THE INDEPENDENT BUDGET

Fiscal Year 2009

A Comprehensive Budget & Policy Document Created by Veterans for Veterans

Prologue

As *The Independent Budget* is presented, American servicemen and -women continue to be placed in harm's way in Iraq, Afghanistan, and other hostile areas around the world. Since fighting began in Afghanistan in October 2001 and Iraq in March 2003, more than 3,500 service members have made the ultimate sacrifice and more than 28,000 have been wounded. These brave soldiers, sailors, airmen, and marines are only the latest in a long line of men and women who have unhesitatingly come forward in time of war to confront those who seek to unalterably change the world we know and the liberty we cherish.

It is for these men and women and the millions who came before them that we set out each year to assess the health of the one federal department whose sole task it is to care for them and their families.

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

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

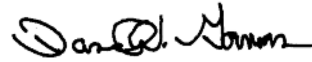
With this reality ever present in our minds, we must do everything we can to ensure that the Department of Veterans Affairs has *all* the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners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

We are proud that *The Independent Budget* has gained the respect that it has over its 22-year history. The coauthors of this important document—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars

of the United States—work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

We hope that each reader approaches *The Independent Budget* with an open mind and a clear understanding that America's veterans should not be treated as the refuse of war, but rather as the proud warriors they are.

James B. King
National Executive Director
AMVETS



David W. Gorman
Executive Director
Disabled American Veterans

Homer S. Townsend, Jr.
Acting Executive Director
Paralyzed Veterans of America

Robert E. Wallace
Executive Director
Veterans of Foreign Wars
of the United States

Supporters

AAALAC International
Administrators of Internal Medicine
African American Post Traumatic Stress Disorder Association
African American War Veterans, USA
Air Force Women Officers Association
Alliance for Academic Internal Medicine
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Military Retirees Association
American Military Society
American Veterans Alliance, USA
American Volunteer Reserve
Armed Forces Top Enlisted Association
Association for Service Disabled Veterans
Association of American Medical Colleges
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Subspecialty Professors
Blinded Veterans Association
Catholic War Veterans, USA, Inc.
Clerkship Directors in Internal Medicine
Enlisted Association of the National Guard of the United States
Fleet Reserve Association
Georgia Department of Veterans Service

Gold Star Wives of America
Iraq and Afghanistan Veterans of America
Japanese American Veterans Association
Jewish War Veterans of the USA
Lung Cancer Alliance
Military Officers Association of America
Military Order of the Purple Heart of the USA, Inc.
National Alliance on Mental Illness
National Association of American Veterans, Inc.
National Association of State Head Injury Administrators
National Association of State Veterans Homes
National Association of Uniformed Services
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Gulf War Resource Center, Inc.
National Spinal Cord Injury Association
Naval Reserve Association
Navy Seabee Veterans of America
New Jersey Veterans Home at Paramus
Non Commissioned Officers Association
Society of Cuban American Veterans
Society of Hispanic Veterans
The Forty & Eight
United Spinal Association
United States Coast Guard CPOA/CGEA
United States Federation of Korea Veterans Organization
Veterans Affairs Physician Assistant Association
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.

Dedication

The four veterans service organizations which collectively author *The Independent Budget (IB)* each year wish to convey our deepest appreciation to Mr. Harley Thomas for his many years of service and dedication to ensure the accuracy and quality of the information contained in the *IB*. Harley passed away in September of 2007. He had managed the production of the *IB* for the previous seven years.

During Harley's tenure, the *IB* gained wide recognition and support by members of Congress and the entire veterans community. As a result of Harley's hard work, more than 50 national organizations have been listed as supporters of the *IB* each year. Harley's legacy will forever be a part of *The Independent Budget*.

Sincerely,

James B. King
National Executive Director
AMVETS

David W. Gorman
Executive Director
Disabled American Veterans

Homer S. Townsend, Jr.
Acting Executive Director
Paralyzed Veterans of America

Robert E. Wallace
Executive Director
Veterans of Foreign Wars
of the United States

Acknowledgments

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

Adrian Atizado, DAV
Kerry Baker, DAV
Denny Boller, AMVETS
Carl Blake, PVA
Gary Coates, PVA
Fred Cowell, PVA
Richard Daley, PVA
Bill Dozier, VFW
James Dudley, PVA
Joy Ilem, DAV
Ray Kelley, AMVETS
Carol Peredo Lopez, AIA, PVA
Gerald Manar, VFW
Chris Needham, VFW
Michael O'Rourke, VFW
Blake Ortner, PVA
Mark Potter, VFW
Alethea Predeoux, PVA
Bo Rollins, PVA
Scott Speser, AIA, PVA

Advisors:

Cheryl Beversdorf, National Coalition for Homeless Veterans
Todd Bowers, Iraq and Afghanistan Veterans of America
John M. Bradley III, Consultant to DAV
Patrick Campbell, Iraq and Afghanistan Veterans of America
Ralph Ibson, National Mental Health Association
Tom Miller, Blinded Veterans Association
Tom Zampieri, Blinded Veterans Association
Robert Norton, Military Officers Association of America
Sheila Ross, Lung Cancer Alliance
Matthew Shick, Association of American Medical Colleges

Special Thanks to:

Kelly Saxton, PVA, for editorial assistance
AMVETS' Communication Department under the supervision of Jay Agg for the cover design

Table of Contents

TABLE OF CONTENTS

Prologue i

FY 2009 *Independent Budget* **Supporters** iii

Guiding Principles v

Dedication vii

Acknowledgments viii

List of Tables & Charts x

Introduction 1

Benefit Programs 3
- Benefits Issues 4
  - Compensation and Pensions 4
    - Compensation 4
    - Dependency and Indemnity Compensation 13
  - Readjustment Benefits 15
    - Montgomery GI Bill 15
    - Housing Grants 17
    - Automobile Grants and Adaptive Equipment 18
    - Home Loans 19
  - Insurance 20
    - Government Life Insurance 20
    - Veterans' Mortgage Life Insurance (VMLI) 21
  - Other Suggested Benefit Improvements 22
    - Protection of Veterans' Benefits Against Claims of Third Parties 23

General Operating Expenses 25
- General Operating Expense Issues 26
  - Veterans Benefits Administration 26
    - VBA Management 26
    - VBA Initiatives 27
    - Compensation and Pension Service 28
    - Vocational Rehabilitation and Employment 31
    - Education Service 32

Judicial Review in Veterans' Benefits 33
- Judicial Review Issues 34
  - Court of Appeals for Veterans Claims 34
    - Scope of Review 34
    - Court Facilities 39
  - Court of Appeals for the Federal Circuit 39
    - Review of Challenges to VA Rulemaking 39

Medical Care 41
- Medical Care Issues 43
  - Finance Issues 43

Mental Health Issues 54
OEF/OIF Issues 59
Access Issues 67
Specialized Services 81
Prosthetics and Sensory Aids 81
Special Needs Veterans 88
Long-Term-Care Issues 103
Assisted Living 110
VA Medical and Prosthetic Research....................112
Administrative Issues 115

Construction Programs 135
Construction Issues 137
Major Construction Account 137
Minor Construction Account 137

Career and Occupational Assistance 145
Career and Occupational Assistance Programs 146
Vocational Rehabilitation and Employment 146

National Cemetery Administration 157
NCA Accounts 158

Tables & Charts

VA Accounts FY 2009 2
Unique VHA Patients and Enrolled Veterans and Total Outpatient Visits 41
Medical Services Recommendations 43
Financial Income Thresholds for VA Health Care 78
NPPD Expense Costs 82
Noise Levels–Common Military Operations 87
Nursing Home Comparison 104
Average Daily Census (ADC) VA's Nursing Home Care Program 104
ADC VA's Community Nursing Home Program 106
ADC State Veterans' Homes 106
ADC for VA Noninstitutional Care Programs 108
Medical and Prosthetic Research 112
Partially Unfunded Projects 136
Major Construction Account 137
Minor Construction Account 137
National Cemetery Administration 158

Introduction

As *The Independent Budget* (*IB*) begins its 22nd year, its four participating authors, AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars, are faced with the responsibility and challenge of predicting the Department of Veterans Affairs (VA) resource requirements for fiscal year (FY) 2009. In addition to making financial recommendations, the *IB* offers program and service recommendations to assist veterans based on the real-life experiences of veterans. Today, fewer and fewer members of Congress are veterans, and the *IB* authors believe that their core mission, service to veterans, must be articulated clearly, accurately, and often.

Currently, VA continues to deny approximately 1.6 million veterans access to health care. However, despite this restriction, its medical care workload is increasing. Thousands more men and women who have sacrificed themselves in the global war on terrorism are returning home. These brave men and women are relying on the VA health-care and benefits system to help them rebuild their lives and become productive members of society. During FY 2009, VA will be caring for an ever-growing number of new veterans as they transition from active duty in the U.S. military to civilian status and become veterans. According to VA, in the first six months of fiscal year 2007, it treated nearly 124,000 new veterans from Operation Enduring Freedom and Operation Iraqi Freedom. This represents a 29 percent increase over the same time period in fiscal year 2006.

Additionally, VA's general veteran population is aging and has an increasing demand for VA's acute medical and long-term-care services. The influx of new veterans entering the VA system coupled with the increasing demand for medical services by an aging veteran population makes adequate resource forecasting difficult but more important year after year.

As America's servicemen and -women continue to be placed in harm's way in the global war on terrorism, it is important that their various needs, upon returning home from the battlefield, are met as expeditiously and as effectively as possible. VA's health-care and benefits systems are critical national resources for our nation's increasing veteran population. Veterans depend on VA for health care, compensation for disability, housing, education, vocational rehabilitation, and insurance benefits they earned serving our country. As the Administration and Congress consider the financial needs of VA this fiscal year, they should pause to consider how much is at stake.

Year after year, we call on Congress to provide funding necessary to meet the health-care needs of veterans and to do so in a timely manner. Unfortunately, Congress continues to be unable to complete the VA appropriation process in time to coincide with the beginning of VA's new fiscal year. Continued Congressional delays in VA funding bolster the *IB* recommendation to alter the current process and make VA health care a mandatory rather than a discretionary expense. Mandatory funding would ensure that the government meets its obligation to provide quality VA health care to America's veterans in an efficient and timely manner.

With regard to veterans' benefits, the *IB* recognizes a vastly growing crisis that has not been properly addressed in years past. It is time to take real steps to fix the backlog in claims processing before the system collapses under its own weight. Continuing to study these problems without developing real solutions serves no other purpose than to delay the benefits that veterans have earned and deserve. Moreover, a large number of adjudication decisions are incorrect or have technical or procedural errors, further exacerbating the problem. Veterans' benefits are part of a covenant between our nation and its defenders and should never be denied, reduced, or delayed.

The *Independent Budget for Fiscal Year 2009* offers comments and recommendations to improve and maintain the broad array of VA services designed to improve the lives of America's veterans. These men and women have answered the call of their country; they have taken an oath to defend and protect America; and they have served our country with honor and distinction. It is the goal of the *IB* to ensure that the promises of a grateful nation are upheld.

The recommendations contained in the *IB for FY 2009* provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans. We are proud that more than 50 veterans, military, and medical service organizations have endorsed the 22nd edition of *The Independent Budget*.

VA Accounts FY 2009 (Dollars in Thousands)

	FY 2008 Appropriation	FY 2009 Admin.	FY 2009 IB
Veterans Health Administration (VHA)			
Medical Services*	29,104,220	34,075,503	34,619,998
Medical Administration*	3,517,000		3,625,762
Medical Facilities	4,100,000	4,661,000	4,576,143
Subtotal Medical Care, Discretionary	**36,721,220**	**38,736,503**	**42,821,903**
*Medical Care Collections***	*2,414,000*	*2,467,000*	
Total, Medical Care Budget Authority** (including Collections)	***39,135,220***	***41,203,503***	***42,821,903***
Medical and Prosthetic Research	480,000	442,000	555,000
Total, Veterans Health Administration	**37,201,220**	**39,178,503**	**43,376,903**
General Operating Expenses (GOE)			
Veterans Benefits Administration	1,327,001	1,371,753	1,693,574
General Administration	277,999	328,114	292,028
Total, General Operating Expenses (GOE)	**1,605,000**	**1,699,867**	**1,985,602**
Departmental Admin. and Misc. Programs			
Information Technology	1,966,465	2,442,066	2,164,938
National Cemetery Administration	195,000	180,959	251,975
Office of Inspector General	80,500	76,500	83,158
Total, Dept. Admin. and Misc. Programs	**2,241,965**	**2,699,525**	**2,500,071**
Construction Programs			
Construction, Major	1,069,100	581,582	1,275,000
Construction, Minor	630,535	329,418	621,000
Grants for State Extended Care Facilities	165,000	85,000	200,000
Grants for Construction of State Veterans cemeteries	39,500	32,000	42,000
Total, Construction Programs	**1,904,135**	**1,028,000**	**2,138,000**
Other Discretionary	155,572	158,000	160,084
Total, Discretionary Budget Authority	**43,107,892**	**44,763,895**	**50,160,660**
Total, Discretionary Budget Authority (including Medical Collections)	***45,521,892***	***47,230,895***	***50,160,660***
Cost for Category 8 Veterans Denied Enrollment			**1,386,482**
Total, Budget Authority			**51,547,142**

*The FY 2009 Administration Request consolidates Medical Services and Medical Administration into one account.
***The Independent Budget* believes Medical Care Collections should be a supplement to and not a substitute for appropriations. As such, our FY 2009 Medical Care recommendation reflects the total funding that we believe is necessary to operate the VA health care system.

Benefit Programs

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

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

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

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

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserve. A group plan also covers service members and members of the Ready Reserve and their family members. Mortgage life insurance protects veterans who have received VA specially adapted housing grants.

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

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

Benefits Issues

COMPENSATION AND PENSIONS

Compensation

Annual Cost-of-Living Adjustment:

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

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

Recommendation:

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

Full Cost-of-Living Adjustment for Compensation:

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

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

Recommendation:

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

Standard for Service Connection:

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

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

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

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

standing by for duty the remainder of the hours in a day. Under other typical circumstances, a service member may live on or near the workstation 24 hours a day, such as when on duty on submarine, on ship, or at a remote military outpost. Even when a military service member is not actively or directly engaged in performing functions of his or her military occupational specialty, the member is indirectly on duty or involved in general military duties and ongoing responsibilities associated therewith. In America's military service, there is no distinction between "on duty" and "off duty" for purposes of legal status, and there is often no clear practical demarcation between being on and being off duty. Moreover, in the overall military environment, there are rigors, physical and mental stresses, and known and unknown risks and hazards unlike, and far beyond, those seen in civilian occupations and daily life. American military service members stationed overseas are often exposed to increased risks of injury and disease, both on and off military facilities.

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

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

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

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

Recommendation:

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

Standard for Determining Combat-Veteran Status:

Veterans should be presumed to have engaged in combat while serving in an active combat zone.

Title 38, United States Code, section 1154(b) requires VA to accept lay or other evidence as sufficient proof of service connection of a disease or injury if a veteran alleges that disease or injury occurred in or was aggravated during combat. While VA recognizes the receipt of certain medals as proof of combat, only a fraction of those who participate in combat receive a qualifying medal. Further, military personnel records do not document combat experiences except for those who receive certain medals. As a result, veterans who are injured during combat or suffer a disease resulting from a combat environment are forced to try to provide evidence that does not exist or wait a year or more while the Department of Defense conducts research to determine whether a veteran's unit engaged in combat.

Congress should amend title 38, United States Code, section 1154(b) to clarify military service to be treatable as service in which a member is considered to have engaged in combat for purposes of determining combat-veteran status. Such clarification would properly allow for utilization of nonofficial evidence as proof of a "triggering-event" occurrence for service-connection of a combat-related disease or injury.

If enacted, this type of legislation would remove a barrier to the fair adjudication of claims for VA benefits filed by veterans who have disabilities incurred or aggravated by their military service in combat zones. Under existing law, veterans who can establish that they served in combat do not have to produce official military records to support their claim for disabilities related to such service. Such legislation would not alter the law's current requirement that a veteran confirm his or her claimed disability through official diagnosis. Further, it would not alter the requirement that a veteran show a connection, either through medical or lay evidence, of the claimed disability to military service. The only alteration from current law would be a relaxed standard of proof required to establish a triggering event that results in eventual disability. This relaxed standard of proof would then apply only to veterans who served in a combat zone.

To understand the need for such legislative change, it must be understood that under current law, service in a "combat zone" does not necessarily produce, for VA purposes, a "combat veteran." There lies the inherent flaw that successfully constructs insurmountable obstacles that lie in the path of rightful benefits earned by thousands of combat veterans.

At present, many veterans disabled by their service in Iraq and Afghanistan, as well as those who served earlier in Korea and Vietnam, are unable to benefit from liberalizing evidentiary requirements found in the current version of section 1154(b). This results because of difficulty, even impossibility, in proving personal participation in combat by official military documents.

Under an opinion of VA General Counsel (12-99), veterans must establish by official military records or decorations that they "personally participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality." Oversight visits by Congressional staff to VA regional offices have found claims denied as a result of this policy because those who served in combat zones were not able to produce official military documentation of their personal participation in an actual fight. The only possible resolution to this problem without amending section 1154(b) is for the military to record the names and personal actions of every single soldier, sailor, airman, and marine involved in every single event—large or small—that constitutes combat, in every single battle, on every single battlefield, and in every single war. Anything less will—and has—resulted in veterans who were disabled in combat being denied rightful benefits to which they are entitled under the law. However, during every war in American history, the military has proven that such recordkeeping is impossible.

Not only have countless World War II, Korean War, Vietnam War, and Persian Gulf War veterans been harmed by this defect in the law, such unfortunate cases already include veterans from the wars in Iraq and Afghanistan. In other cases, extensive delays in claims processing occur while VA adjudicators attempt to obtain official military documents showing participation in combat: documents that may never be located.

The legislative amendment requested herein would overturn the foregoing VA General Counsel precedent opinion—a requirement inconsistent with the original intent of Congress in liberalizing the requirements for proof of service-connection in cases involving veterans

who served in combat areas. The Senate noted in 1941, in the report on the original bill providing special consideration for combat veterans: The absence of an official record of care or treatment in many of such cases is readily explained by the conditions surrounding the service of combat veterans.

It was emphasized in the hearings that the establishment of records of care or treatment of veterans in other than combat areas, and particularly in the States, was a comparatively simple matter as compared to that of the veteran who served in combat. Either the veteran attempted to carry on despite a disability to avoid having a record made lest he or she might be separated from his or her organization, or, as in many cases, the records themselves were lost. Likewise, many records are simply never generated.

Recommendation:

Congress should clarify its intent by amending title 38, United States Code, section 1154(b), with respect to defining a veteran who engaged in combat for all purposes under title 38, as a veteran who during active service served in a combat zone for purposes of section 112 of the Internal Revenue Code of 1986 or a predecessor provision of law.

Concurrent Receipt of Compensation and Military Retired Pay:

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

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

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

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

While Congress has made progress in recent years in correcting this injustice, the members of *The Independent Budget* 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 retired pay, based on longevity, be offset by an amount equal to their rightfully earned VA disability compensation.

CONTINUATION OF MONTHLY PAYMENTS FOR ALL COMPENSABLE SERVICE-CONNECTED DISABILITIES:

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

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

In its deliberation of lump-sum disability severance payments as a means of compensation for disabilities as an alternative to monthly payments, the Veterans' Disability Benefits Commission (VDBC) considered reports from previous Presidential and Congressional commissions, the Government Accountability Office, and VA's Office of Inspector General, as well as a VDBC-commissioned study by the Center for Naval Analysis. In its final report, the VDBC rejected the concept of paying a lump sum in lieu of recurring compensation because the "complexity of lump sum payments would likely be excessive and difficult for veterans to understand and accept…[b]e difficult and costly to administer…would have significant short-term impact on the budget of the United States and the break-even point when the up-front costs would be offset by future savings would be many years in the future…"[1] *The Independent Budget* veterans service organizations strongly oppose any change in law to provide for lump-sum payments of compensation.

Recommendation:

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

[1] "Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century," Veterans' Disability Benefits Commission, October 2007, p. 278.

Increase in Rates of Special Monthly Compensation:

Congress should increase rates of payment to veterans who have been determined to be housebound or in need of regular aid and attendance because of service-connected disabilities.

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

The present special monthly compensation rate of $91 is paid beyond the service-connected compensation level of disability to a veteran who as the result of a service-connected disability has suffered the devastating loss or loss of use of a creative organ, one foot, one hand, or both buttocks. In addition, a veteran who has suffered blindness of one eye having only light perception; complete organic aphonia with constant inability to communicate through speech; deafness of both ears having absence of air and bone conduction; and, in the case of a woman, has received radiation treatment of breast tissue, or the anatomical loss of 25 percent or more of tissue from a single breast or both breasts in combination (including loss by mastectomy or partial mastectomy) as the result of a service-connected disability is entitled to special compensation. The payment of special monthly compensation, while minimally adjusted for inflation each year, is now no longer sufficient to compensate for the special needs of these veterans.

Recommendation:

Congress should enact legislation to increase the special monthly compensation under title 38, United States Code, sections 1114(l)–(s) by an immediate 20 percent above the current base amount and additionally, increase by 50 percent the current base amount of special monthly compensation under 38 U.S.C. § 1114(k).

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

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

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

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

Hearing loss and tinnitus are common among combat veterans. The reason is simple: Combat veterans are typically exposed to prolonged and frequent loud noises from unusual sources, such as gunfire and loud aircraft engines, just to name two. Combat veterans suffer acoustic trauma from black powder and other explosive sources. Exposure to loud noise and acoustic trauma are well-known causes of high-frequency hearing loss and tinnitus. Yet many combat veterans are unable to document their in-service acoustic trauma or that their hearing loss or tinnitus is due to military service. World War II veterans are

particularly at a disadvantage because testing by spoken voice and whispered voice was insufficient to detect hearing loss in many instances.

Many veterans serve in military occupations that typically involve noise exposure sufficient to cause hearing loss. Today's defense against noise-induced hearing loss for these military occupations includes hearing conservation programs and mandatory hearing protection devices. However, many veterans performed those same jobs without protection during earlier periods. Furthermore, the IOM report indicates, "[a] handful of reports over the past 30 years suggest that in some settings, only about half of those who should have been using hearing protection devices were doing so."

As a result of inconsistent audiometric testing and insufficient testing records, Congress has made special provisions for deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control. Congress should do the same for combat veterans and veterans whose military duties are generally recognized to have involved noise exposure sufficient to cause hearing loss and tinnitus, such as artillery gun crews. When these veterans suffer from tinnitus or the type of hearing loss that can result from noise exposure and when their medical records are insufficient to prove absence of service-related hearing loss or tinnitus during service, service connection should be presumed.

Recommendation:

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

Compensable Disability Rating for Hearing Loss Necessitating a Hearing Aid:

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

The VA *Schedule for Rating Disabilities* does not provide a compensable rating for hearing loss at certain levels severe enough to require hearing aids. The minimum disability rating for any hearing loss warranting use of 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 ambulate normally with a prosthetic limb. Providing a compensable rating for this condition would be consistent with minimum ratings provided elsewhere when a disability does not meet the rating formula requirements but requires continuous medication.

Recommendation:

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

Temporary Total Compensation Awards:

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

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

Hospitalization 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 hospital. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications or where immobilization of a major joint by cast is necessary, a temporary 100 percent disability rating is awarded effective the date of hospital admission or outpatient visit.

Although the effective date of the temporary total disability rating corresponds to the beginning date of hospitalization or treatment, the provisions of title 38, United States Code, section 5111 delay the effective date for payment purposes until the first day of the month following the effective date of the increased rating.

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

Therefore, *The Independent Budget* veterans service organizations urge Congress to enact legislation exempting these temporary total disability ratings, administered under title 38, Code of Federal Regulations, sections 4.29 and 4.30, from the provisions of title 38, United States Code, section 5111.

