service (VAVS) program. As the largest volunteer program in the federal government, the VAVS is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of more than 65 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and their auxiliary components, which report to the VA Under Secretary for Health.

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

VAVS volunteers assist veteran patients by augmenting staff in such settings as VA hospital wards, nursing homes, end-of-life care programs, outpatient clinics, community-based volunteer programs, national cemeteries, veterans' benefits offices, and veterans' outreach centers. With the expansion of VA health care for patients in the community setting, additional volunteers have become involved. During FY 2010, VAVS volunteers contributed a total of 12,549,708 hours to VA health-care facilities. This represents 6,031 full-time employee equivalent positions. These volunteer hours represent more than \$261 million if VA had to staff these volunteer positions with full-time employee equivalents.

At national cemeteries, VAVS volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on gravesites for Memorial Day and Veterans Day. Hundreds of thousands of hours have been contributed to improve the final resting places and memorials that commemorate veterans' service to our nation.

VAVS volunteers and their organizations also contribute millions of dollars in gifts and donations annually in addition to the value of the service hours they provide. The combined annual contribution made in 2010 to VA is estimated to be more than \$107 million. These significant contributions allow VA to assist direct-patient

care programs, as well as support services and activities that may not be fiscal priorities from year to year. Monetary estimates aside, it is impossible to calculate the amount of caring and comfort that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers continues to increase dramatically as more demands are placed on VA health-care staff. The way in which health services are provided is changing, providing opportunities for new and less traditional roles for volunteers. Unfortunately, many core VAVS volunteers are aging and are no longer able to volunteer. Likewise, not all VA medical centers have designated a staff person with management experience to recruit volunteers, develop volunteer assignments, and maintain a program that formally recognizes volunteers for their contributions. It is vital that the Veterans Health Administration keep pace with utilization of this national resource.

Recommendations:

Each Veterans Health Administration medical center should designate sufficient staff with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions. The positions must also include experience in maintaining, accepting, and properly distributing donated funds and donated items for the medical center.

Each VHA medical center should develop nontraditional volunteer assignments, including assignments that are age appropriate and contemporary.

COORDINATION OF VA PURCHASED CARE:

The Veterans Health Administration should develop an integrated program of care coordination for veterans who receive care from private health-care providers at VA expense.

Current law authorizes the Department of Veterans Affairs to purchase health care to ensure a complete continuum of medical care is provided to veterans in specified situations, such as where Veterans Health Administration (VHA) facilities are geographically inaccessible to veterans, patient demand for health care exceeds VHA facility capacity, scarce medical specialists unavailable in VA facilities are needed, and to satisfy wait-time requirements.²⁷³ This authority to purchase care is a supportive tool that should be used to supplement the VA health-care system when VHA facilities do not have the resources to provide necessary care to veterans.

The Independent Budget veterans service organizations (IBVSOs) believe this authority is necessary to ensure continuity of and access to health care, but it should be used judiciously and only in these specific circumstances so as not to endanger VHA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. We have consistently opposed blanket proposals to expand VA's purchasing care on a broader basis. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serving larger veteran populations, may not ensure cost-effectiveness where procurement is weighed against maintaining and operating like services in local VHA facilities. Ultimately, such proposals only serve to dilute the quality and variety of VA services for new as well as existing patients.

VA recognizes that use of more than one health-care system to obtain care is common among veterans who seek care at VA whether it is paid for by VA, by third-party health insurance carriers, Medicaid/Medicare, or out-of-pocket. Regardless of the source of payment, the IBVSOs believe VA has the responsibility to ensure the health-care service it buys is provided in a coordinated manner.

For veteran patients who have health insurance and use non-VA providers in their communities, VA policy is to use a "comanaged care" or "dual care" approach where the veteran's assigned VA primary care team is responsible for managing all aspects of care and services available through VA and will assist in coordinating care outside the VA system. This approach requires veterans to inform both VA and non-VA providers that they want to have their care coordinated. They must

complete a "release of information" in order for VA to access the veteran's health information from private providers and inform the primary care team of all names and contact information of non-VA providers as well as prescribed medications.

The IBVSOs commend this policy, as opposed to our concerns with how the care is provided through the Department's fee-basis care program, which is not managed or coordinated at all. In the fee-basis program, for example, VA does not track its related costs by veteran, health outcomes, or veteran satisfaction levels. Our growing concern about how care is delivered through this program is further raised by the rate of increasing expenditures for non-VA purchased care surpassing the rate of increase in VA's medical care budget.

In FY 2009 VA spent about 12 percent of its medical care budget, or approximately \$5.3 billion, to purchase health-care services from non-VA entities²⁷⁴ for eligible veterans. The VHA purchases care through a variety of means but uses two major mechanisms to provide care outside its health-care system. These include (1) contracts on a competitive basis or by agreements with academic affiliates; and (2) noncontracted medical care reimbursed on a fee-for-service basis (fee-basis) from providers in the community.

The VHA indicated that it spent about \$3 billion for contract and fee-basis care in FY 2008, which increased by 27 percent to approximately \$3.8 billion by FY 2009.²⁷⁵ According to the VA Office of Inspector General, the Non-VA Fee Care Program accounts for the bulk of VA's purchased care spending, with estimated FY 2008 expenditures exceeding \$2.6 billion. This program is also VA's fastest-growing purchased care activity. Outpatient fee costs have more than doubled during the four-year period FY 2005–2008, from \$740 million to \$1.6 billion, and in FY 2009 outpatient fee costs were just under \$2 billion.²⁷⁶

Fee-Basis Care

Historically called the "Fee Care Program," which includes fee-basis care for veterans enrolled in VA and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), veterans who are determined by VHA staff to be eligible and are authorized fee-basis care are allowed to choose their own medical providers. However, this program

has material weaknesses that adversely affect the care disabled veterans need.

VA's fee-basis care offers very little in the way of care coordination—other than preauthorizing the care and claims reimbursement processing—to ensure the non-VA care is appropriate, protects patient safety, allows for health information sharing, or is measured for quality. VHA's Dentistry and Geriatrics and Extended Care (GEC) clinical programs represent the largest purchasers of non-VA care. It is all the more concerning that veterans in need of services from GEC generally suffer from chronic conditions for which care coordination is widely recommended as the best practice to result in better health outcomes and improved health status as well as lowering costs of care.

Other veteran patients face a variety of challenges because of the lack of care coordination. Veterans under the Fee Program are sometimes unable to secure treatment from a community provider because of VA's lower payment, less-than-full payment, and delayed payment for medical services. The IBVSOs are especially concerned that service-connected disabled veterans who are authorized to use non-VA care are at times required by the only provider in their community to pay for the care in advance. In these instances, health-care providers frequently charge a higher rate than VA is willing to reimburse, resulting in veterans having to pay out-of-pocket fees for the medical care they need and that are not replenished by VA. In addition to access and related cost issues, VA does not oversee other aspects of care veterans receive through Fee Basis, such as health outcomes, the quality of the provider, or veteran satisfaction levels.

Many of the same challenges hold true for women veterans who use the VA health-care system. According to VA, 51 percent of women veterans who use the VA system split their care across VA and non-VA systems of care. Additionally, a substantial number of women veterans receive care in the community via fee-basis and contract care, and little is known about the quality of that care. The IBVSOs' concerns about the fragmentation of care and disparities in care that exist for women are more fully described in "Women Veterans' Health and Health Care Programs" in this *Independent Budget*.

Because VA will at times approve only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, it makes incorrect payments for outpatient fee care, and some veterans who seek reimbursement from VA are

paying for part of their care. The wide variations in how VA facilities pay facility charges and the lack of clear policies and procedures occur because the Code of Federal Regulations does not address how VA should pay outpatient facility charges.

Management of fee claims by the VHA is predominantly a manual process that generates significant payment errors, resulting from fee clerks with no access to automated payment reimbursement information and data entry mistakes based on complex fee claims as they key in the invoices before sending them to VA's Financial Management System, in Austin, Texas, for payment by check, credit card, or electronic funds transfer. Over the years, VA has made much effort to address existing variability in processing non-VA medical care claims. By initiating improvements to its business practices, VA has begun to address the timeliness of claims payment, but accuracy problems linger.

The IBVSOs applaud the implementation of a national fee-training program for local fee staff as well as certification for authorization and claims processing. Field assistance teams have been deployed to work directly with the field fee offices and facilities to provide standardization in business practices and target specific improvements as requested from the field. Some temporary stand-alone information technology systems have been put in place, but they lack the functionality for centralized reporting, recording, and decision support systems. Clearly, what leadership expects of IT today to manage this program for decision making, policy change, etc., is not being provided by the interim solution. In light of the need for significant changes to be made to the overall infrastructure, the short-term "band-aid" approach may be adequate, but it is not in the best interest of veteran patients or VA to provide timely access to quality health-care services.

In seeking to address substantive issues surrounding non-VA purchased care claims management, VA currently has three pilot projects to select one automated claims system for its Fee Program. We are pleased that the VHA has initiated these efforts in moving toward fee claims automation but are concerned about the process being used to establish these pilots and how VA will determine the approach and software that will be implemented nationwide. There appears to be no coordinated effort with a single point of accountability or an approved plan for how to evaluate these pilots' performance in order to ensure VA makes the best decision on how to automate the fee claims. There is not a publicly available plan defining specific VHA objectives and the metrics that will be used to evaluate each pilot.

The IBVSOs would have preferred that before any pilot program or other project was initiated, a project plan with defined milestones and desired results, performance metrics, and evaluation methodology would have been established, analyzed, and approved—as is now required under VA’s Performance Management and Accountability System (PMAS) to strengthen our IT oversight and performance (see “Centralized Information Technology Impact on VA Operations,” elsewhere in this *Independent Budget*). It appears that each pilot program is being implemented separately, without a single point of Office of Information Technology and program oversight or management of the objectives, costs, schedule, and performance, and without a consistent evaluation framework that holds each pilot accountable for achieving comparable results.

Congress should provide the necessary resources to fulfill the need for an IT infrastructure replacement system for this program. The IBVSOs also believe an outside, unbiased entity should develop a methodology that reflects Veterans Integrated Service Network (VISN)–wide requirements and conduct a review and evaluation of these pilots to ensure objectivity that will withstand VA and Congressional scrutiny. We applaud VA for attempting to address the human capital aspect of automating fee claims processing. It is our understanding that the VHA intends to shift some of the approximately 2,000 VHA facility-level fee staff toward care and case management to perform such functions as overseeing the referral process, assisting veterans with obtaining appointments from private providers, conducting follow-up to such appointments, and sending and receiving clinical information. Other fee staff will work more closely on cost-benefit analysis of purchasing non-VA care or increasing VA capacity. We urge the Department to work with key stakeholders as these events unfold to ensure a smooth transition to retain a full complement of skilled and motivated personnel.

Preferred Pricing Program

The IBVSOs believe it is critical for VA to implement a program of purchased care coordination that includes integrated clinical, record, and claims information for the veterans it directs to community-based providers. Even though these veterans are not receiving care at a VA facility, VA is funding that care and is ultimately responsible for the quality and cost of the care provided. VA medical centers (VAMCs) can save funds under the fee program by allowing veterans to use non-VA medical services under the current “Preferred Pricing Program” (termed by VA as “Claims Repricing”).

In this program, contractors reprice claims—from

billed charges to the contractor’s agreed-on network discount rate—that are sent to VA from community providers when a veteran sees a provider in the contractor’s network. Although Preferred Pricing has been available to all VAMCs, when a veteran inadvertently uses an in-network provider, not all facilities have taken advantage of the cost savings that are available. Thus, in many cases, VA has paid more for contract health care than is necessary. Nevertheless, the IBVSOs were pleased that VA made participation in its Preferred Pricing Program mandatory for all VAMCs in 2005. We understand that during FY 2009 the Preferred Pricing Program yielded a discount of more than \$70 million, although it is not currently being utilized by all VAMCs. However, with full participation in the program, as intended by VA, the potential to exceed projected discounted savings of more than \$75 million for FY 2010 has already been far exceeded, with \$125 million in discounts having been obtained.

While there have been significant savings achieved through the Preferred Pricing Program (\$399 million in gross discounts from inception to date) through enhancements to Preferred Pricing, there are several ways to improve cost reduction. The implementation of electronic data interchange across all VAMCs will allow for expansion of the program and create additional savings for VA by allowing more claims to be submitted to the Preferred Pricing service-disabled veteran-owned contractors. As efficiencies are implemented and the transaction process becomes more simplified, more claims will be submitted for repricing and significantly more funding will be made available to support purchased care programs and the needs of veterans.

Overall, the IBVSOs believe the national Preferred Pricing Program/Claims Repricing is a foundation upon which a more proactive coordinated care program could be established that would not only save significantly more funding when buying care, but, more important, could provide VA a sound mechanism to fully integrate purchased care into its health-care system. By partnering with an experienced managed-care contractor, VA could define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value for VA.

Care Coordination in Project HERO

In accordance with language from House Report 109-305²⁷⁸ accompanying Public Law 109-114, VA was directed “to implement care management strategies that have proven valuable in the broader public and private sectors.” Congress deemed it essential that care pur-

chased from private sector providers for enrollees of the VA health-care system be secured in a cost-effective manner, in a way that complements the larger VHA system of care, and preserves important agency interest, such as sustaining a partnership with academic affiliates.

VA awarded a contract in October 2007 to Humana Veterans Healthcare Services (HVHS), a national managed care corporation that was a major fiscal intermediary and private network manager under the Department of Defense TRICARE program. In January 2008, contract services for dental care under Project HERO were to be made available through Delta Dental. Contracts for this demonstration project have a base year and four option years. Under this demonstration, participating VISNs 8, 16, 20, and 23 are to provide primary care and, when circumstances warrant, must authorize referrals to HVHS for specialized services in the community. These specialty services initially included medical/surgical, diagnostics, mental health, dialysis, and dental.

Unlike VA's Fee Care Program, the agency is able to address care coordination through contracts. According to VA, contract requirements of Project HERO that address patient safety include providers that must be certified or licensed and must practice in facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations or other similar accrediting institutions. Continuity of care is monitored where patients are properly directed back to the VA health-care system following private care and a process is in place for reporting patient safety, complaints, and satisfaction. Moreover, there is limited read-only access of the veteran's medical record in VA's Computerized Patient Record System, which is annotated with the care provided and the associated pharmaceutical, laboratory, radiology, and other key information relevant to the episode(s) of care.

Under the Project HERO program, VA asserts it will improve its capacity to care for veterans at the more than 1,400 sites of care it currently operates and will take steps to ensure that community providers to whom it refers veterans meet VA's quality and service standards. The ultimate goal of Project HERO is to "ensure that all care delivered by VA—whether through VA providers or through our community partners—is of the same quality and consistency for veterans, regardless of where or by whom care is delivered." The IBVSOs are hopeful that some of these improvements in non-VA purchased care will be implemented systemwide.

We are also hopeful VA's Fee Care Program will benefit in the same manner since there are known weaknesses,

which are routinely subjected to criticism by the veteran community, VA's Office of Inspector General, and by the Government Accountability Office. Second, VA does not track fee-based care by veteran, its related costs, outcomes, access, or veteran satisfaction levels. Third, unlike the contract's medical reimbursement prices under Project HERO, VA's fee-based care program is highly decentralized, lacks sufficient guidance, and subsequently suffers from wide variations in reimbursement levels for both facility and professional charges.

Despite the differences between Project HERO and VA's Fee Care Program, VA has decided to use traditional Fee Basis as its control group. One aspect of concern to Congress and the veteran community is its impact on the VA health-care system. Currently, the measurement used under Project HERO is the number of "VHA full-time equivalent employees (FTEEs) in Project HERO VISNs" and the "volume of authorizations to academic affiliates." The most recent information provided by VA indicates an increase of VHA FTEEs within the four VISNs. However, staffing needs are based on an evidence-based approach and analysis of the relationships among staffing numbers, mix, care delivery models, and patient or resident outcomes for multiple points of care. Therefore, without proper evaluation on whether the process used to calculate staffing needs²⁸⁶ is able to isolate Project HERO's impact, we believe this metric is inadequate. VA also cites payment to academic affiliates for care provided within and outside VA facilities. The IBVSOs again do not believe these are adequate measures of Project HERO's impact on affiliates because such relationship is more than just dollars paid—the relationship is also about education and training of health professions students and residents to enhance the quality of care provided to veteran patients. In any case, we have yet to see a comparison of this metric traditional fee basis.

Central to care coordination is patient perception of the care they receive. The IBVSOs applauded the Department when a survey mechanism was implemented in February 2010 to ask veterans about their satisfaction with the health-care services received through other fee-basis care as compared to Project HERO. Results of this survey through July 2010 indicate a comparable overall patient satisfaction.

The IBVSOs have continually advocated for timely sharing of clinical information with private providers and the return of clinical information to VA. While much work needs to be done to ensure HVHS and Delta Dental meet this contract compliance standard, the efforts by all parties to make this a key performance measure in Project HERO should be commended. All

participating VA facilities have electronic (but not computable²⁸⁷) clinical information sharing available with HVHS and Delta Dental—unheard of in other non-VA purchased care programs. The IBVSOs applaud VA for piloting a program to electronically share through a secure website scanned radiological images performed by Delta Dental as well as providing read-only access of VA's electronic health records to HVHS headquarters. Since meeting these contract standards is one component for VA to consider in exercising optional years beyond the current contract, we expect HVHS and Delta Dental to continue an upward trend to meet these targets, and if not, VA should take appropriate action.

Cost analysis is another key factor in Project HERO and portends implications for eventual implementation of care coordination in non-VA services. VA has indicated its contract pricing is comparable to or lower than market rates. However, when factoring in the value-added costs²⁸⁸ per claim, aggregate price exceeds market rates. Moreover, an independent evaluation by Corrigo Health Care Solutions determined these value-added costs do not work well or fit industry standards for service fees. Further, while the IBVSOs have limited information about VA's claims-auditing procedures, they appear in need of refinement to minimize the risk of overpayments.

Our concern lingers that under this demonstration project, VA pays significantly more for contract care due to the additional requirements of HVHS and Delta Dental to meet VA's standards for patient safety, information sharing, timeliness, coordination, quality of care, as well as numerous reporting requirements. Perhaps the inherent vulnerabilities of VA's indefinite delivery, indefinite quantity contract methodology with HVHS as it is applied to providing episodic care in a managed care environment is also in part the culprit when measuring Project HERO costs as against traditional fee basis.

We were encouraged that VA contracted Corrigo to evaluate and provide recommendations on the business processes of Project HERO. This evaluation was due on September 30, 2009, and has been submitted to VA and to Congress; however, the IBVSOs have not been briefed on its results. VA is currently in the process of assessing future options, using a lessons-learned survey to begin this process. The Department intends to use the results of the lessons-learned survey to begin an additional independent evaluation of Project HERO. The next independent external evaluation is to be initiated in the first quarter of FY 2011, purportedly to assist VA in understanding the full results of the demonstration and how these results will inform future health-care purchasing processes.

The IBVSOs believe the enhancements (identification of certified/credentialed/accredited providers, appointment scheduling, sharing of medical information, and other quality metrics) resulting from required VA standards in Project HERO should be appended to all non-VA contract care. Adding such features would ensure veterans receive high-quality care provided by non-VA providers in the community. We further believe that in conducting market research for future contracts the Department should conduct an analysis of cost-effectiveness wherein outside procurement is compared to creating, maintaining, and operating like services within VA facilities, and that the frequency of their use also be considered. The end goal should be to adopt such enhancements across all of non-VA purchased care and create a standardized method of providing non-VA purchased care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to VA, preserves agency interests, and most important, preserves the level of service veterans have come to rely on inside VA.

Need for Care Coordination

Whether the non-VA care provided to veterans is through partnerships with other federal agencies, such as the Department of Defense Military Treatment Facilities, partnerships with university or college health professions affiliates, or purchasing care in the community through contracts, agreements, or on fee basis, VA retains the obligation to coordinate all such care. Many veterans are currently disengaged from the VA health-care system when receiving health-care services from private physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to health care through coordination of community-based care. The IBVSOs urge VA to develop an effective care coordination model that achieves both its health-care and financial objectives. Doing so will enhance patient-centric care, improve patient care quality, more wisely use VA's limited resources, and reduce or eliminate overpayments.

We recommend VA implement a consistent process for veterans receiving contracted care services to ensure:

- care is delivered by fully licensed and credentialed providers;
- non-VA care is appropriate to the patient's medical need and is part of a seamless continuum of services;
- electronic sharing of pertinent medical information occurs between the VA health-care system and non-VA providers; and
- continuity of care is monitored for each individual patient and patients are directed back to the VA health-care system for follow-up when appropriate.

Components of a coordinated care program should also include the following:

- A single care/case manager assigned to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical needs, the care coordination contractor could address both appropriateness of care and continuity of care. The result could be a truly integrated seamless health-care delivery system.
- Access to provider networks that complement the capabilities and capacities of each VAMC and provide a "surge" capacity in times of increased need. Such contracted networks should address timeliness, access, and cost-effectiveness in both urban and rural environments.
- Alternative types of care, including nonclinical coaching via telephone, messaging, secure e-mail, web-based programs, and other forms.
- Mandatory requirements for private providers to meet, such as timely communication of clinical information to VA; proper and timely submission and payment of electronic claims; VA-established access standards; and compliance with other applicable performance measures.

If implemented successfully, a care-coordination system also could improve veteran satisfaction with contract services and optimize workload for VA facilities and their academic affiliates. A key to success in this effort is the coordination of care by VA and non-VA providers and implementation of a disease-management program. The VHA has a number of such programs as well as established specialized systems of care and primary care teams with specialty trained practitioners for veterans who have incurred spinal cord injury or disease, blindness, amputations, polytraumatic injuries, and chronic mental health challenges. Unfortunately, no such programs of similar scale exist with the agency's purchased care environment. The IBVSOs have been advocating contract care coordination for many years in order to reconnect veterans receiving care in the community with their primary care managers in VA. These VA care managers should be overseeing care received in the community and working to find ways to return the veteran into VA when possible, while ensuring the care being provided is of high quality and is cost effective.

Coordination of care is especially critical for chronically ill and complex patients, such as those with cancer, diabetes, chronic obstructive pulmonary disease, and end-stage renal disease. A particularly compelling need is for patients with end-stage renal disease who

require dialysis for survival. These patients often have three to four comorbid conditions in addition to their kidney disease (e.g., diabetes, hypertension, cardiovascular disease). They are typically on 7 to 10 prescribed medications and are often referred to non-VA providers for dialysis. These patients are extremely frail and should be afforded more convenient access to these specialized facilities for a treatment regime that is generally three days per week for four hours each day. Coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians is essential to improving clinical outcomes and reducing the total costs of care.

The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations that frequently cost more than the total cost of dialysis treatments. These interventions also focus on behavioral modification and motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial for VA. The IBVSOs believe a pilot program should be established to demonstrate the value of such an approach to VA and some of the vulnerable veterans it serves.

Care Coordination and the Patient-Aligned Care Teams

The VHA is redesigning primary care around the Patient Centered Medical Home (PCMH) model designed to deliver efficient, comprehensive, and continuous care through active communication and coordination of health-care services. Achieved through a patient-driven, team-based approach, the patient-aligned care teams, or PACTs, will require an expanded greater role of nurses, nurse practitioners, and physician assistants in coordinating care, as well as from the patients in health-care decision making. According to VA, most VHA primary care practices have already adopted many features of patient centered care and the medical home, but complete achievement will involve strategic assessment and redeployment of resources, realignment of priorities, and a cultural shift. The IBVSOs also believe the VHA should pay special consideration to this new model of health-care delivery in developing an integrated program of contract care coordination where veterans receive assistance with referrals to network providers, scheduling appointments, and return of clinical information into VA's Computerized Patient Record System.

Recommendations:

VA should develop an effective integrated care coordination model for all non-VA purchased care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to the VA, preserves agency interests, and most important, preserves the level of service veterans have come to rely on inside VA.

VA should provide Congress and the veteran community a final analysis and evaluation of Project HERO to address both the concerns raised in Congressional hearings as well as the instructions provided in House Report 109-305, the conference report to accompany Public Law 109-114, and its implications in developing an integrated care-coordination model.

As part of the integrated care-coordination model, VA should assign a single individual of a veteran's VA health-care team the coordination of all non-VA purchased care.

As VA shifts fee staff toward care and case management, the Department should work with key stakeholders before this event unfolds to ensure a smooth transition to retain a full complement of skilled and motivated personnel.

Congress should provide oversight and the necessary resources to facilitate development and implementation of an appropriate information technology infrastructure for VA's non-VA purchased care program.

VA should provide the necessary support and place a higher priority for a long-term solution to standardize business practices in the non-VA purchased care program to address vulnerabilities, such as overpayments and efficient and timely processing of claims.

For care acquired through contract, VA should develop a set of quality standards contract care providers must meet that promote care coordination and ensure the care they provide is equivalent to the quality of care veterans receive within the VA system.

VA should develop identifiable measures to assess its integrated care coordination model for *all* non-VA purchased care. The evaluation should be shared with Congress and the veteran community.

VA should take into consideration the Patient Centered Medical Home model and its patient-aligned care teams in developing and integrating non-VA purchased care coordination.

²⁷³ 38 U.S.C §§ 1703, 1725, 1728, and 8153.

²⁷⁴ Other government agencies; affiliated universities; community hospitals; nursing homes; and individual providers.

²⁷⁵ U.S. Congress, Senate Committee on Veterans' Affairs, *A Hearing on VA's Contracts for Health Services*, 111th Cong., 1st sess., September 30, 2009. Answer provided by Gary Baker, chief business officer, Veterans Health Administration, U.S. Department of Veterans Affairs, to a question posed by Senator Daniel Akaka.

²⁷⁶ Belinda J. Finn, assistant inspector general for audits and evaluations, Office of Inspector General, U.S. Department of Veterans Affairs, House Committee on Veterans' Affairs, Subcommittee on Health, Testimony for hearing on *Review of the U.S. Department of Veterans Affairs Contract Health Care: Project HERO* (February 3, 2010) <http://www4.va.gov/OIG/pubs/VAOIG-statement-20100203-Finn.pdf>.