Recommendation:

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

Pension for Nonservice-Connected Disability:

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

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

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

Recommendation:

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

Dependency and Indemnity Compensation

Review of Adequacy of Overall Dependency and Indemnity Compensation Program:

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

The VA Dependency and Indemnity Compensation program provides monthly financial support to the widow or widower of a veteran who dies from a service-connected disability (including the survivor of an active duty service member who dies while still in military service). Historically, DIC was intended to enable a survivor of a veteran to maintain a standard of living above the poverty level that might have ensued because of the loss of a spouse's life income and earning power. Current payment rates for DIC are set in law, and generally the maximum monthly payment is limited to $1,091, about 41 percent of the level of maximum service-connected disability payment to a totally disabled veteran—and considerably less than pensions paid to a survivor of a federal retiree, which are set in law at 55 percent of that federal annuity. Because of inflation and other economic factors, many widows (and some widowers) are in fact now living in poverty due to lack of income other than DIC. Their situations are often compounded by their own disabilities, child-care responsibilities, and consequent inability to work. *The Independent Budget* veterans service organizations believe strongly that no survivor of a veteran who died as a result of service-connected disability—and most certainly no survivor of a service member who died while serving our nation—ever should be reduced to poverty as a result of government compensation policy.

Recommendation:

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

Repeal of Offset Against Survivor Benefit Plan:

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

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

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

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

Recommendation:

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

Increase of Disability and Indemnity Compensation for Surviving Spouses of Service Members:

Congress should elevate rates of disability and indemnity compensation (DIC) to survivors of active duty military personnel who die while on active duty.

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

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

Recommendation:

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

RETENTION OF REMARRIED SURVIVORS' BENEFITS AT AGE 55:

Congress should lower the age required for survivors of veterans who die from service-connected disabilities who remarry to be eligible for restoration of dependency and indemnity compensation (DIC).

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

Recommendation:

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

READJUSTMENT BENEFITS

Montgomery GI Bill

EXPANSION OF MONTGOMERY GI BILL ELIGIBILITY:

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

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

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

Recommendation:

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

Refund of Montgomery GI Bill Contributions for Ineligible Veterans:

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

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

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

Recommendation:

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

GI Bill for the 21st Century:

Congress must invest in our troops, our veterans, and our nation.

Since the inception of the GI Bill, every generation of warriors has had this benefit to ease transition back into civilian life, which provided them an opportunity for education and served as an investment in the future of our nation. Today's GI Bill is not meeting the needs of our veterans; skyrocketing education costs are forcing veterans to shoulder the bulk of college expenses. Our military, in the wake of the current conflict, is suffering from recruiting shortages. Moreover, young veterans are more likely to become unemployed and homeless. A new approach to veterans' transition, stabilization, and education is needed.

The increasing cost of education is diminishing today's GI Bill as a veterans' education benefit. According to the Department of Education, the national average cost of undergraduate tuition, fees, room, and board charged to full-time students in degree-granting institutions for the 2005–06 academic year was $17,447. A veteran in receipt of the active duty full-time GI Bill benefit for the same period received $9,306, approximately 53 percent of the total cost of education. This benefit level makes it difficult for a single veteran to attend college and prohibitive for a married veteran to support his or her family and seek an education.

The Department of Health and Human Services set the 2005 poverty line as individuals earning at or below $9,570, a two-person household at or below $12,830, and a three-person household at or below $16,090. A student veteran earning no additional income is living below the poverty line and struggling to afford an education. Veterans with families who must rely solely on the GI Bill to sustain them and their dependents while they attend college fall dramatically below the poverty line.

The GI Bill has evolved from its origins as a transition and stabilization benefit into a recruitment tool. With each successive year of conflicts in Iraq and Afghanistan, we face the increased challenge of meeting projected recruitment and retention numbers for the military. A robust education benefit would have a positive effect on military recruitment and help broaden the socioeconomic makeup of the military, improving the overall quality of individual recruits.

Veterans are increasingly at a disadvantage relative to their peers in the job market. Of the 200,000 men and women who annually leave service to enter the workforce, veterans are twice as likely as their civilian peers to remain unemployed. The estimate from the Department of Labor of unemployment among veterans between the ages 20 to 24 was 15.6 percent in 2005. Nonveterans of the same age group faced an unemployment rate of 8.7 percent. Increased education benefits improve a veteran's marketability, contribute to his or her long-term career growth, and promote a more positive readjustment experience.

Near the end of World War II, our nation's economy was recovering from the depression and showing promise of expansion. With the creation of the WWII GI Bill, millions of service members took seats in classrooms across the nation. The 7.8 million veterans who took advantage of the WWII GI Bill ushered in an era of prosperity, where for every tax dollar spent the government received approximately $7 in return. The original GI Bill vastly expanded the middle class in America, improved the lives of veterans, and profoundly affected their families and all Americans.

Congress must pass and the President must sign into law a comprehensive GI Bill for the 21st century as an investment in our troops, our veterans, and our nation. It would serve to strengthen the Department of Defense's recruitment efforts, provide the nation with cadre of seasoned and patriotic leaders, and, most important, improve the lives of veterans and their families.

Recommendation:

Congress must pass a comprehensive GI Bill for the 21st century that provides for full tuition support, a small stipend, and other education-related costs.

Housing Grants

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

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

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

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

Recommendation:

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

Grant for Adaptation of Second Home:

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

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

Recommendation:

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

Automobile Grants and Adaptive Equipment

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

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

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

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

Because of a lack of adjustments to keep pace with increased costs, the value of the automobile allowance has substantially eroded through the years. In 1946 the $1,600 allowance represented 85 percent of average retail cost and a sufficient amount to pay the full cost of automobiles in the "low-price field." By contrast, in 2007 the allowance was $11,000, and the average price of new vehicles, according the National Automobile Dealers Association, was $28,500. The 1997 average cost of an automobile was 1,155 percent of the 1946 cost, but the automobile allowance of $5,500 was only 343 percent of the 1946 award. Currently, the $11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be $22,800.

Veterans eligible for the automobile allowance under title 38, United States Code, section 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance

is only a fraction of the cost of even the modest and smaller models, which are often not suited to these veterans' needs.

Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles. The amount of the allowance should be increased to 80 percent of the average cost of a new automobile in 2007, and to avoid further erosion of this benefit, Congress should provide for automatic annual adjustments based on the rise in the cost of living.

Recommendation:

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

Home Loans

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

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

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

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

Recommendation:

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

INSURANCE

Government Life Insurance

VALUE OF POLICIES EXCLUDED FROM CONSIDERATION AS INCOME OR ASSETS:

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

For nursing home care under Medicaid, the government forces veterans to surrender their government life insurance 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. Similarly, dividends and proceeds from veterans' life insurance should be exempt from countable income for purposes of other government programs.

Recommendation:

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

LOWER PREMIUM SCHEDULE FOR SERVICE-DISABLED VETERANS' INSURANCE:

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

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

Recommendation:

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

Increase in Maximum Service-Disabled Veterans' Insurance Coverage:

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

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

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

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

Recommendation:

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

Veterans' Mortgage Life Insurance

Increase in Maximum Veterans' Mortgage Life Insurance Coverage:

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

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

Recommendation:

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

OTHER SUGGESTED BENEFIT IMPROVEMENTS

National Guard and Reserve Benefits:

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

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

Since September 11, 2001, more than 600,000 individuals who serve in National Guard and Reserve forces have been mobilized for a variety of military, police, and security actions. Increasing demands on these serving members impose significant and repeated family separations (the single greatest disincentive for a military career) and create additional uncertainty and interruptions in their civilian career. Moreover, such mobilizations of individuals in the National Guard and Reserve forces are now being affected with regard to future employment opportunities. In particular, civilian employers and potential employers are becoming increasingly hesitant to employ National Guard and Reserve members because of the frequency and uncertainty of deployments, jeopardizing their continued employment and career progress.

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

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

Recommendation:

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

Protection of Veterans' Benefits Against Claims of Third Parties

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

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

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

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

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

We should never lose sight of the fact that it is the veteran, who, in addition to a loss in earning power, suffers the pain, limitations in the routine activities of daily life, and other social and lifestyle constraints that result from disability. The needs and well-being of the veteran should always be the primary, foremost, and overriding concern when considering claims against a veteran's disability compensation. Disability compensation is an earned entitlement based on a veteran's service. Dependent family members are only eligible for secondary compensation because of their relationship to an individual veteran. Therefore, federal law should place strict limits on access to veterans' benefits by third parties to ensure compensation goes mainly to support veterans disabled in the service of their country. Congress should enact legislation to override judicial interpretation and leave no doubt about the exempt status of veterans' benefits.

Recommendation:

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

General Operating Expenses

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

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

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

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION

VBA Management

More Authority over Field Offices:

VA program directors should have more accountability for benefits administration in the field offices.

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

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

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

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

Recommendation:

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

VBA Initiatives

Investment in VBA Initiatives:

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

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

Despite these undeniable needs, Congress has steadily and drastically reduced funding for VBA initiatives over the past five fiscal years. In fiscal year 2001, Congress provided $82 million for VBA initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and in 2006, $23 million.

Funding for FY 2006 was only 28 percent of FY 2001 funding, without regard for the added loss of buying power due to inflation. Moreover, some VBA employees who provided direct support and development for VBA's IT initiatives in FY 2006 were transferred to the VA Chief Information Office. Continued realignment through FY 2007 shifted more funding to VA's IT account, further reducing funding for these initiatives in the General Operating Expenses account to $11.8 million.

With restored investments in initiatives, the VBA could complement staffing adjustments for increased workloads with a support infrastructure designed to increase operations effectiveness. The VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrading and enhancement of training systems, to improve operations and service delivery. While IT initiatives are being funded in the VA's IT appropriation, ongoing VBA initiatives include expansion of web-based technology and deliverables, such as web portal and Training and Performance Support Systems (TPSS); "Virtual VA" paperless processing; enhanced veteran self-service and access to benefit application, status, and delivery; data integration across business lines; use of the corporate database; information exchange; quality assurance programs and controls; and employee skills certification and training.

Some initiative priorities for funding follow:

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

> VETSNET is a suite of applications, which include SHARE, Modern Award Processing-Development, and Rating Board Automation (RBA 2000), that serves to integrate several subsystems into one nationwide information system for claims development, adjudication, and payment administration. TEES serves to provide for electronic transmission of applications and enrollment documentation along with automated expert processing. CWINRS is a case management and information system allowing for more efficient award processing and sharing of information nationwide.

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

> Virtual VA supports pension maintenance activities at three pension maintenance centers. Further enhancement would allow for the entire claims and award process to be accomplished electronically. TIMS is the Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. This initiative is to modify

and enhance TIMS to make it fully interactive to allow for fully automated claims and award processing by Education Service and VR&E nationwide.

■ Upgrade and enhance training systems.

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

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

■ Accelerate implementation of virtual information centers (VICs).

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

With the effects of inflation, the growth in veterans' programs, and the imperative to invest more in advanced information technology, *The Independent Budget* veterans service organizations believe a conservative increase of at least 5 percent annually in VBA initiatives is warranted. Had Congress increased the FY 2001 funding of $82 million by 5 percent each year since then, the amount for FY 2009 would be $121.2 million.

Recommendation:

Congress should provide $121.2 million for Veterans Benefits Administration initiatives to improve its information systems.

Compensation and Pension Service

Improvements in Claims Processing:

To overcome the ongoing problems of the disability claims backlog and lack of quality resulting thereof, Congress should remove the Administration's discretion of continuing claims' development when such claims are already developed adequately for rating purposes.

The Department of Veterans Affairs has an obligation to deliver timely decisions on claims for disability benefits when such claims are adequately prepared for rating purposes. However, VA routinely continues to develop many claims rather than making timely decisions, notwithstanding that evidence development may be complete. This type of action lends validity to many veterans' accusations that whenever VA would rather not grant a claimed benefit, some VA employees intentionally overdevelop cases to obtain evidence against the claim.

Such actions usually result in appeals, followed by needless remands by the Board of Veterans' Appeals (BVA) and/or the Court of Appeals for Veterans Claims (CAVC). In many of these cases the evidence of record

supports a favorable decision on the appellant's behalf, yet the appeal is remanded nonetheless. These unjustified remands usually do nothing but perpetuate the hamster-wheel reputation of veterans' law. While there are countless numbers of cases that exemplify this scenario, one must look no further than the case of Irving M. Levin.[2]

Mr. Levin is a World War II veteran who survived a B-29 crash landing in April 1945 following a bombing run. A number of years after military service, Mr. Levin was diagnosed with spinal cord trauma related to the B-29 crash landing. In April 1988, Mr. Levin filed a claim of service connection for his disability of the spine. Notwithstanding competent medical evidence linking Mr. Levin's spinal condition to the B-29 crash landing, VA denied the veteran's claim. What followed was a continuous appeal lasting until July 2007.

In the course of Mr. Levin's 19-year appeal, the BVA remanded the veteran's case no less the seven times; the CAVC remanded the appeal twice. The court finally reversed the BVA decision on the third appeal. During this entire two-decade-long appeal, Mr. Levin's claim was supported by favorable private and favorable VA medical evidence. In fact, in the process of nearly every remand, even VA's own physicians added additional favorable medical evidence to the claim, yet the VA regional office and the BVA continued to request unnecessary medical opinions. In its final decision, the court determined that VA violated the principles of fair process as embodied by various court decisions. The court further ruled that because there was sufficient evidence to grant the claim much earlier in the appeal, "a remand to develop additional evidence would amount to development of evidence to refute the claim, which VA may not undertake."[3]

Mr. Levin's case is just one example of many that support the increasing number of accusations that VA develops evidence to deny claims. Congress can resolve this problem to some extent by removing VA's "discretion" of continuing to develop additional medical evidence when a claimant has already proffered private medical evidence that is adequate for rating purposes. In far too many cases, VA, the BVA, and the CAVC conclude that remand is required solely to obtain a VA medical opinion notwithstanding the claimant's submission of a private medical opinion adequate for rating purposes. VA's conduct in these cases violates the very purpose of its proclaimant, nonadversarial claims process.

Claimants wanting to participate in securing their own medical evidence, including a fully informed medical opinion, are entitled by law to do so. If a claimant secures an adequate medical opinion, there is no need for VA to seek its own medical opinion. Congress enacted title 38, United States Code, section 5125 for the express purpose of eliminating the former 38 Code of Federal Regulations, section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report prior to an award of VA benefits. Section 5125 states:

> For purposes of establishing any claim for benefits under chapter 11 or 15 of this title, a report of a medical examination administered by a private physician that is provided by a claimant in support of a claim for benefits under that chapter *may* be accepted without a requirement for confirmation by an examination by a physician employed by the Veterans Health Administration if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim.[4]

Section 5125 was therefore codified to eliminate unnecessary delays in the adjudication of claims and to avoid the costs associated with unnecessary medical examinations. In fact, the cumulative costs of VA's overdevelopment of Mr. Levin's case in its 19-year appeal is most likely well above any monetary figure received by Mr. Levin as a result of his claim. In addition to unnecessary costs, this type of overdevelopment significantly adds to VA's increasing claims and appeals backlog.

Notwithstanding the elimination of 38 Code of Federal Regulations, section 3.157, and the enactment of title 38, United States Code, section 5125, VA consistently refuses to render decisions in claims wherein the claimant secures a private medical opinion until a VA medical opinion is obtained. Such actions are an abuse of discretion, which delay decisions and prompt needless appeals. When claimants submit private medical evidence *that is adequate for rating purposes,* Congress should mandate that VA *must* decide the case based on such evidence rather than delaying the claim by arbitrarily requesting an additional medical opinion from the Department.

Recommendation:

Congress should amend title 38, United States Code, section 5125, insofar as it states that a claimant's private examination report "may be accepted without a requirement for confirmation by an examination by a physician employed by the Veterans Health Administration if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim." The foregoing statutory language should be amended to read that a claimant's private examination report, including medical opinion, "must be accepted…if…adequate for the purpose of adjudicating such claim."

[2] *Levin v. Nicholson*, No. 05-1027, 2007 WL 2114677 (U.S. Vet.App., July,19, 2007).

[3] *Levin v. Nicholson*, 2007 WL 2114677 *10 (citing *Mariano v. Principi*, 17 Vet.App. 305, 312 (2003)).

[4] 38 U.S.C. § 5125 (West 2002) (emphasis added).

Sufficient Staffing Levels:

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

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

During FY 2004 and FY 2005, the total number of compensation, pension, and burial claims received in C&P increased by 9 percent, from 735,275 at the beginning of FY 2003 to 801,960 at the end of FY 2005. This represents an average annual growth rate in claims of 4.5 percent. During this same period, the number of pending claims requiring rating decisions increased by more than 33 percent. (As the Under Secretary for Benefits has stated, "[c]laims that require a disability rating determination are the primary workload component because they are the most difficult, time consuming, and resource intensive.")[5] With an aging veterans' population and ongoing hostilities in Iraq and Afghanistan, no reason exists to believe that growth rate will decline during FY 2006 and FY 2007. With a 9 percent increase over the FY 2005 number of claims, VA can expect 874,136 claims for C&P in FY 2007, although it should be acknowledged that actual receipts totaled 810,000 in FY 2006, while VBA had expected to see more than 900,000 during the period. Whatever levels of C&P claims are received in FY 2007 and 2008, it is true that the overall backlog is growing, not shrinking. Without adequate resources and better performance by claims processing staffs, no reason exists to believe VA will be able to hold its pending claims backlog to existing levels, much less ever reduce it.

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

In response to survey questions from VA's Office of Inspector General, nearly half of the adjudicators responding admitted that many claims are decided without adequate record development. They saw an incongruity between their objectives of making legally correct and factually substantiated decisions and management objectives of maximizing decision output to meet production standards and reduce backlogs. Nearly half reported that it is generally or very difficult to meet

production standards without sacrificing quality. Fifty-seven percent reported difficulty meeting production standards when ensuring there is sufficient evidence for rating each case and thoroughly reviewing the evidence. Most attributed VA's inability to make timely and high-quality decisions to insufficient staff, indicating that adjudicator training had not been a high priority in VA.

To allow for more time to be invested in training, the IBVSOs believe it prudent to recommend staffing levels based on an output of 83 cases per year for each direct program FTE. With an estimated 920,000 claims in FY 2009, that would require 11,084 direct program FTEs. With the FY 2008 level of 1,588 support FTEs added (1,100 for management support and 488 for information technology), this would require C&P to be authorized 12,184 total FTEs for FY 2009. These totals do not accommodate the kinds of demands that may arise as a consequence of Congressional injection of attorneys into the claims process, which may cause even more increases in C&P staffing in future years, but it is reasonable to expect that involving attorneys will negatively impact per capita productivity in the claims adjudication process.

Recommendations:

Congress should authorize 12,184 total FTEs for the C&P Service for FY 2009.

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

[5] Written statement of Daniel Cooper, Under Secretary for Benefits, submitted to the House Veterans' Affairs Committee Subcommittee for Disability Assistance and Memorial Affairs. Nov. 3, 2005.

Vocational Rehabilitation and Employment

ADEQUATE STAFFING LEVELS:

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

The cornerstone among several new initiatives is VR&E's Five-Track Employment Process, which aims to advance employment opportunities for disabled veterans. Integral to attaining and maintaining employment through this process, the employment specialist position was changed to employment coordinator and was expanded to incorporate employment readiness, marketing, and placement responsibilities. In addition, increasing numbers of severely disabled veterans from Operations Enduring and Iraqi Freedom (OEF/OIF) benefit from VR&E's Independent Living Program, which empowers such veterans to live, to the maximum extent possible, independently in the community. Independent living specialists provide the services required for the success of severely disable veterans participating in this program. VR&E needs approximately 200 additional full-time employees (FTEs) to offer these services nationally.

Given its increased reliance on contract services, VR&E needs approximately 50 additional FTEs dedicated to management and oversight of contract coun-

selors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force recommended creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

To implement reforms to improve the effectiveness and efficiency of its programs, the task force recommended that VA should add approximately 200 new FTE positions to the VR&E workforce. The FY 2008 total of 1,255 FTEs for VR&E should be increased by 250, to 1,375 total FTEs.

Recommendation:

Congress should authorize 1,375 total FTEs for the VR&E Service for FY 2009.

Education Service

ADEQUATE STAFFING LEVELS:

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

As it has with its other benefit programs, VA has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during FY 2004 and FY 2005, direct program FTEs were reduced from 708 at the end of FY 2003 to 675 at the end of FY 2005. Moreover, the Reserve Educational Assistance Program (REAP), a new type of program with eligibility and payment provisions different from existing programs, was implemented in 2006, thereby increasing the complexity of claims processing procedures. Consequently, the average days to complete education claims (original and supplemental) steadily increased through 2007. Based on experience from previous fiscal years, very conservative estimates indicate the workload will increase by 4 percent in FY 2009.

Although timeliness of claims at the time of this writing had decreased to FY 2005 levels, VA must increase staffing and have the authority to replace FTEs lost by attrition to meet existing and added workload, or service to veterans seeking education benefits will decline. Based on the number of direct program FTEs at the end of FY 2003 in relation to the workload at that time, the Veterans Benefits Administration must increase direct program staffing in its Education Service in FY 2009 to 862 FTEs, 104 more direct program FTEs than authorized for FY 2008. With 172 currently authorized and an additional 20 support FTEs, the Education Service should be provided 1,054 total FTEs for FY 2009.

Recommendation:

Congress should authorize 1,054 total FTEs for the VA Education Service.

Judicial Review in Veterans' Benefits

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

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

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

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

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

Judicial Review Issues

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review

STANDARD FOR REVERSAL OF ERRONEOUS FINDINGS OF FACT:

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

The CAVC upholds VA findings of "material fact" unless they are clearly erroneous, and has repeatedly held that when there is a "plausible basis" for a Board of Veterans' Appeals (BVA) factual finding, it is not clearly erroneous.

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 (Secretary) when there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter. Yet, the CAVC has been affirming many BVA findings of fact when the record contains only minimal evidence necessary to show a "plausible basis" for such finding. This renders 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[6] to expressly require the CAVC to consider, in its clearly erroneous analysis, whether a finding of fact is consistent with the benefit-of-the-doubt rule. The intended effect of section 401[7] of the Veterans Benefits Act of 2002 has not been upheld by the court.

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 CAVC 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."[8] Furthermore, Congress added entirely new language to section 7261(b)(1) that mandates the CAVC 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…."[9]

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.[10]

Prior to enactment of Veterans Benefits Act section 401, the CAVC characterized the benefit-of-the-doubt rule as mandating that "when…the evidence is in relative equipoise, the law dictates that [the] veteran prevails" and that, conversely, a VA claimant loses only when "a fair preponderance of the evidence is against the claim."[11] Nonetheless, such characterizations have

historically proven to be nothing more than meaningless lip service.

Reading amended sections 7261(a)(4) and 7261(b)(1) together, which must be done in order to determine the effect of the Veterans Benefits Act section 401 amendments, reveals that the CAVC is now directed, as part of its scope-of-review responsibility under section 7261(a)(4), to undertake three actions in deciding whether BVA fact-finding that is adverse to a claimant is clearly erroneous and, if so, what the court should hold as to that fact-finding. Specifically, the plain meaning of the amended subsections (a)(4) and (b)(1) requires the court (1) to review all evidence before the Secretary and the BVA; (2) to consider the Secretary's application of the benefit-of-the-doubt rule in view of that evidence; and (3) if the court, after carrying out actions (1) and (2), concludes that an adverse BVA finding of fact is clearly erroneous and therefore unlawful, to set it aside or reverse it.

Therefore, as the foregoing discussion illustrates, Congress intended the Veterans Benefits Act section 401 amendments to section 7261(a)(4) and (b) to fundamentally alter the court's review of BVA fact-finding. This is evident by both the plain meaning of the amended language of these subsections as well as the unequivocal legislative history of the amendments.