²⁷⁷ <http://www.va.gov/oig/52/reports/2009/VAOIG-08-02901-185.pdf>.

²⁷⁸ House Report 109-305, 109th Cong., 1st Sess. (2005) http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_reports&docid=f:hr305.109.pdf.

²⁷⁹ M. Kussman, principal under secretary for health, VHA, House Committee on Veterans' Affairs, Testimony for hearing on *Enhancing Access to Quality Care for Our Nation's Veterans Through Care Coordination Demonstrations—Project HERO* (March 29, 2006) <http://veterans.house.gov/hearings/schedule109/mar06/3-29-06/MichaelKussman.pdf>.

²⁸⁰ *The Independent Budget for Fiscal Year 2010* <http://www.independentbudget.org>.

²⁸¹ Department of Veterans Affairs, Office of Inspector General, *Audit of VHA's Non-VA Outpatient Fee Care Program* (August 3, 2009) <http://www4.va.gov/oig/52/reports/2009/VAOIG-08-02901-185.pdf>.

²⁸² U.S. Government Accountability Office, *VA Health Care: Third-Party Collections Rising as VA Continues to Address Problems in Its Collections Operations* (January 31, 2003) <http://www.gao.gov/new.items/d03145.pdf>.

²⁸³ U.S. Government Accountability Office, *VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans* (July 14, 2009) <http://www.gao.gov/new.items/d09899t.pdf>.

²⁸⁴ Washington, *Ambulatory Care Among Women Veterans*, note 165.

<http://www.hsrd.research.va.gov/publications/forum/nov08/Nov08-5.cfm>

²⁸⁵ Yano, *Translating Research Into Practice*, note 166.

²⁸⁶ Department of Veterans Affairs, Veterans Health Administration, Staffing Plans, VHA Directive 2009-055 (Washington, DC, November 2, 2009).

²⁸⁷ A format that a computer can understand and act on, for example, to provide alerts to clinicians to drug allergies.

²⁸⁸ Fee for administrative services that ranges from \$30.75 to \$48.09 per claim varying by VISN and type of service, which supports provision of such services as coordinating appointments for veterans; returning clinical information (for example, medical records) to VHA; processing provider invoices for reimbursement to providers; and monitoring and reporting access to care, appointment timeliness, and patient safety.

CENTRALIZED INFORMATION TECHNOLOGY IMPACT ON VA OPERATIONS:

While still concerned about the impact of centralization of information technology in the Veterans Health Administration, The Independent Budget veterans service organizations remain optimistic that centralized management with sensitivity to critical needs and more involvement by end users in development in the VHA and the Veterans Benefits Administration will improve VA's overall record in information technology management and improved services to veterans.

Background

As reported in prior editions of *The Independent Budget*, the history of VA's Office of Information and Technology (OI&T) has been characterized by both enormous successes and catastrophic failures. Prominent examples of these failures are large Department-level IT efforts, including the integrated financial management and logistics system, called CoreFLS, led by the VA Office of Finance, and the outpatient scheduling upgrade, titled Replacement Scheduling Application (RSA) program,²⁸⁹ under OI&T management since VA's major realignment in 2006. These programs were so mismanaged, delayed, or internally flawed that in the end they could not be salvaged, resulting in the waste of hundreds of millions of dollars that otherwise could have funded needed veterans' benefits and services, or more worthy IT projects to support those benefits and services. Even more recently, the successor effort to the failed CoreFLS, titled "Financial and Logistics Integrated Technology Enterprise" (FLITE) has been identified on numerous occasions by the VA Inspector General as a candidate for failure.²⁹⁰ We are advised by some VA officials that, in fact, today FLITE is failing along the lines of its predecessor and of the RSA program, for many of the same reasons as earlier failures.

In contrast to these remarkable Department-level IT failures, the Veterans Health Administration (VHA) over more than 30 years successfully developed, tested, and implemented a world-class comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on the VHA's self-developed Veterans Health Information Systems and Technology Architecture (VistA) public domain software, sets the standard for EHR systems in the United States and has been publicly praised by the President and many independent observers.²⁹¹

The importance and effectiveness of VistA and its use in protecting quality and promoting improvements in veterans' health was best reiterated by a 2009 news report:

The VA's system allows doctors and nurses at more than 1,400 facilities to share a patient's history, which means they can avoid ordering repeat MRIs or other unnecessary tests. But the system isn't just a warehouse to store patient data. More important, it has safeguards to improve care quality. The system warns providers, for example, if a patient's blood pressure goes beyond a targeted level, or if he or she is due for a flu shot or cancer screening.

It also helps the VA monitor patient care at home, especially for people with complex, chronic illnesses, such as diabetes and heart failure. VA gives those patients special gadgets free of charge to measure weight, heart rates, blood pressure and other conditions, and the daily results are automatically transmitted into the VA's medical-record system, says cardiologist Ross Fletcher, chief of staff at the VA medical center in Washington. If the numbers exceed target levels, a nurse is notified.²⁹²

Moreover, public domain and commercial versions of VistA have been installed by public and private sector entities into the patient care systems of a number of U.S. and foreign health-care provider networks, including state mental health facilities and community health centers in West Virginia; long-term-care facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and health systems in a number of foreign nations (including Colombia, Finland, Germany, Mexico, Nigeria, and Jordan). One nation is conducting a trial implementation of VistA as its national EHR system.²⁹³

VistA has been a critical tool in VHA efforts to improve health-care quality, continuity, and coordination of care. This EHR system literally saves lives by reducing medication errors and enhances the effectiveness and safety of health-care delivery in general. Therefore, *The Independent Budget* veterans service

organizations (IBVSOs) are acutely aware of the critical importance of effective IT management to veterans' health care and to their very lives. In the past, we have questioned the wisdom of the IT reorganization and centralization of VA's IT management, development processes, and budgeting because these actions were seen to potentially threaten the continued success of VHA IT development and the EHR itself. However, in 2009, VA Secretary Eric Shinseki announced his intention to maintain the centralization of VA's IT enterprise that was implemented and expanded by his three predecessors. Because the Secretary is a strong proponent of the Virtual Electronic Lifetime Record (VLER) of which the EHR is a critical component, we are optimistic that he will drive some of the critical changes needed in both the IT organization and centralization efforts to sustain the VHA's preeminence in health-care delivery.

The IBVSOs appreciate that VA needs to comply with legislative mandates, including the "Clinger-Cohen Act of 1996," which specifies a certain degree of control and central decision making in federal government IT systems. Now that Secretary Shinseki has made the continued-centralization decision (one that we accept with caveats to be further explained), we urge VA to move forward aggressively with modernization of Vista-CPRS, as well as currently publicized efforts to create a lifetime VA-DOD record system and to participate in the overarching national health IT development efforts. We respect the Secretary's decisions on centralization of the management effort, but will maintain our vigilance and oversight during this critical period and urge Congress to do so as well, to ensure the health and benefits of veterans are fully protected. The IBVSOs want to see state-of-the-art technology and cutting-edge IT management applied to all veterans' programs, whether in health care, benefits and services, or administrative and VA management operations.

Evolving History of IT Centralization

Despite its superiority and success, in early 2000, the VHA recognized that VistA was aging and needed to be modernized if it were to serve veterans' health-care needs in the 21st century. However, myriad efforts to "replatform" and update the VHA's electronic health record system and its component parts have lagged during the off-again, on-again IT reorganizations and various centralization efforts.²⁹⁴

In 2002, then-VA Secretary Anthony Principi issued a memorandum that mandated centralization of all VA IT functions and programs, and centralized appropriated funding under a Department-level chief information officer. However, four years were consumed to

fully structure a centralized VA IT organization and management system. By April 2007, all IT resources and staff were centralized to the Department level, including thousands of field staff supporting health information technology programs in VA's 153 medical centers, 58 regional offices, and hundreds of point-of-service clinic locations throughout the nation. This restructuring created changes and significant challenges to the maintenance of reporting relationships, roles, and responsibilities with regard to IT strategic planning, programming, budgeting, IT security, equipment procurement, software development, and provision of service to user groups that interacted with veterans in need of VA's health services and benefits. A key to the past successful deployment and use of VistA was the involvement of clinical and administrative end users throughout the development cycle of the software. In that case the reorganization created a severe chasm in this involvement because of the demarcation of clinical staff that was no longer playing an active role in development due to the rigid demarcation of IT staff, who reported to new leadership in Washington, DC.

The role of the VHA shifted from being in control of its IT planning, solutions development, and budgeting, to being only one (albeit a very large one) of a multitude of the national OI&T's "customers," including the VBA, the National Cemetery System, and a variety of staff and executive offices in Washington and elsewhere. Health-care solutions and quality of care IT software (whether new or old) were no longer assured of receiving the highest priority and attention from VA's IT development and operations/maintenance enterprise. Some of this development is understandable, given VA's competing priorities and limited funds for IT development and deployments. Additionally, new IT leaders were suddenly thrust into simultaneously managing a complex reorganization process, creating their own functional operating units, and working in collaboration with skeptical managers from VHA and other administrations as well as staff offices. In our opinion, in reading many of the trade publications and other news sources on VA's IT progress, it is very difficult, if not impossible, to ensure that the new leaders and their supporting staffs understand their unique business needs and can convert them into requirements, systems, and efficient, effective tools that are used by the VHA's frontline staff to deliver care or services to veterans. All of these are highly specialized areas of operations and ultimately dependent on the clinicians who deliver the care to veterans.

The difficulty and complexity of this reorganization cannot be overstated. Despite the time and resources

devoted to these efforts, much critical work still remains to be done today by OI&T to align roles and responsibilities, define IT governance processes (a key requirement that is still not developed after two years,²⁹⁵ fill existing gaps, and ensure that administration “business owners” were appropriately represented on IT departmental and interagency committees and planning and development activities. Failure to appropriately involve business owners in IT decision making has resulted in catastrophic failures in the past. To ensure the success of future IT development and deployment, business owners must be integrated and involved in each step of the process.

The IBVSOs urge the current Assistant Secretary of OI&T to make needed changes to actively address effective OI&T-user organization collaboration and important interagency coordination challenges. Effective IT programs are vital to VA’s achievement of its core missions, certainly in the VHA but also in other benefits and services arenas important to America’s veterans.

VHA VistA: World-Class Electronic Health Record

The VHA’s unparalleled success in integrating use of its comprehensive EHR system into its day-to-day health-care delivery process has been a critical factor in the VHA’s transformation to becoming the national leader in health-care quality, safety, prevention, and clinical effectiveness. Among health-care and IT industries worldwide, VistA is one of the most successful and remarkable health IT and EHR systems and a critical enabler of the VHA’s ability to deliver consistently high-quality and safe health care to more than 6 million veterans annually. In fact, the VHA’s electronic health record system has earned the reputation as “world class” and is acknowledged by most observers as the most successful EHR operating in the world today, although current failures and lack of progress in moving to the next generation of EHR are quickly and alarmingly jeopardizing that position. It is also important to recognize that the VHA’s EHR is not simply an IT system, but rather is a health-care tool that is just as vital a component of the VHA’s successful health-care delivery capability as its cardiac catheterization laboratories or its magnetic resonance imaging technologies. Without its EHR system, the VHA would be unable to deliver 21st century veteran-centered health care. Therefore, VistA should not, and cannot, be viewed as a standard IT system of network servers and operating systems, but rather as a medical device. In fact, Food and Drug Administration policies consider the VistA system to be a medical device for its regulatory purposes.

In the 10 years since the VHA determined to take the course of replacing VistA with a modernized web-based version called “Healthvet,” maintenance of, and upgrades to, VistA infrastructure have lagged. In a zero-sum budget environment, funds devoted to new developmental initiatives, such as CoreFLS, RSA, FLITE, and other IT initiatives, effectively took away funds that could have been used to replace aging VHA private branch exchange equipment, install wireless capabilities throughout VA health-care facilities, and update or upgrade VHA’s data warehouses, among hundreds to thousands of other unmet IT infrastructure needs across the vast VHA landscape. Current planning at VA suggests HealthVet is being scrapped in favor of a wholly new approach relying on “open source” software, but the current direction still seems vague to us. As described by Assistant Secretary Baker, “So, let’s be clear; in my view, VA over the last 10 years has tried to replace VistA. I don’t think that’s possible. It would be like Microsoft [Corporation] trying to replace Windows with not an evolutionary product, but with something brand new, but it has to come out and it has to be better the day it’s introduced. That, basically, was the criteria for what VA was trying to do. That program was called Healthvet. I have stepped VA away from Healthvet, and what we’re now looking at is how we continue the evolution of VistA.”

Assistant Secretary Baker continues: “It [VistA] is the best electronic health record system in the United States, at this point, especially if you focus on it from a patient-care standpoint. So, how do we then get back to moving the innovation forward in VistA, and that’s really what the whole open source campaign is all about. Medical records systems have moved forward a tremendous amount, in the United States, since the time that VistA was started. And the private sector is doing a lot of stuff that we need to be able to incorporate into VistA. So, our thought is that by being part of an open source community based around VistA, VA can encourage private sector folks to either directly contribute the open source—you know, make improvements. Or integrate their products with the open source, so we can very easily buy a working product, instead of having to go down the government route.”

Assistant Secretary Baker’s conclusion: “The reason that, I believe we’ve got to go the open source route, is that we have two important projects to integrate private sector packages into VistA going on inside the government right now—one is for laboratory and one is for pharmacy. Both of those projects are going on five years, to integrate the private sector product into VistA because we’re doing it the government way. That

is far too long. We need to be able to go out and say, 'I'm interested in a pharmacy package, in six months I'm going to buy one that I prefer, from all the ones integrated with the open source—let's go.' And when an organization like VA says it's going to buy, that could be 200 or 300 million dollars. So, you know generating the private-sector interest in it. I just think we're going to move VistA innovation forward much more quickly if we go the open source route."²⁹⁶

In consonance with Assistant Secretary Baker's view, we believe that in addition to providing veterans with a world-class health record, upgrading the VistA system can provide an EHR that meets national health IT standards with public domain, open source programming code. The potential benefits of a modernized open-source VistA to veterans and the nation could be significant if successful. VA must renew its commitment to these efforts, give them the highest priority, and pursue this goal with the vigor, dedicated effort, resources, and persistence they will undoubtedly require. Nevertheless, in our view, this work must also integrate updates to existing and near-obsolete IT infrastructure that now powers VistA. Whatever roadmap governs the next VistA, VA's IT infrastructure will still serve as the means to achieve it.

The "Blue Button"

In August 2010, the Administration announced the "Blue Button" capability, an electronic means of allowing veterans to download their personal health information from their My Healthevet account. VA developed the Blue Button in collaboration with the Centers for Medicare and Medicaid Services (CMS), the DOD, and others.

The My HealtheVet personal health record is composed of self-entered health information (blood pressure, weight, heart rate, etc.), emergency contact information, test results, family health history, military health history, and other health-related information. The Blue Button extract that veterans can download is a so-called "ASCII text file," the easiest and simplest electronic text format. Blue Button personal health records can be printed or saved on computers and portable storage devices. Having control of this information enables veterans to share this data with health-care providers, caregivers, or people they trust.²⁹⁷

The IBVSOs fully support this development because it gives the veteran the opportunity and direct means to help document his or her own record and health status to provide a basis for better overall health care.

Slow Progress in VA-DOD Health Information Sharing

VA and the DOD have been working on electronic health information sharing for well over a decade. Even as far back as 25 years ago, VA oversight leaders in Congress were calling for VA and the DOD to share VA's then-fledgling "Decentralized Hospital Computer Program," an early precursor to today's VistA. Despite strong and consistent Congressional mandates and oversight over those years, these efforts remain fragmented and have proceeded at a glacial pace. The DOD and VA continue to lack a consistent approach to electronic health record development and to move in divergent directions in their efforts. Significant differences in policy, programs, and approach at least partially explain the lack of timely progress toward health record interoperability across the DOD and VA systems of care. Currently, VA and the DOD do not share all electronically available health records; while some records are shared in a computable form, others are imaged but are only viewable. VA captures all health information electronically; however, many DOD medical treatment facilities are still using paper-based health records. Unlike the VHA's single, comprehensive, integrated electronic health record, the DOD continues to use many different legacy information systems, relying on different (and proprietary) platforms, and the DOD lacks a consistent, uniform approach across service branches in the Army, Navy, and Air Force health records systems. Most DOD electronic health record software was commercially developed and therefore the products lack developmental involvement by their clinician end users. The Armed Forces Health Longitudinal Technology Application (AHLTA) serves as the primary DOD outpatient records system; however, the earlier Composite Health-Care System, which once was the DOD's primary EHR, is still used to capture pharmacy, radiology, and laboratory information.

More than 10 years ago, VA and the DOD began development of their information-sharing initiatives with the development of the Government Computerized Patient Record program. In 2004 the Federal Health Information Exchange (FHIE) was fully implemented. The FHIE enables the DOD to electronically transfer service members' electronic health information to VA when the members leave active duty. Since 2002, the DOD has collected information on 4.8 million service members from its various electronic systems and forwarded those data to VA once these individuals were discharged from active duty. The Laboratory Data Sharing Interface allows DOD and VA facilities to share laboratory orders and test results, but the system is in use at only nine locations. In addition, in 2004 the

Bidirectional Health Information Exchange (BHIE) was developed to allow VA and DOD health-care providers to view records on patients who receive care from both departments. The BHIE has been used successfully to provide viewable access to records of some of the seriously injured service members wounded in Iraq and Afghanistan. Unfortunately, many VA outpatient clinicians report that they are unaware of or do not know how to use the BHIE. Those who are aware of the BHIE often report that they cannot access the patient records that they need most or that the system is so slow that it is virtually unusable in their busy clinics.

The IBVSOs believe VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records and medical images. Additional information can be found “The Continuing Challenge of Caring for War Veterans and Aiding Them in Their Transitions to Civilian Life” in this *Independent Budget*.

Joint IT Test Bed at VAMC North Chicago— Naval Health Clinic Great Lakes

As we indicated in *The Independent Budget for Fiscal Year 2011*, Congress authorized VA and the DOD to execute by memorandum of agreement a formal merger of the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes into one consolidated regional Federal Health Care Center, the James A. Lovell Federal Health Care Center.

The creation of the facility under a single joint VA-Navy management system for the beneficiaries (veterans, DOD active duty, and DOD retirees and their dependents) of the two previously segregated federal facilities creates a unique full-service capability that did not exist previously.

There have been considerable struggles in the frustrating efforts of VA and the DOD to integrate, or link interoperably, their respective electronic health record systems, and in the case of DOD service branches, to create and sustain the AHLTA EHR as an effective, user-friendly, interactive medical tool across Army, Navy, and Air Force health programs. This North Chicago merger presents both a challenge and a remarkable opportunity to determine whether the significant Navy, Marine Corps, dependent, and veteran enrolled populations in the Lake County and Waukegan communities can be served with equity of access, quality, safety, cost-effectiveness, and satisfaction in a combined VA-Navy facility using merged capabilities of VA VistA and DOD AHLTA electronic health records.

First Navy/VA Joint Federal Health Care Center

The Lovell Federal Health Center is the first fully integrated VA and DOD entity, combining manpower and resources from the North Chicago VA Medical Center and Naval Health Clinic Great Lakes. The shared mission of the federal health-care center means active duty military, their family members, military retirees, and veterans will be cared for at the facility by one unified staff and management, a laudable accomplishment.

A unified electronic health record will be critical to the success of this joint facility. VA and the DOD, aided by multiple contractors, are working on six critical functions for an integrated EHR utilizing VistA and AHLTA. We are advised that in several instances, the business processes needed to be consolidated into common services in order for the electronic health record capabilities to function properly. The terminology or code in one system must mean the same thing in the other system (i.e., a chemistry panel and complete blood count test ordered in one system must be identical in the processing system with corresponding results).

We understand that the following functions were to have been tested for final production in December 2010:

Unified Patient Registration/Patient Identification Management Service

- Unifies registration processes such that registering the patient in either system, automatically registers them in both systems. The significance is that for the first-time an EHR will be created for the Active Duty Service Member in the Military Health System and VHA simultaneously.
- Patient identity follows the beneficiary throughout MHS and VHA.
- Actively facilitates merging records under a single ID within each system and linking those records across systems, preventing duplication of patient data in both departments.

Single Sign-on with Patient Context Management

- Enables a provider to log into multiple applications with a single user name and password (user identification management service) and see the records for the same patient in each application.
- Enables a provider to select the same patient among clinical applications, eliminating the need to repeat patient searches when switching applications.
- Contributes to provider satisfaction, continuity of care, and helps ensure patient safety.

- Enables a provider to securely log into multiple applications with a single user name and password to perform clinical support functions and see the records for the same patient in each application.

Orders Management/Order Portability Service

- Provides ability for orders (laboratory and radiology) to be created separate from a specific ancillary system/department.
- Provides the ability for orders to be assigned to a specific system/department.
- Allows orders to be fulfilled by a specific system/department with fulfillment notification back to the order management service.

Outside this list of potential operational joint functions, pharmacy and consult orders will continue to be done separately by each agency, according to VA. VA maintains that these delays are necessitated to maintain the highest standards for patient safety while local efforts continue to eventually gain full joint operational capability to activate these functions jointly.

The IBVSOs understand that several modules were seen as nonessential for operational functionality at the combined site when the health-care clinics were formally integrated in December 2010. It is proposed that these applications be developed and implemented as resources become available. These yet-to-be-completed modules are orders portability (consults and allergies); outpatient appointment scheduling; financial reporting; and material management. While we appreciate the continuing challenges facing a joint activity, we are concerned that some of these modules may, in fact, turn out to become critical gaps, causing untold problems, and we urge that they be made high priorities for production and implementation.

We have learned that facility working groups have identified the baseline EHR interoperable capabilities that will be needed for efficient joint health-care operations and that a common services approach is being taken to implement these capabilities. Common services provides an environment in which functions can be standardized and used across systems and processes, and would enable the DOD and VA to develop business and data services only once, utilizing those services within the DOD-VA continuum of care. Common services would enable the DOD and VA to improve quality and continuity of care through virtual longitudinal EHRs. A common services approach further supports nationwide EHR goals to develop the foundation for

an interoperable, secure, and standards-based health information exchange to potentially conduct business and communicate patient care information with providers outside the DOD and VA, and to do so on an efficient basis.

The IBVSOs applaud this unprecedented progress in North Chicago, and urge VA and the Navy to strongly support these efforts with continued significant IT funding and oversight so that the currently incomplete IT projects identified as of December 2010—projects that may become critical to operational success of the joint facility—will be accomplished.

Also we strongly urge the DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees of both Congressional chambers, to continue monitoring the IT management aspects of this merged health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Finally, North Chicago and its accomplishments may move the federal IT interoperability goals (as well as health resources sharing in general) in a significant and positive new direction.

National Health Information Technology Standards

VA and the DOD are continuing to develop standards for the electronic exchange of clinical information. In recent years, these efforts have been integrated with the Health Information Technology (HIT) Standards Committee led by the Office of the National Coordinator. A number of former VHA leaders are now major contributors to the national HIT efforts led by the Department of Health and Human Services, Office of the National Coordinator, to implement a secure, interoperable, nationwide health IT infrastructure necessary to markedly improve the quality, safety, and efficiency of U.S. health care. These efforts are aimed at producing standards, implementation specifications, certification criteria for electronic information exchange, and prescribed uses of health information technology that align with meaningful use of EHRs required for providers to be eligible for payment incentives from Medicare and Medicaid.²⁹⁸

Public Law 111-5, the "American Recovery and Reinvestment Act," provided funding (\$19 billion) and a variety of new incentives and regulatory requirements for health-care providers nationwide to adopt compatible EHR systems. Early adaptors of EHR systems that meet federal criteria for consistency and interoperability will be rewarded with funding, but providers

that do not move forward on EHR within a prescribed period eventually will face financial penalties in Medicare and Medicaid reimbursement rates.

Given this development, it is critical that VA and the DOD participate and comply with federal standards for electronic health records since many veterans receive care in VA, the DOD, and from private sector systems and providers. VA participates as a member of the American Health Information Community, the Health IT Policy Council, and the Healthcare Information Technology Standards Panel. Both VA and the DOD are developing software solutions that are compliant with existing standards and will seek national HIT certification by the Certification Commission for Healthcare Information Technology. The Social Security Administration began the first pilot of health information exchange. However, in early 2010 VA, the DOD, and Kaiser Permanente in San Diego executed an agreement for a demonstration pilot to share information on patients seen by their separate health-care systems. More recently a similar agreement was completed for health information data exchange among VA, the DOD, and private providers in the Tidewater-Richmond area of Virginia. If these pilot programs are successful, VA plans to expand data exchange to additional federal partners and private providers. The IBVSOs support these initiatives and believe that VA should continue to seek a national leadership role in these crucial HIT efforts.

Virtual Lifelong Electronic Record System

In April 2009, the President announced the creation of the virtual lifetime electronic record (VLER). The VLER is envisioned to facilitate comprehensive, real-time sharing between the DOD and VA of military service and VA records. As it is currently defined, the VLER will enable the DOD and VA to electronically access and manage the health, personnel, benefits, and administrative information required to efficiently deliver seamless health care, services, and benefits to service members, veterans, and their dependents where appropriate. The IBVSOs fully support the development of the VLER, provided privacy and confidentiality concerns can be appropriately addressed and protected. As the DOD and VA move forward with the development and implementation of the VLER, it will be critical to have in place appropriate governance, coordination, and oversight mechanisms to ensure the project's success. This will require VA and the DOD to develop joint policies, budget processes, and dispute-resolution mechanisms to support flexible and efficient IT development and implementation. In the past these issues have slowed or blocked needed change. Technology is available to support the VLER vision, so VA and the DOD should not allow cultural and policy dif-

ferences to impede progress on joint systems development of a lifelong electronic records system for veterans. VA and the DOD must overcome these barriers and expedite completion of this vital effort to better serve the active military, retirees, veterans, and their family members.

Some Lingering Concerns

In 2009, Secretary Shinseki announced the “temporary halt” of 45 IT development projects, most of which were VHA related. The purpose of the temporary suspension was explained by Deputy Secretary Scott Gould at a Congressional hearing on October 15, 2009:

VA is taking on the tough issues with greater transparency. For example, we recently instituted a Performance Management and Accountability System (PMAS) to strengthen our IT oversight and performance. In June, we placed 47 projects under PMAS; in July, we paused 45 of them. Many were over a year behind schedule. Some are too important not to get done. Over the past 60 days, 17 projects were committed to near-term dates, and 15 met their committed dates. We have re-planned and restarted 13 projects, and we have halted or cut funding for 15 or 1/3 of the original 45 projects. We mean business; and we will hold ourselves and our private sector partners accountable for cost, schedule and technical performance.^{299, 300}

According to VA, PMAS is used to increase the Department's success rate for IT systems development projects: “PMAS is a management protocol that requires projects to establish milestones to deliver new functionality to its customers. Failure to meet set deadlines indicates a problem within the project. Under PMAS, a third missed customer delivery milestone is cause for the project to be halted and re-planned.” In addition to PMAS, VA advises us that the IT Dashboard will be a critical indicator of whether major VA IT projects are on schedule and on budget, taking swift action to cut down on waste and redundancy.³⁰¹

Of the 45 projects identified by Secretary Shinseki in his 2009 suspension decision, 33 projects were able to comply with the rigorous PMAS requirements, or were redesigned and had restarted as of publication of this *Independent Budget*. Twelve projects were canceled. The majority of these projects had been rated as “significant concerns” by VA's IT Dashboard. The term “significant concerns” means these projects were seen at a moderate to high risk of failing to accomplish their objectives. These were health-related projects for application to home telehealth, spinal cord injury, out-

patient scheduling, laboratory and pharmacy systems, enrollment, health data repository, and many other sensitive elements related to the operations of the VA health-care system. Also, many of these applications would have become some of the building blocks of the next generation of VistA—which cannot proceed in their absence.

According to the VA Assistant Secretary for Information and Technology, under PMAS, all projects must deliver “customer-facing functionality” every six months (or less) without exception. In an interview he stated that customer-facing functionality means to “[d]eliver software in six months or sooner so that it can be evaluated by the customer. The date is paramount. There are various ways in how it needs to be applied. Nowhere in our PMAS guidance does it say when the software must be in production. The customer is in control. The PMAS gets the project to the point of being accepted by the customer.”³⁰²

According to the Assistant Secretary, this rapid delivery approach, with such name as “Incremental or Agile development,” is already used extensively throughout the private sector. He indicated that VA had combined rapid delivery with a management methodology that enforces strict adherence to project milestones.³⁰³

Caution: Lessons Learned, from an Informed Expert
Dr. Tom Munnecke provided this compelling testimony before the U.S. Senate Committee on Veterans’ Affairs, in October 2010.

VistA was developed directly as a clinical tool, by clinicians, for direct patient care. While there are many administrative needs of an enterprise for logistics, cost accounting, billing, payroll, and the like, these are a fundamentally different kind of computing. Lesson Learned: Decentralization works. The extensive end-user [a.k.a. “business owner”] collaboration was a key factor to the success of VistA.

When I first started at the VA, I ran into the bureaucratic “stovepipe” mentality everywhere I went, even though everyone had a supposedly common goal of providing health care to our veterans. Recalling the words of the sheriff in *Cool Hand Luke*, it seemed that the core problem could be expressed as: “What we have here is a failure to communicate.”

In college, I was struck by the Sapir-Whorf hypothesis that language shapes our thought. I began to focus my attention on ways of using IT to overcome the failure to communicate. This led to the development of an integrated data dictionary that served as a “roadmap” to the patient data. Today, this would be called a “Semantic Web” (see <http://www.caregraf.org/semanticvista> for a modern semantic web interface to the VistA database). We integrated electronic mail directly into the clinical interface, allowing database activities to generate email messages through an email/discussion/workflow system called MailMan. I was amazed at how heavily used MailMan was—in some cases, 25% of the traffic in a VistA system was email traffic. This demonstrated how communications-intensive clinical care is, even outside the formal communications traffic in the specific applications, such as pharmacy, laboratory, or radiology. I think that VistA broke down many of the bureaucratic stovepipe barriers, allowing people to focus on what was best for their clinical practice.

Lesson Learned: The fundamental goal in health IT should be to improve communications. The medical record is but one form of communication.

All of the initial developers of VistA were employed in the field [in VA medical facilities], working closely with end users. Riding the elevator with a gurney headed to the morgue was a sobering experience, and helped keep me focused on the implications of the software I was developing. The trust we placed in the VistA community was well-placed. People felt respected and acted accordingly, knowing that they were contributing to a larger, more successful whole.

The goal of our system was to produce a constantly improving, evolutionary system. Our goal was to get something “good enough” out into the field, and then begin the improvement process. We had neither money nor time for gold-plated requirements and specifications. Our motto was, “generations, not specifications.” We didn’t claim to know the end point of the system when we started, but rather created tools for users to adapt. Someone used to waterfall/requirements driven life cycle process

might find this appalling—that users could interactively develop a system in tandem with developers—but it was a key factor to the success of VistA.

Lesson Learned: Generations, not specifications. Start with “good enough” and allow it to continuously improve through end user interaction.³⁰⁴

While the IBVSOs agree that project management and accountability are critical in today’s environment, we have received reports that confusion and frustration still run high among field facilities about how to maintain conformance with PMAS while moving existing and future critical health IT projects forward. Some have suggested that PMAS is canted or biased toward failure rather than serving as the means to push and achieve success in IT development. In fully implementing PMAS, now in place more than a year, VA leadership must ensure that VA clinicians and program managers at all levels are better educated in navigating this new operating environment, and that, in respect to iterating the next VistA, developers remain mindful of Dr. Munnecke’s wise admonitions.

The IBVSOs continue to believe that IT in VHA serves as a *medical device* that manages health-care delivery and its myriad decision support processes, without which the VHA would be poorer and unable to deliver 21st century veteran-centered health care. Agreeing with Dr. Munnecke, we continue to believe that health IT does not fit the standard concept of a business IT project because when health IT fails, patient care fails. When patient care fails, veterans needlessly suffer. Therefore, while we cannot object to VA’s current management model for controlling the future of HIT, PMAS must not ignore the demands of health-care delivery and must assign it proper weight in prioritizing IT projects, whether within VHA or in other cases.

Other Important VA IT Considerations

The Veterans Benefits Administration (VBA) has embarked on a significant transformation effort to solve its age-old benefits claims-processing problems with new solutions that rely heavily on IT. We have highlighted and discussed the importance of these reforms elsewhere in this *Independent Budget*. Dozens of initiatives are under way across the VBA system to test a variety of methods to make claims processing more accurate and efficient. The most important new initiative is the new Veterans Benefits Management System, which is undergoing its first field test at the regional office in Providence, Rhode Island. The VBA has long

struggled to successfully employ comprehensive IT solutions as a foundation for the processing of veterans’ claims. The centralization decision discussed above also affected the VBA dramatically, and we think it is fair to conclude that the VBA is also struggling with trying to develop and deploy new IT solutions in a centralized IT management environment.

The IBVSOs and the millions of veterans we represent depend on the VBA to make accurate decisions on disability, pension, insurance, education, and other benefit claims from veterans. Those decisions must first and foremost accurately reflect the entitlements Congress granted them in exchange for their honorable service in uniform. We urge the Administration to keep in mind that as these IT reforms proceed, the IBVSOs are monitoring them closely to ensure that veterans’ rights to benefits are being protected and reaffirmed throughout VA’s efforts to develop and implement more timely and efficient means to process claims.

Summary

Despite our concerns about the transitional status we detect in VA IT reforms three years post-reorganization, the IBVSOs remain confident that Secretary Shinseki’s IT and management teams will continue to address the numerous challenges before them and bring VA’s IT community of interests up to the level of performance expected by veterans who must rely on VA health care, benefits, and other services, while being sensitive to necessary priorities and user needs, in particular in the VHA and VBA. As the Secretary has indicated, “Leveraging the power of information technology to accelerate and modernize the delivery of benefits and services to our nation’s veterans is essential to transforming VA to a 21st century organization that is people-centric, results-driven, and forward thinking.” The IBVSOs cautiously concur with the Secretary’s commentary, and most certainly with his stated intent, and urge the VA Office of Information & Technology and Administration officials and staff to meet his challenge to lead the Department’s IT systems to the level of excellence veterans expect.

Recommendations:

The current Assistant Secretary of VA’s Office of Information & Technology should make needed changes to actively address effective OI&T-Administration collaboration and important interagency coordination challenges.

VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health

information system with real-time access to comprehensive, computable electronic health records and medical images.

While VA has ramped up concern about the efficiency, cost-effectiveness, and success of IT projects through use of the Performance Management and Accountability System mechanism, it has allowed myriad needed IT infrastructure upgrade projects to languish. When a given project being monitored by PMAS fails or runs under projected cost, VA should shift the funds associated with that project (or with underage) to infrastructure so that its IT system receives proper maintenance and upgrades in preparation for new VistA technologies to be developed.

VA and the Navy must strongly support the efforts of the joint VA North Chicago-Great Lakes Navy health facility consolidation with continued significant IT funding and oversight so that the currently incomplete IT projects identified by the facility as of December 2010, which may become critical to the ultimate operational success of the joint facility, will be accomplished at the earliest possible date.

The DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees, should continue monitoring the IT management aspects of the merged North Chicago health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Also, the North Chicago pilot test and its accomplishments may move the federal IT interoperability goals in a significant new and positive direction.

VA should continue to seek a national leadership role in developing crucial health information technology efforts prompted by the "American Recovery and Reinvestment Act" and by health insurance reform legislation (Public Law 111-148), now in its implementation phase.

VA should modernize and update the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record system to provide an EHR that meets national health IT standards, relying on public domain, open source programming code, assuming that is the most appropriate way to proceed.

VA and the DOD should develop a virtual lifetime electronic record (with inclusion of an electronic DD 214). VA and the DOD, with the assistance of strong Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have been barriers to past efforts in formulating the virtual lifetime electronic record.

The Administration should keep in mind in reforming the Veterans Benefits Administration's claims-processing system the use of IT solutions as a way to modernize, that *The Independent Budget* veterans service organizations will monitor this process closely to ensure that sick and disabled veterans' rights for equitable treatment by the U.S. government will be protected, and will not be sacrificed to the efficiencies of automation.

²⁸⁹ VA Under Secretary for Health Memorandum, March 20, 2009. www.govexec.com/nextgov/RSAMemo.pdf.

²⁹⁰ Belinda J. Finn, Office of Inspector General, Testimony before the U.S. Senate Committee on Veterans' Affairs, October 6, 2010.

²⁹¹ Joint Commission on Accreditation of Healthcare Organizations (JCAHO), *Guiding Principles for the Development of the Hospital of the Future* (2008) http://www.jointcommission.org/NR/rdonlyres/1C9A7079-7A29-4658-B80D-A7DF8771309B/0/Hospital_Future.pdf

²⁹² "The Digital Pioneer," *The Wall Street Journal* (October 27, 2009) <http://online.wsj.com/article/SB10001424052970204488304574428750133812262.html>.

²⁹³ Reuters, "Jordan Unveils State of the Art Healthcare Technology in Hospital Trial" (October 27, 2009) www.reuters.com/article/pressRelease/idUS200273+27-Oct-2009+PRN20091027.

²⁹⁴ VA Under Secretary for Health Memorandum, March 20, 2009. www.govexec.com/nextgov/RSAMemo.pdf.

²⁹⁵ Finn, Testimony, note 290.

²⁹⁶ Fierce Government, *Q&A: Roger Baker on the future of VistA and VLER* (October 25, 2010) <http://www.fiercegovernmentit.com/story/q-roger-baker-future-vista-and-vler/2010-10-25>.

²⁹⁷ VA's Blue Button Initiative <http://www4.va.gov/bluebutton/>.

²⁹⁸ http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204.

²⁹⁹ Scott Gould, VA deputy secretary, congressional hearing, *Initial 45 Projects Targeted for New Department-wide Management System* (October 15, 2009).

³⁰⁰ Department of Veterans Affairs press release (July 17, 2009) <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1734>.

³⁰¹ Federal IT Dashboard, <http://it.usaspending.gov/> and <http://www.oit.va.gov/dashboard.asp>

³⁰² Alice Lipowicz, "VA weeds out poorly performing programs; For VA CIO Roger Baker, PMAS spells IT project accountability," *Federal Computer Week* (April 26, 2010).

³⁰³ Roger Baker, Testimony before the U.S. Senate Committee on Veterans Affairs, October 6, 2010.

³⁰⁴ Dr. Tom Munnecke, Testimony before the U.S. Senate Committee on Veterans Affairs, October 6, 2010.

VHA PHYSICIAN ASSISTANT RECRUITMENT AND RETENTION:

The Department of Veterans Affairs must update its physician assistant qualification standards and increase retention and recruitment incentives in order to maintain the PA workforce.

V A is one of the largest single federal employers of physician assistants (PAs), with approximately 1,900 full-time PA positions. As a result of VA not updating the PA qualification standards under title 38 since 1993, PA recruitment and retention rates are low. Despite Congress enacting Public Law 111-163, which states that the Under Secretary of Health shall appoint a full-time PA Services director, as of November 1, 2010, VA had yet to fill this position at VA headquarters. For the past several years, *The Independent Budget* veterans service organizations (IBVSOs) have requested that this position be based out of Veterans Health Administration (VHA) headquarters so the PA director is able to adequately address the workforce issues impacting the recruitment and retention of PAs. Specifically, the PA director should work closely with the Office of Rural Health Care and the VHA Primary Care Office on utilization of PAs in the planned expansion of these new initiatives on improving primary care outpatient access for veterans.

In the VA system, PAs provide health care for millions of veterans. PAs work in both ambulatory care clinics, emergency medicine, and in wide variety of other medical and surgical subspecialties. The IBVSOs maintain that PAs are a critical component of VA health-care delivery and have consistently recommended that VA include them in all health-care staffing policy.

As previously stated, the VA’s physician assistant qualification standards have not been updated since 1993. In 2003 new draft recommendations were submitted and reviewed, but still have not been approved within VHA or VA human resources. The VA average retention rate for PAs is not even 9 percent. Despite this retention problem, VA has not requested any legislative changes to improve or increase incentive programs, such as locality pay adjustments, to make PA positions within VHA more attractive to applicants.

VA is simply not competitive with the private sector for new PA program graduates. Approximately 40 percent of PAs currently employed by VA are eligible for retirement in the next five years. As seen in Table

10, the PA workforce has risen by few positions in the past five years when compared to similar positions within VA. The PA percentage of the VHA mid-level practitioner workforce has dropped to 30 percent.

VHA PA Utilization Reflecting 3 Percent Growth Rate as Compared to the Nurse Practitioner Growth Rate

The Office of VA Healthcare Retention and Recruitment reported that in fiscal year 2009, and the first half of FY 2010, less than \$30,000 was spent on the Employee Incentive Scholarship Program (EISP). VA is authorized to provide recruitment incentives to occupations that are difficult to recruit. The use of recruitment incentives is at the discretion of the hiring facility, and they are not used consistently across the VA system.

To effectively address the barriers to PA recruitment and retention, VA must ensure that employee incentive programs, such as the EISP and the VA Employee Debt Reduction Program are made available to PAs.

VA Critical Occupations

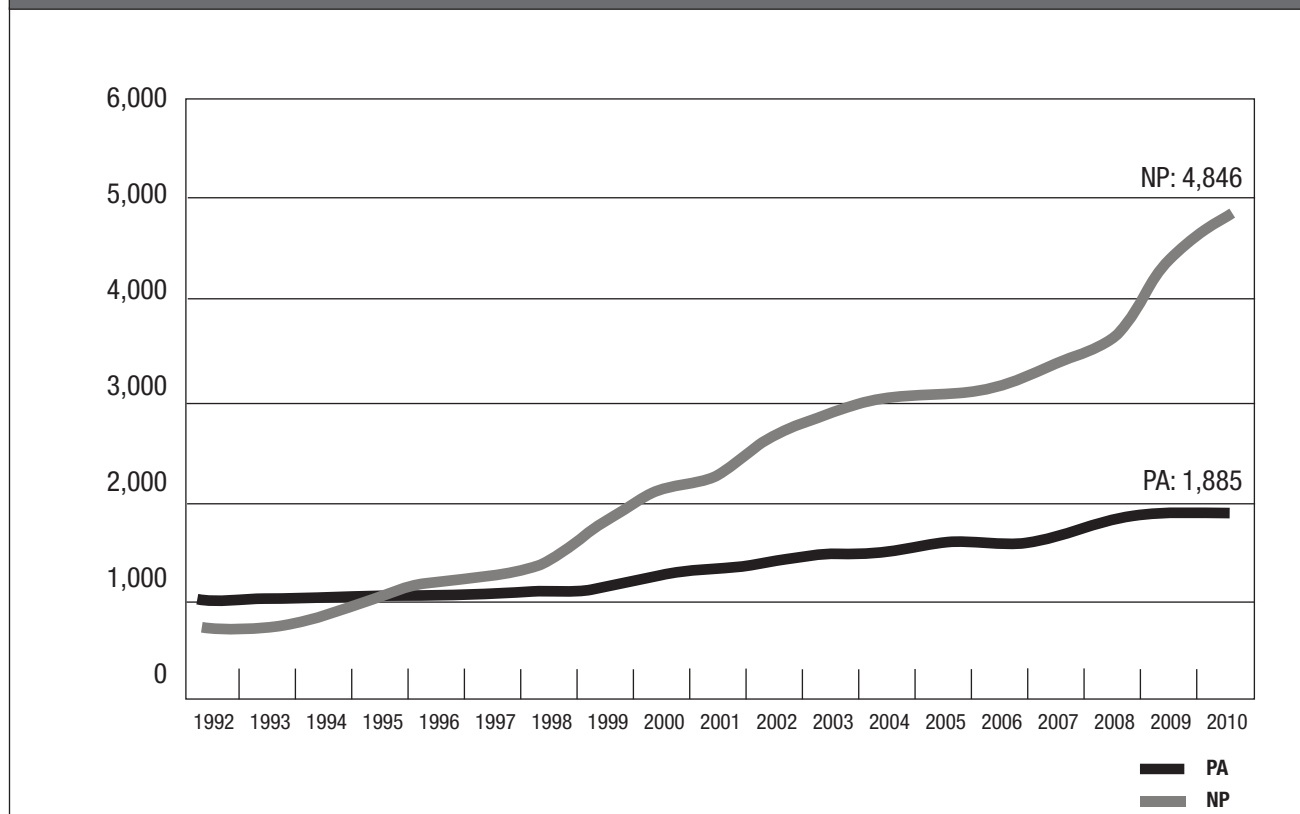
VA identifies specific occupations as “critical occupations” based on the degree of need and the difficulty in recruitment and retention of the occupation. These occupations are identified by VA workforce succession planning through annual evaluations. Hiring patterns and projected hiring reports from Veterans Integrated Service Networks are used as data sources in the evaluation.

Currently, the PA position is not included in this category of professionals. The IBVSOs strongly recommend that VA recognize the physician assistant as a critical occupation in view of this occupation’s vital role in pro-

Table 10. Third Quarter VHA FY 2010 Full-Time Positions Data

		Total Net Gain/Loss from 2nd Qtr
APNs (NPs & CNS)	4,510	+11
NPs	4,264	+11
CNS	246	0
PAs	1,872	- 2

Graph 2. VHA PA Utilization Reflecting 3 Percent Growth Rate as Compared to the Nurse Practitioner Growth Rate



viding a variety of primary clinical services. The difficulty in recruitment of physician assistants has been masked by the changes in employment tracking within VA and in how positions are filled. Although PAs and nurse practitioners are different occupations with different training and academic credentialing requirements, they are functionally interchangeable, especially in primary care clinics. The way a vacancy is posted for a mid-level provider position is, however, locally determined; therefore, nurse practitioners are recruited for positions by management, often not reflecting that the position was originally a PA position.

According to the American Academy of Physician Assistants' 2008 Census Report, PA employment in the federal government, including VA, continues to decline. The AAPA's annual census reports of the PA profession from 1991 to 2008 document an overall decline in the number of PAs who report federal government employment. In 1991, nearly 22 percent of the total profession was employed by the federal government. This percentage dropped to approximately 9 percent in 2008. New graduate census respondents were even less likely to be employed by the government (17 percent in 1991, down to 5 percent in 2008).³⁰⁵ With the growing concern over VA's ability to recruit enough primary care providers for

rural health care, women's health clinics, community-based outpatient clinics, geriatric and long-term care programs, and expanding Operations Enduring and Iraqi Freedom and traumatic brain injury initiatives to improve access with quality, cost-effective, primary health care, we find little evidence of any current VHA workforce planning documents that include any projections of PAs to meet these and other challenges.

Recommendations:

The Independent Budget veterans service organizations (IBVSOs) urge Congress to provide continued oversight on the physician assistant (PA) director implementation, requiring periodic reports from the Under Secretary for Health to the House and Senate Committees on Veterans' Affairs.

VA must implement recruitment and retention tools targeting Employee Incentive Scholarship Program and Employee Debt Reduction Program funding to include PAs and provide succession plans to Congress on this occupation. Veterans Health Administration Human Resources must update and issue new personnel employment policies for PAs.

The IBVSOs urge Congress to request a specific plan from the Veterans Health Administration on including PAs in the Locality Pay System or special pay provisions to address this long-standing problem with PA recruitment and retention change to title 38, United States Code, section 7454.

The VHA should strengthen academic affiliations and expand new agreements to provide clinical rotation sites for PA students. Currently the 147 accredited PA

training programs are searching for qualified facilities for clinical sites, and VA could use this opportunity to recruit new student graduates rotating through VA clinics.

³⁰⁵ American Academy Physician Assistants Employment Census 2009 Survey Data.



SUPPORT FOR FAMILY AND CAREGIVERS OF SEVERELY INJURED VETERANS:

Given the prevalence of severely disabled veterans and their specific needs, the Department of Veterans Affairs should move forward rapidly to establish a series of new programs to provide support and care to immediate family members who are devoted to providing these veterans with lifelong personal care and attendance.

In “The Continuing Challenge of Caring for War Veterans and Aiding Them in Their Transactions to Civilian Life,” *The Independent Budget* veterans service organizations (IBVSOs) describe the nature, prevalence, and degree of injuries that veterans have suffered in Operations Enduring and Iraqi Freedom (OEF/OIF) and New Dawn, as well as legacy injuries and illnesses of veterans who served in prior warfare. These veterans often have disabling physical conditions, such as multiple limb amputations, spinal cord injury, internal shrapnel injury, loss of sight, and residuals of severe burns. Blast injuries are common in Afghanistan and Iraq, resulting in traumatic brain injury (TBI) that compromises cognitive functions and memory and often results in an inability to inhibit certain behaviors that are self-harming, such as domestic violence and substance-use disorder, among other problems and risky behaviors. The violence of an improvised explosive device detonation also results in psychological stress reactions, including post-traumatic stress disorder (PTSD), in many of these severely wounded veterans.

A miraculous number of our veterans are surviving what surely would have been fatal events in earlier periods of warfare, but many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal support.³⁰⁶ Eventually, most of these veterans will be able

to return to their families, at least on a part-time basis, or will be moved to an appropriate therapeutic residential care setting—but with the expectation that family members will serve as lifelong caregivers to facilitate rehabilitation and as personal attendants to help them compensate for the dramatic loss of physical, mental, and emotional capacities as a result of their injuries.

Impact on the Caregiver

Caregiver burden experienced by an individual caring for a disabled veteran is a multidimensional response to the physical, psychological, emotional, social, and financial stressors associated with caring for another person. According to a research synthesis on caregiver role strain conducted at the University of Texas, added burden and strain is experienced when the caregiver is living with the recipient; limited resources are available for tangible support; and the care recipient’s self-perception of health status is poor.³⁰⁷

The primary caregiver of a severely injured veteran shoulders the greatest burden as he or she experiences individual challenges, and, if a spouse, marital stress as well. The injury, the result of an unexpected event, throws the family unit into a situational crisis, not something that is a part of normal family development. Events like these are likely to be perceived as more

stressful than giving care to an elderly family member, simply because it is “off-time”—away from the “normative life cycle.”³⁰⁸

For the first time ever, a study was conducted by the National Alliance for Caregiving on caregivers of veterans injured while serving in the military from World War II, the Korean and Vietnam Wars, Operation Desert Storm, and Operations Iraqi and Enduring Freedom. The purpose of the Caregivers of Veterans—Serving on the Homefront (COV) study was to assess the experiences and challenges of family caregivers of veterans, the impact of caregiving on their lives, and what programs and services would support and assist them.

The picture portrayed by the COV survey is remarkably different from what has been found nationally.³⁰⁹ Caregivers of veterans are overwhelmingly women, 96 percent compared to 65 percent nationally. In addition, given the prevalence of spousal relationships,³¹⁰ it is not surprising that caregivers of veterans are more than three times as likely as family caregivers in general to live in the same household as the person for whom they provide care and far more apt to be the primary caregiver.³¹¹ These findings have significant policy implications since research has found the role of primary caregiver as well as cohabitation to be highly predictive for increased caregiver burden.

Providing care to a veteran with a service-related condition has widespread impacts on the caregiver’s health. The COV study found nearly 90 percent report increased stress or anxiety and nearly 80 percent experience sleep deprivation. Caregivers of veterans report declines in healthy behaviors—such as exercising (69 percent), eating habits (56 percent), and going to one’s own doctor and dentist appointments on schedule (58 percent), and similar proportions have weight gain/loss (66 percent) or experience depression (63 percent). Seven in 10 caregivers of veterans also feel isolated and more than half hesitate to take the veteran anywhere because they are afraid of what might happen, a feeling that can compound one’s sense of isolation.