Furthermore, consistent with the proclaimant nature of the VA adjudication system and the availability of appeal to the CAVC only by the appellant, Congress provided in Veterans Benefits Act section 401 the authority to reverse or set aside only those findings that are adverse to the claimant. Moreover, the legislative history bolsters the plain meaning of the statute by making clear that Congress intended for the court to take a more proactive and less deferential role in its BVA fact-finding review. For example, amendments to section 7261, dealing with the same elements as did Veterans Benefits Act section 401, were included in S. 2079, introduced by Sen. Rockefeller on April 9, 2002.[12] Sen. Rockefeller stated in full regarding section 401:

> Section 401 of the Compromise Agreement would maintain the current "clearly erroneous" standard of review, but modify the requirements of the review the court must perform when making determinations under section 7261(a) of title 38. CAVC would be specifically required to examine the record of proceedings—that is, the record on appeal—before the Secretary and BVA. Section 401 would also provide special emphasis during the judicial process to the "benefit of the doubt" provisions of section 5107(b) as CAVC 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. The addition of the words "or reverse" after "and set aside" in section 7261(a)(4) is intended to emphasize that CAVC should reverse clearly erroneous findings when appropriate, rather than remand the case. This new language in section 7261 would overrule the U.S. Court of Appeals for the Federal Circuit decision of *Hensley v. West,* 212 F.3d 1255 (Fed. Cir. 2000), which emphasized that CAVC should perform only limited, deferential review of BVA decisions, and stated that BVA fact-finding "is entitled on review to substantial deference." However, nothing in this new language is inconsistent with the existing section 7261(c), which precludes the court from conducting trial de novo when reviewing BVA decisions, that is, receiving evidence that is not part of the record before BVA.[13]

Perhaps the most dramatic of the three CAVC actions directed by section 401 was the mandate that the court "take due account of the Secretary's application of section 5107(b)," known as the "benefit-of-the-doubt rule." It is against this more relaxed standard of review that, through Veterans Benefits Act section 401, Congress has now required the court to review the entire record on appeal and to examine the Secretary's determination as to whether the evidence presented was in equipoise on a particular material fact. The foregoing notwithstanding, the court's equipoise review is no better after Veterans Benefits Act section 401 than it was before section 401. Congress's intent has been ignored.

In light of this background, the post–Veterans Benefits Act section 401 mandate supercedes the previous CAVC practice of upholding a BVA finding of fact unless the only permissible view of the evidence of record is contrary to that found by the board and that a board finding of fact must be affirmed where there is a plausible basis in the record for the determination. Yet, the nearly impenetrable "plausible basis" standard continues to prevail as if Congress never amended section 7261.

The legislative history supports the plain meaning of these provisions discussed herein by strongly evidencing the intent of Congress to bring about decisive change in the scope of the court's review of board fact finding. The House and Senate Committees on Veterans' Affairs described the new provisions enacted by section 401 as follows in an explanatory statement they prepared regarding their compromise agreement:[14]

Senate bill

Section 501 of S. 2237 would amend section 7261(a)(4)…to change the [court's] standard of review as it applies to BVA findings of fact from "clearly erroneous" to "unsupported by substantial evidence." Section 502 would also cross-reference section 5107(b) in order to emphasize that the Secretary's application of the "benefit of the doubt" to an appellant's claim would be considered by CAVC on appeal.

House bill

The House bill contains no comparable provision.

Compromise agreement

Section 401 of the Compromise Agreement followed the Senate language with the following amendments.

> The Compromise Agreement would modify the standard of review in the Senate bill in subsection (a) by deleting the change to a "substantial evidence" standard. It would modify the requirements of the review the Court must perform when it is making determinations under section 7261(a)…since the Secretary is precluded from seeking judicial review of decisions of the Board, the addition of the words "adverse to the claimant" in subsection (a) is intended to clarify that findings of fact favorable to the claimant may not be reviewed by the Court. Further, the addition of the words "or reverse" after "and set aside" is intended to emphasize that the Committees expect the Court to reverse clearly erroneous findings when appropriate, rather than remand the case. [The Committees' expectations are being ignored by the court.]
>
> 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. This would not alter the formula of the standard of review on the Court, with the uncertainty of interpretation of its application that would accompany such a change. 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.[15]

At the time of the Senate's final action on S. 2237, VBA section 401 was quite extensively explained by Senator Rockefeller, who was the Chairman of the Senate Committee, the floor manager of the bill in the Senate, and the principal author of VBA section 401. In explaining section 401, he emphasized, as did the two committees in their explanatory statement,[16] that the combination of the new requirements that the CAVC "examine the…record on appeal," consider the benefit-of-the-doubt rule, and "make…findings of fact in reviewing BVA decisions" is "intended to provide for more searching appellate review of BVA decisions and thus give full force to the 'benefit of the doubt' provision."[17] Chairman Rockefeller concluded that the court should "reverse clearly erroneous findings when appropriate, rather than remand the case."[18] His statement is particularly significant (1) because only the Senate had passed provisions to amend the court's section 7261 scope-of-review provisions (in S. 2237), and the Committees on Veterans' Affairs explained that section 401 generally "follows the Senate language," and (2) because there is no legislative history that is inconsistent with his statement.[19] Rep. Evans, the ranking minority member of the House Committee, spoke in strong support of S. 2237 and explained that "the bill…clarifies the authority of the Court of Appeals for Veterans Claims to reverse decisions of the [BVA] in appropriate cases and requires the decisions be based upon the record as a whole, taking into account the pro-veteran rule known as the 'benefit of the doubt.'"[20]

With the foregoing statutory requirements, the Court of Appeals for Veterans Claims should no longer uphold a Board of Veterans' Appeals finding of material fact solely because it has a plausible basis, inasmuch as that would clearly contradict the requirement that the CAVC's decision must take due account whether the factual finding adheres to the benefit-of-the-doubt rule. Yet, such CAVC

decisions upholding BVA denials are justified because of plausible bases continue as if Congress never acted.

The CAVC has essentially construed these amendments—intended to require a more searching appellate review of BVA fact-finding and to enforce the benefit-of-the-doubt rule—as making no substantive change. The court's precedent decisions now make it clear that it will continue to defer to and uphold BVA fact-finding without regard to whether it is consistent with the statutory benefit-of-the-doubt rule.

Congress should not allow any federal court to thumb its nose at its legislative power, particularly one charged with the protection of rights afforded to our nation's disabled veterans and their families. To ensure the CAVC enforces the benefit-of-the doubt rule, Congress should replace the clearly erroneous standard with a requirement that the court will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

Recommendation:

Congress should amend title 38, United States Code, section 7261, to provide that the Court of Appeals for Veterans Claims will hold unlawful and reverse any finding of material fact that is not reasonably supported by a preponderance of the evidence.

[6] Pub. L. No. 107-330, 401, 116 Stat. 2820, 2832.
[7] Section 401 of the Veterans Benefits Act, effective December 6, 2002, amended title 38, United States Code, sections 7261(a)(4) and (b)(1).
[8] 38 U.S.C. § 7261(a)(4) (emphasis indicates amendments by Veterans Benefits Act section 401(a)). See also 38 U.S.C. § 7261(b)(1).
[9] See 38 U.S.C. § 7261(b)(1).
[10] 38 U.S.C. § 5107(b)(emphasis added).
[11] *Gilbert v. Derwinski,* 1 Vet.App. 49, 54–55 (1990).
[12] See S. 2079, 107th Cong., 2d Sess., § 2.
[13] 148 CONG. REC. S11334 (remarks of Sen. Rockefeller) (emphasis added).
[14] 148 CONG. REC. S11337, H9007.
[15] 148 CONG. REC. S11337, H9003 (daily ed. Nov. 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).
[16] 148 CONG. REC. S11337, H9007.
[17] 148 CONG. REC. S11334 (emphasis added).
[18] *Id.*
[19] 147 CONG. REC. S11337, H9003.
[20] 148 CONG. REC. H9003 (emphasis added).

Claims Backlog at the Court:

The Court of Appeals for Veterans Claims (CAVC) must overcome the ongoing problems of the disability claims backlog and resulting delays in delivery of crucial disability benefits to veterans and their families.

The Board of Veterans' Appeals (BVA) and the CAVC needlessly remand countless cases on appeal time after time. In many of these appeals, the evidence of record fully supports a favorable decision on the appellant's behalf, yet the appeal is remanded nonetheless. These unjustified remands not only perpetuate the hamster-wheel reputation of veterans law, but also risk depriving the appellant of the benefits to which he or she is entitled based on facts already of record. In these cases, appellants are denied rightful benefits, usually for many additional years, without any remedy for such delays.

As it is for VA, the greatest challenge facing the CAVC is the backlog of appeals. As a result of long delays in claims processing at VA, it can take years for appeals to reach the CAVC. A significant number of disabled veterans are elderly and in poor health, and many do not live to witness resolution to their claims.

Over the years, the CAVC has shown a reluctance to reverse errors committed by the BVA. Rather than addressing an allegation of error raised by an appellant, the CAVC has a propensity to vacate and remand cases to the board based on an allegation of error made by the VA Secretary for the first time on appeal, such as an inadequate statement of reasons or bases in the board decision. Another example occurs when the Secretary argues, again for the first time on appeal, for remand by the CAVC because VA failed in its duty to assist the claimant in developing the claim notwithstanding the Board's express finding of fact that all development is complete. Such actions are particularly noteworthy because the Secretary has no legal authority to appeal a board decision to the CAVC.[21]

Consequently, the CAVC will generally decline to review alleged errors raised by an appellant that actually serve as the basis of the appeal. Instead, the court remands the remaining alleged errors on the basis that an appellant is free to present those errors to the board even though an appellant may have already done so, leading to the possibility of the board repeating the same mistakes on remand that it had previously. Such remands leave errors by the board, and properly raised to the court, unresolved; reopen the appeal to unnecessary development and further delay; overburden a backlogged system already past its breaking point; exemplify far too restrictive and out-of-control judicial restraint; and inevitably require an appellant to invest many more months and perhaps years of his or her life in order to receive a decision that the court should have rendered on initial appeal. As a result, an unnecessarily high number of cases are appealed to the CAVC for the second, third, or fourth time.

In addition to postponing decisions and prolonging the appeal process, the CAVC's reluctance to reverse BVA decisions provides an incentive for VA to avoid admitting error and settling appeals before they reach the court. By merely ignoring arguments concerning legal errors rather than resolving them at the earliest stage in the process, VA contributes to the backlog by allowing a greater number of cases to go before the court. If the CAVC would reverse decisions more frequently, *The Independent Budget* veterans service organizations believe VA would be discouraged from standing firm on decisions that are likely to be overturned or settled late in the process.

Recommendations:

Congress should introduce legislation to amend title 38, United States Code § 7261 to require the CAVC, to the extent necessary to its decision and when presented, on a de novo basis: (1) to decide all relevant questions of law; (2) to interpret constitutional, statutory, and regulatory provisions; and (3) to determine the meaning or applicability of the terms of an action of the Secretary. The CAVC's jurisdiction should also be amended to require it to decide all assignments of error properly presented by an appellant.

Additionally, so that it has an accurate measure of the CAVC's performance, Congress should require the Court to submit an annual report that includes:

- the number of appeals filed;
- the number of petitions filed;
- the number of applications filed under title 28, United States Code, section 2412;
- the number and type of dispositions, including:
  - settlements,
  - joint motion for remand,
  - voluntary dismissal,
  - the number of BVA decisions affirmed,
  - the number of dispositions both reversed and remanded by a single-judge decision, and
  - the number of single-judge decisions by "each" judge.
- the median time from filing to disposition;
- the number of oral arguments;
- the number and status of pending appeals and petitions and of applications described in paragraph (3);
- a summary of any service performed by recalled retired judges during the fiscal year;
- the number of decisions or dispositions rendered by a single judge, multijudge panels, and the full court;
- the number of cases pending longer than 18 months;
- the number of cases appealed to the court more than once; and
- the number of appellants who die while awaiting a decision from the court.

These additional data will allow Congress to more accurately assess the CAVC's workload and its need for additional resources. Presenting the information in this suggested format would give Congress a clearer picture of the CAVC's accomplishments and its failures.

[21] 38 U.S.C.A. § 7252(a) (West 2002) ("The Court of Appeals for Veterans Claim shall have exclusive jurisdiction to review decisions of the Board of Veterans' Appeals. The Secretary may not seek review of any such decision.")

Court Facilities

Courthouse and Adjunct Offices:

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

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

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

Recommendation:

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

COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Review of Challenges to VA Rulemaking

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

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

Under title 38, United States Code, section 502, the Court of Appeals for the Federal Circuit (CAFC) may review direct challenges to VA's rulemaking. However, section 502 exempts from judicial review actions relating to the adoption or revision of the VA *Schedule for Rating Disabilities*.

Formulation of criteria for evaluating reductions in earning capacity from various injuries and diseases requires expertise not generally available in Congress. Similarly, unlike other matters of law, this is an area outside the expertise of the courts. Unfortunately, without any constraints or oversight whatsoever, VA is free to promulgate rules for rating disabilities that do not have as their basis reduction in earning capacity. The coauthors of *The Independent Budget* have become alarmed by the arbitrary nature of recent proposals to adopt or revise criteria for evaluating disabilities. If it

so desired, VA could issue a rule that a totally paralyzed veteran, for example, would only be compensated as 10 percent disabled. VA should not be empowered to issue rules that are clearly arbitrary and capricious. Therefore, the CAFC should have jurisdiction to review and set aside VA changes or additions to the rating schedule when they are shown to be arbitrary and capricious or clearly violate basic statutory provisions.

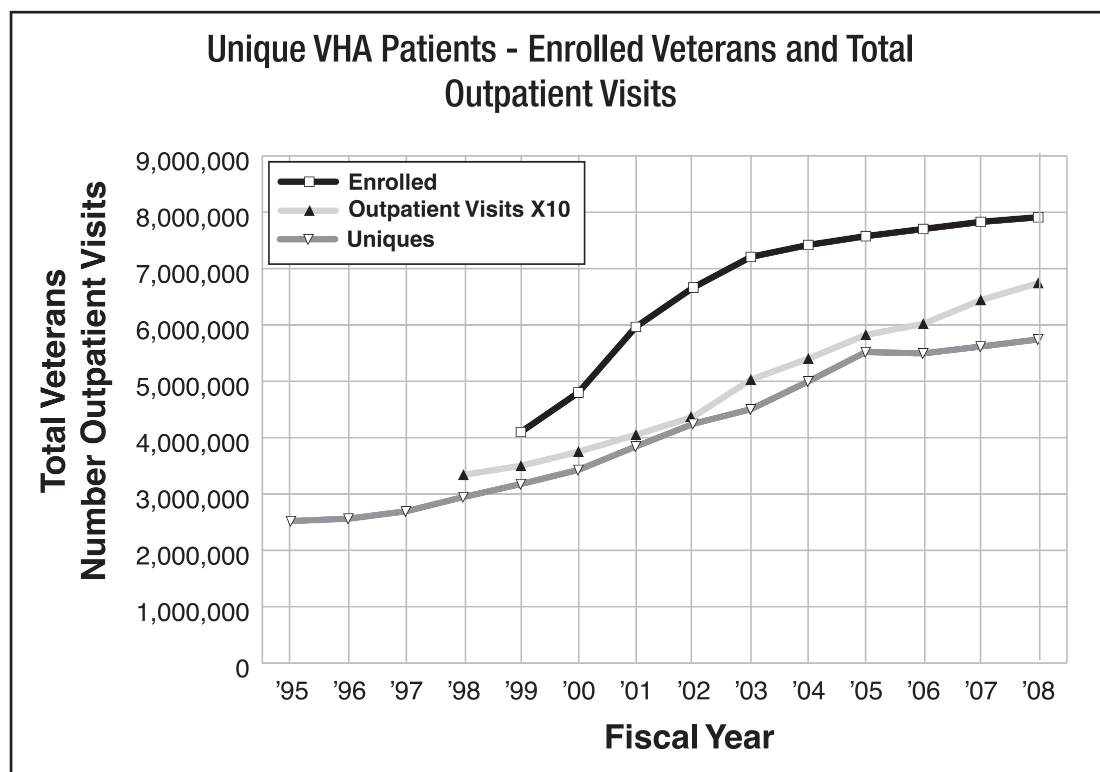
Recommendation:

Congress should amend title 38, United States Code, section 502 to authorize the CAFC to review and set aside changes to the VA *Schedule for Rating Disabilities* found to be arbitrary and capricious or clearly in violation of statutory provisions.

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. Additionally, the VHA is the nation's primary backup to the Department of Defense (DOD) in time of war or domestic emergency.

Of the nearly 8 million veterans the Department of Veterans Affairs (VA) anticipates enrolling in the health-care system in fiscal year 2008, the VHA will provide health care to nearly 75 percent of them—approximately 6 million unique patients. 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.



Unique VHA Patients & Enrolled Veterans—This chart shows the trend toward the increasing number of patients treated in VHA facilities and the increase of veterans enrolled for care.

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

While VA has historically faced inadequate appropriations, Congress and the Administration have shown some desire to correct this trend in the past couple of years. But more work remains to be done. Appropriations continue to be delayed beyond the start of the fiscal year on October 1, placing the VHA at a competitive disadvantage for hiring health-care professionals. This delay has an impact on VA's ability to hire quality professionals in a timely manner, which leads to longer wait times for health-care appointments and creates significant access problems for veterans. As a result of these occurrences, *The Independent Budget* continues to advocate for a method to ensure VA receives adequate funding in a timely manner in order to continue providing timely, quality health care to all veterans.

Meanwhile, VA also must continue to meet the demands of the newest generation of veterans as they turn to the VHA for their care. The difficulties in this crossover between VA and the DOD have elevated seamless transition to the top of concerns for both departments. As such, it is critically important for VA and the DOD to implement the policies needed to make this transition, particularly from one health-care system to the other, as smooth as possible. Paramount in this endeavor is the full implementation of a bidirectional, interoperable electronic records exchange.

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

Medical Care Issues

Finance Issues

Adequate Funding for VA Health-Care Needed

VA must receive adequate funds to meet the ever-increasing demands of veterans seeking health care.

Last year proved to be a difficult year for the appropriations process. The year started with an incomplete appropriation for FY 2007. Congress eventually completed the FY 2007 funding bills in February, placing the Department of Veterans Affairs in a very difficult position. While the funding levels provided for FY 2007 were very good, the fact that the bill was not completed for nearly five months after the start of that fiscal year is wholly unacceptable. Congress then followed that action up by providing more than $1.8 billion in supplemental funding for the VA.

Unfortunately, the FY 2008 appropriations process did not go any smoother. As a result of political wrangling over the federal budget, VA did not receive its appropriation until December. *The Independent Budget* veterans service organizations (IBVSOs) were very disappointed that VA was forced to endure this situation for the 13th time in the past 14 years. This was particularly disappointing in light of the fact that the Administration guaranteed that the bill would be signed into law and because the bill was completed before the start of the fiscal year on October 1.

The appropriations bill was eventually enacted, but it included budgetary gimmicks that *The Independent Budget* has long opposed. While the maximum appropriation available to VA would match or exceed our recommendations, the vast majority of this increase was contingent upon the Administration making an emergency funding request for this additional money. Fortunately, the Administration recognized the importance of this critical funding and requested it from Congress. This emergency request provided VA with $3.7 billion more than the Administration requested for FY 2008.

For FY 2008, the Administration requested $36.6 billion for veterans' health care. This included approximately $2.4 billion for medical care collections. Although this represented another step forward in achieving adequate funding for the VA, it still falls well short of the recommendations of *The Independent Budget*.

The Independent Budget for Fiscal Year 2009 recommends approximately $42.8 billion for total medical care, an increase of $3.7 billion over the FY 2008 operating budget level established by P.L. 110-161, the Omnibus Appropriations bill. Our recommendation reinforces the long-held policy that medical care collections should be a supplement to, not a substitute for, real dollars. The IBVSOs believe the cost of medical care services should be provided for entirely through direct appropriations. In order to develop this recommendation, we used the maximum appropriation amount included in P.L. 110-161 for VA medical care and added the projected medical care collections to that amount to formulate our baseline.

The medical care appropriation includes three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2009, *The Independent Budget* recommends approximately $34.6 billion for Medical Services. The IBVSOs' Medical Services recommendation includes the following:

Current Services Estimate	$ 32,574,528,000
Increase in Patient Workload	$ 1,045,470,000
Policy Initiatives	$ 1,000,000,000
Total FY 2007 Medical Services	**$ 34,619,998,000**

The current services estimate was developed by first adding the estimated collections for FY 2008 to the Medical Services appropriation for FY 2008. This amount was then increased by relevant rates of inflation.

Our increase in patient workload is based on a projected increase of 120,000 new unique patients—category 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $792 million. The increase in patient workload also includes a projected increase of 85,000 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans at a cost of approximately $253 million.

The policy initiatives include $325 million for improvement of mental health services and traumatic brain injury care, $250 million for long-term-care services, $325 million for funding the fourth mission, and $100 million to support centralized prosthetics funding.

For Medical Administration, *The Independent Budget* recommends approximately $3.6 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $4.6 billion. This amount includes an additional $250 million for nonrecurring maintenance for VA to begin addressing the massive backlog of infrastructure needs.

Although *The Independent Budget* health-care recommendation does not include additional money to provide for the health-care needs of category 8 veterans being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy decision. During FY 2008, VA estimated that a total of more than 1,500,000 category 8 veterans would have been denied enrollment into the VA health care system. Based on projected increase in this population of veterans over the past five years, *The Independent Budget* estimates that more than 1,870,000 will have been denied enrollment by FY 2009. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that VA will require approximately $456 million in order to meet this new demand. We believe the system should be reopened to these veterans and that this money should be appropriated in addition to our Medical Care recommendation.

We remain concerned that VA continues to face significant delays in receiving its budget. VA cannot be competitive in the market for health-care professionals if it does not have the funding necessary to do so or if it does not receive its appropriation in a timely manner. When managers do not have a budget for the coming year, they are unable to plan for new hires of critical staff. VA is forced to place hiring freezes on its medical centers nationwide. The hiring freezes have forced individual medical facilities to assign non-nursing duties to current nurses. This detracts from immediate bedside care and ultimately jeopardizes the health of the veteran.

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

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

Recommendation:

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

Sufficient, Predictable, and Timely Funding for VA Health Care:

The current system for funding VA health-care programs must be comprehensively reformed to provide sufficiency, predictability, and timeliness, and thus ensure VA's ability to provide quality and timely health-care services to all eligible veterans.

While significant strides have been made to increase the level of VA health-care funding during the past several years, the inability of Congress and the Administration to agree upon and enact VA health-care funding legislation on time continues to hamper and threaten the delivery of health-care services to America's veterans. Additionally, cumulative shortfalls and critical funding needs have forced VA to ration health-care services for veterans, resulting in long waiting times especially for specialty health-care services, thus negatively affecting the quality of care.

The First Session of the 110th Congress saw new leadership for the first time in a dozen years. The year started with an incomplete appropriation for FY 2007. Congress eventually completed the FY 2007 funding bills in February, placing VA in a very difficult position.

The FY 2008 appropriations process did not go any smoother, and VA did not receive its appropriation until December. *The Independent Budget* veterans service organizations (IBSVOs) were very disappointed that VA was forced to endure this situation for the 13th time in the past 14 years. Fortunately, the President agreed to request the $3.7 billion in contingency emergency spending included in the FY 2008 Omnibus Appropriations bill that provides VA with a significant increase in funding. However, this process still reinforces the challenges to getting sufficient, timely, and predictable funding.

For almost two decades, the dysfunctional budget and appropriations process for veterans' health care has prevented VA officials from efficiently managing and planning for the future of veterans' health-care programs and services. Not knowing when or what level of funding it will receive from year to year—or whether Congress will approve or oppose Administration policy proposals directly affecting the budget—severely impairs VA's ability to recruit and retain staff, contract for services, procure equipment and supplies, and perform planning and administrative functions. VA has faced such problems as a result of late appropriations bills and continuing resolutions in 13 of the past 14 years; over the past 5 years the VA appropriation has been late by an average of 105 days, almost one-third of the entire fiscal year. This systemic problem can only be solved through comprehensive budget and appropriations reform that ensures sufficiency, predictability, and timeliness of VA health-care funding.

Guaranteeing the long-term viability and vitality of the VA health-care system is and must remain a national priority. The conflicts in Iraq and Afghanistan are producing a new generation of wounded, sick, and disabled veterans, some with severe types of polytrauma never seen before in warfare. These young Americans wounded in Southwest Asia today and suffering brain injury, limb loss, or blindness will need the VA health-care system for the remainder of their lives. The IBSVOs support enactment of a long-term solution for funding VA health care that guarantees these veterans and all enrolled veterans will have a dependable system for the future, not simply next year. Reformation of the whole funding system is essential to securing federal funds on a timely basis, allowing VA to manage the delivery of care and to plan effectively to meet known and predictable needs. In our judgment, a change is warranted and long overdue. To establish a stable and viable health-care system, any reform must include *sufficiency, predictability,* and *timeliness* of VA health-care funding.

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), composed of nine veterans service organizations, has advocated for reforming the VA health-care budget process. The Partnership has worked with both House and Senate veterans' leaders to craft legislation that would change VA health-care's funding process from a discretionary to a mandatory system. Legislation has been introduced in both the Senate and the House in recent Congresses: The current House version is H.R. 2514; a Senate companion bill has not yet been introduced.

It is significant that, for the first time ever, both the Senate and House held hearings in 2007 to examine VA health-care funding and consider possible alternative funding methods. At these hearings a number of issues were raised regarding the current mandatory funding proposal, including the accuracy of the formula, future growth of spending, and PAYGO (pay-as-

you-go) implications. At the Senate hearing in July, however, Dr. Uwe Reinhardt, a renowned health-care economist from Princeton University, made persuasive arguments for the propositions that the VA system can be sustained, is affordable, and would be more efficient if funded through a mandatory, rather than discretionary, system. At the House hearing in October, economist Richard Kogan from the Center on Budget and Policy Priorities stated, "…mandatory funding in the form of capitation payments to a government agency that administers health care is, in concept, a pretty good way to go." Under questioning, fellow economist Henry Aaron of the Brookings Institution aligned himself with Dr. Kogan's comments.

While members of both Committees differ on how to address the recurring problems in the VA health-care funding system, it is clear that the current system must be comprehensively reformed. This can be accomplished through a mandatory funding formula, a mixed system of mandatory and discretionary funding, or a new hybrid proposal that meets the three tests while addressing the concerns expressed by Congress and the Administration. As long as the VA health-care system remains part of today's dysfunctional discretionary funding system, it will remain vulnerable to budget and partisan politics that threaten the quality of care for all veterans.

The failure to provide sufficient funding has resulted in VA prohibiting enrollment to hundreds of thousands of priority group 8 veterans who sought care at VA facilities in the past several years. Even with the anticipated increase in veterans' health-care funding, VA still would not have sufficient resources to remove the prohibition on enrollment of priority group 8 veterans that has been in effect since January 17, 2003. Last year the House Committee on Veterans' Affairs held a hearing to examine the issues surrounding the moratorium on new enrollment of priority group 8 veterans. The Committee requested that VA produce a report that details the direct and indirect costs, such as expanding facilities, that would be needed to reopen the VA health-care system to priority group 8 veterans. *The Independent Budget for FY 2008* estimated that such a policy change would cost approximately $366 million in the first year, assuming that about 314,000 such veterans would enroll in and use the system. Congress must carefully examine VA's report, including the projected number of new enrollees, and then provide sufficient resources to reopen the system to as many priority group 8 veterans as possible. Such a change, however, must be made in a manner that allows VA to provide both quality and timely health care to new and existing enrolled veterans.

Recommendations:

Congress and the Administration must reform the budget and appropriations process that funds the VA health-care system by creating a new system of mandatory funding, a combination of mandatory and discretionary funding, or a new hybrid system that best meets the goals of sufficiency, predictability, and timeliness.

After receiving and reviewing VA's report on the costs and resources needed to open enrollment to priority group 8 veterans, Congress and the Administration should provide sufficient funding to accommodate new enrollment in a manner that does not threaten the timeliness or quality of health-care services for new and existing enrolled veterans.

Accountability:

VA must hold its leaders accountable for running high-quality health-care programs and ensure that accountability systems that measure accomplishment of goals are synchronized with needs of veterans.

Like the private sector, government organizations have seen the need for developing systems of accountability. Accountability is simplified when everyone's goals are shared—for example, goals of for-profit corporations align with maximizing profits and cost savings. However, the process of identifying goals that meet the needs of a government program, such as the Veterans Health Administration, and satisfy a variety of stakeholders, establishing objectives and measures and assigning responsibility for their successful completion, can be extremely challenging.

The federal government has committed to the establishment of practices that demonstrate its effectiveness to taxpayers. For example, the Office of Management and Budget (OMB) has reengineered its operations to focus more resources on managing federal government programs (reviewing performance) and the General Accounting Office renamed itself the Government Accountability Office (GAO). Congress has also demonstrated interest in ensuring that the programs it funds are meeting their goals. In 1993, Congress enacted the Government Performance and Results Act (GPRA), which established the framework for the development of strategic plans and performance measurement for the federal government agencies. The GPRA requires each agency to develop a five-year strategic plan, which is to be reviewed every three years. Both the OMB and GAO attempt to ensure that federally funded programs use resources effectively to meet strategic goals.

The most recent OMB Performance Assessment Rating for Veterans Health Care (in 2003) found that the Department of Veterans Affairs was "adequate" in terms of meeting its goals. Goals assessed included targeting resources at lower-income, service-disabled, and veterans with special eligibilities; collecting data to demonstrate effective care, such as use of widely accepted clinical indices for managing chronic conditions and preventive measures; and establishing data collection methods to link performance to the budget.

Managerial accountability systems encompass several important components: clearly defined, measurable goals that affected parties agree are in the best interest of the organization, accurate tools to measure the goals, and the appropriate and fair assignment of responsibility for achieving the goals.

In accordance with the GPRA, VA developed five broad strategic goals to accomplish the following:

- restore to the greatest extent possible the capabilities of veterans with disabilities and improve the quality of their lives and that of their families;
- ensure a smooth transition for veterans from active military service to civilian life;
- honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the nation;
- contribute to the public health, emergency management, socioeconomic well-being, and history of the nation; and
- deliver world-class service to veterans and their families by applying sound business principles that result in effective management of people, communications, technology, and governance.

The final goal is an "enabling goal," which, if fulfilled, allows VA to meet the first four. Each goal is followed by a series of objectives and each objective by measures that relate to those objectives' fulfillment.

Following a collective summit that included the OMB, GAO, and Congress, VA ultimately identified measures related to achieving its strategic goals: *efficiency* (effective use of time and resources), *outcome* (achieves the desired result), or *output* (numbers produced). VA also identified acceptable targets by which it assesses performance. Ideally, quality systems want to ensure that "outcomes" goals are met—for example, rather than counting how many medical records indicated that veterans had been advised not to smoke (an output measure), ideally, an overall reduction in smoking among VA users (an outcome measure) would be a goal. While *The Independent Budget* veterans service organizations agree with the broadly defined strategic goals, we have some concern with the objectives or the measures and targets VA used to define success. "Efficiency" as one goal may mean decreased access to another. For example, it might be more efficient (fewer

employees and less overhead) to require veterans to travel greater distances to access certain health-care services, but quality might be affected. These results must be carefully balanced so there will be no unintended consequences.

We also question if all of the information used to assess achievement of objectives is accurate. For example, one measure of success that VA continues to claim it has achieved is seeing primary and specialty care patients within 30 days of a requested appointment time. VA's Inspector General continues to assert that VA's data are suspect. This is particularly important because these measures constitute two of only seven key performance measures for VA health care. Other datasets used for evaluating health-care performance include patient experience surveys and its medical records, which measure compliance with evidence-based practices in prevention and chronic disease management. A final measure identifies average daily census in noninstitutional long-term-care settings against a set target. It is unclear how this target was established and whether it has any relationship to demand or appropriateness of treatment settings for veterans.

VA's Office of Budget produces an annual Performance and Accountability Report under the GPRA. The FY 2007 report (published Nov. 15, 2007) finds 11 areas in need of significant improvement—mostly concerned with claims processing and adjudication for benefits programs. VA also uses performance measures to assess its leadership's effectiveness in programs, networks, and facilities. It also links their performance to financial bonuses. In 2007 this practice came under scrutiny when some VA officials received financial rewards for "superior" service based on performance measures but had a record of continuing adverse outcomes within their responsibilities. In a government health-care setting, however, it is difficult to assign credit or blame for some outcomes because the officials' authority is limited—often they are not empowered to change factors, such as beneficiary demand, revenues, copayments, hiring practices, or facility design, which they may believe are obstructing the successful execution of their goals and objectives. For example, a facility manager might believe that a new outpatient clinic would increase the efficiency of clinicians and improve waiting times and patient satisfaction ratings. Generally, that manager, however, has no authority over whether that outpatient clinic would be approved and funded.

In government programs, there are often many "uncontrollables" that hinder individuals' ability to achieve desired results—e.g., resources are limited, laws and regulations proscribe managerial actions, and demand from beneficiaries may be more or less than systems can accommodate. Additionally, if a network director treats a population of veterans that has increased rates of growth in demand relative to other networks along with a static fiscal year budget, is it fair to expect the director to meet the corporate standard waiting time for primary and specialty care? What if the veterans he or she treats are older and sicker? These are factors that are generally out of the medical center directors' control. Finding the right measures to link "controllable" outcomes to managerial actions, then, is a delicate balance.

The Independent Budget veterans service organizations support continued emphasis on establishing greater accountability in government programs. We want to ensure that VA leaders are accountable and that accountability systems measure VA's accomplishment of goals that are synchronized with the needs of veterans.

Recommendations:

The Office of Management and Budget must continue to ensure that beneficiaries' access to high-quality service, benefits, and programs is paramount in all strategic goals, objectives, and measures. Efficiency and cost-effectiveness are also appropriate goals but should be secondary to fulfillment of the mission of the agency.

VA should ensure that objectives and performance measures are directly related to each other and the strategic goal they support.

The Inspector General should periodically audit databases used to manage key performance measures and take steps to ensure that VA confirms the accuracy of its performance measures and, thereby, the integrity of its accountability systems.

VA should replace output measures with outcome measures, and Congress should charge the Government Accountability Office with review of key VA managers' performance to ensure that they are accountable for performance of functions over which they have direct control.

Seamless Transition from the DOD to VA:

The DOD and VA must ensure that all servicemen and -women separating from active duty have a seamless transition from military to civilian life.

As servicemen and -women return from the conflicts in Iraq and Afghanistan, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service and become veterans. The transition from DOD to VA continues to be inconsistent and generally difficult. This simply creates additional hardship for new veterans trying to gain access to VA. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The problems with transition from the DOD to VA were never more apparent than during the controversy that occurred at Walter Reed Army Medical Center in 2007. While much of the media coverage misrepresented the problems at Walter Reed as being a problem with care for injured service members, the real problems reflected many of the administrative difficulties associated with transitioning from the DOD to VA.

The Independent Budget continues to stress the points outlined by the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report released in May 2003, and reinforced by the President's Commission on Care for America's Returning Wounded Warriors in September 2007, regarding transition of soldiers to veteran status. Foremost among the recommendations made by the PTF and the President's Commission is increased collaboration between the DOD and VA for the transfer of personnel and health information. Unfortunately, the need is still not being met.

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

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

The IBVSOs likewise concurred with the President's Commission's recommendation that the DOD and VA implement a single comprehensive medical examination, and we believe that this must be absolutely done as a prerequisite of promptly completing the military separation process. However, we would like to reiterate our belief that if and when a single separation physical becomes the standard, VA should be responsible for handling this duty. VA simply has the expertise to conduct a more thorough and comprehensive examination as part of its compensation and pension process. Moreover, the inconsistencies with the physical evaluation board process from the different branches of the service can be overcome with a single physical administered from the VA perspective, and not the DOD's.

The problem with separation physicals identified for active duty service members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists. Though the physical examinations of demobilizing reservists have improved in recent years, there are still a number of soldiers who "opt out" of the physicals, even when encouraged by medical personnel to have the physical. Though the expense, manpower, and delays needed to facilitate these physicals might be significant, the separation physical is critical

to the future care of demobilizing soldiers. We cannot allow a recurrence of the lack of information that led to so many issues and unknowns with Gulf War syndrome, particularly among our National Guard and Reserve forces. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

In the past several years, the DOD and VA have made good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's (DOL) Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) handled by the Veterans Employment and Training Service (VETS) are generally the first services that a separating service member will receive. Local military commanders, through the insistence of the DOD, now generally allow their soldiers, sailors, airmen, and marines to attend well enough in advance to take greatest advantage of the programs. These programs are provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. Furthermore, they have provided VA an improved outreach opportunity.

TAP and DTAP continue to improve. But challenges continue at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service members who wish to file a claim for VA compensation benefits and thus other ancillary benefits are dissuaded by the specter of being assigned to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in providing this information. Though individuals are receiving the information, the haphazard nature and quick processing time may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center despite still being 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. DTAP has not had the same level of success as TAP, and it is critical that coordination be closer between the DOD, VA, and VETS to improve this.

Though the achievements of the DOD and VA have been good in regard to departing active duty soldiers, there is a much greater concern with the large numbers of reserve and National Guard soldiers moving through the discharge system. Because of the number of troops that are on "stop-loss"—a DOD action that prevents troops from leaving the military at the end of their enlistments during deployments—large numbers of troops rapidly transition to civilian life upon their return. Both the DOD and VA seem ill-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. Unless they are injured, they may clear the demobilization station in a few days. Little of this time is dedicated to informing them about veterans benefits and services. Additionally, DOD personnel at these sites are most focused on processing them through the site. Lack of space and facilities often allow for limited contact with the demobilizing service members by VA representatives.

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

Recommendations:

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

The DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. These electronic medical records should also include an easily transferable electronic DD214.

In accordance with the recommendation of the FY 2008 National Defense Authorization Act 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 responsible for handling this duty.

Congress and the Administration must provide adequate funding to support the TAP and DTAP programs managed by the DOL-VETS to ensure that active duty, as well as National Guard and Reserve, service members do not fall through the cracks while transitioning.

Inappropriate Billing:

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

The Veterans Health Administration (VHA) continues to bill veterans and their insurers for care provided for conditions directly related to service-connected disabilities. Reports of veterans with service-connected 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 continue to surface. Inappropriate billing for secondary conditions forces veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden both to veterans and an already backlogged claims system.

Additionally, veterans with more than six service-connected disability ratings are frequently billed improperly due to VA's inability to electronically store more than six service-connected conditions in the Compensation and Pension (C&P) Service Benefits Delivery Network (BDN) master record and the lack of timely and/or complete information exchange about service-connected conditions between the Veterans Benefits Administration (VBA) and the VHA.

VA has undertaken a five-step approach to change the process by which it electronically shares C&P eligibility and benefits data with the VHA, particularly information about service-connected conditions that exceed the six stored in the BDN. According to VA, because of difficulties in the development and implementation of the first two steps, the plan for improving VBA/VHA sharing of information about veterans' service-connected conditions has been delayed. Furthermore, VA acknowledges that not all these cases, with six service-connected conditions, have been identified under the new plan; however, it will determine the best course of action to take to further address the cases with incomplete service-connected disability information.

Nonservice-connected veterans are also frustrated with VA's billing process. Overbilling and inappropriate charging for copayments is becoming the norm rather than the exception.

Inappropriate bill coding is causing major problems for veterans subject to VA copayments. Veterans using VA outpatient services and VA's home-based primary care programs are reporting multiple billings for a single visit. Often these multiple billing instances are the result of follow-up medical team meetings in which a veteran's condition is discussed. Somehow these discussions and subsequent entries into the veteran's medical chart 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 even occurred.

Recommendations:

The Under Secretary for Health should firmly establish and enforce policies that prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that relate to an original service-connected disability rating.

The Under Secretary for Health should establish specific deadlines for the action plan to develop methods to improve the electronic exchange of information about service-connected conditions that exceed the maximum of six currently captured in the Compensation and Pension Service Benefits Delivery Network master record.

VA's cost-recovery system must be reviewed to determine how multiple and inappropriate billing errors are occurring. Billing clerk training procedures must be intensified and coding systems must be altered to prevent inappropriate billing.

Homeland Security/Funding for the Fourth Mission:

The Veterans Health Administration (VHA) is playing a major role in homeland security and bioterrorism prevention. This vital statutory fourth mission will require a budget of more than $300 million from medical care in the fiscal year 2009.

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 (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters[.]"

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

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

The NDMS is a partnership between the Department of Homeland Security (DHS), VA, the DOD, and the Department of Health and Human Services (HHS). According to the VA website, www.va.gov, some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance, and evaluation of the local NDMS program. VA has also assigned "area emergency managers" (AEMs) 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 are classified as large, which can supply 2,000 casualties for two days, and 53 would supply 1,000 casualties for two days. VA's national acquisition center manages four pharmaceutical and medical supply caches for the Department of Homeland Security

and the Federal Emergency Management Agency (FEMA) as a part of their 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 those individuals affected by terrorist activities.

In 2002, Congress also enacted P.L. 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002. This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and would develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons, or devices posing threats to the public health and safety. In addition, the centers would provide education, training, and advice to health-care professionals. They would also provide laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or responding to a disaster or emergency. These centers, although authorized by law, have not received any funding.

The disasters caused by Hurricanes Katrina and Rita in the Gulf Coast region in 2005 more than met the criteria for the fourth mission. VA proved to be fully prepared to care for veterans affected by the hurricanes. Nearly 10,000 VA employees around the country received recognition for their actions during the hurricanes. 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 (DMU), the deployable pharmacy unit (DPU), and the response support unit (RSU).

The deployable medical unit is a self-contained medical unit that can be onsite of an emergency within 24–48 hours. It contains examination and treatment areas, 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 patient prescriptions data via satellite communications with the VA prescription database. The response support unit serves as a platform to assist a VISN to manage an emergency or support VA personnel deployed as part of a federal response.

The Independent Budget veterans service organizations (IBVSOs) are concerned that VA lacks the resources to properly fulfill its fourth mission responsibilities. In FY 2002 the funding for Homeland Security initiatives was $84.5 million. In FY 2004 it increased to $271 million, and *The Independent Budget's* request for 2009 will be more than $300 million. Without additional funding and resources, VA will have 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 specifically received any funding to support the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. Homeland security funding—estimated to be more than $300 million in FY 2008—is simply taken from the medical care account. This leaves VA with fewer resources with which to meet the health care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, already scarce resources will continue to be diverted from direct health-care services.

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

Recommendations:

Congress should provide funds necessary in the Veterans Health Administration's FY 2009 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 included as a separate line item in the Medical Care appropriation.

Mental Health Issues

Mental Health Services:

VA must deliver on its promise to transform its mental health and substance-use care programs and rise to the challenge of increasing access and quality of care for veterans of prior eras and the latest generation of combat veterans from Iraq and Afghanistan.

VA Mental Health Strategic Plan

This year will mark the fifth anniversary of the release of the President's New Freedom Commission on Mental Health Report. Based on the commission's recommendations, VA undertook a comprehensive and critical review of its mental health and substance-use programs and produced its own road map for the future of veterans' mental health care, the Mental Health Strategic Plan (MHSP). While VA mental health care compares favorably with other U.S. providers, the evaluation found systemic problems in access, scope, and quality of its behavioral health programs. Until recently, like other institutions, VA failed to actively support recovery from mental illness and build veterans' resilience to face life's challenges. Too often VA care simply managed symptoms and accepted long-term disability as being inevitable. In 2004, VA's MHSP gave veterans hope that mental illness would be treated with the same seriousness as medical illnesses, such as heart attack and cancer, and that care would become more veteran- and family-centered. *The Independent Budget* veterans service organizations (IBVSOs) are pleased that the focus of VA mental health programs is now on recovery.

The VA MHSP includes a number of action items that build on the recommendations of the President's Commission and the VA Secretary's Mental Health Task Force recommendations. Funding for these actions has been provided through a mental health initiative that supports implementation in four key areas: (1) enhancing capacity and access for mental health services; (2) integrating mental health and primary care; (3) transforming mental health specialty care to emphasize recovery and rehabilitation; and (4) implementing evidence-based care. Funding for the initiative is provided outside of the routine Veterans Equitable Resource Allocation (VERA) model and augments the capitated funding for mental health programs. The IBVSOs applaud progress made under these initiatives, including improvements in capacity and access through expansion of mental health services in community-based outpatient clinics (CBOCs), expansion of use of telemental health, and enhancements in both treatment and outreach for post-traumatic stress disorder (PTSD). Particularly important are efforts to foster the integration of mental health and primary care by funding evidence-based programs in more than 100 sites, and integration of mental health care of older veterans into home-based primary care. Recovery and rehabilitation programs are being facilitated by development of additional psychosocial rehabilitation programs, expanding residential rehabilitation services, increasing the number of beds and the degree of coordination in homeless programs, enhancing mental health intensive case management, and funding a recovery coordinator in each medical center. These developments are encouraging, and the IBVSOs are hopeful that their promise will be actualized in the near future. However, we note that recovery programs have had slow, prolonged start-up periods, and program managers have not made consistent efforts to involve veterans and family members locally. Despite this progress, the current level of effort and provision of services in stigma reduction, PTSD, substance abuse, and family and marriage counseling, all pointed toward recovery goals, remain inadequate. Congress should maintain oversight to ensure that veterans' needs for quality mental health care are met, and the promise for recovery is achieved.

VA Mental Health Budget

In March 2007, VA testified that the anticipated spending for mental health services for FY 2007 and FY 2008 would be $2.8 billion and $2.96 billion, respectively. These amounts represent increases of $390 million and $545 million from actual spending of $2.42 billion in FY 2006, an increase of 16 percent and 23 percent, respectively. VA's challenge will be to execute the budget increases effectively and allocate its resources wisely; if successful, the funding would be adequate to initiate implementation of the MHSP, fill existing gaps in mental health and substance abuse care, and enhance targeted mental health services.

Oversight of these programs will be critical to success. In November 2006, the Government Accountability Office (GAO) issued a report on resources allocated to VA's MHSP initiatives. The GAO documented that VA did not spend all of the allocated budget planned for new FY 2005 mental health initiatives. Additionally, the GAO found that the VA Central Office did not inform network and medical center officials that funds were to be used for specific mental health priorities, and therefore it is likely that the funding was spent on other health care needs. The Veterans Health Administration (VHA) is aware of concerns about spending of funds from the mental health initiative in FY 2005 and FY 2006 and has made adjustments to its processes to better track use of these funds. According to the Mental Health Strategic Healthcare Group, these funds have been used to improve capacity and hire more than 3,500 new mental health providers to date. Congressional scrutiny is vital to ensure effective and efficient use of these funds, continuous progress on all facets of the MHSP, improvements in mental health outcomes, and proper use of dedicated mental health funding.

In November 2007, the Institute of Medicine (IOM) published the report "Gulf War and Health: Volume 6 Physiologic, Psychologic, and Psychosocial Effects of Deployment Related Stress."[22] The IOM committee studied literature covering World War II, the Korean War, the Vietnam War, the 1991 Persian Gulf War, and Operations Enduring and Iraqi Freedom (OEF/OIF). Potential health effects considered included both physiological and psychological effects, including PTSD, anxiety disorders, depression, substance abuse, and psychosocial effects, such as marital conflict and incarceration. After review of the scientific evidence, the IOM found the evidence sufficient to conclude that there is an association between deployment to a war zone and the following conditions: PTSD, anxiety disorders, depression, alcohol abuse, suicide, and accidental death in the early years after deployment, as well as marriage and family conflict. In addition, the committee found that there was suggestive evidence of an association between deployment stress and drug abuse, chronic fatigue syndrome, fibromyalgia and other pain syndromes, gastrointestinal symptoms and functional disorders, skin disorders, increased symptom reporting and unexplained conditions, and incarceration. The committee noted that there was insufficient investigation by VA and the DOD to allow them to draw cause-and-effect conclusions regarding the effects of deployment stress on physiological, psychological, and psychosocial conditions. To remedy this problem, the committee recommended further epidemiologic studies as well as enhanced predeployment screening to identify exposures most stressful to the veteran and regular longitudinal reassessments at five-year intervals thereafter to identify long-term health and psychosocial health effects. Considering the importance of these findings to all combat veterans and the urgency to develop effective programs for OEF/OIF veterans, the IBVSOs strongly urge VA and the DOD to move rapidly to develop health policy and research inquiries that are responsive to these important recommendations.

VA's Specialized PTSD Programs

According to VA data, it operates a network of more than 190 specialized PTSD outpatient treatment programs nationwide, including specialized PTSD teams or a PTSD specialist at each VA medical center. VA has indicated that treating PTSD among returning veterans is one of its highest priorities. VA's past experience with combat deployments should have triggered VA to anticipate that utilization of specialized PTSD services would increase after combat in the global war on terrorism. This historic knowledge should have resulted in appropriate planning and resource allocation. VA and DOD studies have indeed verified that veterans with combat exposure in Iraq and Afghanistan had the expected increased risk for PTSD and other mental health concerns post-deployment. Since the beginning of Operations Enduring and Iraqi Freedom, 799,791 service members have been discharged and become eligible for VA health care. Through January 2008, VA reported that, of the 299,585 separated OEF/OIF veterans who have sought VA health care since fiscal year 2002, a total of 120,049 unique patients had received a diagnosis of a possible mental health disorder. Almost 60,000 enrolled OEF/OIF veterans had a probable diagnosis of PTSD; almost 40,000 OEF/OIF veterans have been diagnosed with depression; and more than 48,000 reported nondependent abuse of drugs.[23] These data are consistent with DOD studies of U.S. Army service members who served in Iraq.