In the veteran population, cognitive and behavioral issues play a striking role in caregiver burden. A study of female partners of veterans with PTSD found that significant others also suffer from caregiver burden. The partners in this study exhibited high levels of psychological stress, with their clinical stress scale scoring above the 90th percentile.³¹² In the COV study, 7 of 10 caregivers reported that their loved ones experience depression or anxiety, and 6 of 10 reported they their loved ones experience symptoms of PTSD, compared to the

national measure (where 28 percent of care recipients suffer from mental or emotional health problems).

According to VA, limited empirical research exists that details the specific relationship challenges that couples must face when one of the partners has PTSD. However, clinical reports indicate that significant others are presented with a wide variety of challenges related to their partner’s PTSD. Spouses of PTSD-diagnosed veterans tend to assume greater responsibility for household tasks (e.g., finances, time management, house upkeep) and the maintenance of relationships (e.g., children, extended family).³¹³

Caregivers of the severely injured and ill often must give up their own employment (or withdraw from school in many cases) to care for, attend to, and advocate for their injured veterans. They often fall victim to bureaucratic mishaps in the shifting responsibility of conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation). Also, they rely on this much-needed subsistence in the absence of other personal income. Many of them consequently struggle financially, even to the extent of approaching bankruptcy.³¹⁴

Of the caregivers of veterans who were employed at some point while serving as a caregiver, a large share experiences employment changes that result in a loss of income or benefits. Six in 10 caregivers in the COV survey cut back the number of hours in their regular schedule and almost half stopped work entirely or took early retirement. Fewer than 1 in 10 nationally reported neither of these impacts. Fifty percent of caregivers of veterans report feeling a high degree of financial hardship, compared to 13 percent nationally.

With the increased burden of care, it is not surprising that the impact of caregiving on their lives and the life of the family is greater than for other caregivers in general. Of those currently married, separated, or divorced, three-quarters say caregiving or the veteran’s condition placed a strain on their marriage. The COV study found that 3 in 10 caregivers who participated in the survey fell into the classic “sandwich generation”—balancing their caregiver role between the veteran and their children under the age of 18. In these households more than two-thirds report having spent less time with their children than they would have liked and nearly 60 percent report that their children or grandchildren had emotional or school problems as a result of their caregiving or the veteran’s condition. Many of these impacts of caregiving are manifest more frequently among caregivers who provide care to a vet-

eran with PTSD, TBI, or mental illness, such as depression or anxiety.

These findings indicate caregivers of severely injured veterans bear a heavier burden compared to caregivers nationally. Notably, a National Alliance for Caregiving study on caregiving nationwide found that more than 10 million people are caring for veterans, and nearly 7 million of those caregivers are themselves veterans. Clearly, the tremendous sacrifices made by caregivers of severely injured veterans have gone unrecognized and their needs have been unmet for decades, until the passage of Public Law 111-163, the “Caregivers and Veterans Omnibus Health Services Act of 2010.”

Support for the Caregiver

Research suggests that caregiver support services (e.g., individual and family counseling, respite care, education, and training) can help to reduce the burden, stress, and depression arising from caregiving responsibilities and can improve overall well-being.³¹⁵ This outcome would serve to better the veteran’s quality of life and help veterans remain in their communities.

The spouse of a severely injured veteran is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. Complicating matters is the fact that an increasing number of the severely injured served in reserve components (primarily Army and Marine Corps) and National Guard units. For the most part, these families never lived on military bases and do not have access to the vibrant social support services and networks connected with active duty military life, including caregiver support networks.³¹⁶

The primary caregivers of many younger, unmarried veterans are the parents, who have limited eligibility for military assistance, often are on limited incomes, and have had no eligibility at all for VA benefits or services of any kind. They face the same or worse dilemmas as spouses of severely injured veterans because of their advancing age and life circumstances. The support systems they need are limited or restricted, often informal, and clearly inadequate for the long term.

Under P. L. 111-163, VA is required to create a caregiver support program, in which caregivers of veterans of all eras would receive supportive services, such as caregiver training and education, counseling and mental health services, and respite care (including 24-hour, in-home respite care). This new program will provide additional caregiver support benefits to those caring for certain eligible OEF/OIF veterans. This supple-

mental benefit includes lodging and subsistence payments when accompanying the veteran on medical care visits; health-care coverage through VA’s Civilian Health and Medical Program (CHAMPVA), and a monthly living-wage stipend based on the level of care they provide. VA is also required to submit a report to Congress advising on the extension of the more comprehensive benefits provided to the caregivers of OEF/OIF veterans to caregivers of veterans of all other eras, no later than two years after the implementation of the program. While VA is in the midst of implementing the new caregiver support program, the IBVSOs have concerns about existing services caregivers of severely injured veterans are currently using:

Care/Case Manager: Through congressional oversight and independent reports, VA and the DOD have placed tremendous emphasis on care or case managers to assist in the rehabilitation and transition process. Half of caregivers in the COV report who say the veteran in their care has one or more care managers recognize them as a potential support resource. However, 65 percent of caregivers of veterans say the care manager has been at least somewhat helpful in locating, arranging, and coordinating care and resources for the veteran, and only 43 percent feel the care manager has been helpful in finding support for the caregiver. In general, care managers have proven more helpful for the veteran than for the caregiver.

This surprising finding—that the presence of one or more care managers does not appear to ease caregivers’ situations in terms of lowered stress, lower likelihood of isolation, greater ease of finding resources that they seek, or reduced impacts on employment—places a greater burden on caregivers to advocate for themselves when their primary focus is on meeting the needs of their veteran and family.

Respite Care: Considered the dominant service strategy, respite care is used to support and strengthen caregivers. VA provides respite care designed to temporarily relieve the family caregiver from caring for a chronically ill, injured, or disabled veteran at home. Respite services can include in-home care, a short stay in a VA community living center or other institutional setting, or adult day health care.

The importance of this service is highlighted by a survey conducted on the Aged and Disabled (A/D) Medicaid Home and Community-Based Services (HCBS) waiver program that asked respondents to choose from a list of 20 items the services their program provides specifically to family caregivers. Respite care received

a 92 percent response, followed by information and assistance, homemaker/chore/personal care, and care management/family consultation at 48 percent each.³¹⁷

It is interesting that the COV survey found the likelihood of the caregiver receiving respite care does increase in relation to the number of care managers. Of great concern to the IBVSOs is that the large majority, 82 percent, of caregivers indicate they have not received any respite services from VA or any other organization in the past year and only 15 percent have. Although caregivers with a high burden of care are nearly twice as likely to receive respite as those with a medium burden, only about 20 percent of those high burden caregivers receive respite care. Furthermore, only 11 percent of caregivers of veterans suffering PTSD received respite services.

VA's respite care can be provided through a volunteer network, adult day health care, in-home, or institutional placement. VA's authority to provide respite care to all general caregivers of veterans enrolled in VA health care is under title 38, United States Code, section 1720B. In addition, P. L. 111-163 requires VA to provide to eligible primary caregivers respite care that is medically and age-appropriate (including in-home) of not less than 30 days annually, including 24-hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite. This law also amends section 1720B to provide respite care that is also medically and age appropriate for the veteran, including 24-hour per day in-home care. In this, Congress recognized the need for additional caregivers of veterans other than primary caregivers. In addition to providing respite care during training, they will receive appropriate instruction and training, travel, lodging, and per diem for training, lodging and subsistence when accompanying the veteran for appointments, ongoing technical support, and counseling.

The Volunteer Respite Program prepares volunteers to provide temporary relief to primary caregivers of veterans. The trained volunteer is intended to be a vital part of a support network of family, friends, social service, and health professionals who provide comfort and assistance to homebound veterans. Through this program, volunteers provide a much-needed break to the caregivers so they can renew their energy and spirit and provide compassionate support to ill and injured veterans in their homes. The local VAMC voluntary service specialist has primary responsibility for establishing and operating a community-based volunteer home respite program to benefit OEF/OIF veterans and their primary caregivers. They also directly support the

Volunteer Caregiver Support Network program, a collaborative effort between VA Voluntary Service and the Office of Care Coordination. They will support the mission of expanding Respite and Caregiver Support service options for veterans and their families. The IBVSOs recommend VA expand the number of voluntary service specialists throughout its Veterans Integrated Service Networks and VA medical centers.

The IBVSOs urge the VHA to revise its respite care handbook³¹⁸ to reflect the new requirement of P. L. 111-163. Today, VA's system for providing respite care for severely injured veterans—and providing needed rest for a family caregiver—is fragmented, unpredictable, and governed by local VA nursing home care unit and adult day health-care policies. Understandably, these programs are targeted to older veterans with chronic illnesses, whereas veterans who survived horrific injuries in Afghanistan and Iraq are still in the early parts of their lives. Just as VHA policy encourages advanced respite care planning, so too must the VHA plan where appropriate services are not available because of geographic barriers. The VHA should develop contractual relations with appropriate, qualified private or other public facilities to provide respite services tailored to this population's needs.

The IBVSOs also believe VA should enhance this service to reduce the variability and availability across a veteran's continuum of care by eliminating applicable copayments. Furthermore, we believe state veterans' homes can play a small but vital role in greatly increasing access to services and can offer a less intensive alternative to VA medical facilities in serving as a source of respite for families of those severely injured. Since availability has historically been an issue in providing respite care and the COV survey shows caregivers of veterans have used little respite care, VA should work with state veterans' homes in reviewing its relationship including the referral and payment processes to gain needed capacity and increase the likelihood caregivers will use this critical support service.

Transportation: The IBVSOs are also concerned about the accessibility and availability of transportation for the veteran, which would provide significant relief in time and effort, particularly with caregivers who are trying to remain employed. If a veteran meets VA eligibility criteria for beneficiary travel reimbursement,³¹⁹ he or she may be eligible for special mode transportation to and from medical appointments. Caregivers may accompany the veteran if there is a designated need for an attendant, which is determined by a VA provider. Since the term "medically indicated" is not ex-

Explicitly defined, the use of this benefit varies considerably. In general, the definition refers to veterans requiring ambulance, ambulette, air ambulance, wheelchair transportation, or transportation specially designed to transport disabled persons. Beneficiary travel regulations specifically indicate that normal modes of transport, such as passenger automobile, bus, subway, taxi, train, or airplane, are not included.

Mental Health: P. L. 110-387, the “Veterans’ Mental Health and Other Care Improvements Act of 2008,” significantly amended VA authority to provide counseling, training, and mental health services for immediate family members under title 38, United States Code, sections 1701 and 1782. This authority is referenced in P. L. 111-163 for caregivers of veterans other than the primary caregiver. Services covered under this authority are certainly a critical part of the support services for caregivers, but it has concerning limitations.

Such support can only be provided to caregivers who live with the veteran³²⁰ and must be necessary in connection with the veteran’s treatment.³²¹ Moreover, VA’s current authority is silent on providing prolonged support services for other than primary caregivers beyond acute or subacute treatment and rehabilitation of the veteran.

According to the COV survey, 77 percent of participating caregivers say they have no life of their own, 72 percent feel isolated, and 63 percent suffer from depression. Three-quarters found counseling or therapy for the caregiver or his/her family is helpful. Eighty-four percent of caregivers with veterans under the age of 45 were more apt to rate counseling as helpful compared to those with a veteran ages 45 to 64 (75 percent) or 65+ (73 percent). The study notes that the presence of several medical conditions is perhaps related to receptivity to counseling: PTSD (81 versus 71 percent with no PTSD), TBI (83 versus 75 percent), and depression/anxiety (81 versus 69 percent).

The IBVSOs believe that in developing plans to implement these services under P. L. 111-163 and P. L. 110-387 VA should deploy such services in every location in which it treats veterans who have caregivers, and at a minimum should provide such services at every VHA access point, including all medical centers and substantial community-based outpatient clinics. When warranted by circumstances, these services should be made available through other means, including the use of telehealth technology and the Internet. For more information on these rural telehealth issues and challenges, see “Veterans Rural Health Care” in this *Independent Budget*. When necessary because of scarcity or rural access challenges, VA’s

local adaptations should include consideration of the use of competent community providers on a fee or contract basis to address the needs of these families.

Other In-Home Support: Through its purchased Home and Community-Based Services programs, VA provides in-home and community-based care that includes skilled home health care, homemaker home health aide services, community adult day health care, and home-based primary care. Nearly 60 percent of caregivers of veterans who participated in the COV survey said they received help from other unpaid caregivers, but only one-third have received help from paid caregivers.

The IBVSOs are deeply concerned over the low utilization of HCBS that would directly support the caregiver and allow the veteran to live in the community. While all enrolled veterans are eligible for the full range of services covered under VHA’s Uniform Benefits Package, we have received reports of planned reductions in the HCBS program.

The sources for such reductions are as varied as they are many, but the primary cause is that demand is far exceeding available capacity and budgetary resources. Couple this with the confusion among VA medical facilities as to the appropriate hours of HCBS services that are to be provided to veterans and their caregivers, and the IBVSOs are concerned that veterans and caregivers will unduly suffer. We strongly encourage the VHA to provide evidence-based guidelines in determining the amount of support and types of services that should be used to ensure the veteran is able to remain at home as long as possible and improve the quality of life of the veteran and caregiver.

Information, Education, and Training: Three in 10 caregivers report that VA or Department of Defense military systems proactively gave them information or links to information to help them understand the veteran’s condition, treatment, or services. This appears to help caregivers feel more confident in their first six months of caregiving. However, at least two-thirds of caregivers who participated in the COV survey indicate their top challenges include not knowing what to expect medically with the veteran’s condition; not being aware of VA services that could help; not knowing how to address PTSD or mental illness (among those who report that such a condition is present); difficulty getting through bureaucracies in order to obtain services; not knowing where to obtain financial assistance; not knowing where to turn to arrange a break from caregiving; and not knowing where to obtain specialized care. Several of these challenges are more commonly noted by caregivers of veterans who have TBI.

It is not surprising that caregivers of veterans in the COV survey say they resort to word of mouth as the most commonly used source of information when looking for caregiver resources and information. Additionally, while more caregivers of veterans turn to VA and non-VA health providers as resources, 73 percent are more likely to consider non-VA providers as helpful compared to VA (43 percent for the VHA and 41 for the VBA). Other sources of information are not used as frequently, but each is considered as helpful by at least two-thirds of caregivers, including online forums, groups, or blogs; disease-specific organizations; and in-person support groups.

The IBVSOs believe caregivers of severely disabled veterans need practice before they are saturated with responsibilities in caring for their extraordinary veterans. To this end, VA should provide severely disabled veterans and family members residential rehabilitation services, to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans. Recognizing the tremendous disruption to their lives, this service should focus on helping the veteran and other family members restart, or “reboot,” their lives after surviving a devastating injury. An integral part of this program should include family counseling and family peer groups so they can share solutions to common problems.

The COV survey highlights those programs and services that caregivers of veterans would prefer to receive to assist them in their role, including:

- a toll-free 24-hour help line with support information and referrals;
- immediate, easy, and direct access to information and training specific to caregiver needs; immediate, easy, and direct access to service providers;
- a single point of entry for care management, coordination, advocacy, and legal assistance; and
- local access to transportation and reliable and trustworthy respite care.

The Future for Caregiver Support

As severely injured troops are released from active duty, they are in need of full-time care. Without caregivers to assist veterans transitioning from military to veteran status, the options lead to greater dependency on government programs. These include institutional care provided by or paid for by VA or full-time care in the home supported by a VA-provided caregiver. Were it not for recent laws and initiatives, such as P. L. 110-387; P. L. 111-163, the “Caregiver Assistance Pilot Programs”³²² authorized in P. L. 109-461; and the Veteran Directed Home and Community-Based Services

Program, the VA health-care system historically offered little recognition of the sacrifices being made daily by spouses and families in taking over the care of their wounded loved ones at home.

VA health care encompassed in title 38 had been written in view of the veteran as the primary recipient of benefits and services. The IBVSOs believe these recent laws and initiatives offer a necessary and balanced approach in recognizing and including caregivers as a primary member in the care and rehabilitation of our nation’s severely disabled veteran population. With our concern that institutional bureaucracy and inertia would work against such a change, we welcome the November 8, 2010, VA press release marking the National Family Caregiver Month. In this communication the Department succinctly stated caregiver benefits provided under P. L. 111-163 will be in addition to programs and services already available from VA for veteran caregivers.

This public message, that new caregiver benefits from P. L. 111-163 will be used to supplement, not supplant, existing benefits, is equally important to caregivers and the veterans they care for as it is to VHA facilities across the nation. We urge the VHA to consider this in times when resources are limited and facilities may directly or indirectly delay or deny needed services. For example, clearly recognizing the urgency of need, VA providers give a significant amount of training, instruction, counseling, and health care to caregivers of severely injured veterans who are attending veterans during their hospitalizations. The IBVSOs are concerned this work is going without recognition within VA’s resource allocation system. VA facilities are in essence being penalized for doing the right thing where scarce resources that are needed elsewhere are being diverted to those needs.

In the implementation of the new caregiver support program, the IBVSOs are greatly concerned that just as there is marked variability in the availability of the full array of noninstitutional long-term-care benefits designed to meet the needs of severely disabled veterans in the community, so, too, will it be with benefits and services for caregivers of veterans. Known criticism of community-based VA care involves the availability of services generally not being provided, lack of flexibility of existing services, lack of local availability of services, varied quality of services received, and trust and privacy issues of VA and non-VA staff. Therefore, as the IBVSOs applaud VA’s leadership on the effort it is investing to implement the caregiver support program, it is critically important that Congress conduct rigorous

oversight on the agency's implementation plan, the access to, as well as the availability and effectiveness of benefits and services for caregivers of veterans.

The IBVSOs thank Congress for passing P. L. 111-163, which recognizes the role caregivers play in providing the highest quality of life possible for their severely injured veterans. Certainly, the law requires VA to submit to Congress a report no later than February 2012 on the feasibility and advisability of expanding the caregiver benefits to those veterans injured before September 11, 2001; however, as the COV survey finds, these support services are needed by caregivers of veterans regardless of when they served or were injured.

Moreover, the IBVSOs believe making and planning policy to better serve caregivers of severely injured veterans should depend on statistically representative data that can be used to determine validity, reliability, and statistical significance. We note that in passing P. L. 111-163, the provision to authorize VA and the DOD to contract for a national survey of family caregivers of seriously disabled veterans and service members and report to Congress with their findings was not included. VA estimates the survey would cost approximately \$2 million over the four-year period. As evidenced by the information derived from the COV and other surveys, such as the Informal Caregiver Survey,³²³ we urge Congress and VA to conduct a study to assess the caregiver population being served, their challenges, needs, and whether existing programs are meeting those needs.

Caregivers of severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical³²⁴ and emotional problems³²⁵ of the severely injured veteran plus deal with the complexities of the systems of care³²⁶ that these veterans must rely on, while struggling with disruption of family life, interruptions of personal and professional goals and employment, and dissolution of other "normal" support systems because of the changed circumstances resulting from the veteran's injuries and illness. While caregivers may be driven by empathy and love, they are also dealing with guilt over the anger and frustration they feel. The very touchstones that define their lives—careers, love relationships, friendships, even their goals and dreams—are often being sacrificed.

The organizations that coauthor *The Independent Budget* intend to be vigilant to ensure that VA's response to the new statute extending benefits and services to caregivers of veterans fulfills the nation's pledge to these American heroes.

Recommendations:

Congress should conduct oversight and VA should evaluate the effectiveness of its care and case management.

The VA case management system should be seamless for veterans and family caregivers. Case manager advocates must be empowered to assist with caregiver and family support services, and medical benefits, including vocational services, financial services, and child care services.

VA must address the multiplicity of care and case managers and consider a single point of entry for caregiver support and assistance.

VA should establish clear policies outlining the expectation that every VA nursing home and adult day health-care program provide appropriate facilities and programs for respite care for severely injured or ill veterans. These facilities should be restructured to be age appropriate, with strong rehabilitation goals suited to the needs of a younger population, rather than expecting younger veterans to blend with the older generation typically resident in VA nursing home care units and adult day health-care programs. VA must adapt its services to the particular needs of this new generation of disabled veterans and not simply require these veterans to accept what VA chooses to offer.

Congress must address limitations in VA's authority to provide mental health and counseling to other than primary caregivers of veterans.

VA should develop and disseminate specific disease-related information in a manner that would be useful for caregivers of veterans.

VA should provide severely disabled veterans and family members residential rehabilitation services to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans.

As part of its implementation plan, VA should include action items to increase currently underutilized caregiver support programs, such as respite care and mental health services and counseling.

VA must ensure there is standard availability and accessibility of caregiver support services, with particular consideration for veterans residing outside a Veterans Health Administration catchment area.

The VHA must ensure its resource allocation recognizes all caregiver support services provided by the Department's providers.

Congress and VA should review the detailed findings of the "Caregivers of Veterans—Serving on the Homefront" survey and address the recommendations contained therein.

Congress should conduct rigorous oversight on VA's implementation plan, the access to, as well as the availability and effectiveness of benefits and services for caregivers of veterans.

The VHA should expand the number of voluntary service specialists throughout the system of care to improve the delivery of voluntary respite and other support programs for caregivers of severely disabled veterans.

VA should develop support materials for caregivers of veterans, including the following:

- A "Caregiver Toolkit," in hard copy and from the Internet—to supplement the recently published "National Resource Directory," which may not be fully responsive to their needs—and to include a concise "recovery road map" to assist families in understanding, and maneuvering through, the complex systems of care and resources available to them);
- Social support and advocacy support for caregivers of severely injured veterans, including peer support groups, facilitated and/or assisted by committed VA staff members; appointment of caregivers to local and VA network patient councils and other advisory bodies within the VHA and the Veterans Benefits Administration; a monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled OEF/OIF veterans, through My HealtheVet or another appropriate web-based platform.

Congress should require the Government Accountability Office to examine the current Civilian Health and Medical Program of Veterans Affairs to ensure the health coverage available to primary caregivers is adequate.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys of caregivers of seriously injured veterans that will yield statistically representative data for policy and planning purposes.

VA should conduct caregiver assessments to identify the particular problems, needs, resources, and strengths of

family caregivers of severely injured service members and veterans, and determine appropriate support services to establish a basis for helping caregivers maintain their health and well-being.

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³¹⁰ 80 percent to 23 percent nationally.

³¹¹ 82 percent to 53 percent nationally.

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³¹⁶ United States Agency for Healthcare Research and Quality, 2007 National Healthcare Quality & Disparities Reports (Rockville, MD: 2008). Also, Jim Garamone, "U.S. Military Recruiting Demographics," American Forces Press Service (November 23, 2005); David S. Riggs, "Difficulties in Family Reintegration Following Military Deployments," *Healing the Scars of War* (New York: Institute for Disaster Mental Health, April 11, 2008); U.S. Department of Defense, Population Representation in the Military Services (Washington, DC: Office of the Under Secretary of Defense, Personnel and Readiness, 2006), http://www.defenselink.mil/prhome/PopRep_FY06.

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³¹⁸ DVA Veterans Health Administration, *Respite Care, Handbook* 1140.02 (Washington, DC: November 10, 2008).

³¹⁹ DVA Veterans Health Administration, *Beneficiary Travel, Handbook* 1601B.05 (Washington, DC: July 29, 2008).

³²⁰ 38 U.S.C. § 1701(5)(B).

³²¹ 38 U.S.C. § 1782(a) and (b).

³²² P. L. 109-461, Title II, section 214, Pilot Program on Improvement of Caregiver Assistance Services.

³²³ The Informal Caregiver Survey (ICS) of the National Long Term Care Survey (NLTC).

³²⁴ Stacy A. Brethauer, Alex Chao, et al., "U.S. Navy/Marine Corps Forward Surgical Care During Operation Iraqi Freedom," *Archives of Surgery* 143 no. 6 (2008): 564–69.

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³²⁶ Atul Gawande, "Casualties of War: Military Care for the Wounded from Iraq and Afghanistan," *New England Journal of Medicine* 351, no. 24 (2004): 2471–75.

³²⁷ U.S. Government Accountability Office, VA Vocational Rehabilitation and Employment: Better Incentives, Workforce Planning, and Performance Reporting Could Improve Program, GAO Report GAO-09-34, 7.

³²⁸ House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, Statement of Ruth A. Fanning, director, Vocational Rehabilitation and Employment Service, Veterans Benefits Administration, U.S. Department of Veterans Affairs (April 2, 2009), 4.

³²⁹ ORC Macro, Economic Systems Inc., Hay Group, Evaluation of VA Pension and Parents' DIC Programs—VA Pension Program Final Report (December 22, 2004) <http://www1.va.gov/op3/docs/pension.pdf>.

³³⁰ Department of Veterans Affairs National Cemetery Administration Fact Sheet (July, 2010). <http://www.cem.va.gov/pdf/facts.pdf>.

³³¹ FY 2011 Budget Submission Summary Vol. III, 1A-6.

Construction Programs

The Department of Veterans Affairs (VA) manages a wide portfolio of capital assets throughout the nationwide system of health-care facilities. According to the latest VA Capital Asset Plan, VA owns 5,405 buildings and almost 33,000 acres of land. It is a vast network of facilities that requires much time and attention from VA's capital asset managers. Unfortunately, VA's infrastructure is aging rapidly. Although Congress has funded a significant number of new facilities in recent years, the vast majority of existing VA medical centers and other associated buildings are on average more than 60 years old.

Aging facilities create an increased burden on VA's overall maintenance requirements. They must be maintained aggressively so that their building systems—electrical, plumbing, capital equipment, etc.—are up to date and that these facilities are able to continue to deliver health care in a clean and safe environment. Older, out-of-date facilities do not just present patient safety issues: from VA's perspective, older buildings often have inefficient layouts and inefficient use of space and energy. This means that even with modification or renovation, VA's operational costs can be higher than they would be in a more modern structure.