An IOM expert committee recently studied the evidence for treatments proven effective for PTSD,[24] and reported that there is sufficient evidence to conclude that exposure to cognitive behavior therapies is effective in treatment of PTSD. The IOM noted that there may be important treatment response differences between civilians and veteran populations with PTSD, as well as differences between older and younger veterans. The IOM committee was not convinced that the

evidence is sufficient regarding efficacy of the currently used pharmacological interventions and cautioned that evidence regarding the effectiveness of group therapy is inadequate. The committee made important recommendations to improve VA's ability to provide evidence-based treatments. Of particular note is the committee's finding that available research has significant gaps in evaluation of the efficacy of treatment interventions in the subpopulation of veterans with comorbid traumatic brain injury, major depression, and substance abuse; and in women, racial and ethnic minorities, and older individuals. The IBVSOs are pleased with the increased federal investments in PTSD research; however, we believe that there should be greater attention to these specific areas of study as recommended by the IOM. It is disheartening to learn that despite widespread recognition of the importance of deployment stress and PTSD in veterans that the committee found "it striking that so few of the studies were conducted in populations of veterans."

Investigators recently published a study using VA administrative data indicating that between 1997 and 2005, the total numbers served by VA mental health programs increased by almost 300,000 unique veterans, a 56 percent increase. In addition, the number of veterans diagnosed with PTSD doubled while the number who received mental health diagnoses other than PTSD increased by 40 percent. The largest numbers of veterans (80 percent) were from earlier eras; however, the largest proportionate increases occurred in veterans born after 1972. During this period, the number of clinic contacts per veteran per year declined steadily, resulting in a cumulative decline of 37.5 percent. Declines were observed in both PTSD and other mental health diagnoses. The total number of mental health clinic visits showed real number reductions of 2.7 percent from 10.18 visits in FY 1997 to 9.91 visits in FY 2005. During the period after the beginning of combat in Iraq, the rate of increase in PTSD and other mental health patient loads grew further. Mental health service use among both Gulf War era and older veterans increased progressively while service intensity declined steadily. This suggests that increasing demand was met by decreasing the number of visits per veteran. These changes cannot be explained by improvements in evidence-based treatment protocols; therefore, it is likely that the reported declines were accompanied by reductions in continuity of care. While VA has increased funding to specialized care programs in FY 2007, we are extremely concerned that care be taken to immediately reverse the above-reported trends so that veterans may benefit from the highest quality mental health care available.[25]

Readjustment Counseling Service

The Readjustment Counseling Service (RCS) currently provides counseling and readjustment services to veterans at 209 Vet Centers, located throughout the nation. RCS will be expanding the number of Vet Centers to 232 over the next two years. Vet Centers provided more than 1 million visits to more than 228,000 unique combat veterans from all service eras in FY 2006, and 101,000 veterans were seen through outreach efforts.

In addition to the expansion of Vet Center sites already noted, these centers have also expanded the depth and range of services provided. Vet Centers have been innovative in use of technology to expand services, including use of telehealth linkages with VA medical centers. Use of telehealth has increased geographic access to mental health service delivery in remote areas to underserved veteran populations. Since their inception, Vet Centers have provided a recovery focus and an alternative to traditional access for mental health care that some veterans may be reluctant to seek in medical centers and clinics. They serve as a model for veterans' psychosocial readjustment and rehabilitation, and support ongoing enhancements under the VA MHSP. Since 2003, Vet Centers have provided bereavement services to surviving family members of service members killed while serving on active duty. This successful new program has provided support to more than 1,200 family members of more than 900 fallen warriors, most of whom were killed in action in OEF/OIF.

The Vet Center program is the one of the few VA programs to address the veteran's full range of needs within family and community. Family counseling is provided when needed for the readjustment of the veteran. Families provide the "front line" of support network for returning veterans. Spouses are often the first to identify readjustment issues and facilitate veterans' evaluation and treatment when concerns are identified. Repeated deployments, financial hardships, long absences from home, and the stresses of reintegration with family routines have put a tremendous strain on OEF/OIF veterans' marriages. Divorce rates and interpersonal conflict have increased since the start of the Iraq War.[26] New studies suggest that deployments have also led to a dramatic increase in the rates of child abuse in military families.[27] VA should expand its support and counseling services for veterans and their fam-

ilies. The IBVSOs believe that this expansion optimally should occur in all VA major care facilities. However, in the near term, Vet Centers should increase their coordination with VA medical centers to accept referrals for family counseling; increase distribution of outreach materials to family members with tips on how to better manage the dislocation; improve reintegration of combat veterans who are returning from a deployment; and provide information on identifying warning signs of suicidal ideation so veterans and their families can seek help with readjustment issues.

Substance Abuse Treatment

In the past, population-based surveys have demonstrated that veterans report higher rates of alcohol abuse than nonveterans and are more likely to meet criteria for alcohol abuse and dependence. Recent studies have demonstrated no reduction in overall veteran need for substance abuse services and an increase in alcohol concerns by OEF/OIF veterans.

Army investigators recently published the first longitudinal study of health concerns among soldiers serving in Iraq. The study found that questionnaires administered immediately after redeployment underestimate the physical health, mental health, and substance-use burden on service members who served in Iraq. Surveys conducted later showed increased reporting of both physical health and mental health concerns and increased referrals to care. In this study, while 11.8 percent of soldiers reported alcohol misuse, only 0.2 percent of those individuals were subsequently referred for treatment. Moreover, of those referred, only a small number received care within 90 days of screening.[28]

The IBVSOs are concerned that the number of veterans who received specialized outpatient substance abuse treatment services in VA declined between FY 1998 and FY 2005. We believe the overall decline in supply of substance abuse services occurred despite stable or increasing veterans' demands for such services. Last year, despite significant effort by VA, there was only a 1 percent increase in veterans receiving substance abuse treatment. These trends should be monitored on a regional and national level by VHA and additional actions taken if substantial improvements are not seen this year.

We urge VA to provide a full continuum of care for substance-use disorders, including more consistent and universal periodic screening of OEF/OIF combat veterans in all its health-care facilities and programs—especially primary care. Outpatient counseling and pharmacotherapy should be available at all larger VA community-based outpatient clinics, and short-term outpatient counseling, including motivational interventions, intensive outpatient treatment, residential care for those most severely disabled, detoxification services, ongoing aftercare and relapse prevention, self-help groups, opiate substitution therapies, and newer drugs to reduce craving, should be included in VA's overall program for substance abuse and prevention. Additionally, we note that VA substance abuse services are primarily focused on service for veterans who have a significant substance abuse problem—therefore VA should increase its efforts on prevention of substance abuse.

Suicide Prevention

VA has made suicide prevention a major priority and has developed a broad program based on increasing awareness, prevention, and training of health-care staff to recognize suicide risk. A national suicide prevention hotline has been established, and suicide prevention coordinators have been hired in each VA medical center. Research into the risk factors associated with suicide in veterans and prevention strategies is under way. The IBVSOs applaud these efforts but recognize that the most effective investments will be those VA makes to improve the effectiveness of treatment for PTSD, depression, substance abuse, and other mental health disorders. Experts assert that those conditions, if left untreated or poorly treated, can lead to suicidal tendencies.

Veterans of the Wars in Iraq and Afghanistan

The United States is once again engaged in armed conflict. There is growing concern that the special needs of these recent combat veterans have received insufficient advance planning and inconsistent effort since the first deployments in October 2001. Because of the importance of stepping up efforts directly on behalf of OEF/OIF veterans, the IBVSOs have included a separate section in this report, titled "The Challenge of Caring for Our Newest Generation of War Veterans."

Summary

The IBVSOs recognize the unprecedented efforts made by VA to improve the safety, timeliness, and effectiveness of mental health care for veterans. We are also pleased that the DOD has reported its findings on the post-deployment health assessment and longitudinal re-

assessment approximately six months after soldiers have returned from combat. Collaboration between VA and the DOD and public information sharing are of paramount importance. Although we recognize and acknowledge the successful efforts made thus far, the agencies have a long road ahead to address the complex needs of recent combat and older veterans.

Evidence is mounting that the burden of illness is high in veterans who served in Afghanistan and Iraq. Combat exposure is associated with increased risk of PTSD and elevated utilization of health-care services. In addition to the growing needs of these veterans, evidence from VA studies indicates that the demand for PTSD, mental health, and substance abuse care by older veterans has increased substantially in the past decade. VA and the DOD must be accountable for providing state-of-the art, evidence-based care to meet these needs. It is the unique obligation of VA to provide the care for our nation's veterans. In order to adequately assess whether the health and health-care needs of OEF/OIF, Vietnam, Korea, and World War II veterans are being met, VA and the DOD must track relevant performance data and make it available to all stakeholders. In this way, VA, the DOD, and Congress can remain vigilant and design flexible solutions to the new challenges that will undoubtedly require speedy solutions.

Recommendations:

The Departments of Veterans Affairs and Defense must ensure that veterans' needs for mental health, PTSD, traumatic brain injury, and alcohol and other substance abuse treatment programs are met.

The IBVSOs recommend that VA work with the DOD to ensure that early mental health interventions are provided to veterans who identify concerns on post deployment assessments. Both VA and the DOD should continue to provide periodic, universal screening for mental health and substance abuse concerns to service members and veterans.

VA must enhance its efforts to provide veteran- and family-centered care programs, including family therapy and marriage counseling.

VA and the DOD must track and publicly report performance measures relevant to their mental health and substance-use disorder programs.

Congress should continue to provide scrutiny and oversight for VA's mental health transformation and implementation of VA's National Mental Health Strategic Plan. Frequent periodic reports should be shared with Congressional staff and the Consumer Council of the VA's Advisory Committee on Veterans with Serious Mental Illness.

The IBVSOs believe that additional VA research on effective prevention and treatment of PTSD and other mental health readjustment conditions is required, including research on improved screening tools and stigma reduction methodology.

[22] Gulf War and Health: Volume 6. *Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress.* The National Academy Press, Washington, DC, 2007.

[23] Department of Veterans Affairs, VHA Office of Public Health and Environmental Hazards. "Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans: Operation Enduring Freedom, Operation Iraqi Freedom," January 2008.

[24] "Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence," The National Academy Press, Washington, DC, 2007.

[25] Rosenheck, R.A., Fontana, A.F. "Recent Trends in VA Treatment of Post-Traumatic Stress Disorder and other Mental Health Disorders." *Health Affairs* 26(6); 2007:1720-1727.

[26] Zoroya, G. "Soldiers' divorce rates up sharply," *USA Today,* 7 June 2005: http://www.usatoday.com/news/nation/2005-06-07-soldier-divorces_x.htm.

[27] Davis, R., and Zoroya, G. "Study: Child abuse, troop deployment linked," *USA Today,* 7 May 2007: http://www.usatoday.com/news/nation/2007-05-07-troops-child-abuse_N.htm.

[28] Milliken, C.S., Auchterlonie, J.L., Hoge, C.W. "Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War." *JAMA*. 2007; 298(18):2141–2148.

OEF/OIF Issues

The Challenge of Caring for our Newest Generation of War Veterans:

The DOD and VA face unprecedented challenges in meeting the needs of a new generation of disabled veterans, who suffer from devastating injuries that are both visible and invisible but that are the inevitable cost of war.

The Departments of Defense and Veterans Affairs share a unique obligation to meet the health-care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from severe readjustment difficulties as a result of combat deployments. Military deployments in Iraq and Afghanistan are among the most demanding since the Vietnam War four decades ago. As of December 2007, the DOD had reported 28,661 service members wounded in action in Iraq, and, as of December 1, 2007, 1,821 had been wounded in Afghanistan.[29] Military medicine has advanced to levels of excellence that results in saving almost all soldiers and marines who are being injured today. In fact, for each service member fatality, seven service members survive injured—a survival rate nearly three times that of deaths to injuries in Vietnam and Korea (2.6 and 2.8, respectively).[30] However, for many returning service members, their wounds are grievous, and their needs are great.

These deployments are also causing heavy casualties in what are considered the "invisible" wounds of war: post-traumatic stress disorder (PTSD), depression, substance abuse problems, suicide, marital strife, and a number of other social and emotional consequences for those who have served. The DOD, VA, and Congress must remain vigilant to ensure that federal programs aimed at meeting the extraordinary needs of these severely disabled veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts, including World War II, Korea, Vietnam, and the Persian Gulf War. Also, Congress must remain apprised about how VA spends the significant new funds that have been added and earmarked specifically for the purpose of meeting postdeployment mental health care and physical rehabilitation needs of veterans who served in Operations Enduring and Iraqi Freedom (OEF/OIF).

Polytrauma

According to the July 2007 Report of the President's Commission on Care for America's Returning Warriors, as a result of the conflicts in Iraq and Afghanistan, more than 3,000 veterans have been seriously wounded—many with multiple injuries, including traumatic brain injury (TBI), amputations, serious burns, spinal cord injury (SCI), and blindness. VA has termed care for these multiple and serious injuries as "polytrauma" care. Veterans with injuries to more than one physical region or organ system generally require extensive rehabilitation and lifelong personal and clinical support, including neurological, medical, and psychiatric services, as well as physical, psychosocial, occupational, and vocational therapies. VA has established four polytrauma centers colocated with lead centers for TBI in Tampa, Richmond, Palo Alto, and Minneapolis. In fall 2007 it announced that San Antonio will also provide specialized polytrauma care. Each of VA's networks has established a lead center for follow-up care of polytrauma and TBI patients referred from the four lead centers or directly from military treatment facilities. The goal of the polytrauma rehabilitation centers is to offer a comprehensive, interdisciplinary approach to meeting the goals of an individualized treatment plan to return each injured veteran to optimal functioning.

Just as other "special emphasis" rehabilitation programs (spinal cord injury, blind rehabilitation, and amputation care programs, for example) continue to evolve from meeting the "acute" needs of the newly injured, VA's new polytrauma centers must ensure that they offer continuous follow-up care to meet the lifetime care needs of the seriously injured veterans. For many of these grievously injured veterans, this will involve supporting daily living skills (such as eating, toileting, and transferring) and independent daily living skills (e.g., personal finances, cooking, and homemaking). It may also involve finding the least restrictive age-appropriate institutional care settings or providing

support to family caregivers (usually parents and spouses), particularly as these caregivers age. Ideally, these young veterans should return home with appropriate support, but if their needs are too great, VA must explore congregate living arrangements that allow seriously wounded veterans to reside with younger veterans like themselves. We do not believe nursing homes for the frail and elderly are the most optimal care settings for this younger population of veterans.

The Independent Budget veterans service organizations (IBVSOs) plan to carefully monitor the creation and evolution of these special programs to ensure that they continue to meet the needs of this vulnerable population of veterans throughout their lifetimes.

Traumatic Brain Injury

TBI, SCI, and other serious injuries account for almost 20 percent of the combat casualties sustained by U.S. soldiers and marines in OEF/OIF.[31] Explosive blast pressure waves from improvised explosive devices (IEDs) violently shake or compress the brain within the closed skull and cause devastating and often permanent damage to brain tissues. There has been universal recognition that veterans with severe TBI will need a lifetime of intensive services to care for their injuries. However, the IBVSOs are concerned that, at all levels, development of programs to address the needs of veterans with mild, subclinical TBI have not been fully developed or implemented.

DOD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these IED detonations. Veterans suffering from this milder form of TBI may not be readily detected; however, symptoms can include chronic headaches, irritability, disinhibition, sleep disorders, confusion, executive functioning and memory problems, and depression, among other symptoms. With tens of thousands of IED detonations now recorded in Iraq alone, it is believed that many OEF/OIF service members have suffered mild, but pathologically significant, brain injuries (including multiple concussions) that have gone undiagnosed and largely untreated thus far.[32] TBI and its associated symptoms may be detected later only *if* proper screening is conducted.

The IBVSOs are concerned about emerging literature that strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DOD and VA mental health experts, mild TBI can produce behavioral manifestations that mimic PTSD or other conditions. And TBI and PTSD can be coexisting conditions. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. We believe VA should conduct more research into the long-term consequences of brain injury and development of best practices in its treatment; however, we suggest that any studies undertaken include older veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. Their medical and social histories could be of enormous value to VA researchers interested in the likely long-term progression of these new injuries. Likewise, such knowledge of historic experience could help both the DOD and VA better understand the policies needed to improve screening, diagnosis, and treatment of mild TBI in combat veterans of the future.

Individuals suffering from mild brain injury often present complex, difficult-to-assess complaints and conditions that can masquerade as other diagnoses. This complexity requires an integrated, personalized recovery plan coordinated by a cadre of specialists with expertise in TBI to diagnose and manage their medical, psychological, and psychosocial needs.

Although VA has initiated new programs and services to address the needs of severe TBI patients, gaps in services still exist. The VA's Office of the Inspector General (OIG) issued a report July 12, 2006, titled "Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation." The report assessed health care and other services provided for veterans and active duty patients with TBI, and then examined their status approximately one year following completion of rehabilitation.

The report found that better coordination of care between DOD and VA health-care services was needed to enable veterans to make a smooth transition. According to the report, the goal of achieving optimal function of each individual requires further interagency agreements and coordination between the DOD and VA. The IBVSOs believe the true measure of success will be the extent to which those most severely injured veterans are eventually able to recover, reenter their communities, or at minimum, achieve stability of function at home or in the least restrictive, age-appropriate continuing care facilities provided by VA to meet

their needs and preferences. Until those results become clear, we will continue to consider this program as a work in progress.

Additionally, the IBVSOs remain concerned about whether VA has addressed the long-term emotional and behavioral problems that are often associated with TBI, and the devastating impact on both the veteran *and* his or her family. As noted in the July 2006 OIG report, "these problems exact a huge toll on patients, family members, and health care providers." The following excerpt from the report is especially telling:

> In the case of mild TBI, the [veteran's] denial of problems which can accompany damage to certain areas of the brain often leads to difficulties receiving services. With more severe injuries, the extreme family burden can lead to family disintegration and loss of this major resource for patients.

The OIG conducted interviews with 52 patients to assess four areas of concern: general well-being, functional status, social adjustment and behavior, and access to health-care services. There were several key issues identified by patients and families that the IBVSOs believe warrant action by VA and continued oversight by Congress:

- Patients and families highlighted the importance of case managers in facilitating care but reported significant variances in the effectiveness of currently assigned case managers, rating them from "outstanding" to "poor."
- Access to care due to distance from a VA facility was perceived as a barrier for patients living in remote areas.
- There were significant problems with discharge planning in some cases, with gaps in follow-up care.
- Working spouses feared they would lose their jobs due to the demands of caring for their loved ones.
- Spouses and parents reported feeling isolated and suggested the need for a support network.
- Some families received psychological support they needed while others reported they had not.
- Many families reported difficulty with behavioral problems, including memory loss, disruptive acts, depression, and substance abuse—common problems associated with TBI. They also reported issues with anger, community reintegration, and socialization.

The OIG recommendations included improving case management for TBI patients to ensure lifelong coordination of care; improving collaborative policies between the DOD and VA; starting new initiatives to support families caring for TBI patients, including providing access to VA or contract caregivers; and recommending that rehabilitation for TBI patients be initiated by the DOD when clinically indicated. We fully concur with the OIG's recommendations and recognize that supporting these patients for a lifetime of care and service will be a continuing challenge for VA.

VA now requires a case manager be assigned to each OEF/OIF veteran enrolled in VA health care. The case manager's duty is to communicate and coordinate all VA benefits and services. Also, VA has created liaison and social work positions in DOD facilities to assist injured service members with their transitions to veteran status and to provide advice and assistance to them and their families in accessing VA services. The IBVSOs commend VA for its efforts to improve the knowledge and skills of VA clinicians through educational initiatives defining the unique experience and needs of this newest generation of combat veterans. We also acknowledge VA's dedication and commitment to meeting the needs of veterans with TBI through high-quality services at its polytrauma-TBI lead centers, for ongoing research into this debilitating injury, and for establishing effective services with academic and military affiliates to fill gaps in service when and where they are found. However, we are concerned about media reports from veteran patients with TBI and their family members who claim that VA TBI care is not up to par in certain locations, prompting them to seek rehabilitation services from private facilities. VA must ensure that its TBI network provides excellent care to all veterans irrespective of their degree of impairment. VHA's current continuing education programs should be enhanced to ensure that all VA providers are knowledgeable about the spectrum of clinical presentation and treatment of veterans with combat-related TBI. The IBVSOs encourage VA to periodically evaluate and update this program as necessary.

We encourage VA and Congress to ensure that severely wounded TBI veterans are receiving the best treatment and rehabilitation care available and that the needs of their family caregivers be met with innovative and effective programs.

Mental Health

Current research highlights that OEF/OIF combat veterans are at higher risk for PTSD and other mental health problems as a result of their military experiences. The most recent research indicates that 25 percent of OEF/OIF veterans seen at VA have received mental health diagnoses.[33]

VA reports that OEF/OIF veterans have sought care for a wide array of possible comorbid medical and psychological conditions, including adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. Through January 2008, VA reported that of the 299,585 separated OEF/OIF veterans who have sought VA health care since fiscal year 2002, a total of 120,049 unique patients had received a diagnosis of a possible mental health disorder. Almost 60,000 enrolled OEF/OIF veterans had a probable diagnosis of PTSD, almost 40,000 OEF/OIF veterans have been diagnosed with depression, and more than 48,000 reported nondependent abuse of drugs.[34]

The DOD has made a concerted effort to conduct mental health screening of military service members who served in Iraq and Afghanistan; however, the IBVSOs believe improvements in the screening and evaluation process are needed. The DOD Post Deployment Health Assessment (PDHA) is administered immediately upon redeployment from the combat theater. A recent report of PDHA screening results from those who served in Iraq demonstrated that 38 percent of active duty soldiers and 31 percent of active duty marines acknowledged a psychosocial problem. The positive screening rates for reservists were even higher, at 46 percent and 50 percent for Army reserve and National Guard members, respectively, and 44 percent for Marine Corps reserve members.[35] In March 2007, a DOD study of more than 1,700 soldiers and marines in deployment in Iraq found that 20 percent of soldiers and 15 percent of marines screened positive for a mental health problem. These rates rose to 30 percent among those exposed to the highest levels of combat. Screening rates were also positively correlated with repeated and longer duration deployments (e.g., rates for multiple deployments were 27 percent, versus 17 percent for one-time deployments).[36] In November 2007, these findings were further amplified by publication of a longitudinal assessment of mental health problems of 88,235 U.S. Army personnel who served in Iraq. The published study demonstrated a large and growing burden of mental health and substance abuse concerns. Soldiers reported more mental health problems and were referred at higher rates for mental health care on the Post Deployment Health Reassessment (PDHRA) when they were screened approximately six months after completing deployment. Clinicians identified 20 percent of active duty and 42 percent of Army reservists as requiring mental health care. In addition, soldiers reported a fourfold increase in interpersonal conflict on the delayed PDHRA compared to immediate PDHA screenings. Of great concern to the IBVSOs is the high rate of alcohol issues reported by soldiers but the virtual absence of referral to treatment programs as a result of these screening programs.[37]

Outreach

While VA has taken some steps to improve outreach to veterans, such as hiring additional outreach coordinators for OEF/OIF and announcing plans to open 25 new Vet Centers, it must continue to proactively identify this population's unmet needs for post-deployment mental health services. In addition to conducting debriefings done as troops demobilize from deployments, VA must initiate an aggressive outreach campaign to inform veterans and their families of risk factors for mental health problems and programs available to meet veterans' needs. In our view, this would involve modernizing the VA website, developing listservs to communicate with veterans through email, electronic bulletin boards, sponsored "chat rooms," and other innovative means of communicating to the ".com" generation in addition to such traditional methods as telephone calls and letters.

Stigma

There are currently no comprehensive data collected from returned OEF/OIF veterans on their personal perceptions of barriers to care. However, one of the most serious hurdles Iraq and Afghanistan veterans face in getting mental health care is the stigma associated with mental health problems. More than 50 percent of soldiers and marines in Iraq who test positive for a mental health problem are concerned that they will be seen as weak by their fellow service members, and almost one in three of these troops worries about the effect of a mental health diagnosis on their career.[38] To help reduce stigma associated with seeking mental health services, the DOD should develop a screening tool to assess cognition, psychological functioning, and overall psychological readiness for every active duty service member, reservist, and National Guard member as part of

a routine annual primary care examination. VA has already adopted a screening tool that is part of its primary care preventive health assessment process. In both settings, mental health–trained providers should be accessible to interpret responses and mental health professionals should be immediately available to receive appropriate referrals.[39]

The DOD has acknowledged its need to incorporate some of the recommendations of its Task Force on Mental Health, including conducting appropriate screenings in private environments, identifying options for screening active duty, reservists, and guardsmen annually and ensuring that its mental health assessment tools are valid and reliable. In November 2007 it planned to begin using mental health visits for predeployment health assessments at one large installation in each branch of service as a three-year pilot project. The IBVSOs will continue to monitor progress of this initiative.

Substance Abuse Challenges

As demonstrated in the aforementioned longitudinal PDHRA screening study, abuse of alcohol and other substances is a major and potentially growing health problem for OEF/OIF veterans. The IBVSOs are concerned that even when soldiers report alcohol issues, few are referred to the DOD or VA providers (0.2%) and only a small fraction of those referred were seen for treatment in less than 90 days.[40]

With respect to mental health and substance abuse treatment, both VA and DOD systems seem overburdened and understaffed. Over the past decade VA has drastically reduced its substance abuse treatment and related rehabilitation services, and has made little progress in restoring them—even in the face of increased demand from veterans returning from OEF/OIF. There are multiple consistent indications that the misuse of substances will continue to be a significant problem for OEF/OIF service members and veterans. In a recent study, VA New Jersey-based researchers examined substance abuse and mental health problems in returning veterans of the war in Iraq. Researchers noted that although increasing attention is being paid to combat stress disorders in veterans, there has been little systemic focus on substance abuse problems in this population. In the group studied (292 New Jersey National Guard members who had returned from Iraq within 12 months), there was a 39.4 percent prevalence of a substance abuse problem; 37.1 percent reported problem drinking; and a 21.2 percent prevalence of alcohol abuse or dependence. Highlights of the study indicated that nearly 47 percent of veterans studied had reported a mental health and/or substance abuse problem. Substance abuse problems were found to be higher among veterans with other mental health problems; access to treatment both during and after deployment was especially low for those needing substance abuse treatment (among veterans with dual disorders, 41 percent received mental health treatment, but only 9 percent received treatment for substance abuse). Similarly, a study of returning Maine National Guard members found substance abuse problems in 24 percent of the troops surveyed.[41] In the most recent DOD anonymous "Survey of Health Related Behaviors Among Active Duty Personnel" 23 percent of respondents acknowledged a significant alcohol problem.[42]

Both VA and DOD current evidence-based treatment guidelines for substance-use disorders document the substantial research supporting the effectiveness of a variety of treatments. VA must continue to educate its primary care providers about guidelines, including the detection of substance-use disorders, to ensure that problems are identified and treated early. In addition, substance use—common as a secondary diagnosis among newly injured veterans and others with chronic long-term-care illness or injury—can often be overshadowed by acute care needs that are seemingly more compelling. Untreated substance abuse often results in health consequences for the veteran, including a marked increase in medical expenditures and additional stresses on families as a result of loss of employment and legal fees. We urge VA and the DOD to continue research into this critical area and to identify the best treatment strategies to address substance abuse and other mental health and readjustment issues collectively.

We urge VA to provide a full continuum of care for substance-use disorders, including more consistent, universal periodic screening of OEF/OIF combat veterans in all its health-care facilities and programs—especially primary care. Outpatient counseling and pharmacotherapy should be available at all larger VA community-based outpatient clinics, and short-term outpatient counseling, including motivational interventions, intensive outpatient treatment, residential care for those most severely disabled, detoxification services, ongoing aftercare and relapse prevention, self-help groups, opiate substitution therapies, and newer

drugs to reduce craving, should be included in VA's overall program for substance abuse and prevention.

Suicide—A Special Concern

According to the recent report of the DOD task force on the mental health of the active duty force, suicide rates have risen among OEF/OIF active duty members.[43] The task force reported that alcohol abuse contributed in 65 percent of the instances of suicidal behavior in military service members. Depression, marital, and relationship difficulties were seen as additional key contributors to suicidal ideology. Recognizing the risk, the DOD is now reinforcing its suicide prevention efforts, and VA is deploying resources specifically targeting suicidal behavior among returning veterans, including linkage to the National Suicide Prevention Hotline, 800-273-TALK, sponsored by the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services. Ready access to robust mental health and substance abuse treatment programs, including prevention, stigma reduction, screening, and early intervention, are critical components of any effective suicide prevention effort.

VA's Specialized PTSD Programs

Without question, the VHA has the most comprehensive mental health programs in the nation to treat veterans with readjustment problems stemming from military combat, including combat stress, and acute and chronic PTSD. The VHA employs a cadre of highly skilled, dedicated clinicians and researchers who specialize in and are dedicated to helping veterans deal with the unique mental health challenges they face as they return to civilian life from a military combat deployment.

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. The VA Readjustment Counseling Service (RCS) currently provides counseling and readjustment services to veterans at 209 Vet Centers located throughout the nation. Additionally, the RCS plans to expand the number of Vet Centers to 232 over the next two years. Vet Centers provided more than 1 million visits to more than 228,000 unique combat veterans from all service eras in FY 2006 and saw 101,000 other veterans through outreach efforts. Since 2004 only 133 new staff members have been added to the nationwide Vet Center program, bringing its total staffing to 1,126. While VA has announced plans to increase the number of Vet Centers in the near future, the IBVSOs believe that currently operating centers must also bolster their staffing levels to ensure that all the centers can meet the rapidly expanding caseload—which now includes not only traditional counseling but outreach, much-needed bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma with PTSD.

In 1989, VA established the National Center for Post-Traumatic Stress Disorder as a focal point to promote research into the causes and diagnosis of this disorder, to train health-care and related personnel in diagnosis and treatment, and to serve as an information clearinghouse for professionals. The center offers guidance on the effects of PTSD on family and work, and notes treatment modalities and common therapies used to treat the condition. Even though VA has led in researching efficacious and best practices for the care of patients with PTSD and substance abuse disorders, these findings have not been adequately disseminated across the system, and are thus unavailable to many of the veterans who most need this state-of-the-art care. Such dissemination is a daunting task, but the need is now and early intervention is critical. We urge VA to redouble its efforts to incorporate these best practices into all clinical care programs for PTSD.

Services and Training for Families

We strongly believe that VA and the DOD must embrace new models of support for this generation of combat veterans. Family counseling support services that are needed by recently returning OEF/OIF veterans are only available on a limited basis in VA despite increasing need for such services. For example, in the most recent survey of soldiers and marines in Iraq, which included a large number of reservists, 20 percent of soldiers and 13 percent of marines indicated that they were planning a divorce—double the rate found just two years ago.[44] In a recent anonymous survey of Maine National Guard members, after repatriation from deployments, 36 percent acknowledged relationship problems with a spouse and/or children.[45] Yet few VA medical centers or VA community-based outpatient clinics provide any marital and family counseling.

Families provide the most basic support network for returning veterans. Spouses, not veterans, are usually

the first to identify readjustment issues, and they are usually the best advocates for shepherding the veteran into professional care. Unfortunately, the conflict in Iraq has put a tremendous strain on military marriages, and the strain has been increasing over time.[46] There has been a significant spike in divorce rates since the start of the conflict in Iraq.[47] New studies suggest that deployments have also led to a dramatic increase in the rates of child abuse in military families.[48] VA and the DOD must begin to shore up military families by providing training to family members on what to expect with a returning veteran and tools for caring for these veterans when they display readjustment symptoms.

Cultural Competency Training for All Mental Health Providers

The IBVSOs believe that VA delivers the best post-deployment mental health-care services available; however, we realize that VA services are not accessible or available in every community. Training mental health professionals in best practices, then, is critical to ensuring quality care for all veterans. VA should be actively sharing these best-practice principles throughout the country to help provide an increased national level of cultural competency. VA has a unique resource—the National Center on PTSD—at its disposal, which can assist it in disseminating information about the needs of veterans and their families to the general medical community. VA should approach mental health advocates, professional societies, and mental health associations to offer assistance in educating their members about post-deployment mental health needs. VA should consider all available channels to ensure that civilian mental health providers are providing culturally competent care to veterans with PTSD or other combat-related readjustment issues.

Because of increased roles of women in the military and their exposure to combat in OEF/OIF theaters, as well as the potential for them to carry the dual burden of combat exposure and sexual assault, we encourage VA to continue to address, through its treatment programs and research initiatives, the unique needs of women veterans in treatment of combat-related PTSD and military sexual trauma. (A more thorough evaluation of the needs of OEF/OIF women veterans is included in the “Women Veterans Health and Health-Care Programs” section of this *Independent Budget*.)

Summary

Emerging evidence suggests that the health-care burden for OEF/OIF veterans will be heavy. Utilization rates for health-care and mental health services predict an increasing requirement for such services in the future. The evidence suggests that the current wars are presenting new challenges to the DOD and VA health-care systems. The devastating effects of polytrauma, PTSD, TBI, blindness, limb loss, burns, sexual assault, and other injuries with mental health consequences that are not so easily recognizable can lead to serious health catastrophes, including occupational and social disruption, personal distress, and even suicide if left untreated. We must ensure a stable, robust VA health-care system that is dedicated to the unique needs of the nation’s veterans—one that is there now for aging veterans of World War II, Korea, and Vietnam and will remain viable for the newest generation of veterans who will need specialized medical and mental health care for decades to come. Congress must remain vigilant to ensure that research and treatment programs are authorized and sufficiently funded.

The Departments of Defense and Veterans Affairs have taken the first steps toward improving mental health services for active duty members and veterans of OEF/OIF. The DOD has acknowledged it needs to improve its process for conducting pre- and post-deployment health assessments to ensure that they are reliable and valid. The DOD must also continue to improve collaboration with VA to ensure this information is accessible to VA clinicians. *The Independent Budget* veterans service organizations do commend the DOD and VA for attempting to deal with the issue of stigma and the barriers that prevent service members and veterans from seeking mental health services. Although we recognize and acknowledge both agencies’ efforts, the DOD and VA are still far from meeting the mental health needs of OIF/OEF veterans and achieving the universal goal of “seamless transition.”

These challenges will require an unprecedented level of interagency cooperation. Nevertheless, the IBVSOs believe that with proper resources, clearly defined goals, and determination to overcome stigma and other institutional, cultural, and social barriers, our government can fulfill its commitment to providing the best available health care and rehabilitation services to service members and veterans with combat-related physical and mental health injuries.

Recommendations:

VA must work more effectively with the DOD to ensure a seamless transition of early intervention services to help returning service members from Iraq and Afghanistan obtain effective treatments and follow-up services for war-related physical and mental health problems.

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

VA should support research into the long-term health consequences of traumatic brain injury and mild TBI in OEF/OIF veterans as well as establish a broader research portfolio of studies of TBI prevention and treatment. Research studies of injured OEF/OIF veterans, compared to similar injuries in previous generations of combat veterans, are needed.

To ensure a smoother transition for veterans with TBI and their caregivers, VA should provide additional assistance to immediate family members of brain-injured veterans, including additional resources for improved case management, respite, training, counseling, and other necessary services, and continual follow-up.

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

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

VA should initiate surveys and other research to assess the variety of barriers to VA care for OEF/OIF veterans, with special emphasis on reservists and guardsmen returning to veteran status after combat deployments; rural and geographically remote veterans; veterans from racial and ethnic minorities; and female OEF/OIF veterans. These surveys should assess barriers among *all* OEF/OIF veterans—not only the subset of veterans who actually enroll or otherwise contact VA for health care or other services.

The DOD and VA must work collaboratively to eliminate the stigma attached to service members and veterans seeking care for readjustment issues, mental illness, and substance abuse with the same urgency and sincerity that we give to "medical" illnesses. Otherwise, some veterans will not seek help and may fall into despair and be at risk for suicide.

VA must provide access for OEF/OIF veterans and their spouses to marital and family counseling to help restore relationships that deteriorate as a consequence of military deployment and separation and to strengthen the social support system these veterans need as they reintegrate into their homes and communities.

VA should provide Congress its strategic plan, through its Office of Rural Health, for OEF/OIF veterans living in rural areas far from VA facilities and essentially without access to any form of direct VA service in mental health and otherwise. We urge VA to find acceptable ways for these rural veterans to gain access to the full continuum of health-care services offered by VA.

---

[29] Department of Defense. Statistical Information Analysis Division (SIAD), Personnel & Procurement Reports and Data Files, US Military Casualties, Operation Iraqi Freedom and Operation Enduring Freedom, December 8, 2007.

[30] *Ibid.* and Department of Veterans Affairs, Office of Public Affairs, America's Wars, July 2007.

[31] DOD sources and Wallsten and Kosec, AEI-Brookings Working Paper 05-19, September 2005, estimate of 20% serious brain injuries, 6% amputees, and 24% other serious injuries, as cited in Bilmes, L. JFK School of Government, Harvard University, "Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits" (RWP07-001). January 2007.

[32] Multi National Corps - Iraq (MNC-I) Press Conference, Major General James Simmons, MNC-I Deputy Commanding General, November 15, 2007.

[33] Seal, K.H., Bertenthal, D., Miner, C.R., Sen, S., Marmar, C. "Bringing the War Back Home: Mental Health Disorders Among 103,788 US Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities," Arch Intern Med, 2007, March 12; 167(5):476-82.

[34] Department of Veterans Affairs, VHA Office of Public Health and Environmental Hazards. "Analysis of VA Health Care Utilization Among US Global War on Terrorism (GWOT) Veterans: Operation Enduring Freedom, Operation Iraqi Freedom," January 2008.

[35] Defense Medical Surveillance System, Army Medical Surveillance Activity, US-ACHPPM. Post Deployment Health Surveys of 1 Jun, 2005, March 5, 2007.

[36] Office of the Surgeon Multinational Force – Iraq (OMNF-I) and Office of the Surgeon General United States (OTSG), U.S. Army Medical Command. (2006).

Mental Health Advisory Team (MHAT-IV). Operation Iraqi Freedom 04-06.

[37] Miliken, C.S., Auchterionie, J.L., Hoge, C.W. Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War, JAMA 2007;298(18):2141-2148.

[38] Mental Health Advisory Team (MHAT) IV Final Report, 17 November 2006, p. 25.

[39] These recommendations are consistent with those made by the DOD Task Force on Mental Health, Mental Health Advisory Team (MHAT) IV Final Report, 17 November 2006, p. 25.

[40] Wheeler, E. Self-Reported Mental Health Status and Needs of Iraq Veterans in the Maine Army National Guard. Community Counseling Center, 2007 (unpublished).

[41] *Ibid*.

[42] Bray, R., Hourani, L., Olmstead, K., Witt, M., Brown, J., Pemberton, M., Marsden, M., Marriott, B., Scheffler, S., Vandermaas-Peeler, R., Weimer, B., Calvin, S., Bradshaw, M., Close, K., & Hayden, D. (2006, August). 2005 Department of Defense Survey of Health-Related Behaviors Among Active Duty Military Personnel: A Component of the Defense Lifestyle Assessment Program (DLAP). Prepared for the Assistant Secretary of Defense for Health Affairs, U.S. Department of Defense, Cooperative Agreement RTI/7841/006-FR). Research Triangle Park, NC: Research Triangle Institute.

[43] An Achievable Vision: The Report of the Department of Defense Mental Health Task Force, June 15, 2007.

[44] Office of the Surgeon Multinational Force – Iraq (OMNF-I) and Office of the Surgeon General United States (OTSG), U.S. Army Medical Command, Mental Health Advisory Team (MHAT-IV), Operation Iraqi Freedom 05-07 Final Report, 17 November 2006.

[45] Wheeler, E. Self-Reported Mental Health Status and Needs of Iraq Veterans in the Maine Army National Guard. Community Counseling Center, 2007 (unpublished).

[46] General James T. Conway, Commandant of the Marine Corps. "Mental Health Advisory Team (MHAT) IV Brief," 18 April 2007, p. 19.

[47] Zoroya, G. "Soldiers' divorce rate drops after 2004 increase," USA Today, 1 January 2006: http://www.usatoday.com/news/nation/2006-01-09-soldier-divorce-rate_x.htm.

[48] Davis, R., and Zoroya, G. "Study: Child abuse, troop deployment linked," *USA Today*, 7 May 2007: http://www.usatoday.com/news/nation/2007-05-07-troops-child-abuse_N.htm.

Access Issues

Timely Access to VA Health Care:

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

In 1996, Congress passed the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104-262, which changed eligibility requirements and the way health care was provided to veterans. As a result of this landmark legislation and a number of other factors, greater numbers of veterans chose to access the VA health-care system. The shift allowed VA to close thousands of unnecessary hospital beds while establishing new facilities called community-based outpatient clinics (CBOCs) to provide greater numbers of veterans with more convenient access to care. VA outreach, through its Veterans Integrated Service Networks (VISNs), encouraged veterans to enroll in a reformed VA health-care system. As a result, millions of veterans enrolled in VA health care for the first time in their lives. A decade later, VA health care is a remarkable success story.

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 zenith, 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 directive denied health-care access to 164,000 so-called "priority group 8" veterans in the first year alone following that decision. Since 2003, VA notes that more than 400,000 priority group 8 veterans had sought access to VA health care but were denied.

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 Health

Improvement (IHI). The strategy emphasizes managing demand in order to improve patient flow and thus access to services. The IHI principles identified "bottlenecks" (such as limited clinical staff, care space, clerical staff, and equipment) in order to ensure that the process was optimally efficient. One important element of the IHI strategy is to allow patients to always see the same care provider. 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 about the accuracy of data collected to confirm these reductions remain.

To assess its success in reducing waiting times, VA used scheduling software developed in the 1970s, supplemented by electronic waiting lists. VA's goals are to provide requested clinic appointments within 30 days to all veterans who are service-disabled and rated 50 percent and higher, and for care for any service-connected condition. It has also added all veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) to this "high priority" list. *All other care is to be provided within 120 days.* Any veteran who is not able to make an appointment within this time frame is supposed to be placed on an electronic waiting list.

At first, VA produced data that demonstrated steady declines in waiting times at many of the six monitored clinic stops nationwide (primary care, urology, cardiology, audiology, orthopedics, and ophthalmology). Today VA uses performance measures from nine clinic stops. However, the Veterans Information Systems and Technology Architecture collects waiting time data from 50 high-volume clinic stops throughout the system. Since FY 2002, VA has measured waiting times for primary and specialty care separately, but starting in FY 2008, VA will use one metric (rather than two matrices) for reviewing waiting times. The new measure will incorporate both new and established patients and primary and specialty care.

However, VA has repeatedly failed to ensure that established protocols for scheduling appointments are followed. A September 2007 VA Inspector General's (IG) report, "Audit of the Veterans Health Administration's Outpatient Waiting Times," challenges VA'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 time. VA claims even better results for FY 2007: 97.5 percent of primary care and 95 percent of specialty care patients fall within the 30-day time frame.

The IG is particularly concerned that VA has repeatedly failed to accurately document the "desired date"—the baseline of calculating a "waiting time"—for an appointment. The IG found discrepancies between requested appointment times documented in medical records and in the databases and incomplete waiting lists. This finding led the IG to believe that VHA waiting times are significantly understated. It also concluded that VA had not implemented five of the eight recommendations that the IG made in a 2005 report on this same topic.

To achieve the goals of the IHI, many VA facilities use "recall" lists—a policy that purports to allow veterans to schedule appointments with established providers at their convenience within a month of their desired appointment. VA patients may be told by their physicians to schedule an appointment to see them in six months. The idea is for VA to remind the veteran to call back five months later to schedule the appointment in the next 30 days. Apparently, however, the protocol does not always work as planned. For example, if a veteran tries to schedule an appointment within 30 days and there are no available appointment slots, clerks are often unwilling or unable to "override" the system to schedule the appointment for a later time. Instead of being placed on an electronic waiting list in accordance with VHA policy, veterans are told to call back. This can happen repeatedly until the clinician has an opening. Under the current process, VA would never count these veterans as "waiting" even if it took more than a month to schedule their appointments.

Veterans report that some facilities keep recall lists off the automated systems and give reminders only when there are openings in the schedule. VA acknowledged to the IG, for example, that the scheduling process for new patients begins when clerks first attempt to create appointments electronically, which by policy could be delayed up to a week after the new patient requests the appointment. Additionally, if a primary care physician refers an established patient to the cardiology clinic at which that veteran had never been seen, the veteran would be coded as a "new" patient for cardiology. The IG believes this practice seriously understates waiting times for consultative specialty care. Oftentimes, it found specialist consultations took longer than seven business days to be scheduled (similar to a new pa-

tient), but that these individuals were never placed on waiting lists. In addition, the IG found that in most cases VA did not contact patients who had missed appointments or contact them in a timely manner.

In light of its findings, the IG concluded that VA is not in compliance with its own policies in scheduling procedures. It recommended that the VHA take corrective action and develop internal processes to ensure that:

- desired dates documented in medical records are accurately reflected in measuring waiting times;
- schedulers comply with policy;
- consultations that fall outside acceptable time frames are properly reflected on electronic waiting lists;
- schedulers receive annual training; and
- alternatives to the current process of scheduling appointments be assessed.

In reviewing the IG recommendations, VA cited many challenges in developing scheduling software for such a large health-care system, but generally agreed that its process of scheduling and collecting scheduling data should gradually evolve to address the IG's concerns. The IG considers this nonresponsive because it does not outline concrete steps to ensure that the VHA will enforce its own policy. VA also argued that its patient satisfaction survey found that most veterans believed they had timely access to primary and specialty care. The IG disagreed that these data were valid to document that the VHA was meeting its goals for waiting times. The *The Independent Budget* veterans service organizations (IBVSOs) believe VA is in the forefront by even attempting to measure clinical waiting times for such a vast health-care enterprise because most providers only use proxies, such as patient satisfaction or clinicians' estimates. Nonetheless, we believe there is still the need for significant improvement. We are encouraged, however, that VA is reportedly in the process of a detailed study of its scheduling policy and processes, including steps it can take to improve the accuracy of its waiting time data.

VA is also migrating the principles of the IHI access initiative for clinics to other areas. This new program of system redesign (Full Improvement in Implementation Initiative, or "FIX") includes clinics, but also encompasses administrative processes, such as medical care cost recovery and human resources, management, and inpatient flow. At this point VA reports that several collaborative efforts have taken place to address different inpatient processes, such as scheduling operating rooms and the bottlenecks posed by such factors as too little intensive care unit capacity in five regions across the country.

The IBVSOs believe timely access is crucial to high-quality health care. Without ensuring that veterans are receiving timely access to care, VA cannot assure our nations's veterans that they will have continuity or quality of health care.

Recommendations:

The Veterans Health Administration should continue to roll out the Institute for Health Improvement's (IHI) principles in order to maximize productivity of clinical care resources by identifying additional high-volume clinics that could benefit.

VA should continue to identify other clinical areas (such as procedure rooms, operating rooms, nuclear medicine, etc.) where scheduling should be redesigned to improve efficiency and access and apply the IHI principles to them, as well.

VA should take a systematic approach to monitoring change in the processes to which the IHI principles have been applied in order to identify whether the process is resulting in desired outcomes.

VA should ensure that valid waiting time data from its 50 high-volume clinics are used to measure performance of networks and facilities. In addition to using its automated data collection, it should audit a sampling of medical records for desired appointment times as recommended by the Inspector General.

VA should identify bottlenecks caused by limited resources, such as clinical staff, clinical space, equipment, and clerical staff shortages, and request funds to address these when IHI processes cannot identify "workarounds" to meet waiting time goals.

VA must ensure that schedulers receive adequate annual training on scheduling policies and practices in accordance with the Inspector General's recommendations.

VA must consider recommendations made by its contractor currently reviewing its scheduling software, policy, and practice in order to address ongoing concerns about the accuracy of its waiting time data.

COMMUNITY-BASED OUTPATIENT CLINICS:

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

The Independent Budget veterans services organizations (IBVSOs) commend the Veterans Health Administration's (VHA) efforts to expand access to needed primary care services. There are currently 727 CBOCs located throughout the country, and there are 52 that are on the approved list, according to the latest VA statistics. For many veterans who live long distances from VA medical centers (VAMCs) and for those whose medical conditions make travel to VAMCs difficult, CBOCs reduce the need/necessity for travel. CBOCs also improve veterans' access to timely attention for medical problems, reduce hospital stays, and improve access to, and shorten waiting times for, follow-up care. As VA proceeds in implementing the CBOCs and engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant. VA will need to enhance access to care in underserved areas with large numbers of veterans outside of access guidelines and in rural areas. VA also needs to enable overcrowded facilities to better serve veterans and must support sharing initiatives with the Department of Defense.