VA has begun a patient-centered reformation and transformation of the way it delivers care and new ways of managing its infrastructure plan based on the needs of sick and disabled veterans in the 21st century. Regardless of what the VA health-care system of the future may look like, our focus must remain on ensuring a lasting, accessible, modernized system that is dedicated to the unique needs of veterans while also providing unparalleled and timely care when and where veterans need it.

The Capital Asset Realignment for Enhanced Services (CARES) process, VA's data-driven assessment of current and future construction needs, gave VA a long-term roadmap and has helped guide its capital planning process over the past 10 years. The CARES process developed a large number of significant construction objectives that would be necessary for VA to fulfill its obligation to sick and disabled veterans. Over the past several years, the Administration and Congress have made significant inroads in funding these priorities. Since fiscal year (FY) 2004, \$5.9 billion has been allocated for these projects. *The Independent Budget* veterans service organizations believe that CARES was a necessary undertaking and that VA has made slow but steady progress on many of these critical projects.

In the post-CARES era, many essential construction projects are still awaiting authorization and funding, and the IBVSOs firmly believe that Congress cannot allow the construction needs that led to the CARES blueprint to be disregarded. Both strong oversight and sufficient funding are critical in this ongoing task of maintaining the best care for veterans.

Given the challenges presented by the CARES blueprint, including a backlog of partially funded construction projects, high costs of individual projects, and our concern about the

timeliness of these projects—noting that it can take the better part of a decade from the time VA initially proposes a project until the doors actually open for veterans’ care—VA has proposed a new program, named “Strategic Capital Investment Planning” (SCIP). This initiative will address some of the infrastructure issues that have been noted in *The Independent Budget*.

SCIP is VA’s newest approach to reevaluating its aging and underutilized infrastructure, as well as examining the lack of infrastructure in various locations around the country. The intent of SCIP, according to VA, is to scrutinize all property so that VA can best address gaps in delivery of care and services to veterans. Unlike CARES, SCIP will cover all of VA, not only Veterans Health Administration facilities; however, similar to CARES, SCIP is designed to evaluate the condition of VA infrastructure, in order to build a 10-year integrated capital plan. The goal is to improve quality of and access to VA services by modernizing facilities based on current and future needs. If SCIP is approved as VA’s capital planning method, the Department plans to begin this process with the FY 2012 budget cycle.

VA has also advised the IBVSOs that SCIP is intended to address the funding shortfall of \$24.3 billion to deal with major construction and facility condition assessment backlogs, inefficient use of resources, and high maintenance costs, as well as an existing commitment of about \$4.4 billion to complete ongoing major construction projects.

If approved, the goal of this new initiative must be a comprehensive plan that will improve quality by providing equitable access to services for all veterans across the VA system of care and services. As the age of VA structures increase, costs go up, often dramatically so. Accordingly, more funding is spent on older projects, leaving less for other maintenance and construction needs and increasing the overall budget for both

major and minor construction. VA must adopt a plan for the future that will review and assess all current and future needs while providing priorities and transparency at the forefront.

A draft of the SCIP proposal was most recently provided to the IBVSOs in October 2010. The overview included a future-oriented view of VA capital needs beginning with the 2012 budget. According to VA, SCIP would adapt to changes in environment, provide a comprehensive planning process for all projects, and result in one prioritized listing of capital projects VA-wide. The list intends to ensure equitable access to services for veterans across the country and includes major and minor construction, nonrecurring maintenance, and leasing.

Because SCIP is a new initiative, the *The Independent Budget* veterans service organizations encourage VA to be transparent during the process and would advise that challenges must be met when reviewing all current and future needs of its aging infrastructure. The goal must be a comprehensive plan that will improve quality by maintaining equitable access to services across the VA system. The changing health-care delivery needs of veterans, including reduced demand for inpatient beds and increasing demand for outpatient care and medical specialty services, along with limited funding available for construction of new facilities, has created a growing backlog of projects that are becoming more expensive to complete. VA has advised that SCIP is intended to address the funding shortfalls of its current capital backlog needs.

Major and Minor Construction Accounts

The Department of Veterans Affairs continues to be faced with challenges with respect to the maintenance backlog. VA regularly surveys each facility as part of the Facilities Condition Assessment (FCA) process. VA estimates the cost of repair and uses this cost estimate as a component of its Federal Real Property Report requirements. According to its latest Five-Year Capital Plan, VA has estimated the total cost of repairing all “D-rated” and “F-rated” FCA deficiencies at a cost of \$8 billion, even as it and Congress have greatly increased the amount of funding and resources devoted to this critical aspect of capital asset management.

Although Congress has increased recent funding for non-recurring maintenance (NRM), these funding levels only touch the surface of the backlog. For years, NRM and other maintenance needs were significantly underfunded, and massive backlogs ensued (see “Increased Spending on Nonrecurring Maintenance” in this *Independent Budget*).

Maintenance is only a small fraction of the major infrastructure issues confronting the system. *The Independent Budget* veterans service organizations (IBVSOs) are also concerned about the huge backlog of major medical construction projects and the political and economic reality that fully funding each of these projects and constructing them in a timely manner may not be feasible.

One of the reasons for such a large backlog of construction projects is because Congress allocated so little funding during the Capital Asset Realignment for Enhanced Services (CARES) process. The Appropriations Committees provided few resources during the initial review phase, and against our advice, preferred to wait for the result of CARES. Because of our convictions that a number of these projects needed to go forward and that they would be fully justified through any plans developed by CARES, the IBVSOs argued that a *de facto* moratorium on construction was unnecessary and would be harmful. The House agreed with our views as evidenced by its passage of the Veterans Hospital Emergency Repair Act, March 27, 2001; however, Congress never appropriated funding to carry out the purposes of that act, and the construction and maintenance backlogs continued to grow. Upon completion of the CARES decision document in 2004, former VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans’ Affairs. He noted that CARES “reflects a need for additional investment of approximately \$1 billion per year for the next five years to modernize VA’s medical infrastructure and enhance

Table 11. Major Construction Recommendations

Category	Recommendation (\$ in Thousands)
Major Medical Facility Construction	\$1,850,000
NCA Construction	\$61,000
Advance Planning	\$45,000
Master Planning	\$15,000
Historic Preservation	\$20,000
Medical Research Infrastructure	\$150,000
Miscellaneous Accounts	\$60,000
TOTAL	\$ 2,201,000

Table 12. Minor Construction Recommendations

Category	Funding (\$ in Thousands)
Veterans Health Administration	\$450,000
National Cemetery Administration	\$100,000
Veterans Benefits Administration	\$20,000
Staff Offices	\$15,000
TOTAL	\$585,000

veterans’ access to care.” In a November 17, 2008, letter to the Senate Committee on Veterans’ Affairs, then-Secretary James Peake reported that VA would need at least \$6.5 billion over the following five years to meet its funding requirements for major medical facility construction projects.

As noted previously, VA has proposed a new program, Strategic Capital Investment Planning (SCIP), to address some of the construction and infrastructure issues presented in *The Independent Budget*. Given the President’s pledge to create a VA for the 21st century, the IBVSOs expect the Department to proceed with its SCIP plan in a transparent way, coordinate the plan through our community and other interested parties, and provide its plan to Congress for review and approval if required. However, until SCIP is fully implemented, we fear that VA’s capital programs and the significant effects on the system as a whole and veterans individually will go unchanged, ultimately risking a diminution of care and services provided by VA to sick and disabled veterans in substandard facilities.

Until the SCIP plan is approved and in place across the VA network of care, the IBVSOs will continue to argue

for sufficient funding needs to maintain VA's capital infrastructure and to ensure a safe and useful system for all veterans who need VA health care.

With this in mind, the IBVSOs would like to outline the components of our Major and Minor Construction account requests of this *Independent Budget*. We view these issues as the critical areas that must be addressed when developing our funding recommendations.

Major Medical Facility Construction — This amount would allow VA to continue to address the backlog of partially funded construction projects. Depending on the stage in the process and VA's ability to complete portions of the projects within the fiscal year, remaining funds could be used for projects identified by VA as part of SCIP.

National Cemetery Administration — This amount would fund a number of national cemeteries from VA's priority list as well as potential projects identified by SCIP.

Advanced Planning — This amount helps develop the scope of the Major Medical Facility construction project as well as to identify proper requirements for their construction. It allows VA to conduct necessary studies and research similar to the planning process in the private sector.

Master Planning — A description of *The Independent Budget* request follows later in the text.

Historic Preservation — A description of *The Independent Budget* request follows later in the text.

Miscellaneous Accounts — These included the individual line items for such accounts as asbestos abatement, the judgment fund, and hazardous waste disposal.

Minor Construction Account — SCIP has already identified minor construction projects that update and modernize VA's aging physical plant, ensuring the health and safety of veterans and VA employees.

Medical Research Infrastructure — Funding needs to be allocated by Congress to allow for needed renovations to VA research facilities.

Medical Research Infrastructure — A description of *The Independent Budget* request follows later in the text.

National Cemetery Administration — This includes minor construction projects identified by SCIP to include the construction of several columbaria, installation of crypts, and landscaping and maintenance improvements.

Veterans Benefits Administration — This includes several minor construction projects identified by SCIP in addition to the leasing requirements the Veterans Benefits Administration needs. It also includes \$2 million transferred yearly for the security requirements of its Manila office.

Staff Offices — This includes minor construction projects related to staff offices, including increased space and numerous renovations for the VA Office of Inspector General.

INADEQUATE FUNDING AND DECLINING CAPITAL ASSET VALUE:

The Department of Veterans Affairs must protect against deterioration of its infrastructure and a declining capital asset value.

Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs, such as seismic correction, compliance with the Americans with Disabilities Act (ADA) and Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards, replacing aging physical plant equipment, and projects that were identified by the Capital Asset Realignment for Enhanced Services (CARES) initiative, the VA construction budget continues to be inadequate.

During the past decade of underfunded construction budgets, VA has not adequately recapitalized its facilities. Recapitalization is necessary to protect the value of VA's capital assets through the renewal of the physical infrastructure. This ensures safe and fully functional facilities long into the future. VA facilities have an average age of more than 60 years, and it is essential that funding be increased to renovate, repair, and replace these aging structures and physical systems.

In the past, *The Independent Budget* veterans service organizations (IBVSOs) have cited the recommendations of the final Report of the President's Task Force to Improve Health Care Delivery for Our Nations Veterans (PTF). To underscore the importance of this issue, we again cite the recommendations of the PTF. It was noted that VA health-care facility major and minor construction over the 1996 to 2001 period averaged only \$246 million annually, a recapitalization rate of 0.64 percent of the \$38.3 billion total plant replacement value. At this rate of investment, VA would be recapitalizing its infrastructure every 155 years. If maintenance and restoration were considered along with major construction, VA invests less than 2 percent

of plant replacement value for its entire facility infrastructure nationwide. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain health-care infrastructure. If this rate is not improved, veterans could be receiving care in potentially more unsafe and dysfunctional settings as time goes along. Improvements in the delivery of health care to veterans require that VA adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

The FY 2008 VA Asset Management Plan provided the most recent estimate of plant replacement value (PRV). Using the guidance of the federal government's Federal Real Property Council, VA's PRV is more than \$85 billion. Accordingly, using the 5 percent to 8 percent PRV standard for capital construction, VA's annual capital budget should be between \$4.25 billion and \$6.8 billion.

The IBVSOs appreciate the Administration's efforts to increase the total capital budget, and we hope future requests will be more in line with the system's needs.

Recommendation:

Congress and the Administration must ensure that adequate funds are appropriated for VA's capital needs so that it can properly invest in its physical assets to protect their value and to ensure that it can continue to provide health care in safe and functional facilities long into the future.

INCREASED SPENDING ON NONRECURRING MAINTENANCE:

The deterioration of many VA properties requires increased spending on nonrecurring maintenance.

For years *The Independent Budget* veterans service organizations (IBVSOs) have stressed the importance of providing necessary funding for nonrecurring maintenance (NRM) accounts to ensure that long-standing and continual upkeep requirements at VA facilities are met. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors, among other routine maintenance needs. Nonrecurring maintenance is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

When NRM projects are ignored, the results can be detrimental to the value of a VA property and the quality of care they facilitate for veterans. Nonrecurring maintenance projects that are left undone inevitably require more costly and time-consuming repairs when they are eventually addressed. Furthermore, this lack of attention to basic structural maintenance issues jeopardizes the safety of staff and patients. Because delayed maintenance projects always require a more invasive response as opposed to situations in which NRM is responsibly managed, the IBVSOs believe neglecting such projects is tantamount to denying veterans timely and professional care and even placing them in danger. Accordingly, to fully maintain its facilities, VA needs an NRM annual budget of at least \$1.7 billion.

Teams of professional engineers and cost estimators survey each medical facility at least once every three years as part of VA's Facilities Condition Assessment (FCA) process. These surveys assess all components of a given facility to include internal issues, such as plumbing, and external issues, such as parking and mobility barriers. Each component of a facility is given a letter grade, A through F. Areas given a grade of F no longer function or are in danger of imminent structural or system failure. VA estimates the cost of repair for each item that is rated D or F and then uses this cost estimate as a component of its Federal Real Property Report requirements.

VA's latest Five-Year Capital Plan estimated the total cost of repairing all D-rated and F-rated FCA defi-

ciencies at a staggering \$8 billion, even as VA and Congress have greatly increased the amount of funding and resources devoted to this critical aspect of capital asset management. Since that time, NRM received a one-time allocation of \$1 billion through Public Law 111-5, the "American Recovery and Reinvestment Act."

VA uses the FCA reports as part of its Federal Real Property Council metrics. The department calculates a Facility Condition Index (FCI), which is the ratio of the cost of FCA repairs compared to the cost of replacement. According to the FY 2008 Asset Management Plan, this metric has declined from 82 percent in 2006 to 68 percent in 2008. VA's strategic goal is 87 percent, and for the Department to meet that goal, it would require a sizeable investment in NRM and minor construction.

Given the low level of funding NRM accounts have historically received, the IBVSOs are not surprised that basic facility maintenance remains a challenge for VA. In addition, the IBVSOs have long-standing concerns with how this funding is apportioned once received by VA. Because NRM accounts are organized under the Medical Facilities appropriation, it has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This formula was intended to allocate health-care dollars to those areas with the greatest demand for health care, and is not an ideal method to allocate NRM funds. When dealing with maintenance needs, this formula may prove counterproductive by moving funds away from older medical centers and re-allocating the funds to newer facilities where patient demand is greater, even if the maintenance needs are not as intense. We are encouraged by actions the House and Senate Veterans' Affairs Committees have taken in recent years requiring NRM funding to be allocated outside the VERA formula, and we hope this practice will continue.

Another issue related to apportionment of funding and the budget cycle has been well documented. Prior to the passage of advance appropriations, the Government Accountability Office (GAO) had found that the bulk of NRM funding was not apportioned until September, the final month of the fiscal year. For example, the GAO reported that 60 percent of total NRM funding for FY 2006 was allocated in September of that year. In other words, during the first 11 months of FY

2006, only 40 percent of NRM funding had been allocated even as VA knew any unobligated funds would be remitted to the Department of the Treasury by statute.

This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and with NRM funding year to year, those conditions, which lead to a functional mishandling of essential funds, have been changed by advance appropriations. Medical accounts are now appropriated by Congress a year in advance to allow VA the ability to plan farther in advance and reduce the impact of delayed appropriations. Not receiving timely appropriations from Congress has curtailed the positive impacts of medical spending over the years, and Congress must now provide oversight of this process to ensure that these up-front dollars for NRM and all medical spending realize their potential benefits.

Congress and VA should provide oversight to ensure this change will not result in medical center managers continuing to sit on unspent funds for longer periods of time, but that it will produce more efficient spending and better planning, thereby eliminating the previous situation in which these managers sometimes spent a large portion of their maintenance funding very late in the fiscal year.

Recommendations:

VA must dramatically increase funding for nonrecurring maintenance (NRM) in line with the industry standard of 2 percent to 4 percent of plant replacement value in order to maintain modern, safe, and efficient facilities.

Congress should provide VA with additional maintenance funding in the Medical Facilities appropriation to enable the Department to begin addressing the substantial maintenance backlog of Facilities Condition Assessment-identified projects.

Congress should provide NRM funding to support maintenance and upgrades to VA's research infrastructure.

Portions of the NRM account should continue to be funded outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that have the greatest maintenance needs, rather than based on other criteria unrelated to the condition of facilities.

Congress must provide oversight of the NRM funding allocated through the advance appropriations process to ensure NRM funds are being spent in such a way to meet their full potential.

MAINTAIN CRITICAL VA HEALTH INFRASTRUCTURE:

The Department of Veterans Affairs must execute a comprehensive, strategic health infrastructure plan that is focused on the unique needs of its veteran population. In order to reduce the growing backlog and maintenance needs of its medical facilities, Congress and the Administration must work together to secure the Department's future by designing the "VA of the 21st century."

Today we find ourselves at a critical juncture with respect to how VA health care will be delivered and what VA of the future will be like in terms of its health-care facility infrastructure. One fact is certain—our nation's sick and disabled veterans deserve and have earned a stable, accessible VA health-care system that is dedicated to their unique needs and can provide high-quality, timely care where and when they need it.

Given these significant challenges and the shift in care in many areas, in 2008 VA developed a new approach to dealing with infrastructure, the Health Care Center Facility (HCCF) leasing program. Under the HCCF leasing program, in lieu of the traditional approach to major medical facility construction, VA would obtain by long-term lease a number of large outpatient clinics built privately to VA specifications. These large clinics could provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery. According to VA, inpatient needs at such sites would be managed through contracts with affiliates or local private medical centers.

The Independent Budget veterans service organizations (IBVSOs) believe that the adoption of Strategic Capital Investment Planning (SCIP) and more HCCF leasing proposals illustrate a shift toward reliance on health-care leasing or a build-to-suit strategy with reliance on community providers or academic affiliates for inpatient services, rather than VA constructing its own comprehensive medical centers. We remain watchful as to how such arrangements will be managed and what unintended consequences may await sick and disabled veterans and those who represent them. Further, SCIP must be clearly explained and integrated with all stakeholders involved in the process—specifically, how will it be developed and prioritized, and will the implementation of the HCCF model impact VA's specialized medical care programs, continuity of high-quality care, delivery of comprehensive services, protection of VA biomedical research and development programs, and particularly the sustainment of VA's renowned graduate medical education and health profession training programs?

VA noted that, in addition to any new HCCF facilities, it would maintain its VA medical centers, larger inde-

pendent outpatient clinics, community-based outpatient clinics (CBOCs), and rural outreach clinics. VA has argued that adopting the HCCF model would allow it to quickly establish new facilities that would provide 95 percent of the care and services veterans need in their catchment areas, specifically primary care, a variety of specialty care services, mental health, diagnostic testing, and same-day ambulatory surgery.

Initially, the IBVSOs have been supportive of the goals of this program. The HCCF model seems to offer a number of benefits in addressing VA capital infrastructure problems, including more modern facilities that meet current life-safety codes, better geographic placements, increased patient safety, reductions in veterans' travel costs, and increased personal convenience. This process could also offer the advantage of quick completion as compared to the existing major construction design-authorization-appropriation process, thus allowing more flexibility to respond to changes in patient loads and technologies and making possible net savings in operating costs and in facility maintenance.

While it offers these obvious advantages, the HCCF model raises concerns about VA's plan for providing inpatient services. VA suggests it will contract for these essential services with affiliates or community hospitals. The IBVSOs believe this program would privatize many services that we believe VA should continue to provide directly to veterans. We are also deeply concerned about the overall impact of this new model on the future of VA's system of care, including the potential unintended consequences on continuity of high-quality care; maintenance of VA's specialized medical programs for spinal cord injury, blindness, amputation care, and other health challenges of seriously disabled veterans; delivery of comprehensive services; its recognized biomedical research and development programs; and, in particular, the impact on its renowned graduate medical education and health profession training programs, in conjunction with long-standing affiliations with nearly every health professions university in the nation.

Moreover, we believe the HCCF model could well challenge VA's ability to provide alternatives to maintain-

ing directly its existing 130 nursing home care units (now called “community living centers”), homelessness programs, domiciliary facilities, compensated work therapy programs, hospice and respite, adult day health-care units, the Health Services Research and Development Program, and a number of other highly specialized services, including 24 spinal cord injury/dysfunction centers, 10 blind rehabilitation centers, a variety of unique “centers of excellence” (in geriatrics, gerontology, mental illness, Parkinson’s, and multiple sclerosis), and various critical care programs for veterans with serious and chronic mental illnesses.

In general, the IBVSOs believe the HCCF proposal could be a positive development, with good potential. But the process must be transparent to all those involved—veterans, stakeholders, community leaders, VA employees—and there must be a well-thought-out and well-communicated plan to carry out the HCCF policy. It has been proven that leasing can help to diminish long and costly in-house construction delays and can be adaptable, especially when compared to costs for renovating existing VA major medical facilities. Leasing options have been particularly valuable for VA as evidenced by the success of the leased-space arrangements for many VA community-based outpatient clinics, Vet Centers, and leased VA regional office staff expansions.

However, the IBVSOs remain concerned with VA’s plan for obtaining inpatient services under the HCCF model, and have many unanswered questions. There are major concerns with the pervasive contracting that would be mandated by this type of proposal. Acknowledging all the changes taking place in health care, VA needs to look very closely at all its infrastructure plans, and needs to do a better job explaining to veterans, their representatives, and Congress what its plans are for every location, with a full exposition based on facts.

Responding to a Congressional request, VA addressed a number of specific questions related to its plan for the HCCF leasing initiative, including whether studies had been carried out to determine the effectiveness of the current approach; the full extent of the current construction backlog of projects; its projected cost over the next five years to complete; the extent to which national veterans organizations were involved in the development of the HCCF proposal; the engagement of community health-care providers related to capacity and willingness to meet veterans’ needs; the ramifications on the delivery of long-term care and specialized services; and whether it would be able to ensure that needed inpatient capacity would remain available indefinitely.

Based on its response, the IBVSOs believe VA has a reasonable foundation for assessing capital needs and has been forthright with the estimated total costs for ongoing major medical facility projects, and that the HCCF model can be a basis for meeting some of these needs at lower cost. We agree with VA’s assertion that it needs a balanced capital assets program, of both owned and leased buildings, to ensure that demands are met under current projections. Likewise, we agree with VA that the HCCF concept could provide modern health-care facilities relatively quickly that might not otherwise be available because of the predictable constraints of VA’s major construction program. However, what is not clear to us is the extent to which VA plans to deploy the HCCF model. In areas where existing CBOCs need to be replaced or expanded with additional services due to the need to increase capacity, the HCCF model would seem appropriate and beneficial.

On the other hand, if VA plans to replace the majority or even a large fraction of all VA medical centers with Health Care Center Facilities, such a radical shift would pose a number of concerns for us. Nevertheless, the IBVSOs see this challenge as only a small part of the overall picture related to VA health infrastructure needs. The emerging HCCF plan does not address the fate of VA’s 153 medical centers located throughout the nation that are on average 60 years of age or older. It does not address long-term-care needs of the aging veteran population, inpatient treatment of the chronically and seriously mentally ill, the unresolved rural health access issues, the lingering questions on improving VA’s research infrastructure, or the fate of VA’s academic training programs. Fully addressing these and related questions is extremely important and will have an impact on generations of sick and disabled veterans far into the future.

We reiterate: Creating a VA of the 21st century must include all stakeholders’ interests. The IBVSOs expect VA to establish any new infrastructure plan in a transparent way; vet that plan through our community and other interested parties; and provide its plan to Congress for review, oversight, and approval if required by law. Congress and the Administration must work together to secure VA’s future to design a VA of the 21st century. It will take the joint cooperation of Congress, veterans’ advocates, and the Administration to support this reform, while setting aside resistance to change, even dramatic change, when change is demanded and supported by valid data.

Finally, one of our community’s frustrations with respect to VA’s infrastructure plans is lack of consistent

and periodic updates, specific information about project plans, and even elementary communications. The IBVSOs ask that VA improve the quality and quantity of communications with us, our larger community, enrolled veterans, concerned labor organizations, and VA's own employees, affiliates, and other stakeholders as the VA capital planning process moves forward. We believe that all of these groups must be made to understand VA's strategic plan and how it may affect them, positively and negatively.

Talking openly and discussing potential changes will help resolve the understandable angst about these complex and important questions of VA health-care infrastructure. While we agree that VA is not the sum of its buildings, and that a veteran patient's welfare must remain at the center of the Department's concern, VA must be able to maintain an adequate infrastructure around which to build and sustain "the best care anywhere." If VA keeps faith with these principles, the IBVSOs are prepared to aid and support VA in accomplishing this important goal.

Recommendations:

VA must develop a well-thought-out health-care infrastructure and strategic plan that becomes the means for it to establish a veterans health-care system for the 21st century.

Congress, the Administration, and internal and external stakeholders must work together to secure VA's future, while maintaining the integrity of the VA health-care system and all the benefits VA brings to its unique patient population.

VA's new proposal, Strategic Capital Investment Planning (SCIP), and its Health Care Center Facility (HCCF) leasing proposals must be clearly explained and integrated with all stakeholders involved in the process, including how both SCIP and HCCF proposals will be developed and how they will impact VA's specialized medical care programs, continuity of high-quality care, delivery of comprehensive services, protection of VA biomedical research and development programs, and particularly the sustainment of VA's renowned graduate medical education and health profession training programs.

VA must improve the quality and quantity of communications with internal and external communities of interests, including the authors of this *Independent Budget*, concerning its plans for future infrastructure improvements through the HCCF leasing and other approaches.

EMPTY OR UNDERUTILIZED SPACE AT MEDICAL CENTERS:

The Department of Veterans Affairs must use empty and underutilized space appropriately.

The Department of Veterans Affairs maintains approximately 1,100 buildings that are either vacant or underutilized. An underutilized building is defined as one where less than 25 percent of space is used. It costs VA from \$1 to \$3 per square foot per year to maintain a vacant building.