While the IBVSOs support establishment of CBOCs, we remain concerned that they often fail to meet the needs of veterans who require specialized services. For example, many CBOCs do not have appropriate mental health providers on staff, nor do they necessarily improve access to specialty health care for either the general veteran population or those with service-connected mental illness. To VA's credit, the revised criteria for establishment of CBOCs include the availability of mental health with disease-specific documentation. Moreover, too often CBOC staff lack the required knowledge to properly diagnose and treat conditions commonly secondary to spinal cord dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, some veterans service organizations caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care programs. Inadequately trained providers are less likely to render appropriate primary or preventive care or to accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with required accessibility standards in Section 504 of the Rehabilitation Act.[49] Regarding physical accessibility to medical facilities, veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

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

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

Recommendations:

The Veterans Health Administration must ensure that community-based outpatient clinics (CBOCs) are staffed by clinically appropriate providers capable of meeting the needs of veterans.

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

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

[49] 29 United States Code, section 791 et seq.

Veterans Rural Health Care:

VA should work to improve access to VA health-care services for veterans living in rural areas without diminishing existing internal VA health-care capacities to provide specialized services.

The Independent Budget veterans service organizations (IBVSOs) believe that, after serving their country, veterans should not see their health-care needs neglected by VA because they choose to live in rural and remote areas far from major VA health-care facilities. We have reviewed pertinent findings dealing with rural health care, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). From these data we are able to gain insights on the special, and even unique, needs of rural veterans:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and concerns for stress, depression, suicide, and anxiety disorders as major rural health concerns.[50]
- More than 44 percent of U.S. military recruits, and those serving in Iraq and Afghanistan, come from rural areas.
- More than 30,000 service members have been wounded in Iraq and Afghanistan, and tens of thousands have reported difficulties in mental health following their deployments.
- Disparities exist between rural and urban veterans in heath status, and those issues deserve further study. According to VA's 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."[51]
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive compensation;[52] 38 percent of VA health care enrollees come from rural areas; and 1.5 percent live in " highly rural" areas, as defined by VA.[53]
- According to another study, "the smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services."[54]
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.[55]
- Nearly 22 percent of our elderly live in rural areas; rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term care systems. In rural areas some 7.3 million people need long-term care services, accounting for one in five of those who need long-term care.[55]

Currently, VA operates 854 outpatient clinics, of which 727 are community-based outpatient clinics (CBOCs)—333 of these 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. At present, 12 such VA outreach clinics are operational, and VA plans more. The IBVSOs also understand that VA's intended strategic direction in rural care is to enhance noninstitutional care solutions, with less dependence on large institutions. VA provides home-based primary care as well as other home-based programs, and is using telemedicine and telemental health—but on a limited basis, in our judgment—to reach into veterans' homes and community clinics, including some Native American tribal clinics. It is hoped that this will allow VA to directly evaluate and follow veteran patients without their needing to travel to large and distant VA medical centers. VA reported it has also begun to use an Internet site to provide information to veterans, including up-to-date research information, access to their health records, and online ability to refill prescription medication. The IBVSOs believe that the use of technology, including the World Wide Web, telecommunications, and telemetry, offers VA a great but still unfulfilled opportunity to improve rural veterans' access to VA care and services. We urge the Office of Rural Health (ORH) to pursue additional ways of using technology to the advantage of these veterans.

In accordance with section 212 of the Public Law 109-461, the Veterans Health Administration (VHA) has established the Office of Rural Health, appointed a director, and established VA rural care designees in all its VISNs to serve as points of contact and liaisons with the new ORH, as required by law. We are concerned that, while VA has designated the liaison positions within the VISNs, these employees serve these purposes only on a part-time basis, along with other duties as assigned. The IBVSOs believe rural veterans' needs are sufficiently crucial to deserve full-time attention. Therefore, in consideration of other recommendations dealing with rural veterans' needs that we put forward in this *Independent Budget,* we urge VA to establish a full-time rural liaison position in each VISN, with exception of VISN 3 (urban New York City).

As described by VA, the mission of the ORH 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 office is accomplishing this by coordinating delivery of current services to ensure that the needs of rural veterans are being considered. With confirmation of these developments, we believe the VHA would be beginning to incorporate the unique needs of rural veterans as new VA health-care programs are conceived and implemented; however, the ORH is a new function within the VA Central Office and it is only at the threshold of effectiveness as a program, with much remaining to be done; therefore, the IBVSOs reserve judgment on this VA claim.

Without question, section 213 of Public Law 109-461 is the most significant advance to date to address health-care needs of veterans living in rural areas. This legislation is aimed at better addressing the needs of rural veterans who have served in Iraq and Afghanistan. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, VA is required to collaborate with employers, state agencies, community health centers, rural health clinics, critical access hospitals (as designated by Medicare), and local units of the National Guard, to ensure that returning veterans, guardsmen, and reservists, after completing their deployments, can have ready access to the VA health benefits they have earned by that service. We urge VA to move forward with dispatch on this outreach effort—and that any outreach under this authorization be closely coordinated with VA's ORH to avoid duplication and to maintain consonance with VA's overall policy on rural health care.

Stimulated by concerns about the health status of OEF/OIF veterans, several legislative proposals have been introduced in both chambers of Congress over the past year to provide rural veterans greater access to VA-sponsored care exclusively through private providers. While we applaud the sponsors' intentions, these measures could result in unintended consequences for VA; chief among these is the diminution of established quality, safety, and continuity of VA care for these veterans.

It is important to note that VA's specialized health-care programs, authorized by Congress and designed expressly to meet the special needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma, and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would suffer irreparable impact by the loss of veterans from those programs. The VA's medical and prosthetic research program, designed to study and, it is hoped, cure the ills of disease and injury consequent to military service, would lose focus and purpose were service-connected and other enrolled veterans no longer present in VA health care. Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of these specialized medical programs and not to let their capacity fall below the level that existed at the time when Public Law 104-262 was enacted.

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 enactment of these vouchering and privatization bills, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records, and bar code medication administration (BCMA). These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, which are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and, ultimately, may result in lower quality of care for those who deserve it most.

As indicated elsewhere in this *Independent Budget*, in general, current law places limits on VA's ability to con-

tract for private health-care services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits, there is no general authority in the law to support broad-based contracting for the care of populations of veterans, whether rural or urban.

The IBVSOs believe VA contract care for eligible veterans should be used judiciously and only in these authorized circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient and outpatient services for all enrolled veterans. We believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those 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 only exacerbates the problems currently encountered.

Nevertheless, after considerable deliberation, and in good faith to be responsive to those who have come forward with legislative proposals to offer alternatives to VA health care, we ask VA to consider developing a series of tailored demonstration projects and pilot programs to provide VA-coordinated care (or VA- coordinated care through local, state, or other federal agencies) in a selected group of rural communities, and to provide to the Committees on Veterans' Affairs reports of the results of those programs, including relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, compared to similar measurements of a like group of veterans in VA health care. To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health professions' academic affiliates. We recommend the principles of our recommendations from the "Contract Care Coordination" section of this *Independent Budget* be used to guide VA's approaches in this effort, and that the effort be closely monitored by a Rural Veterans Advisory Committee, recommended further on in this section. Also, any such demonstration and pilot projects should be funded within the Veterans Equitable Resource Allocation (VERA) system, and their expenditures should be monitored in comparison with VA's historic costs for rural care. The ORH should be designated the overall coordinator of these demonstrations and pilot efforts, in collaboration with other pertinent VHA offices and local rural liaison staff in the VHA's involved VISNs.

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IBSVOs believe that these veterans, too, should have access to specialized services offered at VA's Vet Centers. Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives counseling related to their military experiences. Building on the strength of the Vet Centers program, VA should be required to establish a pilot program for mobile vet centers that could help reach veterans in rural and highly rural areas where there is no other VA presence.

Health workforce shortages and recruitment and retention of health-care personnel are a key challenge to rural veterans' access to VA care and to the quality of that care. "The Future of Rural Health" report cited previously recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health-care professionals working in rural areas. To this end, VA's deeper involvement in education of future rural clinical providers seems appropriate to improve 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. These relationships of VA facilities to schools of the health professions should be put to work in aiding rural VA facilities with their health personnel needs. The VHA Office of Academic Affiliations, in conjunction with the ORH, should de-

velop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

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 Indian Health Service (IHS) and the HHS Office of Rural Health Policy, collaborating in the delivery of health care in rural communities, but we 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 new ORH should pursue these collaborations and coordinate VA's role in participating in them.

Rural veterans, veterans service organizations, and other experts need a seat at the table to help VA consider important program and policy decisions, such as those described here, that would have positive effects on veterans who live in rural areas. The IBVSOs were disappointed that Public Law 109-461 failed to include authorization of a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans organizations, and other rural health experts to recommend policies to meet the challenges of veterans' rural health care. We believe Congress should have included this concept in establishing the ORH because of the value of an outside advisory committee to the new rural health office as it develops its role and responsibilities in VA health care. Nevertheless, even without that Congressional mandate, the Secretary of Veterans Affairs retains the authority under law to establish advisory committees to aid VA's work. Given our discussion above, and considering the number of unresolved issues that need to be addressed with regard to rural veterans, we continue to believe strongly that a rural health issues advisory committee is clearly warranted. The IBVSOs urge the Secretary to establish this new advisory committee, chartered under the Federal Advisory Committee Act, and for membership in that committee to include the authors of *The Independent Budget*.

In summary, the IBVSOs believe VA is working in good faith to address its shortcomings in rural areas and that, in the long term, its methods and plans offer veterans the best opportunity to obtain quality care to meet their specialized health-care needs. We vigorously disagree with proposals to privatize, voucher, and contract out VA health care for rural veterans on a broad scale because such a development would be destructive to the integrity of the VA system, a system of immense value to veterans and to the IBVSOs.

Recommendations:

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

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

VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with VHA's Office of Rural Health (ORH).

Mobile vet centers should be established, at least on a pilot basis, to provide outreach and counseling for veterans in rural and highly rural areas.

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

The VHA Office of Academic Affiliations, in conjunction with the Office of Rural Health, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

The VA Secretary should use existing authority to establish a Rural Veterans Advisory Committee under the Federal Advisory Committee Act to include membership by veterans service organizations (including those that have authored this *Independent Budget*).

In areas of particularly sparse veteran population and absence of VA facilities, the VA Office of Rural Health 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 coordinator of care. The projects should be reviewed and monitored by the Rural Veterans Advisory Committee otherwise recommended in this section. Funding should be made available to the ORH to conduct these demonstration and pilot projects outside of Veterans Equitable Resource Allocation, and VA should report the results of these projects to the Committees on Veterans' Affairs.

At highly rural VA community-based outpatient clinics, VA should establish a staff function of rural outreach workers to collaborate with rural and frontier non-VA providers to establish referral mechanisms to ease referrals by these providers to direct VA health care when available, or VA-authorized care by other agencies.

Rural outreach workers in VA's rural community-based outpatient clinics should receive funding and authority to enable them to purchase and provide public transportation vouchers and other mechanisms to promote rural veterans' access to VA health-care facilities that are distant from their rural residences. This travel program should be inaugurated as a pilot program, in a small number of facilities. If successful as an effective access tool for rural, remote, and frontier veterans who need access to VA care and services, it should be expanded into other rural areas.

The ORH should seek and coordinate the implementation of novel methods and means of communication, including use of the World Wide Web and other forms of telecommunication and telemetry, to connect rural, remote, and frontier veterans to VA health-care facilities, providers, technologies, and therapies, including greater access to their personal health records, prescription medications, and primary and specialty appointments.

[50] "Rural Healthy People 2010," Vol. 2, Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.
[51] Weeks WB, Kazis LE, Shen Y, Cong Z, Ren XS, Miller D, Lee A, Perlin JB. "Differences in health related quality of life in rural and urban veterans. *American Journal of Public Health* 2004; 94: 1762–1767. Wallace AE, Weeks WB, Wang S, Lee AF, Kazis LE. "Rural/urban disparities in health related quality of life among veterans with psychiatric disorders. *Psychiatric Services* 2006; 57(6): 851–856. Weeks WB, Wallace AE, Wang S, Lee A, Kazis LE. "Rural-urban disparities in health related quality of life within disease categories of veterans." *Journal of Rural Health* 2006; 22(3):204–211.
[52] *Am. J. Pub. Health,* Oct. 2004.
[53] VA testimony, Senate Committee on Veterans' Affairs, 8/2/07.
[54] "Quality Through Collaboration: The Future of Rural Health," Institute of Medicine, Committee on the Future of Rural Health Care, 2005
[55] President's New Freedom Commission on Mental Health, July 2003.
[56] "Rural Healthy People 2010," Vol. 3, Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.

VHA-DOD Sharing:

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

The Independent Budget veterans service organizations (IBVSOs) have been discussing this initiative for a number of years, as has Congress, with little success for our efforts. The Untied States Constitution, Article I, Section 8 requires Congress: "To raise and support Armies…to provide and maintain a Navy…[and] to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers…." Additionally, federal law states: "The Secretary and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed to operate such facilities properly[.]."[58]

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

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

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

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

Leadership and Reporting

Even though progress has been slow, 2006 showed a marked improvement in the data sharing that has occurred between the two departments. It is a direct reflection of the leadership of the VA-DOD Joint Executive Council that a strategic plan has been put in place by setting six goals to achieve their mission "to improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, service members, military retirees, and their families through an enhanced VA and DOD partnership."

The Benefits Executive Council has reached several milestones. In 2000, the Defense Manpower Data Center (DMDC) provided an initial load of all current and separated active duty, National Guard and reserve members, and all retirees to VA, as well as daily transactions consisting of all military accessions and separations to VA. From 2005 to February of 2007 automated data flow from DMDC to VA has been activated to share combat military pay, activation and mobilization of troops, Montgomery GI Bill and other educational benefits eligibility, and Unit Identification Code mailing address. At the end of 2006, data feeds from the DOD were consolidated from 31 to 20, and the data feeds from VA to the DOD were consolidated from 11 to 8.

Currently, and by the commission's own admission, a successful collaborative relationship between the DOD and VA is driven by leadership. There must be a clear commitment from their senior leadership, both to the internal establishment of collaboration and to its ongoing maintenance, especially when there is a change of leadership. The commission noted a number of collaborations that did not continue after one or both of the senior local leaders was reassigned or retired.

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

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

Joint Venture Sites

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

VA and DOD Access Standards

VA has had access standards since 1995, but these standards have not been enforced. The DOD, however, has mandatory standards and is required, by statute, to meet them. The DOD standards drive funding levels to meet demands for care at MTF and within TRICARE. In examining the funding mismatch, the PTF, in its report, concluded that the VHA should receive "full funding to meet demand, within access standards[.]"[58]

Fully Funded Enrolled Veterans

The PTF recommended that the "Federal Government should provide full funding to ensure that enrolled veterans…are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism[.]"[59]

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

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

Recommendations:

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

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

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

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

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

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

Congress should require mandatory funding of VA health care.

[57] Title 38, United States Code, section 8111(a).
[58] President's Task Force to Improve Health Care Delivery for Our Nation's Veterans at 81.
[59] *Ibid.*, at 77.

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

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

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 the means-tested levels. Catastrophically disabled veterans were granted this heightened priority for VA health-care eligibility in recognition of the unique nature and need to avail themselves of the complex specialized health-care system. The higher priority 4 enrollment category also protects these veterans from not having access to the system were they, under usual circumstances, to be considered in the lower priority group 8 or priority group 7 should VA health-care resources be curtailed.

The addition of nonservice-connected catastrophically disabled veterans to priority group 4 was in recognition of the distinct needs of these veterans and the VA's vital role in providing their care. However, access to VA 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. Current VA regulation stipulates that catastrophically disabled veterans are to be considered priority 4, for the purpose of enrollment, because of their specialized needs; however, they still have to pay all health-care fees and copayments as though they were still in the lower eligibility category. Catastrophically disabled veterans are not casual users of VA health-care services; they require a lot 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. In most instances, VA is the only as well as the best resource for a veteran with a catastrophic disability; yet these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they had no priority at all. This puts great financial hardship on the catastrophically disabled veterans who need to use far more VA health-care services at a far greater extent than the average VA health-care user. 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.

The hardship endured by a catastrophic injury or disease is unique and devastating to the veteran and the family who may be responsible for his or her care. At a time when the veteran is in need of specialized assistance to regain some independence and quality of life, the financial burden of medical bills should be lifted. Any veteran determined by VA to be catastrophically disabled and placed in the priority group 4 should be afforded the same benefits as if rated as entitled to Aid & Attendance to eliminate medical/prescription copays and provided assistance with travel for that care.

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and

Financial Income Thresholds for VA Health Care
Financial Test Year 2008

Veteran with:	Free VA prescription and travel benefits	Free VA health care: 0% and nonservice-connected	Medical expense deductible: 5% of maximum allowed pension rate from previous year
0 dependents	$ 11,180	$ 28,429	$ 559
1 dependent	$ 14,642	$ 34,117	$ 732
2 dependents	$ 16,551	$ 36,026	$ 828
3 dependents	$ 18,460	$ 37,935	$ 923
4 dependents	$ 20,369	$ 39,844	$1,019
For each additional, add	$ 1,909	$ 1,909	5% max allowable pension rate
Medicare Deductible	$ 1,024	Income & Asset (I&A) net worth: $80,000	I&A net worth: $80,000

their families despite the nature of their catastrophic disabilities. Far too often, veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and other federal and state support systems. In so doing, they fall within the complete definition of priority 4 health-care enrollment and are exempt from all fees and copayments. Yet, because of a veteran's ambition and employment, which brings annual income above the means test levels, he or she is then unduly penalized by exorbitant fees. The current VA regulation that requires catastrophically disabled veterans to pay all health-care fees and copayments does little to reward or provide an incentive for these veterans to maintain employment and a productive life.

NOTE:

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 authors of *The Independent Budget* believe it is important to recognize that even though some veterans have incomes above the means test levels that many of these veterans should certainly not be considered as "high-income" individuals.

Recommendation:

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

Non-VA Emergency Services:

Enrolled veterans are being denied reimbursement for non–VA emergency medical services as a result of restrictive eligibility requirements.

Sections 1725 and 1728 of title 38, United States Code authorize the Department of Veterans Affairs to reimburse for emergency treatment of VA patients outside of VA facilities when these veterans believe a delay in seeking care will seriously jeopardize their lives or health. This term for defining "emergency," commonly known as the "prudent layperson" standard, has been widely used in the health-care industry. According to a 2004 study,[60] most states now require managed care providers to reimburse care under the prudent layperson standard. The study noted that while there have not been significant increases in patients seeking emergency treatment, fewer insurers deny claims for such care.

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 emergency, 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.

Many veterans have filed claims for emergency treatment and for the 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. VA has also questioned veterans' "prudence" in seeking emergency care even when admitting symptoms could be interpreted as manifest of more severe diagnoses than are ultimately rendered and even in cases where VA refers veterans to seek non-VA emergency care. Anecdotally, *The Independent Budget* veterans service organizations (IBVSOs) understand that there have also been significant delays in VA's reimbursement of approved claims. Delayed reimbursements can damage veterans' credit—because by definition of the eligibility criteria, the veteran is liable for these costs.

The IBVSOs believe that 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. In addition, we believe VA should either reimburse for post-stabilization care or transfer the veteran at the Department's expense to a VA or other federal government facility for this care once stabilization is achieved. At this writing, pending legislation approved by the Senate would extend eligibility for post-stabilization care if the non-VA facility had documented contact with VA after stabilization and sought a transfer. Specifically, bill S. 2142 would amend the definition of reimbursable emergency treatment to include that time when a VA or other federal facility declines to accept a stabilized veteran who is ready for transfer from a non-VA facility and the non-VA provider has made reasonable attempts (with documentation) to make such a transfer. The IBVSOs support this legislation as a start to addressing the concerns detailed above.

Recommendations:

Congress should eliminate the requirement for veterans to have used VA health-care services within the past 24 months to trigger reimbursement of emergency treatment claims of enrolled veterans who would otherwise be eligible.

Congress should enact S. 2142 and its House counterpart, H.R. 3819, to allow VA to reimburse post-stabilization care in non-VA facilities if VA declines to accept transfer of the stabilized veteran.

Congress should investigate 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 consistent with policies of the Centers for Medicare and Medicaid Services and other payers who operate under "prudent layperson" standards.

[60] Hall, Mark A. "The Impact and Enforcement of Prudent Layperson Laws," *Annals of Emergency Medicine,* Vol. 43, No. 5, May 2004.

Specialized Services

Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

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

The VISN Integrated Prosthetics Service (VIPS) for the VA Prosthetics and Sensory Aids program continues to experience problems with the distribution of service and equipment.

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

The IBVSOs also are in full support of the decision to distribute FY 2008 prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures and utilization reporting. This decision continues to improve the budget-reporting process.

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

The IBVSOs support senior VHA officials implementing and following the proper accounting methods while holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate prediction of the prosthetic needs for the future.

The Independent Budget veterans service organizations are pleased that centralized funding continued in FY 2007. The present 2008 proposed allocated budget for prosthetics is $1,339,131,000. Funding allocations for FY 2008 were primarily based on FY 2007 NPPD expenditure data, coupled with Denver Distribution Center billings, and other pertinent items, but allocations were not primarily based on NPPD and DDC spending in FY 2007. The VHA also looked at VISN requests, past accuracy between request and expenditures, and new programs being established. The prosthetics budget also includes funds for surgical, dental, and radiology implants.

Because of the increased compliance rate between prosthetics obligations and NPPD expenditure data, we expect VHA facilities to spend $1,363,376,836 in FY 2008 budget allocations. It is anticipated that $1,403,073,454 will be required to cover the FY 2009 prosthetics budget. The advancements in prosthetics technology, telehealth, and the Health Informatics Service Architecture, or HISA, raise future costs with VHA budget proposals.

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

Listed on the next page are examples of NPPD expense costs in fiscal year 2007 with projected expense costs for new equipment as well as prosthetic repairs for fiscal year 2008. These expenses include the Denver Distribution Center expenses.

NPPD Expense Costs		
Prosthetic Item	**Total Cost spent in FY 07**	**Projected Expenditure in FY 08**
Wheelchairs & Access	$ 140,203,704	$ 155,556,010
Artificial Legs	$ 77,227,364	$ 85,683,760
Artificial Arms	$ 3,812,082	$ 4,299,505
Orthosis/Orthotics	$ 36,840,603	$ 40,874,649
Shoes/Orthotics	$ 29,445,383	$ 32,669,652
Sensori-Neuro Aids	$ 61,560,354	$ 68,301,213
Restorations	$ 3,679,539	$ 4,082,449
Oxygen & Respiratory	$ 178,592,688	$ 198,148,587
Medical Equip & Supplies	$ 163,880,889	$ 181,825,846
Medical Supplies	$ 12,065,941	$ 13,387,162
Home Dialysis	$ 1,146,120	$ 1,271,620
HISA	$ 5,582,601	$ 6,193,896
Surgical Implants	$ 354,630,421	$ 393,462,452
Other Items	$ 8,343,310	$ 9,256,902
Miscellaneous	$ 5,010,636	$ 5,559,301
Denver Distribution Center (DDC)	$ 146,799,308	$ 162,873,832
Total	**$ 1,228,820,943**	**$ 1,363,376,836**

Recommendations:

The Veterans Health Administration should enforce a uniform line of authority VISN Intergrated Prosthetics Service (VIPS) Line to decrease problems with the distribution of service and equipment.

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled 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 to prosthetics to ensure that the prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

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

The VHA should continue to utilize the Prosthetics Resources Utilization Workgroup to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the National Prosthetics Patients Database (NPPD).

The VHA's senior leadership should continue to hold its field managers accountable for ensuring that data are properly entered into the NPPD.

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

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

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

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

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

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

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

Currently, Prosthetics must compete with all other information technology (IT) requests for funding. This has resulted in delayed IT projects not being adequately funded to provide prosthetics with IT applications and enhancements required to support the ever-changing requirements and needs to maintain health information of this special emphasis group. In FY 2008, prosthetics IT development will likely be funded at $984,993. This is not enough funding to support the 19 IT projects planned. Moreover, at the present time, 7 prosthetics IT projects have been rolled over from FY 2006, with 12 IT projects on hold. Patient care can be more adequate if clinical systems are in place for all VA facilities.