Studies have shown that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been shown that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not. Medical facility planning is complex. It requires intricate design relationships for function, as well as the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor used as a medical surgical unit, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect on everything around it. These secondary impacts greatly increase construction expense and can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot necessarily be altered. Different aspects of medical care have various requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Laboratories should have long structural bays and function best without windows. When renovating empty space, if an area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient if simply renovated.

Renovating old space, rather than constructing new space, often provides only marginal cost savings. Renovations of a specific space typically cost 85 percent of

what a similar, new space would cost. Factoring in domino or secondary costs, the renovation can end up costing more while producing a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but are rarely economical.

As stated earlier in this analysis, the average age of VA facilities is 60 years. Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing war veteran population are simply unable to be renovated for modern needs. Most of these so-called “Bradley-style” buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it is impossible to retrofit them for modern mechanical systems. Many of them also have long, narrow wings radiating from small central cores, 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 existing unused space is its location. Much of it is not 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.

Public Law 108-422 incentivized VA’s efforts to properly dispose of excess space by allowing VA to retain the proceeds from the sale, transfer, or exchange of certain properties in a Capital Asset Fund. Further, that law required VA to develop short- and long-term plans for the disposal of these facilities in an annual report to Congress. VA must continue to develop these plans, working in concert with architectural master plans and the long-range vision for all such sites.

Recommendations:

VA must develop a plan for addressing its excess space in nonhistoric properties that is not suitable for medical or support functions because of its permanent characteristics or locations.

PROGRAM FOR ARCHITECTURAL MASTER PLANS:

Each VA medical facility must develop a detailed master plan and delivery models for quality health care that are in a constant state of change as a result of factors that include advances in research, changing patient demographics, and new technology.

The Department of Veterans Affairs must design facilities with a high level of flexibility in order to accommodate new methods of patient care and new standards of care. VA must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs. VA must also provide for growth in existing programs based on projected needs through capital planning strategy.

A facility master plan is a comprehensive tool to examine and project potential new patient care programs and how they might affect the existing health-care facility design. It also provides insight with respect to growth needs, current space deficiencies, and other facility needs for existing programs and how they might be accommodated in the future with redesign, expansion, or contraction.

In many past cases VA has planned construction in a reactive manner. Projects are first funded and then placed in the facility in the most expedient manner, often not considering other future projects and facility needs. This often results in short-sighted construction that restricts rather than expands options for the future.

The Independent Budget veterans service organizations believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility; \$15 million should be budgeted for this purpose.

We believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility.

VA has undertaken master planning for several VA facilities, and we applaud this effort. But VA must ensure that all VA facilities develop master plan strategies to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

Recommendations:

Congress must appropriate \$15 million to provide funding for each medical facility to develop a 10-year comprehensive facility master plan. The master plan should include all services currently offered at the facility and should also include any projected future programs and services as they might relate to the particular facility. Each facility master plan is to be reviewed every five years and modified accordingly based on changing needs, technologies, new programs, and new patient care delivery models.

ARCHITECT-LED DESIGN-BUILD PROJECT DELIVERY:

The Department of Veterans Affairs must evaluate use of architect-led design-build project delivery.

VA currently employs two project delivery methods: design-bid-build and design-build. Design-bid-build project delivery is appropriate for all project types. Design-build is generally more effective when the project is of a low complexity level. It is critical to evaluate the complexity of the project prior to selection of a method of project delivery.

Design-bid-build is the most common method of project design and construction. In this method, an architect is engaged to design the project. At the end of the design phase, that same architect prepares a complete set of construction documents. Based on these documents, contractors are invited to submit a bid for construction of the project. A contractor is selected based on this bid and the project is constructed. With the design-bid-build process, the architect is involved in all phases of the project to insure that the design intent and quality of the project is reflected in the delivered facility. In this project delivery model, the architect is an advocate for the owner.

The design-build project delivery method attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to VA and reduce the project delivery schedule. Design-build, as used by VA, is broken into two phases. During the first phase, an architect is contracted by VA to provide the initial design phases of the project, usually through the schematic design phase. After the schematic design is completed, VA contracts with a contractor to complete the remaining phases of the project. This places the contractor as the design builder.

One particular method of project delivery under the design-build model is called contractor-led design-build. Under the contractor-led design-build process, the contractor is given a great deal of control over how the project is designed and completed. In this method, as used by VA, a second architect and design professionals are hired by the contractor to complete the remaining design phases and the construction documents for the project. With the architect as a subordinate to the contractor rather than an advocate for VA, the contractor may sacrifice the quality of material and systems in order to add to his own profits at the expense of VA. In addition, much of the research and user interface may be omitted, resulting in a facility that does not best suit the needs of the patients and staff.

Use of contractor-led design-build has several inherent problems. A short-cut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents often do not provide adequate scope for the project, leaving out important details regarding the workmanship and/or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, compromising VA's design standards.

Contractor-led design-build forces VA to rely on the contractor to properly design a facility that meets its needs. In the event that the finished project is not satisfactory, VA may have no means to insist on correction of work done improperly unless the contractor agrees with VA's assessment. This may force VA to go to some form of formal dispute resolution, such as litigation or arbitration.

An alternative method of design-build project delivery is architect-led design-build. This model places the architect as the project lead rather than the builder. This has many benefits to VA. These include ensuring the quality of the project, since the architect reports directly to VA. A second benefit to VA is the ability to provide tight control over the project budget throughout all stages of the project by a single entity. As a result, the architect is able to access pricing options during the design process and develop the design accordingly. Another advantage of architect-led design-build is in the procurement process. Since the design and construction team is determined before the design of the project commences, the request-for-proposal process is streamlined. As a result, the project can be delivered faster than the traditional design-bid-build process. Finally, the architect-led design-build model reduces the number of project claims and disputes. It prevents the contractor from "low-balling," a process in which a contractor submits a very low bid in order to win a project and then attempts to make up the deficit by negotiating VA change orders along the way.

In addition to selecting the proper method of project delivery, there is much to learn from the design and construction process for each individual project. It is important for VA to apply these "lessons learned" to future projects.

Recommendations:

VA must establish a category system ranking design/construction project types by complexity. This system should be used to determine if the project is a candidate for the design-build method of project management.

The design-build method of project delivery should only be used on projects that have a low complexity, such as parking structures and warehouses. For health-care projects, VA must evaluate the use of architect-led design-

build as the preferred method of project delivery in place of contractor-led design-build project delivery.

VA must institute a program of “lessons learned.” This would involve revisiting past projects and determining what worked, what could be improved, and what did not work. This information should be compiled and used as a guide to future projects. This document should be updated regularly to include projects as they are completed.



INCREASE NEED FOR VA RESEARCH SPACE AND INFRASTRUCTURE IMPROVEMENTS:

The Department of Veterans Affairs needs research space renovations and improved infrastructure.

A state-of-the-art physical environment for VA research promotes excellence in science as well as teaching and patient care. Research opportunities help VA recruit and retain the best and brightest clinician scientists to care for veterans. However, many VA facilities effectively have run out of usable research space. Also, research “wet” laboratory ventilation, electrical supply, plumbing, and other projects appear frequently on internal VA lists of needed upgrades along with research space renovations and new construction, but these projects languish due to the weight VA places on direct medical care projects as opposed to research space and facility needs.

Five years ago, the House Appropriations Committee expressed concern (House Report 109-95) that “equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department’s research facilities remain competitive.” The committee directed VA to conduct a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies. To comply, VA initiated a comprehensive assessment of VA research infrastructure.

To prompt VA to complete its long overdue assessment, House Report 111-564 accompanying the FY 2011 VA appropriations bill directed the Department to provide its final report to Congress by September 1, 2010, with details of any recent renovations or new construction. As of publication of this *Independent Budget*, VA had

not released the results of its review. According to an October 26, 2009, VA report to the VA National Research Advisory Committee, however, preliminary results of the review indicated, “there is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety.”

The Independent Budget veterans service organizations (IBVSOs) are concerned that a significant cause of VA’s research infrastructure neglect is that neither VA nor Congress provides direct funding for research facilities. The VA Medical and Prosthetic Research appropriation excludes funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on their local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA’s research laboratories. As a result, VA research competes with other medical facility direct patient care needs (such as medical services infrastructure, capital equipment upgrades and replacements, and other medical maintenance needs) for funds provided under either the Major Medical Facility, Minor Construction, or Medical Facilities appropriations accounts.

The IBVSOs believe that correction of VA’s known infrastructure deficiencies should become a higher VA and Congressional priority. Therefore, we recommend VA promptly submit to Congress the report it requested in 2006, provide construction funding sufficient to address VA’s five highest priority research facility construction needs as identified in its facilities

assessment report, and approve a pool of funding targeted at renovating existing research facilities to address the current and well-documented shortcomings in research infrastructure. For these funding needs we recommend \$150 million and \$50 million, respectively.

Additionally, an emerging problem is that VA research facilities often are not an integral component of planning for new VA medical centers (including new medical centers in Las Vegas, Denver, and Orlando). Modern-day biomedical research needs customized power, safety, privacy, and configuration requirements that should be fundamental to the new construction planning processes, not an expensive afterthought. The IBVSOs urge the Administration to require that research space be made an integral component of planning for every new medical center and that such space be designed by architects and engineers experienced in contemporary research facility requirements.

Recommendations:

Congress should require VA to report its findings from its research infrastructure review, now pending more than five years.

Congress should authorize construction of, and appropriate \$150 million in FY 2012 to advance, the five highest priority research construction projects identified by VA in its research infrastructure review, and provide VA an additional \$50 million in maintenance funding (in the Non Recurring Maintenance account) in FY 2012 to address current shortfalls in VA's research laboratories and other research space.



PRESERVATION OF VA'S HISTORIC STRUCTURES:

The Department of Veterans Affairs must further develop a comprehensive program to preserve and protect its inventory of historic properties.

The Department of Veterans Affairs has an extensive inventory of historic structures that highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, of those who cared for their wounds, and of those who helped to build this great nation. Of the approximately 2,000 historic structures in the VA historic building inventory, many are neglected and deteriorate year after year because of a lack of any funding for their upkeep. These structures should be stabilized, protected, and preserved because they are an integral part our nation's history.

Most of these historic facilities are not suitable for modern patient care but may be used for other purposes. For the past seven years, *The Independent Budget* veterans service organizations (IBVSOs) have recommended that VA conduct an inventory of these properties to classify their physical condition and study their potential for adaptive reuse. VA has moved in that direction; historic properties have been identi-

fied. Many of these buildings have been placed in an "Oldest and Most Historic" list and require immediate attention.

The cost for saving some of these buildings is not very high considering that they represent a part of American history. Once gone, they cannot be recaptured. For example, the Greek Revival Mansion at the VA Medical Center in Perry Point, Maryland, built in the 1750s can be restored and used as a facility or network training space for about \$1.2 million. The Milwaukee Ward Memorial Theater, built in 1881, could be restored as a multipurpose facility at a cost of \$6 million. These expenditures would be much less than the cost of new facilities and would preserve history simultaneously.

The preservation of VA's historic buildings also fits into the VA's commitment to "green" architecture. Materials would be reused, reducing the amount of resources needed to manufacture and transport new materials to building sites.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

The IBVSOs encourage VA to use the tenants of Public Law 108-422, the "Veterans Health Programs Improvement Act," in improving the plight of VA's historic properties. This act authorizes historic preservation as one of the uses of the proceeds of the capital assets fund resulting from the sale or leases of other unneeded VA properties.

Recommendations:

VA must continue to develop a comprehensive program to preserve and protect its inventory of historic properties.

VA must allocate funding for adaptive reuse of historic structures and empty or underutilized space at medical centers.

Education, Employment, and Training

During this time of persistent, record unemployment in our country, the veterans community has been hit especially hard. Estimates suggest that the unemployment rate among veterans returning from Iraq and Afghanistan is at least 2 percent greater than the national average. Our veterans have made tremendous sacrifices for our nation, and our leaders must make a concerted effort to ensure that veterans have access to education, employment, and training opportunities to ensure success in an unfavorable civilian job market.

Helping those who have served to secure the right skills, certifications, and degrees so that they can achieve personal success is and should always be central to our support of veterans. People with disabilities, including disabled veterans, often encounter barriers to entry or reentry into the workforce or lack accommodations on the job that make obtaining appropriate training, education, and job skills especially problematic. These difficulties, in turn, contribute to low labor force participation rates and leave many disadvantaged veterans with little choice but to rely on other government assistance programs. At present funding levels, entitlement programs cannot keep pace with the current and future demand for benefits. The vast majority of working-age veterans want to be productive in the workplace, and we must provide greater opportunities to help them achieve their career goals.

Education

In 2009, Congress made history and ensured that today's veterans have greater opportunities for success after their years of voluntary service to our nation. *The Independent Budget* veterans service organizations (IBVSOs) were pleased with the quick passage of the Post-9/11 GI Bill; unfortunately, the swift passage and implementation of this landmark benefit has led to some unforeseen inequities, which must be addressed quickly to keep with the intent of the law.

As it stands, the Post-9/11 GI Bill only provides benefits to service members who served in the active duty armed forces or who were called to service under title 10, United States Code for active duty service and who seek traditional on-campus, public education through an institution of higher education. Unfortunately, this leaves a large percentage of today's veterans ineligible for benefits because they may have served on active duty under title 32 (National Guard) orders. The women and men who are activated under title 32 have to leave their civilian careers and oftentimes their families to serve where our nation needs them. Therefore, we believe chapter 33, title 38, United States Code should be expanded to include certain service under title 32.

In past GI bills, veterans who did not choose traditional education could use their educational benefits for nondegree training and certificate programs. These programs are critical to ensuring that our veterans have the skills to succeed in a competitive job market. Therefore, the IBVSOs also recommend that chapter 33 benefits be expanded to cover nondegree programs.

Inequities also exist for veterans who choose to obtain their degree online or attend private universities or graduate school through the Yellow Ribbon Program. Students who enroll in these kinds of programs should be eligible for benefits comparable to those of their counterparts attending traditional, public universities—whether through living stipends for online learners or baseline tuition and fee reimbursements for private schools and graduate programs.

Also, chapter 31, VA's Vocational Rehabilitation and Education program, must be updated to keep pace with chapter 33 and to account for the unique needs of disabled veterans responsible for the well-being of their family members. The subsistence allowance under chapter 33 is a better benefit than the one our wounded troops are entitled to receive under chapter 31. This may drive them to abandon the program designed specifically to meet their unique needs. Exacerbating this situation is a lack of resources to assist disabled veterans with dependents.

The IBVSOs believe that Congress must make additional resources available to chapter 31 recipients to ensure their families are cared for through the rehabilitation process. We hope Congress will work quickly to remedy these inequities in an effort to ensure that our veterans have access to all of the education and employment training benefits they have earned.

DENIAL OF LIVING STIPENDS FOR NONTRADITIONAL STUDENTS:

Veterans who choose to seek higher education through programs other than on-campus programs should be afforded the living stipend just as their counterparts who attend class on a traditional college campus receive.

Attending online universities and enrolling in online programs from traditional universities have become popular methods of reaching educational goals. Traditional universities are continually increasing the number of courses and programs that are offered online.

Many students choose online education for the convenience it provides, but in many cases veterans choose this option out of necessity. Family, work, and physical limitations caused by service-connected disabilities make attending traditional college settings difficult. Veterans who choose to attend college online should

not be denied the living stipend that veterans who attend on campus receive.

Recommendation:

Congress should enact legislation that will provide a living stipend at a rate that is 50 percent of the Basic Allowance for Housing allowed for an E-5 with dependents within the zip code in which he or she resides.



ABSENCE OF BENEFITS UNDER TITLE 32:

Members of the National Guard who are activated under title 32 orders must have their service credited for chapter 33 education benefits.

The men and women of the National Guard and the reserves have answered the call of duty without flinching or hesitation. They have not agreed to serve exclusively overseas or only to assist with our domestic needs at home; rather, they give their all no matter the mission. Unfortunately, their service is not credited equitably under the Post-9/11 GI Bill.

Since the creation of this critical new program, approximately 45,000 service members under title 32 orders have been excluded from its benefits while they have served in uniform to patrol our southern border, to secure our skies in Operation Noble Eagle, and to protect lives and the environment during Hurricane Katrina relief and the Gulf oil spill cleanup efforts, in

addition to other national security requirements. These efforts should be prized, rewarded, and credited toward a good education along with similar active-duty service that originates under title 10 orders.

Recommendation:

Congress should enact legislation that would credit time spent activated under title 32 orders toward Post-9/11 GI Bill eligibility.

INCLUSION OF NONDEGREE-SEEKING TRAINING AND CERTIFICATES:

Chapter 33 must be expanded to include vocational and on-the-job training, apprenticeships, and certification programs.

The original GI Bill provided benefits for more than 8 million World War II veterans and was pivotal in spurring the economic growth that followed. Yet only approximately 2 million of those veterans went to a four-year, degree-seeking college or university. The vast majority of those returning veterans sought career advancement through apprenticeships, on-the-job training, and vocational training.

The Post-9/11 GI Bill does not provide the same benefit, but, instead, constrains the choices of our veterans by limiting usage of the benefit to only a college or university. Veterans who choose to pursue a vocational career

are being penalized by being forced to pay into the Montgomery GI Bill to later receive far less educational assistance. Returning veterans should be able to apply the Post-9/11 GI Bill benefit they have earned to pursue their occupational goals regardless of the nature of the work.

Recommendation:

Congress should enact legislation that would allow the Post-9/11 GI Bill benefit to be used for apprenticeships, on-the-job training, and vocational programs.

**CHAPTER 33 YELLOW RIBBON PROGRAM SIMPLIFICATIONS:**

The Department of Veterans Affairs should establish a national standard for private and graduate schools to ensure predictability and continuity in tuition and fee rates.

The Yellow Ribbon GI Educational Enhancement Program (Yellow Ribbon Program) provides degree-granting institutions of higher learning within the United States the opportunity to enter into an agreement with VA to contribute up to 50 percent of tuition expenses that exceed the highest in-state undergraduate tuition rate. VA, in turn, will match what the institution contributes.

This is a great opportunity for veterans to attend private schools or obtain advanced degrees. However, the complexity and continually changing tuition rates have caused confusion, unpredictability, and an arbitrary baseline for how much assistance a veteran will receive. Because of the complexity, veterans risk being unexpectedly billed as the result of a misunderstanding of the tuition-and-fee-payment system. Universities also routinely change their tuition and fee rates, making it difficult to predict how much assistance will be given from one year to the next. In addition, because of certain high-cost undergraduate programs, the amount of pre-Yellow Ribbon Program contribution for veterans varies from state to state, thus providing a greater amount of assistance to some.

Recommendation:

VA should implement regulations that will fully cover tuition and fees at all public undergraduate schools. Additionally, the Department should establish a national standard for private and graduate schools to ensure predictability and continuity in tuition and fee rates.

EQUAL SUBSISTENCE ALLOWANCE BETWEEN VOCATIONAL REHABILITATION AND EDUCATION (CHAPTER 31) AND THE POST-9/11 GI BILL (CHAPTER 33) ENROLLEES:

Veterans who choose to participate in the VA Vocational Rehabilitation program should not be penalized by receiving a lesser subsistence allowance than veterans receiving Post-9/11 GI Bill Benefits.

Many service-connected disabled veterans who are eligible for the Post-9/11 GI Bill (chapter 33) also qualify for VA Vocational Rehabilitation and Education (chapter 31) benefits. *The Independent Budget* veterans service organizations are concerned that veterans will base their choice of which program to utilize on the amount of living stipend benefit and not on which program will assist them the most.

Veterans who choose chapter 31 will receive a wide range of services to include personalized career counseling, skills assessment, specialized adaptive training, and job

placement. Veterans should not be forced to choose between the short-term benefit of a chapter 33 living stipend and the long-term benefits chapter 31 can provide.

Recommendation:

Congress should enact legislation to authorize subsistence allowance for veterans participating in chapter 31 at the same rate as those eligible for chapter 33 benefits.



FOR MANY DISABLED VETERANS WITH DEPENDENTS, VR&E EDUCATION TRACKS ARE INSUFFICIENT:

More services are needed to help disabled veterans with dependents rehabilitate while utilizing Vocational Rehabilitation and Employment.

For many veterans with dependents, the Vocational Rehabilitation and Employment (VR&E) educational track provides insufficient support. Veterans with dependents are the second largest group seeking assistance from VR&E and they are often those with the most pressing need to secure meaningful long-term employment. There are many seriously disabled veterans who are unable to pursue all of their career goals due to the limited resources provided to disabled veterans with children and spouses. We must not forget who VR&E is designed to assist—veterans who will live with a life-long disability they incurred in service to our country. Veterans with spouses and/or children tend to utilize VR&E's employment track at a rate higher than disabled veterans without dependents. This is often because immediate employment, while not as advantageous in the long term, is necessary to meet the immediate demands of bills, family, and security in cases where VA assistance is inadequate. VA should recognize that all veterans seeking help have different circumstances and different needs and should always work to help veterans meet their needs as they seek to be productive and prosperous members of society. Assisting these veterans as they labor toward independence and in efforts to secure

a career that will allow them to provide for themselves and their families, will further enable them to enjoy long-term success and an increased quality of life.

Recommendation:

Resources geared toward meeting the essential living requirements need to be allocated to assist veterans with dependents while they receive training, rehabilitation, and education. Particularly, increased living stipends are necessary to assist these veterans with cost-of-living increases to account for the needs of their nuclear family as well. The provision of child care vouchers or stipends would be particularly helpful to these heavily burdened families, as child care is a substantial expense for many of these veterans, and without aid specifically geared to assist with this expense, more favorable long-term educational or vocational rehabilitation will continue to be beyond the reach of many disabled veterans.

Vocational Rehabilitation and Employment

The Department of Defense indicates that each year approximately 25,000 active duty service members are found “not fit for duty” as a result of medical conditions that may qualify for VA disability ratings and eligibility for Vocational Rehabilitation and Employment (VR&E) services. The ability of veterans to access VR&E services has, however, remained problematic. The Government Accountability Office in its report *VA Vocational Rehabilitation and Employment: Better Incentives, Workforce Planning, and Performance Reporting Could Improve Program* noted:

For more than 25 years, we, along with others who have reviewed the program, veterans service organizations, and VA, have found shortcomings in the VR&E program. These reviews generally concluded that the program had not fulfilled its primary purpose, which is to ensure that veterans obtain suitable employment. In 1996, we reported that the program primarily emphasized providing training and did not place enough emphasis on providing employment services. Additionally, the 1999 Congressional Commission on Servicemembers and Veterans Transition Assistance found that VR&E had not achieved its statutory purpose and noted that “employment assistance is the most valuable service the Nation can provide to personnel transitioning from active duty to the civilian workforce.” In 2003, we designated federal disability programs, including those at VA, as high risk because they had difficulty managing their programs and were in need of transformation.¹

In response to criticism of the 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 of the VR&E program.” The Secretary asked the task force to recommend “effective, efficient, up-to-date methods, materials, and metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need” to obtain employment.² In March of 2004, the task force released its report, with 110 recommendations for VR&E service improvements.³

As a direct result of this report, VR&E Service implemented the Five-Track Employment Process, which did strengthen the program’s focus on employment. How-

ever, despite this program realignment VR&E’s incentive structure for veterans remains primarily aligned with education and training programs, with no financial incentive for those seeking immediate employment. Specifically, if a veteran chooses to use the employment services, he or she does not receive a monthly stipend while participating in the employment track of VR&E’s programs.

The President’s Commission on Care for America’s Returning Wounded Warriors in 2007 cited several studies of VR&E conducted within the past decade. It noted that by the end of FY 2007, 89 of the 110 recommendations from the VR&E Task Force had been implemented. The commission, in its own report,⁴ identified a host of ongoing problems with the program, including the following:

- a need for a more aggressive and proactive approach to serving veterans with serious employment barriers;
- limited numbers of VR&E counselors and case managers to handle a growing caseload;
- inadequate and ineffective tracking and reporting on participants;
- employment outcomes that are measured no further than 60 days after hiring; and
- the current 12-year limit for veterans to take advantage of VR&E, which may be unrealistic.

The Independent Budget continues to support the recommendations of the Vocational Rehabilitation and Employment Task Force, as well as the following recommendations of the President’s Commission:

- Expand access to all medically separated service members.
- Make all disabled veterans eligible for vocational rehabilitation and counseling services.
- Screen all applicants for Individual Unemployability for employability.
- Increase VR&E staffing and resources; track employment success beyond 60 days.
- Implement satisfaction surveys of participants and employers.
- Create a monthly stipend for those participating in the employment track of VR&E’s programs.
- Create incentives to encourage disabled veterans to complete their rehabilitation plans.

The Independent Budget veterans service organizations believe that more must be done to ensure that our highly trained and qualified service members do not

face unnecessary barriers as they transition from the military to civilian life. We recommend that the Departments of Defense, Labor, and Veterans Affairs work with employers, trade unions, and licensure and credentialing entities to provide a means for military personnel to receive the necessary civilian equivalency to their chosen career fields when receiving military education and training, thus honoring their military service and allowing them to more easily transition into a civilian occupation without the need for complex and

repetitive training or apprenticeships. We look forward to monitoring the continued implementation of these recommendations and future program changes.

¹ GAO-09-34, *VA Vocational Rehabilitation and Employment: Better Incentives, Workforce Planning, and Performance Reporting Could Improve Program*, 7.

² Department of Veterans Affairs Strategic Plan FY 06-11, Office of the Secretary, Oct 2006. www1.va.gov/op3/docs/VA_2006_2011_Strategic_Plan.pdf

³ GAO-09-34, 1.

⁴ *Serve, Support, Simplify. Report of the President's Commission on Care for America's Returning Wounded Warriors* (July 2007).



VOCATIONAL REHABILITATION & EMPLOYMENT PRODUCTIVITY:

Staffing levels of the VA Vocational Rehabilitation & Employment Service are not sufficient to meet the needs of our nation's veterans in a timely manner.

The VA Vocational Rehabilitation & Employment (VR&E) Service is charged with preparing service-disabled veterans for suitable employment or providing independent living services to those veterans with disabilities severe enough to render them unemployable through its VetSuccess program. Due to the increasing number of service members returning from Iraq and Afghanistan with serious disabilities, VR&E must strengthen its program to reflect these additional needs. Veterans utilizing VR&E require both vocational rehabilitation and employment services. There is no VA mission more important during or after a time of war than that of enabling injured military personnel to lead a productive life after serving their country.

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 had been experiencing a shortage of staff nationwide because of insufficient funding, which, as a result, has caused delays in providing VR&E services to disabled veterans, thus reducing veterans' opportunities to achieve successful timely rehabilitation.

The Department of Veterans Affairs is working to increase the awareness of the VR&E services available to veterans. In April 2009, before the U.S. House of Rep-

resentatives Committee on Veterans' Affairs Subcommittee on Economic Opportunity, Ruth Fanning, director, Vocational Rehabilitation and Employment Service, stated:

In order to increase Servicemember and Veteran awareness of the services provided by the VR&E program, VR&E is launching a marketing campaign. This campaign will focus on branding the employment and independent living services provided through the VR&E program as "VetSuccess." VR&E Service redesigned its Veteran-focused Web site—VetSuccess.gov. The VetSuccess.gov Web site provides Veterans with access to a variety of program and on-line tools to assist them in achieving their career goals.⁵

The Independent Budget veterans service organizations (IBVSOs) look forward to updates on the results of this branding initiative.

To increase emphasis on employment, the service has begun an initiative called "Coming Home to Work" (CHTW). This program provides transitioning military personnel with expedited entry into the VR&E program, easing their transition into new educational and career paths. Outreach is conducted at Department of Defense facilities, VA medical centers, and special homecoming events. CHTW was expanded in 2009 to provide greater outreach to Guard and Reserve members during Post Deployment Health Reassessment

events and Yellow Ribbon functions. To make sure transitioning military personnel on medical hold have easy access to VR&E services, 13 full-time vocational rehabilitation counselors are stationed at 12 DOD military treatment facilities. VA has also appointed a CHTW coordinator in every regional office. This is 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 programs will require additional staff to maintain efforts nationwide.

The number of veterans in the various phases of VR&E programs is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Even though the focus of the VR&E program has changed to career development and employment, it is not clear whether VA is able to meet the current and future demand for employment services. It is just not good enough to say the program's focus is on employment, when the data demonstrate that only 11,000 veterans were placed in employment out of more than 117,000 active cases in fiscal year 2010, according to the Department of Veterans Affairs.⁶

In addition, there are no specific data to demonstrate how long beyond 60 days that a newly employed veteran remains in the workforce. After the veteran has been placed, there is minimal follow-up by VR&E with the employer.

For many years, the IBVSOs have criticized VR&E Service programs and complained that veterans were not receiving suitable vocational rehabilitation and employment services in a timely manner. Many of these criticisms remain a concern, including the following:

- inconsistent case management, with lack of accountability for poor decision making;
- delays in processing initial applications due to staff shortages and large caseloads well beyond the 125 to 1 goal;
- declaring veterans rehabilitated before suitable employment is retained for at least six months;
- inconsistent tracking by the electronic case management information system; and
- failure to follow up with veterans, employers, and referral agencies beyond 60 days to ensure employment placements are appropriate for the veterans.

Recommendations:

VA needs to strengthen its Vocational Rehabilitation and Employment (VR&E) program to meet the demands of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce and providing placement follow-up with employers for at least six months.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

The VR&E Service must place a higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

⁵ House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, April 2, 2009, Statement of Ruth A. Fanning, director, Vocational Rehabilitation and Employment Service, Veterans Benefits Administration, U.S. Department of Veterans Affairs, 4.

⁶ Department of Veterans Affairs, *Annual Benefits Report FY 2010, Vocational Rehabilitation and Employment*, 71 http://www.vba.va.gov/REPORTS/abr/2010_abr.pdf.

VOCATIONAL REHABILITATION AND EMPLOYMENT NATIONAL SURVEY AND PERFORMANCE DATA:

The Department of Veterans Affairs should report accurate performance data that include all veterans who participate in the Vocational Rehabilitation & Employment program and initiate a national survey to determine why veterans drop out prior to rehabilitation.

Performance reporting for chapter 31 benefits is the mechanism used by VA and Congress to authorize funding and staffing needs for the Vocational Rehabilitation and Employment (VR&E) program. VA consistently reports rehabilitation rates that reach the 70th percentile, but in reality these rates are much lower. In order to provide a more accurate assessment of the rehabilitation rate, it is imperative that VA also improve its performance reporting.

Performance reporting for the VR&E chapter 31 benefits program that is used by VA and Congress to authorize funding and staffing needs must be improved. For example, in FY 2009, in its Performance and Accountability Report (PAR) and Budget Submission, VA reported 11,022 participants placed in employment, with a rehabilitation rate of 74 percent. However, VA excluded 5,002 veterans who discontinued participation in the program even though these veterans represent a significant portion of veterans served. Recalculating the rehabilitation rate for 2009 by including all participants finds the VR&E success rate to be 45 percent, not 74 percent. As a result of this lack of clarity in analysis and reporting, decision makers and Congress are not totally aware of the overall performance rate when making decisions on needed resources.

The number of veterans in various phases of VR&E programs is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. In fact, participation has increased by 9.4 percent, from 97,100 participants in FY 2008 to 106,200 in FY 2009, according to the FY 2009 PAR. Even though the focus of the VR&E program has drastically changed to career development and employment, it is not clear whether VA is able to meet the current and future demand for employment services. Because the data demonstrate that only 11,022 veterans out of more than 106,200 active cases were placed in employment, it would be inaccurate to conclude that the program's focus is on employment.

Without clear accounting and understanding of why such a high percentage of chapter 31 benefits program participants are classed as "Max Rehabilitation Gained" and what can be done to retain these veterans in a re-

habilitation plan, VR&E will continue to be underfunded and appear deceptive in its reporting.

A greater understanding of the needs of program participants and the accuracy of reporting of program outcomes could be found in the longitudinal study required by Public Law 110-389, section 334, if VA had the necessary funding to launch this study. VA was required to conduct a longitudinal study of its vocational rehabilitation programs, tracking individuals over a 20-year period who began participating in a vocational rehabilitation program during fiscal years 2010, 2012, and 2014. Annual reports are due to the Committees on Veterans' Affairs of the Senate and House of Representatives on July 1 of each year with the first one due in 2011. The focus of the study is to assess the long-term outcomes of the individuals participating in the vocational rehabilitation programs. *The Independent Budget* veterans service organizations are appreciative of Congressional efforts to fully examine this critical program, as the results of such a study have the potential to provide fresh insights into the complex issue of delivery of these services to our nation's veterans. Unfortunately, the necessary funding has not yet been identified.

VR&E continues with a reengineering analysis of current practices and procedures and the future state they hope to achieve as they seek to expand program outreach and enhance capability. Now that this phase of analysis has been completed, VR&E has have brought back a consultant to develop a strategy in order to achieve that future state.

Recommendation:

Congress should provide the necessary funding to carry out the longitudinal study as required by Public Law 110-389, section 334, part of which should reveal the reasons veterans discontinue participation in the Vocational Rehabilitation and Employment program, and use the information to design interventions to reduce the probability of veterans dropping out of the program.

The VR&E Service needs to report the true number of veterans participating in the program and accurate performance data in order for Congress to determine the sufficient level of funding to be allocated to the program.

VOCATIONAL REHABILITATION & EMPLOYMENT ELIGIBILITY:

Congress needs to change the eligibility requirements for the VA Vocational Rehabilitation and Employment program.

The period of eligibility for Vocational Rehabilitation and Employment (VR&E) benefits is 12 years from the date of separation from the military or the date the veteran was first notified by VA of a service-connected disability rating. Unfortunately, many veterans are not informed of their eligibility to VR&E services or do not understand the benefits of the program. In addition, veterans who later in life may become so disabled that their disabilities create an employment barrier would benefit from VR&E services well beyond the 12-year delimiting date. Eliminating VR&E's delimiting date would allow veterans to access the VR&E program on a needs basis for the entirety of their employable lives.

Veterans would still have to be approved by VR&E as having an employment handicap resulting from their service-connected disability and would still be subject to the total cap of services. However, dropping the arbitrary delimiting date would ensure rehabilitation for veterans should their service-connected disability negatively progress over time.

Furthermore, the current VR&E program can take up to several months to begin a program of training. This occurs primarily because VR&E is required to validate that entitlement is present. It is extraordinarily rare that entitlement is not found for the VR&E program. If a veteran has proven eligibility for VR&E, the entitlement should be assumed, thereby minimizing veterans' time in gaining access to VR&E programs.

Recommendation:

Congress needs to change the eligibility delimiting date for VA Vocational Rehabilitation and Employment services by eliminating the 12-year eligibility period for chapter 31 benefits. Congress should allow all veterans with employment impediments or problems with independent living to qualify for VR&E services for the entirety of their employable lives.



**MAXIMUM LENGTH OF PARTICIPATION AND ANNUAL CAP
IN THE INDEPENDENT LIVING PROGRAM:**

Congress should eliminate the 30-month maximum program participation for Independent Living Services and the statutory cap of 2,700 new, per annum, Independent Living program participants.

The Independent Living (IL) Program, established by Congress in 1980, focuses on providing services to veterans with severe disabilities. The program's goal is to provide the necessary services to veterans to enable them to achieve maximum independence in daily living. Recently, Vocational Rehabilitation and Employment (VR&E) has made improvements to the program by hiring a national IL coordinator and establishing standards of practice in the delivery of IL services.

With the passage of Public Law 107-103, the "Veterans Education and Benefits Expansion Act of 2001," the limit on the number of new IL cases per year increased from 500 to 2,500. It was modestly increased again in FY 2008 from 2,500 to 2,600. Most recently,

P. L. 111-275, the "Veterans Benefits Act of 2010," increased the cap to 2,700.

The VR&E Service monitors newly developed IL cases monthly to track total IL cases in comparison to the legislative cap. On average, 2,300 new cases have entered IL services each of the past several years. Unfortunately, current statute limits the time a veteran can receive IL services to a 30-month maximum and forces the VR&E to abide by an arbitrary cap of 2,600 new cases each year. The consequence of this cap is that as VR&E approaches the cap limit each year it must slow down or delay delivery of independent living services for new cases until the start of the next fiscal year. While VR&E may not reach its cap of 2,700 partici-

pants per year, VA personnel responsible for admission keenly monitor total admissions. As admissions approach this maximum allowed cap, veterans with severe disabilities who have been determined eligible and entitled to the VR&E program in mid- to late summer have had to wait until October to receive full services. *The Independent Budget* veterans service organizations (IBVSOs) recommend that VR&E be given additional professional full-time employment slots for IL specialist counselors who are fully devoted to delivering services to those individuals determined to have serious employment handicaps. Moreover, we strongly oppose the arbitrary IL cap of 2,700 veterans.

Furthermore, the IBVSOs anticipate that the continued military efforts in Iraq and Afghanistan will unfortunately result in greater numbers of service members who sustain serious injuries; therefore, the need for IL services will likely increase beyond current demand.

Recommendations:

Congress should eliminate the 30-month maximum program participation for Independent Living (IL) services and the statutory cap of 2,700 new, per annum, Vocational Rehabilitation and Employment (VR&E) IL program participants. The effect of the cap, with the increasing veteran demand for services, will delay needed IL programs to severely disabled veterans.

With the removal of the IL cap and a greater focus on serving veterans with severe disabilities, VA should establish additional professional, full-time employment slots for IL specialist counselors in VR&E who are fully devoted to delivering services to those individuals determined to have serious employment handicaps.



CENTRALIZATION OF VETERANS' EDUCATION, EMPLOYMENT, AND BUSINESS PROGRAMS ACROSS VA INTO A NEW VETERANS ECONOMIC OPPORTUNITY ADMINISTRATION:

In order to achieve better outcomes for veterans, VA programs designed to enhance economic security, such as those focused on employment, education, and business assistance, should be centralized into a single new administration inside the Department, commensurate with the Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery Administration.

To assist veterans in achieving economic security—both those transitioning out of the military and those already separated from it—the Department of Veterans Affairs provides education, training, employment, entrepreneurship, homelessness, and housing assistance through a number of programs and offices. However, despite this array of services and benefits, veterans continue to face significant challenges in today's weak economy.

While all Americans face challenges during economic downturns, veterans have been particularly hard hit. Statistics clearly illustrate the struggle that veterans face while transitioning from military service to civilian life. Unemployment statistics for July 2010 from the Labor Department's Bureau of Labor Statistics

showed the overall unemployment rate for all veterans rose to 8.4 percent, up from May's 7.8 percent. For veterans from the Iraq and Afghanistan conflicts, the unemployment rate rose to 11.8 percent, an increase over June's rate of 11.5 percent and May's 10.6 percent. While there is some improvement from March 2010, when the unemployment rate was 14.7 percent for this group, it is still higher than the national average. Moreover, younger veterans, those ages 18–24, are at times twice as likely to be unemployed as their civilian counterparts.

On any given night there are 107,000 homeless veterans—while a decrease in recent years, still a number that is too high. Congress approved a historic new GI Bill for Post-9/11 veterans, but VA has struggled im-

plementing this program and delivering this benefit. Vocational rehabilitation programs for disabled veterans have failed to achieve adequate success rates despite improvements in recent years. VA programs designed to provide assistance to veteran entrepreneurs have fallen short of expectations, in part due to the lack of funding and proper organization.

In order to achieve better outcomes for veterans, *The Independent Budget* veterans service organizations (IBVSOs) believe that VA programs that effect veterans' economic status should be housed under a new and separate administration—the Veterans Economic Opportunity Administration (VEOA) within VA, commensurate with the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA). The VEOA would be headed by an under secretary for veterans economic opportunity who would administer all VA programs of economic opportunity assistance to veterans and their dependents and survivors. This new administration would be responsible for vocational rehabilitation and employment, educational assistance, veterans' entrepreneurship, home loan programs, and homeless veterans' programs. The VEOA would also serve as the single point of interagency exchange regarding programs that are administered for veterans outside of VA, such as the Department of Labor's Veterans' Employment and Training Service (VETS), and other such programs in other departments.

Currently, these programs within VA are administered by the VBA, which includes five separate service lines: Compensation and Pension (C&P), Vocational Rehabilitation and Employment (VR&E), Education, Insurance, and Home Loan Guaranty. As currently organized, the C&P service dominates the budget, resources, staff, and attention of the VBA. As a result of the significant challenges facing VA's disability compensation program outlined earlier in this *Independent Budget*, it is understandable that both VA and VBA senior leadership would be so focused on the transformation of the C&P claims-processing system. As a result, the remaining services have a more difficult time addressing their own inadequate staffing levels, insufficient information technology (IT) systems, and other management problems. Centralization of the management of veterans' employment, education, and business programs under one single office headed by an under secretary solely focused on providing greater economic opportunities for veterans could provide greater focus and stronger oversight and accountability for these vital programs. The IBVSOs believe that reorganizing these economic-related programs into a

single entity will not only create new opportunities for greater collaboration among them, but will also relieve some of the burden on the VBA, which is already facing significant challenges in reforming a broken claims process.

The IBVSOs propose that the new Veterans Economic Opportunity Administration be composed of the following existing programs within the VBA:

- Vocational Rehabilitation and Employment Service;
- Education Service (GI Bill);
- Office of Small and Disadvantaged Business Utilization (OSDBU);
- Homeless Veterans Program Office (HVPO); and
- Home Loan Guaranty.

The Vocational Rehabilitation and Employment Service focuses on providing individualized services to veterans with service-connected disabilities in an effort to assist them in achieving functional independence in daily activities, becoming employable, and obtaining and maintaining suitable, quality employment. VR&E refers to their program as the "VetSuccess" Program, which assists veterans who have service-connected disabilities to prepare for, find, and keep suitable employment. For veterans with service-connected disabilities so severe that they cannot immediately consider seeking employment, VetSuccess offers services to build upon and improve their ability to live as independently as possible. As noted elsewhere in this *Independent Budget*, VR&E has focused more on the vocational rehabilitation aspect and less on employment. For example, VR&E only conducts a 60-day follow-up on individuals recently employed as a measure to determine if they are "fully rehabilitated." Even more disturbing is the fact that if a veteran discontinues the use of VR&E services, regardless of the reasoning, VR&E reports it as a successful case of "full rehabilitation." It is imperative that programs designed to prepare veterans for employment, both vocational rehabilitation and education programs, be better integrated with programs designed to secure veterans' employment.

The VBA Education Service provides eligible veterans, service members, guardsmen and -women, and reservists, survivors, and dependents the opportunity to achieve their educational or vocational goals. Education programs also assist the armed forces in their recruitment and retention efforts, as well as assisting veterans in their readjustment and transition back into civilian life. These benefits serve to enhance the nation's competitiveness through the development of a

highly educated and more productive workforce. VA administers a number of education programs, including the Montgomery GI Bill and the Post-9/11 GI Bill, a new education program that provides financial support to individuals with at least 90 days of aggregate service on or after September 11, 2001, or individuals discharged with a service-connected disability after 30 days. Enactment of the Post-9/11 Educational Assistance Act on June 30, 2008, gave the VBA approximately 14 months to develop a new, highly complex system to ensure eligibility and payments are made for hundreds of thousands of claimants who would be eligible to receive benefits under the new program beginning August 1, 2009. Unfortunately, the VBA's failure to fully implement this complex new law results in thousands of veteran students not receiving their education benefits in time for fall 2009 enrollment in colleges and universities. Additionally, when an individual does have the opportunity to complete his or her education under the Post-9/11 GI Bill, Montgomery GI Bill, or other educational programs, there is little to no assistance with job placement after the degree is earned. While the VBA has begun to address the staffing and IT problems that have plagued the Post-9/11 GI Bill program, the IBVSOs believe that this program could be even further improved by placing it inside a Veterans Economic Opportunity Administration.

The Office of Small and Disadvantaged Business Utilization (OSDBU), which consists of the Center for Small Business Programs (CSBU) and the Center for Veterans Enterprise (CVE), serves as and advocate for veteran-owned small businesses (VOSBs), service-disabled, veteran-owned small businesses (SDVOSBs), historically underutilized business zone businesses, and woman-owned small businesses. The OSDBU provides outreach and liaison support to business (small and large) and other members of the private sector concerning small business acquisition issues. The OSDBU is responsible for monitoring VA implementation and execution of socioeconomic programs. It works with contracting officers and monitors prime and subcontracting plans for compliance with their subcontracting goals. CVE maintains VA's database of SDVOSBs and VOSBs. The database www.VetBiz.gov, the vendor information pages (VIP), lists businesses that are 51 percent or more owned by veterans.

Given the almost 30 percent influx of VOSBs and SDVOSBs, it is vital that the CVE be ready and able to meet the growing demand for their services. However, the IBVSOs do not believe that the CVE is serving the needs of the veterans it was originally designed to help. As the result of a lack of leadership over the past year,

we have seen the CVE slowly move from the role of assisting and advocating for VOSBs and SDVOSBs to that of an information and referral agency for other federal and state agencies. The CVE must be brought back up to par with what it was originally tasked to do: assist our veteran population in all aspects for their entrepreneurship endeavors. In order to effectively accomplish this, it must be properly staffed, trained, and funded.

While the OSDBU is charged with the responsibility to serve as advocates for small business owners, its ability to effectively manage VIP remains problematic. Concern continues over the lack of transparency in the application process; the backward logic of restricting veterans to owning a single business; a current wait time of 10 months for an annual certification, which hampers veterans' ability to develop their businesses; and continued delays in processing applications.

VIP was originally established to act as a single-source database of certified SDVOSBs and VOSBs. The database was intended to supply all federal agencies and prime contractors with a continually updated and verified source of SDVOSBs and VOSBs intended to assist the federal government with achieving the minimum 3 percent goal of set-aside contracts for SDVOSBs and/or contracts being awarded to SDVOSB or VOSB concerns, as mandated in Public Law 106-50, enacted August 17, 1999. Furthermore, P. L. 109-461 (subsection 8127) required verification of veterans' ownership of listed SDVOSBs and VOSBs, as well as verification of the service-disabled status of SDVOSBs. Requisite resources, contract officer training, and proper oversight of the SDVOSB/VOSB program are just a few examples of necessary policies and procedures needed to effectively carry out the mandates. However, all of the federal agencies tasked with ensuring set-asides and timely, comprehensive verification have failed to do so.

The CVE is funded by an internal revolving fund called the "VA Supply Fund." The supply fund is controlled by an internal board of directors. This is the same board that approved expansion of the resources dedicated to the CVE to enhance the VIP database. However, these resources have been slow in distribution and intended use as they were originally appropriated for: the improvements to VIP and the verification process. In the current economic environment, rapid progress and strong oversight are essential in securing the financial well-being of our SDVOSB and VOSB communities. The IBVSOs strongly believe this can be properly achieved through the realignment of the OSDBU under a newly formed Veterans Economic Opportunity Ad-

ministration. The consequences occurring as a direct result of the broken verification system and procedures are hurting all veterans choosing to pursue federal awards. The realignment would provide and allocate the strict oversight and resources necessary to ensure the integrity of the entire federal procurement system, as well as finally providing veterans all of the proper resources and protections in federal procurement.

VA has set out an ambitious plan to eliminate all veteran homelessness within five years. The Homeless Veterans Programs Office is charged with this responsibility and ensuring proper oversight of all programs and resources allocated to help achieve this huge and necessary undertaking. All veterans identified as at risk for becoming homeless or attempting to gain assistance so they are no longer homeless must have easy access to programs and services, as well as the proper outreach and education to the homeless veteran population to inform them of the resources available to them. VA and private sector agencies will be required to design, develop, and implement an entirely new outreach campaign, in order to meet the special needs of this diverse and underserved population. VA must be sensitive to the perspective of homeless veterans, many of whom may feel as though the agency and their country have failed or forgotten them, thus making them less likely to actively seek out the resources available to them. If we truly aim to end veteran homelessness within the next five years, we are going to have to provide the strongest of oversight of all of the programs working together to achieve this goal.

Efforts to assist homeless veterans are provided through a variety of programs. The National Call Center for Homeless Veterans ensures that homeless veterans or veterans at risk for homelessness have free, 24/7 access to trained counselors. The Health Care for Reentry Veterans Program is designed to address the community reentry needs of incarcerated veterans. The program's goals are to prevent homelessness; reduce the impact of medical, psychiatric, and substance abuse problems upon community readjustment; and decrease the likelihood of reincarceration for those leaving prison.

The Veteran Justice Outreach initiative seeks to avoid the unnecessary criminalization of mental illness and extended incarceration among veterans by ensuring that eligible justice-involved veterans have timely access to VHA mental health and substance-abuse services when clinically indicated, as well as other VA services and benefits that may be needed. The Supportive Services for Veteran Families program is a new

VA program that will provide supportive services to very low-income veterans and their families who are in or transitioning to permanent housing. These programs have been more successful under the current Administration than many others as a result of the concerted efforts of Secretary Shinseki to coordinate a multiagency approach. In order to achieve long-term success for homeless veterans, these programs must also remain coordinated and integrated with programs for education and employment, which will be better accomplished within the framework of the new VEOA.

Home loan guarantees from VA helps veterans become fully reintegrated into their communities with minimal disruption to their lives. Despite problems in the nation's housing market, VA-backed mortgage loans had a lower foreclosure rate than any other type of home loan in the industry, as of June 2010, the latest available data. Currently, about 1.4 million active home loans were obtained using VA's Home Loan Guaranty Program. The program makes home ownership more affordable for veterans, service members, and some surviving spouses by protecting lenders from loss if the borrower fails to repay the loan. In 2010, VA guaranteed 314,000 loans for either the purchase of a home or to lower the interest rate on an existing home loan.

More than 90 percent of VA-guaranteed loans are made without a downpayment. Despite this, VA has the lowest serious delinquency rate in the industry, according to the Mortgage Bankers Association. Furthermore, VA's percentage of loans in foreclosure is the lowest of all measured loan types—lower even than prime loans, which require high credit scores and a 20 percent downpayment by the borrower. Much of the program's strength stems from the efforts of VA employees and loan servicers nationwide, whose primary mission is to help veterans stay in their homes, avoid foreclosure, and protect their credit lines from the consequences of a foreclosure, Shinseki said. Since 1944, when home-loan guarantees were offered under the original GI Bill, through the fiscal year that ended September 30, VA has guaranteed more than 19 million home loans worth \$1.1 trillion. Inclusion of Home Loan Guaranty Service as a component of the new VEOA would provide an essential tool in fighting homelessness and well as aiding others in providing shelter as they transition from military service.

As veterans' programs have become more complex over the years, the dispersed nature of these programs has challenged VA's senior management to effectively monitor the delivery of each program. The VEOA would be responsible for the administration of all VA

economic-related programs, including vocational rehabilitation and employment; educational assistance; and entrepreneurship, home loan, and homeless veterans programs. Creation of the VEOA would also allow the overburdened VBA to focus on the monumental task of reforming the disability compensation claims-processing system.

Recommendation:

VA programs designed to enhance economic security, including all programs focused on employment, education, and business assistance, should be centralized into a single new Veterans Economic Opportunity Administration inside the Department, commensurate with the Veterans Health Administration, Veterans Benefits Administration, and the National Cemetery Administration, headed by an under secretary for veterans economic opportunity.



VOCATIONAL REHABILITATION AND EMPLOYMENT COUNSELING PARTNERSHIPS:

The Department of Veterans Affairs needs to continue improving its coordination with non-VA counselors and vocational programs to ensure that veterans are receiving the full array of benefits and services to which they are entitled in a timely and effective manner.

Under the VA Strategic Plan for FY 2006–2011, the agency has acknowledged that it plans to continue the utilization of non-VA providers to supplement and complement services provided by Vocational Rehabilitation and Education (VR&E) staff. Many state vocational rehabilitation agencies have memoranda of understanding with their state departments of veterans' services to coordinate services for veterans with disabilities, and some state agencies have identified counselors with military backgrounds to serve as liaisons with VA and veterans' groups. Moreover, the Department of Veterans Affairs is increasingly engaged with state vocational rehabilitation agencies in outreach to the business community to promote veterans with disabilities as a valuable talent pool. In addition, numerous nonprofit vocational rehabilitation providers have served veterans with disabilities for many years in partnership with VA.

These partnerships, however, create challenges that VA needs to address. Whereas qualified providers can partner easily with most state vocational rehabilitation agencies, VA's national acquisition strategy is viewed as overly cumbersome by private providers wishing to serve veterans with disabilities. As a result, private non-VA providers that could address some of the demand by veterans with disabilities for employment assistance are shut out by complicated contracting rules. At the same time, state vocational rehabilitation agency staff may not

always be familiar with veteran-specific disability issues related to traumatic brain injury, post-traumatic stress disorder, and other combat-related injuries and conditions. In addition, because of funding and staffing shortages experienced by state vocational rehabilitation agencies, veterans with disabilities seeking employment could bounce between VA VR&E and state vocational rehabilitation agencies without being properly served.

Even as it seeks to strengthen its engagement with the broader workforce development system, VR&E must maintain its responsibility to the veterans it serves by monitoring the quality and impact of vocational rehabilitation services delivered by these non-VA agencies.

Recommendations:

The VA Vocational Rehabilitation and Employment (VR&E) Service should improve its national acquisition strategy to make it easier for qualified vocational rehabilitation providers to offer services to veterans with disabilities.

State vocational rehabilitation and VA VR&E programs should offer joint training to their staffs on traumatic brain injury, post-traumatic stress disorder, and other veteran-specific disability issues to improve cross-agency coordination.

VA leaders should continue to work with the leadership of the Rehabilitation Services Administration to promote nationwide adoption of memoranda of understanding between their respective regional and local offices and to address any policy or programmatic barriers that may unnecessarily deny services to these veterans.

Until such time as the VR&E Service's resources can accommodate the full range of services needed by veterans with disabilities, better coordination by VA with state vocational rehabilitation programs, One-Stop Career Centers, and private sector vocational rehabilitation programs can help prepare veterans for interviews, offer assistance creating résumés, and develop proven ways of conducting job searches.

VR&E Service staff must improve the oversight of private non-VA counselors to ensure veterans are receiving the full array of services and programs in a timely and effective manner.

The VR&E Service should improve case management techniques and use state-of-the-art information technology to track the progress of veterans served outside VR&E.

The VR&E Service should follow up with rehabilitated veterans for at least six months to ensure that the rehabilitation and employment placement plan has been successful.



NATIONAL VETERANS TRAINING INSTITUTE INADEQUATELY FUNDED:

The National Veterans Training Institute lacks adequate funding for its important mission of preparing veterans' employment representatives.

The National Veterans Training Institute (NVTI) is a contracted program administered by the U.S. Department of Labor's Veterans' Employment and Training Service (VETS) through the University of Colorado at Denver. Each state sends new veterans' representatives for intensive training to further develop and enhance the professional skills of state employment representatives, which include the Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representatives (LVERs). VETS also sends their staff members to the NVTI for training in the details of the Uniformed Services Employment and Reemployment Rights Act and the Transition Assistance Program.

Of the 2,557 DVOP/LVER positions nationwide, historically, the turnover rate exceeds 20 percent annually. This turnover rate is attributed to veterans who initially enter a state's employment system through the DVOP and LVER positions eventually applying for other positions within the state that have a higher salary. This turnover consequently requires new candidates to receive necessary training from the NVTI.

Often these state employment representatives will be the first support contact the newly discharged service

member will have as he or she begins to make the difficult transition to civilian life. Each state has DVOP representatives who are trained to provide intensive services to assist the disabled veteran and veterans with barriers to employment in finding suitable work. The LVER positions work with nondisabled veterans, informing them of employment opportunities in their community, and perform outreach to businesses in their community to locate employment opportunities.

Because of inadequate funding, the NVTI has performed its responsibilities over the past two years with a staff shortage of at least two to three full-time staff members. This has limited its ability to fulfill additional training requests of VETS and to travel to select locations to conduct training in the field. Currently all classes for FY 2011 are scheduled and have staff assignments. Under Public Law 109-461, the NVTI is required to provide training to all DVOPs and LVERs within a minimum of three years of initial employment. This requirement has filled their training calendar completely. P. L. 111-175, the "Veterans Benefits Improvement Act of 2010," changed this requirement to 18 months. Consequently, the NVTI will not be able to meet the requirement without additional funds. Also,

VETS has designed a totally new version of the Transition Assistance Program, replacing the old program developed more than 20 years ago. This new program will require additional training and support from the NVTI. As the VETS program continually searches for new avenues for assisting veterans with employment, having the option of requesting support from NVTI would be a valuable asset. However, as long as the NVTI remains underfunded, this option is not available.

Recommendation:

Congress must provide sufficient funding for the National Veterans Training Institute to ensure the professional training programs can be available for state and federal employment representatives on a timely basis. With additional funding above minimal operating levels NVTI staff could travel to various regions to present their programs to employment personnel as the need arises.



VETERAN ENTREPRENEURSHIP:

Accountability in meeting the federal procurement goals of Executive Order 13360 is needed.

Supporting service-disabled, veteran-owned small businesses (SDVOSBs) contributes significantly in restoring veterans' quality of life while aiding in their transition from active duty to civilian life.

Now, more than ever before, federal agencies must be held accountable to meeting the federal procurement goals outlined by Executive Order 13360 and sections 15(g) and 36 of the Small Business Act. As more and more service-disabled military members begin to transition into civilian life, they are choosing to start their new lives as entrepreneurs. Recent studies of our newly returning and current veteran population show a 33 percent increase in the formation of new business entities over the past five years. Currently there are more than 13,500 SDVOSBs registered in the Central Contractor Registration database. Astoundingly, this number does not accurately reflect the true number of SDVOSBs and veteran-owned small businesses that may not yet be registered, have their statuses verified, or even be familiar with how to register for inclusion in federal procurement databases.

Recommendations:

There must be stronger oversight and outreach to all federal agencies by the U.S. Department of Labor, Office of Small Business Programs, Small Business Administration, and all other federal agencies tasked with protecting and promoting service-disabled, veteran-owned small businesses, to assist in the development and implementation of stronger strategies/plans to reach the 3 percent goal.

Congress must ensure that adequate resources are available to effectively monitor and recognize those agencies that are not meeting the 3 percent goal and hold them accountable for why the goal is not being met. The annual reports filed by all federal agencies, reporting the prior fiscal years' actual percentage of goal achieved, should serve as guidance on which agencies need the most assistance in the development and implementation of stronger contracting plans.

CENTER FOR VETERANS ENTERPRISE:

The Center for Veterans Enterprise must assist veterans with all entrepreneurship endeavors.

The Center for Veterans Enterprise (CVE) was established to assist veterans with all aspects of establishing and maintaining a small business. The CVE is a subdivision of the Office of Small and Disadvantaged Business Utilization that extends entrepreneurial services to veterans who own or who want to start a small business. The CVE also aides other federal contracting offices with identifying veteran-owned small businesses that are working to comply with Executive Order 133600. In the past, VA faced many obstacles, from a lack of leadership to lack of best practices with its entrepreneurship programs, which prevented the success of veteran-owned businesses. For this reason, VA established the CVE as a response to the passage of Public Law 106-50, the “Veterans Entrepreneurship and Small Business Development Act of 1999.” Furthermore, on December 22, 2006, President Bush signed P. L. 109-461, the “Veterans Benefits, Health Care, and Information Technology Act of 2006,” in an effort to successfully identify and grant status to service-disabled, veteran-owned small businesses (SDVOSBs). Effective June 20, 2007, this legislation authorized a unique “Veterans First” approach, specific to VA contracting.

As we move through the 21st century, during a time of war, the veteran-owned small business (VOSBs) and SDVOSB population continues to rise at a rate not seen since the end of World War II. As America’s veterans transition back into civilian life, many are choosing to pursue lives as entrepreneurs. Given the almost 30 percent influx of VOSBs and SDVOSBs, it is vital that the CVE be ready and able to meet the growing demand for their services.

Recommendations:

The Center for Veterans Enterprise has slowly moved from the role of assisting veteran-owned small businesses and service disabled veteran-owned small businesses to that of an information and referral agency for other federal and state agencies. The CVE must be brought back up to par with what it was originally tasked to do: assist our veteran population in all aspects for their entrepreneurship endeavors. Furthermore, Congress must provide VA with dedicated funding, properly trained staff, and oversight to ensure the success of the CVE.

VA VENDOR VERIFICATION DATABASE:

All federal agencies should utilize a continually updated, single centralized source database in the verification of all businesses claiming preferred status as a veteran-owned small business or service-disabled, veteran-owned small business.

At present, vendors desiring to do business with the federal government must register in the Central Contractor Registration database, and those who indicate they are veterans or service-disabled veterans, self-certify their status without verification. Public Law 109-461 required the Department of Veterans Affairs to establish a Vendor Information Page database to accurately identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. This database was originally designed to act as a reliable, centralized database enabling all federal agencies a single source in the identification of possible service-disabled, veteran-owned small businesses and veteran-owned small businesses for consideration during their procurement processes. As of April 15, 2009, approximately 18,000 SDVOSBs were registered in the Central Contractor Registration. As the result of a lack of oversight and uninformed, inconsistent status verification processes, many nonveteran-owned businesses are receiving protections they not are entitled to under the law.

Recommendations:

All federal agencies should be required to certify veteran status and ownership through the VA's Vendor Information Page program before awarding contracts to companies claiming veteran status.

Congress should take the necessary actions to require all federal agencies to use a single-source database in all verifications of veteran-ownership status before awarding contracts to companies on the basis of a claim of service-disabled, veteran-owned small business or veteran-owned small business preference. Furthermore, internal promotion and education on proper usage of the database should coincide with implementation of databases use.

**PROTECTING VETERAN SET-ASIDES WITHIN THE FEDERAL PROCUREMENT SYSTEM:**

The Department of Veterans Affairs must increase personnel training for the federal procurement process.

Public Law 109-461, the "Veterans Benefits, Health Care and Information Technology Act of 2006," was signed December 22, 2006, and went into effect on June 20, 2007. The law allows VA special authority to provide set-aside and sole-source contracts to small businesses owned and operated by veterans and service-disabled veterans. This legislation is codified in title 38, United States Code, sections 8127 and 8128. After more than three years since its enactment, no significant change has been implemented with regard to how federal contracting officers are trained. VA personnel involved in the acquisition process need to be trained and familiarized with all current and new authorizations and responsibilities under P. L. 109-461, and all other procurement directives regarding veteran-owned small businesses and service-disabled, veteran-

owned small businesses. Our service-disabled veterans who own small businesses cannot afford to wait any longer for VA to enforce compliance with the law.

Recommendations:

VA must develop and implement a uniform preliminary and continued education program for all personnel involved with the federal procurement process, with special focus on contracting officers.

VA must develop and implement systems to identify the strengths and weaknesses in its procurement processes, as well as regular internal evaluations of contracting staff and compliance in efforts to successfully identify weaknesses within the program as a whole.

OUTREACH TO LOCAL AND NATIONAL EMPLOYERS:

Educating employers on how to connect with the veterans community, on the local and national levels, is vital in ensuring the success and increased employment opportunities to veterans nationwide.

Recent studies indicate an overwhelming number of employers want to hire veterans. However, these studies also indicated that most potential employers were not clear on how to connect with veterans to offer employment opportunities. Given the disproportionate unemployment statistics for veterans in 2010, immediate actions must be taken to address this very serious issue. Additionally, a critical issue facing veterans and employers is the translation and transfer of military skills and experience into relevant civilian employment qualifications and expressing this in employment applications and on résumés. This certainly should not be a barrier to veterans' employment. With proper tools, veterans would be able to highlight their skills and offer employers the opportunity to bring dynamic, motivated, and very skilled veterans into their workforce.

With regard to federal procurement, the Office of Federal Contract Compliance Programs' 2007 rules and regulations do not address federal contractors' requirements to actively reach out to the veterans community. Employer

relations are a pivotal component to successful veteran entrepreneurship and employment.

Recommendation:

The Department of Labor, Small Business Administration, Office of Federal Contract Compliance Programs, and Employment and Training Administration must collaborate in developing and implementing a single-source database and employer outreach program for the promotion of veterans' entrepreneurship at local and national levels. This system must allow all employers to locate veterans for employment as well as provide an updated listing of employment opportunities. There needs to be a resource available to all veterans that would allow for the transformation of military skills into required civilian qualifications and résumé language. Additionally, all veterans must have equal access to federal subcontractors held by larger prime contractors, and there needs to be stronger oversight of compliance and consistently enforced penalties for noncompliance.



VETERAN-OWNED SMALL BUSINESS SET-ASIDE PROGRAMS:

For veteran-owned small business success, there must be better oversight and stronger enforcement of the set-aside program.

In 1978, Congress passed the Small Business Act, creating 3 percent small business set-asides for federal contracts. The objective of the set-aside program was to act as a tool for achieving economic and national security policy stated in the Small Business Act's preamble. In addition to this law, Congress has passed several laws granting service-disabled, veteran-owned small business (SDVOSB) and veteran-owned small business (VOSB) preference in many procurement processes. However, the Small Business Administration Office of the Inspector General and the VA OIG have conducted numerous investigations that have indicated that an alarmingly large number of procurement awards, designated as set-asides for SDVOSBs and VOSBs have been awarded to large nonveteran businesses, yet these agencies are still receiving credit as having awarded the contracts to veterans.

Recommendation:

VA, the Department of Labor, the Small Business Administration, and the Office of Federal Contract Compliance Programs must exercise better oversight and stronger enforcement of consequences for any government agency or nongovernment business claiming to be awarding set-asides to veteran-owned businesses when, indeed, they are not. There needs to be an immediate focus on proactive measures to eliminate untruths, such as "rent a vet," and cease only exercising "reactive" strategies. VA, the DOL, SBA, and OFCCP should pool all their resources and successful strategies to ensure swift action and nonduplication of measures.

FEDERAL IN-SOURCING AND THE EFFECT ON VETERAN-OWNED BUSINESSES:

Definitions left open to interpretation can have a very negative effect on service-disabled, veteran-owned small businesses and veteran-owned small businesses.

In an attempt to reduce the federal deficit, there has been a proposed rule change to the Code of Federal Regulations by the Office of Federal Procurement Policy (OFPP) in the Office of Management and Budget (OMB) regarding “inherently governmental” functions and the insourcing of thousands of federal contracts. On March 31, 2010, the OFPP issued a proposed policy letter on inherently governmental functions and other “work reserved for performance by federal government employees.” The Administration’s proposed guidance for agencies determining if something is inherently governmental is (1) whether particular functions are inherently governmental and (2) when functions closely associated with the performance of inherently governmental functions and critical functions should be performed by government personnel.

Under existing law, agencies cannot contract out inherently governmental functions, and they must give “special consideration” to using government personnel in performing functions closely associated with the performance of inherently governmental functions (48 C.F.R. § 7.503(a)). In keeping with section 321 of Public Law 110-417, the “National Defense Authorization

Act for Fiscal Year 2009,” which tasked the OMB with developing a “single consistent definition” of “inherently governmental function,” the proposed policy letter adopts the definition of “inherently governmental function” in the Federal Activities Inventory Reform Act. The act defines an “inherently governmental function” as one that is “so intimately related to the public interest as to require performance by federal government employees.”

Recommendation:

In order to refrain from causing undue burdens and hurdles to the service-disabled, veteran-owned small business and veteran-owned small business communities, it is critical that all terms included in the final definition and rule are clearly delineated in the final published rule. Until all terms, such as “critical function” and “reasonably identified,” are provided clear, concise definitions, *The Independent Budget* recommends no immediate action be taken. Definitions left open to interpretation can have a very negative effect on SDVOSB and VOSB success in the federal procurement process.



VA PENSION WORK DISINCENTIVES:

VA pension work disincentives should be removed.

Many veterans who serve this country honorably and are discharged in good health later acquire significant disabilities. If their income is low enough, they will qualify for a VA pension. The Veterans Pension Program is often likened to Supplemental Security Income (SSI) under Social Security. However, unlike SSI, VA pensioners face a “cash cliff,” in which benefits are terminated once an individual crosses an established earnings limit. Because of a modest work record, many of these veterans or their surviving spouses may receive a small Social Security Disability Insurance (SSDI) benefit that supplements their VA pension. If these individuals attempt to return to the workforce, however, not only will their SSDI benefit

be terminated but their VA pension benefits will be reduced, dollar for dollar, by their earnings.

More than 20 years ago, under Public Law 98-543, Congress authorized the Department of Veterans Affairs to undertake a four-year pilot program of vocational training for veterans awarded a VA pension. Modeled on the Social Security Administration’s trial work period, veterans in the pilot were allowed to retain eligibility for pension up to 12 months after obtaining employment. In addition, they remained eligible for VA health care up to three years after their pension terminated because of employment. Running from 1985 to 1989, this pilot program achieved some mod-

est success. However, it was discontinued because prior to VA eligibility reform most catastrophically disabled veterans were reluctant to risk their access to VA health care by working.

The VA Office of Policy, Planning, and Preparedness examined the VA pension program in 2002 and, though small in number, 7 percent of unemployed veterans on pension and 9 percent of veteran spouses on pension cited the dollar-for-dollar reduction in VA pension benefits as a disincentive to work.⁷ Now that veterans with catastrophic nonservice-connected disabilities retain access to VA health care, work incentives for the VA pension program should be reexamined and policies toward earnings should be changed to parallel those in the SSI program.

Recommendation:

Work disincentives in the Veterans Pension Program should be reexamined and consideration given to changes that would parallel Social Security work incentives, such as a trial work period and reduction in benefits as earned income rises.

⁷ Department of Veterans Affairs, *FY 2011 Budget Submission, Benefits and Burial Programs and Department Administration, Vol. 3 of 4* (February 2010), 4E-10, 4E-5.

National Cemetery Administration

The Department of Veterans Affairs (VA) National Cemetery Administration (NCA) currently maintains more than 3 million graves at 131 national cemeteries in 39 states and Puerto Rico. Of these cemeteries, 71 are open to all interment; 19 will accept only cremated remains and family members of those already interred; and 41 will only perform interments of family members in the same gravesite as a previously deceased family member. The NCA also maintains 33 soldiers' lots and monument sites. All told, the NCA manages 19,300 acres, half of which are developed.¹

Today there are nearly 23 million living veterans who have served our nation as far back as World War I and in every conflict and peacetime era since. However, it is estimated that approximately 653,000 veterans died in 2010. VA interred more than 106,000 veterans in 2009, and the Department expects that number to slowly climb and peak at 116,000 in 2013 and to maintain that level through 2015. VA expects to maintain 400,000 more graves during that same period of time.²

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and cherished.

The Independent Budget veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of NCA staff who continue to provide the highest quality of service to veterans and their families. We call on the Administration and Congress to provide the resources needed to meet the changing and critical nature of NCA's mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

¹ Department of Veterans Affairs National Cemetery Administration Fact Sheet (July, 2010) <http://www.cem.va.gov/pdf/facts.pdf>.

² *FY 2011 Budget Submission Summary Vol. III, 1A-6.*

NATIONAL CEMETERY ADMINISTRATION

NCA Accounts

In FY 2010, \$250 million was appropriated for the Operations and maintenance of the National Cemetery Administration (NCA), with approximately \$2 million in carryover. This constitutes less than 1 percent of the total Operations and Maintenance budget. The NCA awarded 47 of its 50 planned minor construction projects, and the three unobligated projects will be obligated in FY 2011. The State Cemetery Grants Program awarded \$48.5 million to fund 12 state cemeteries.

The NCA has done an exceptional job of providing burial options for 90.5 percent of veterans who are part of the 170,000 veterans within a 75-mile radius threshold model. The NCA realized that, without adjusting this model, only one area, St. Louis, would qualify for a cemetery within the next five years and that the five highest veteran population centers would never qualify. *The Independent Budget* veterans service organizations (IBVSOs) are pleased to see that the NCA has adjusted its model and will begin using the model of 80,000 veterans within a 75-mile radius for future cemetery placement. This modification will allow the NCA to continue to provide burial options for veterans who would otherwise be limited geographically for this benefit.

The IBVSOs recommend an Operations and Maintenance budget of \$275 million for the National Cemetery Administration for FY 2012 so that it can meet the increasing demands for interments, gravesite maintenance, and related essential elements of cemetery operations.

The NCA has worked tirelessly to improve the appearance of our national cemeteries, investing \$45 million in the National Shrine Initiative in FY 2010 and approximately \$25 million per year for the three previous years. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries. In 2006 only 67 percent of headstones and markers in national cemeteries were at the proper height and alignment. By 2009 it had reached 76 percent. The NCA is on target to reach 82 percent proper height and alignment in FY 2011. To ensure that the NCA has the resources to reach its strategic goal of 90 percent, the IBVSOs recommend the NCA's Operations and Maintenance budget be increased by \$20 million per year until the operational standards and measures goals are reached.

In addition to the management of national cemeteries, the NCA is responsible for the Memorial Programs Service. This program provides for lasting memorials through headstones 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 cemeteries. P. L. 110-157 gives VA authority to provide a medallion to be attached to the headstone or marker of veterans who are buried in a private cemetery. This benefit is available to veterans in lieu of a government-furnished headstone or marker.

Table 13. FY 2012 National Cemetery Administration (dollars in thousands)

FY 2011 Administration Request	\$250,504
FY 2011 <i>IB</i> Request	\$274,500
FY 2011 Enacted*	\$250,000
FY 2012 <i>IB</i> Recommendation	
Operations and Maintenance	\$275,000
*Amount based on H.R. 1, the "Continuing Resolution for FY 2011."	

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.

THE STATE CEMETERY GRANTS PROGRAM:

The State Cemetery Grant Program is a cost-effective way for the National Cemetery Administration to achieve its mission.

The State Cemetery Grants Program (SCGP) complements the National Cemetery Administration's (NCA's) mission to establish gravesites for veterans in areas where it cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including 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 the available acreage and accommodated more than a 100 percent increase in burial through this program. The SCGP faces the challenge of meeting a growing interest from states to provide burial services in areas not currently served. The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the "Veterans Benefits Improvement Act of 1998," the NCA has been able to

strengthen its partnership with states and increase burial services to veterans, especially those living in less densely populated areas without access to a nearby national cemetery. Currently there are 48 state and tribal government matching grants for cemetery projects.

The Independent Budget recommends an appropriation of \$51 million for the SCGP for FY 2012. This funding level will allow the SCGP to establish new cemeteries, at their current rate, that will provide burial options for veterans who live in regions that currently have no reasonable accessible state or national cemetery.

Recommendation:

Congress should fund the State Cemetery Grants Program at a level of \$51 million for FY 2012.



VETERANS' BURIAL BENEFITS:

Burial benefits have lost their value.

In 1973 the National Cemetery Administration established a burial allowance that provided partial reimbursement for eligible funeral and burial costs. The current payment is \$2,000 for burial expenses for service-connected deaths, \$300 for nonservice-connected, and \$300 for plot allowance. At its inception, the payout covered 72 percent of the funeral cost for a service-connected death, 22 percent for a nonservice-connected death, and 54 percent of the cost of a burial plot. By 2007 these benefits eroded to 23 percent, 4 percent, and 14 percent, respectively.

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potter's fields. In 1923 the allowance was modified. The benefit was determined by a means test, and then in 1936 the means test was removed. In its early history the burial al-

lowance was paid to all veterans, regardless of their service connectivity of death. In 1973 the allowance was modified to reflect the status of service connection.

The plot allowance was introduced in 1973 as an attempt to provide a plot benefit for veterans who did not have reasonable access to a national cemetery. Although neither the plot allowance nor the burial allowance was intended to cover the full cost of a civilian burial in a private cemetery, the recent increase in the benefit's value indicates the intent to provide a meaningful benefit. *The Independent Budget* veterans service organizations are pleased that the 111th Congress acted to improve these benefits. Now, recipients of the plot allowance will receive \$700, up from \$300. Also, included in the increase is \$700 for certain veterans. These increases will take effect on October 1, 2011.

However, there is still a serious deficit between the original value of the benefit and its current value. In order to bring the benefit back up to its original intended value the payment for service-connected burial allowance should be increased to \$6,160, the nonservice-connected burial allowance should be increased to \$1,918, and the plot allowance should be increased to \$1,150.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that the Department of Veterans Affairs separate burial benefits into two categories: veterans who live inside the VA accessibility threshold model and those who live outside it.

For veterans who live within reasonable accessibility of a state or national cemetery that would be able to accommodate their burial needs but who would rather be buried in a private cemetery, the burial benefit should be adjusted as well. These veterans' burial benefits should be based on the average cost for VA to conduct a funeral. The benefit for a service-connected burial should adjust to \$2,793; the amount for a non-service-connected burial would increase to \$854; and the plot allowance would increase to \$1,150. This will provide a burial benefit at equal percentages, but based on the average cost for a VA funeral and not on the private funeral cost that will be provided for veterans who do not have access to a state or national cemetery.

Recommendations:

Congress should divide the burial benefits into two categories: veterans within the accessibility model and veterans outside the accessibility model.

Congress should increase the plot allowance from \$700 to \$1,150 for all eligible veterans and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected burial benefits from \$2,000 to \$6,160 for veterans outside the radius threshold and to \$2,793 for veterans inside the radius threshold.

Congress should increase the nonservice-connected burial benefits from \$300 to \$1,918 for all veterans outside the radius threshold and to \$854 for all veterans inside the radius threshold.

Congress should enact legislation to adjust these burial benefits for inflation annually.

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