Recommendations:

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

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

The VHA must continue to exempt 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.

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

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

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

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

VA should increase funding for prosthetics IT systems projects and consider dedicating full-time resources to prosthetics IT systems to ensure that these functions are enhanced in a timely manner.

Restructuring of Prosthetics Programs:

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

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

- Designate a qualified VISN prosthetics representative who will be the technical expert responsible for ensuring implementation and compliance with national goals, objectives, policies, and guidelines on all issues of interpretation of the prosthetics policies.
- Ensure that VISN prosthetics representatives have direct line of authority or input into the performance evaluation of all prosthetics full-time employee equivalents at local facilities that are organized under a consolidated VISN prosthetics program or product line.
- Ensure that no VISN prosthetics representative has collateral duties as a prosthetics representative for a local VA facility within his or her VISN.
- Provide a single VISN budget for prosthetics and ensure that the VISN prosthetics representative has control of and responsibility for that budget.
- Hold Prosthetics staff to time limits for prosthetics denials in order to expedite the appeal process.

Recommendations:

The VHA must require all VISNs to adopt consistent operational parameters and authorities in accordance with national prosthetics policies.

VISN directors as well as VHA central office staff should be held responsible for implementing a consistent prosthetics program that reduces the need for central office intervention.

Time limits for denial of prosthetics requests should be established and adhered to.

FAILURE TO DEVELOP FUTURE PROSTHETICS STAFF:

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

The Veterans Health Administration (VHA) has developed and requested 12 training billets for the National Prosthetics Representative Training Program, projected in fiscal years 2008 and 2009. Interns in this program are invited to the annual National Prosthetic Representative Training Conference for a one-week intense prosthetics forum.

This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. In the past, some Veterans Integrated Service Networks (VISNs) have selected individuals who do not have the requisite training and experience to fill the critical VISN prosthetics representative positions. There are some VISNs who have developed their own prosthetics representative training program. These VISN trainees are included in the annual National Prosthetic Representative Training Conference. *The Independent Budget* veterans service organizations (IBVSOs) recommend that all VISNs have a prosthetic representative training program to enhance the quality of health-care service within the VHA system. The IBVSOs believe the future strength and viability of VA's prosthetic program depends on the selection of high-caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients.

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

Recommendations:

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

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

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

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

HEARING LOSS AND TINNITUS:

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

As service members return from the conflicts overseas in Iraq and Afghanistan, they face adversity in returning to civilian life. Many have been wounded by roadside bombs that left them with both visible and unseen injuries, such as loss of limbs, traumatic brain injuries (TBI), and spinal cord injuries. The federal government has recognized the need for improved health-care services for these returning members of the military. Although the VA budget has increased, it still does not cover the growing needs of our veterans—past, present, and future. Estimates for long-term health care for this new generation of veterans reach into the billions of dollars.

While loud noise has been part of military life since muskets and cannons were part of the arsenal, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are some the noisiest battlegrounds yet. Roadside bombs—the signature of the country's insurgency—regularly hit patrols, popping eardrums and leading to hearing loss and tinnitus. In addition, TBI, the signature wound of these conflicts, is also producing a whole new generation of soldiers with both mild and severe head injuries resulting in tinnitus. The VA Polytrauma Center in Tampa, Florida, reports that even those soldiers with no measurable hearing loss have tinnitus in conjunction with milder forms of TBI. Head and neck trauma is the number two–reported cause of tinnitus. According to VA data, hearing loss and tinnitus are the third most common disability among veterans. Friends of VA report that hearing loss and tinnitus are the number one health cost of any war. A study conducted by Walter Reed Army Medical Center from 2003–2005 on combat soldiers exposed to blasts in Iraq and Afghanistan reported that 49 percent experience tinnitus.[61]

Invisible Injury

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

Tinnitus is defined as the perception of sound in the ears where no external source is present. Some with tinnitus describe it as "ringing in the ears," but people report hearing all kinds of sounds, such as crickets, whooshing, pulsing, ocean waves, or buzzing. For millions of Americans, tinnitus becomes more than an annoyance. Chronic tinnitus can leave an individual feeling isolated and impaired in their ability to communicate with others. This isolation can cause anxiety, depression, and feelings of despair. Tinnitus affects an estimated 50 million, or more, people in the United States to some degree. Ten to 12 million are chronically affected and 1 million to 2 million are incapacitated by their tinnitus.[62] It is estimated that 250 million people worldwide experience tinnitus.[63]

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 and spiked sharply in the past 5 years. Since 2001, service-connected disability for tinnitus has increased alarmingly by 18 percent per year. Based on that five-year trend, by 2011 the number of vets receiving service-connected disability for tinnitus will near 1 million. Veterans with tinnitus may be awarded up to a 10 percent disability, which currently equals about $115 a month. Though it is considered to be a "disease of the ear" according to title 38, United States Code (the veterans disability rating handbook), only one "ear" is considered in determining disability rating for tinnitus.

Translated into economic terms, the government paid out nearly $539 million in disability compensation for tinnitus in 2006. If you couple that dollar amount with what was paid out for hearing loss disability compensation, the total is more than $1.5 billion for fiscal year 2006 alone. If tinnitus continues on the upward trend seen over the past five years, which has been compensated at an average annual rate of $53.6 million, the cost to taxpayers for tinnitus disability claims will reach $1.1 billion by 2011 and exceed $2 billion by 2020. This is one of the many reasons why the federal government needs to begin addressing this epidemic from an effective medical research and prevention standpoint.

Noise-Induced Hearing Loss and Tinnitus

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

According to the National Institute on Deafness and other Communication Disorders, any sounds that emit noise of 80 decibels (dBA) or higher can cause tinnitus and hearing damage. The National Institute for Occupational Safety and Health reports that prolonged exposure from sounds at 85+ dBA can also be damaging, depending on

the length of exposure time. 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. A single exposure at 140+ dBA may cause tinnitus and damage hearing immediately. The chart below shows a few common military operations and their associated noise levels.

Noise Levels—Common Military Operations

Type of Artillery	Position	Decibel Level (dBA) (Impulse Noise)
105mm 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

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

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

Many soldiers develop tinnitus and other hearing impairments prior to active combat as a result of training. If a soldier is disabled prior to combat, his or her effectiveness already may be compromised at the beginning of active duty. A study in Tank Gunner Performance and Hearing Impairment concluded that hearing impairments may delay a soldier's ability to identify his or her target by as much as 50 seconds.[64]

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

The Role of Medical Research

Research has increased our knowledge on hearing loss and how it comes about, while less has been discovered about tinnitus. We do know that tinnitus is a condition of the auditory system. The sound a person hears is actually generated in the brain. This raises another question of a possible correlation with TBI. Traumatic brain injuries are the signature wound of these current conflicts. Of 692 TBI patients at Walter Reed Army Medical Center between January 2003 and March 2006, nearly 90 percent had nonpenetrating head injuries (*National Geographic,* Dec. 2006).

Because tinnitus is something that happens in the brain, we now know that there is a correlation between tinnitus and TBI. However, the extent and epidemiology of the two conditions affecting each other will remain unknown unless the federal government funds more medical research as encouraged by *The Independent Budget* veterans services organizations (IBVSOs).

In FY 2005, VA funded about $4.4 million in auditory research. About 10 percent of that was spent on clinical research to learn best practices for treating veterans with tinnitus. Based on evidence from VA data, an audiological evaluation should be mandatory upon separation from the military.

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

In 2006, 390,933 veterans were disabled for tinnitus; however, VA estimates that it is likely that 3 million to 4 million veterans incurred tinnitus as a result of their time in the service.[65]

Recommendations:

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

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

Congress must increase funding for VA and the DOD to prevent, treat, and reverse tinnitus.

[61] Cave et al. 2007.
[62] Brown et al. 1990.
[63] Holme et al. 2005.
[64] Garinther & Peters, Army RD&A Bulletin, 1990.
[65] ncrar.research.va.gov.

Special Needs Veterans

Blinded Veterans:

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

The VA Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. VA currently operates 10 comprehensive residential blind rehabilitation centers (BRCs) located across the country with plans for 3 new BRCs, but these are pending construction projects. Currently approximately 47,438 blind veterans were enrolled in FY 2006 with the Visual Impairment Service Team (VIST) coordinators' offices, and projected demographic data estimate that by 2012 the VA system could sustain a rise to approximately 53,000 enrolled blind and visually impaired veterans requiring rehabilitative services.

The Independent Budget (IB) emphasizes that in addition to the above already enrolled blinded veterans, recent data compiled by the DOD show that 16 percent of wounded service members evacuated from Iraq had experienced eye injuries. As of August 2007 more than 1,168 combat wounded had sustained serious eye wounds with either moderate to severe visual injuries, with 230 already service connected for visual injuries within Veterans Benefits Administration. Approximately 52 of these service members have attended 1 of the 10 VA blind rehabilitation centers while others are in the process of being referred for admission. Nevertheless, *The Independent Budget* coauthors fear that many are unaccounted for and have become lost in the DOD system. A military eye trauma "center of excellence" and registry immediately need to be established and funded. The *IB* requests that Congress exercise greater oversight on the lack of tracking of these combat eye-injured service members from Operations Enduring and Iraqi Freedom (OEF/OIF) and those with dual sensory hearing and vision loss and create a "military eye-trauma registry."

As of November 14, 2007, the DOD reported 4,471 TBI-wounded, but by several estimates this number is probably low for TBI injury exposure screening.[66] VA has been stepping up its TBI screening, questioning all OEF/OIF service members who have returned from combat and entered the VA system. As a result, "VA found that of the 61,285 veterans screened since April 14, 2007, nearly 20 percent screened positive for traumatic brain injury symptoms."[67] The *IB* recommends specialized low-vision screening for neurological vision dysfunction if VA receives complaints of visual symptoms during TBI screening. When the VHA identifies more veterans with TBI, we can expect those veterans to turn to VA for low-vision care and rehabilitation.

One study at VA polytrauma center of veterans with TBI found that 63 percent of them had associated visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, and the inability to interpret print, with 4 percent of those cases resulting in legal blindness and other manifestations known as post-trauma vision syndrome (PTVS). This makes direct-combat eye trauma and TBI visual dysfunction the third most common injury from the current conflicts. In ad-

dition, many service members suffer from hearing loss associated with these blast injuries. *The Independent Budget* fully appreciates the increased funding of $12.5 million for FY 2008 to start to implement the VHA's plan for the full continuum of outpatient blind and low-vision programs because these outpatient programs can provide services to the TBI injured and the aging population of veterans with low vision or blindness.

Historically, the residential BRC program has been the primary option for severely visually impaired and blinded veterans to receive services. The VHA made the transition to increased outpatient primary care systems of health-care delivery in the 1990s, and the BRS needs to continue to make the same transition for blind rehabilitation services for veterans.

Currently, approximately 1,000 blinded veterans are waiting an average of 16 weeks for entrance into 1 of the 10 VA BRCs. Under the present system, many older veterans will not travel long distances to attend a residential BRC, so they do not receive any type of rehabilitation. *The Independent Budget* encourages directed funding of an additional $14,500,000 in FY 2009 for these new models of blind rehabilitation outpatient services and recommends encompassing the full spectrum of visual impairment services—blind rehabilitative outpatient specialists (BROS) and intermediate and advanced low-vision blind outpatient programs—so that these various new services could screen those service members with high risk or history of traumatic brain injury for TBI neurological visual complications that might otherwise be undiagnosed. This would be a cost-effective outpatient program for the aging population of veterans requiring these specialized services.

Congressionally mandated capacity must be maintained and the BRS must continue to provide for critical full-time employee equivalents (FTEEs) within each blind center to increase capacity to provide comprehensive residential blind rehabilitation services for those veterans requiring that care. Other critical BRS positions, such as the 93 full-time VIST coordinators and the current number of 35 BROS, must be increased and are necessary for all designated VA polytrauma centers. VIST and BROS teams are essential full-time positions, which, in addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center, also facilitate blind rehabilitation training in veterans' homes. They also assist in follow-up training and training for new technology when veterans return from a blind rehabilitation center.

Recommendations:

The Veterans Health Administration must restore the bed capacity and full staffing levels in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

The VHA must continue the implementation of the full continuum of outpatient programs for blinded and low-vision veterans, which Secretary Nicholson promised in January 2007, at a cost of $45 million over three years.

Congress must create a DOD military eye-trauma "center of excellence" and "eye-trauma registry" that electronically exchange information with eye care professionals within the VHA to improve seamless transition.

The Congressionally Directed Peer Medical Research Program must continue to include eye and vision research in the DOD appropriation for FY 2009, and Congress should authorize more VHA-DOD research funding on eye trauma.

The VHA must require the networks to restore clinical staff resources in inpatient blind rehabilitation centers and increase the number of full-time VIST coordinators.

VHA headquarters must undertake aggressive oversight of the FY 2008 appropriation and include an additional $14.5 million to ensure that the full continuum of care for blind services is started.

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

[66] "Zoroya, G. "20,000 vets' brain injury not listed in Pentagon tally," *USA Today*, November 22, 2007.

[67] "Akaka Reacts to New Data on Combat Traumatic Brain Injury," Press release, Nov. 1, 2007, Veterans' Affairs Committee.

SPINAL CORD DYSFUNCTION:

The continuum of care model for quality health care delivered to the patient with spinal cord injury or dysfunction (SCI/D) continues to be hindered by the lack of trained staff to support the mission of the SCI/D program.

SCI/D Leadership

The continuum of care model for the treatment of veterans with SCI/D has been established in a "hub-and-spokes" model. This model has proved to work very well as long as all patients are seen by qualified SCI/D-trained staff. As a result of staff turnover and the need for better coordination and ongoing training with oversight by the "hub" facility, there is a general lack of understanding in outlying "spoke" facilities. Not all SCI/D patients have the advantage of appropriate and timely referrals, consults, and annual evaluations in a SCI/D center.

This is further complicated by confusion as to where veterans with spinal cord diseases, such as multiple sclerosis (MS) and ALS (Lou Gehrig's disease) are to go for care that restores and maintains function. Some SCI/D centers treat these patients, while others deny them 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. While admission to an SCI/D center may not be appropriate for all SCI/D veterans, a care model must be developed to follow these veterans through their illness with a protocol that meets the treatment needs of the patient.

Nursing Staff

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

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

A consistent national policy of salary enhancement should be implemented across the country to ensure that qualified staff are recruited. Funding to support this initiative should be made available from the network or central office in order to supplement the operating budgets of these medical facilities.

Patient Classification

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

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

Nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.1 and VHA Directive 2005-001. It was derived on 71 FTEEs per 50 staffed beds, based

on an average category III SCI/D patient. Currently, nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

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

At the end of fiscal year 2007 nurse staffing was 1,315. This number is 32.6 FTEEs short of the mandated requirement of 1,347.6. Considering that some facilities are staffed to meet the actual acuity level (above minimum levels), the real shortage is 67.9 nursing staff for the remaining centers to meet minimum staffing levels. The 1315 FTEEs includes nursing administrators, non-bedside RNs (77.5), and light-duty staff (39). Removing the administrators and light-duty staff makes the total number of nursing personnel 1198.5 FTEEs to provide bedside nursing care. This coupled with the shortage of 67.9 FTEEs reveals a shortfall of 217 nursing FTEEs to meet the mandated requirement of 1,347.6.

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio of professional nurses to other nursing personnel. There are 509.9 RNs working in SCI/D. Out of that, 77.5 are in non-bedside or administrative positions, leaving 432.4 RNs providing bedside nursing care. With 1,315 nursing personnel, 509.9 of which are RNs, this leaves an RN ratio of 39 percent to provide bedside nursing care. If the non-bedside RNs were excluded, the percentage of RNs drops to 35 percent. These numbers are well below the mandated 50 percent RN ratio.

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

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

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

Recommendations:

The Veterans Health Administration should ensure that the SCI/D continuum of care model is available to all SCI/D veterans across the country. VA must also continue mandatory national training for the "spoke" facilities.

VA should develop a comprehensive continuum of care model for SCI/D patients to include diseases of the neurological system, such as MS and ALS.

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

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

Gulf War Veterans:

VA must aggressively pursue answers to the health consequences of veterans' Gulf War service. VA cannot reduce its commitment to Veterans Health Administration (VHA) programs that address health care and research or Veterans Benefits Administration (VBA) 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 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 reserve and National Guard members 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. During deployment, Gulf War veterans reported a wide variety of chronic illnesses and disabilities after their military service. Many Gulf War veterans have been diagnosed with chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, and gastrointestinal problems. The multisystem condition or constellation of symptoms has often been referred to as Gulf War syndrome, Gulf War illness, or Gulf War veterans' illnesses; however, no single unique illness has been definitely identified that explains the complaints of all veterans who fit this description. Both the DOD and VA have invested in providing health care, research, and benefits to address the concerns of Gulf War veterans and their families. These efforts have flagged in the past months as other veterans' issues have captured the attention of Congress and the federal agencies. However, 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.

Since the Gulf War, federal agencies have sponsored numerous research projects related to Gulf War illnesses. VA testified that that as of September 30, 2006, VA, the DOD, and the Department of Health and Human Services have funded 330 research projects related to Gulf War illnesses, totaling $314 million. As current troops in Iraq continue to fight in the same areas as our Gulf War veterans, VA's response to this unique situation was to broaden the scope of Gulf War illness research to include "deployment-related health research." In reviewing VA-funded research on Gulf War illnesses, the Research Advisory Committee on Gulf War Veterans' Illnesses has raised questions on the nature of some VA-funded research as to whether these research projects will directly benefit veterans suffering from Gulf War illnesses by answering questions most relevant to their illnesses and injuries. The IBVSOs are concerned that the decision to change the direction of Gulf War illness research will dilute its focus and divert attention to the admittedly urgent issues faced by newer veterans of Operations Enduring and Iraqi Freedom (OEF/OIF), instead of into this critical area. The IBVSOs believe that the federal research budget needs to prioritize investigations in both post-deployment groups.

While it is unclear whether veterans of the current Southwest Asia conflict should be categorically grouped with veterans of the first Gulf War for purposes of VA research on Gulf War illnesses, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of the other.

At the September 25, 2007, Senate Veterans' Affairs Committee hearing on Gulf War illness, Dr. Lea Steele, scientific director of the Research Advisory Committee on Gulf War Veterans' Illnesses (advisory committee), highlighted its key findings to date:

- Gulf War illness is real and affects a large number of veterans from the 1991 Gulf War.
- Gulf War illnesses are not caused by psychological stress.
- There are established links between Gulf War illness and exposure to neurotoxins—including pyridostigmine bromide (PB), pesticides, and nerve agents.
- There are no effective treatments for Gulf War illness to date for thousands of veterans who are seriously ill.[68]

These findings by the advisory committee may be correct, but they remain controversial and contentious.

Preeminent, respected scientists continue to debate the accuracy of some of the advisory committee's conclusions, especially in making such definitive statements, and many would openly disagree. While the IBVSOs recognize the disagreements within the scientific community, the state of the science is such that the basic epidemiological, physiological, and psychological information necessary to obtain definitive answers is simply not available. However, our position is clear: Gulf War illness *is* real, and efforts should continue to resolve scientific questions about the effects of all exposures and the underlying causes of the health consequences of service in the 1991 Gulf War. *The Independent Budget* position is that all combat environments are hostile and traumatic; consequently, some Gulf War veterans *have* suffered the consequences of combat-related stress, and their bravery in dealing with the aftermath of service should be neither discounted nor 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.

In 1998, Congress passed PL 105-277 and PL 105-368. These acts established authorities for new health-care and research programs in VA, and directed VA to enter into contracts with the National Academy of Science Institute of Medicine (IOM) to review and evaluate the scientific and medical literature regarding associations between the illnesses of Gulf War veterans and their exposures during deployment. Since that time, the IOM has published six reports on Gulf War and health. Among that series, *Volume 4, Health Effects of Serving in the Gulf War*, found that Gulf War veterans report higher rates of nearly all symptoms than veterans who were not deployed to Operations Desert Storm/Desert Shield. Gulf War veterans suffered from a higher prevalence not only of individual symptoms but also of chronic multisymptom, multisystem illnesses, according to the study. The medical and scientific literature indicated that chronic multisymptom illnesses, such as fibromyalgia, chronic fatigue syndrome, and multiple chemical sensitivity, occurred more frequently in deployed versus nondeployed veterans. As experienced by veterans of all previous combat, deployed Gulf War veterans were at higher risk for psychological symptoms that met diagnostic criteria for PTSD, other anxiety disorders, depression, and substance abuse.[69] In November 2007, the IOM released *Gulf War and Health: Vol. 6. Physiologic, Psychologic and Psychosocial Effects of Deployment-related Stress*. In completing its investigation, the committee reviewed about 3,000 studies of World War II, Korean War, Vietnam War, Gulf War, and OEF/OIF veterans to draw its conclusions. The advisory committee found that there was sufficient evidence of an association between deployment to a war zone and the following:

- psychiatric disease, including PTSD, other anxiety disorders, and depression;
- alcohol abuse;
- accidental death in early years post-deployment;
- suicide in the early years post-deployment; and
- marital and family conflicts.

In addition, the IOM found that there was suggestive evidence of an association with drug abuse, chronic fatigue syndrome, functional gastrointestinal disorders, skin disorders, fibromyalgia and chronic widespread pain, increased symptom reporting, unexplained illnesses—and incarceration. An important contribution of this report is the advisory committee's review of recent research that investigated the nervous system and endocrine and immune responses to stressors. Investigations have shown that when a stressor is eliminated, the stress response may be turned off very slowly or not at all. The long-term exposure to the secondary effects of prolonged activation has serious health consequences. Under this response, the brain activates the heart, lungs, immune, liver, and gastrointestinal systems. If the response is not turned off, prolonged and serious symptoms and illness are possible. There is evidence that these physiologic effects are influenced by genetics, environmental factors, and genetic-environmental interactions. Research into these complex systems has implicated them in development of obesity, hypertension, diabetes, heart disease, chronic pain syndromes, and cognitive problems.[70] This promising research has far-reaching implications for Gulf War and all other veterans and should be vigorously pursued by the National Institutes of Health, the DOD, and VA without delay. Congress should hold hearings and develop budgetary and legislative initiatives to support this effort.

In every military conflict of the 20th and 21st centuries, veterans have faced serious illness or injuries as a consequence of their service to our nation. Each war has given rise to multisystem symptoms; however, because no specific syndrome can be identified, many have faced similar problems attempting to gain recognition of their health conditions as service-connected.[71] With respect to Gulf War veterans, even after countless studies and extensive research, there are many unanswered ques-

tions. Accordingly, the IBVSOs urge that Congress reauthorize section 1710(e)(3)(B) of title 38, United States Code, thus reinstating VA health-care eligibility for veterans who served in Southwest Asia during the 1991 Gulf War who may not have been able to gain eligibility through any other authorities. In recognition of the strength of evidence connecting combat service to serious post-deployment health conditions, we strongly recommend establishment of permanent eligibility for VA health care for all combat veterans. It is VA's obligation to assist Gulf War veterans who are sick as a result of their wartime service. In all likelihood, combat veterans of other U.S. wars have experienced many similar symptoms that have gone unrecognized, uncompensated, and untreated.

Recommendations:

Congress should ensure that sufficient, dedicated funding is provided for research into the health consequences of Gulf War veterans' service. The unique issues faced by Gulf War veterans should not be lost in the urgency to address other issues related to armed forces personnel currently deployed.

VA should continue to foster and maintain a close working relationship with the National Academy's Institute of Medicine in an effort to determine the best treatments for Gulf War veterans' illnesses and the effects of toxic exposures, trauma, and stress on the health of Gulf War veterans. Congress should allocate new research funding to implement the recommendations of the IOM in these areas.

VA and the DOD should review and comment on the recommendations from the Gulf War Veterans Advisory Committee, the IOM, and other organizations, such as the Government Accountability Office.

Congress and VA should review the evidence connecting combat exposure to serious post-deployment health conditions, and take three actions:

- Immediately reinstate expired statutory authority in title 38, United States Code, section 1710(e)(3)(B) for VA health-care eligibility for Gulf War combat veterans;
- Establish permanent eligibility for VA health care for *all* combat veterans; and
- Consider new policy creating presumptive service-connection for the health conditions found by the IOM to be associated with exposure to combat stress.

[68] Steele, Lea, Ph.D. Testimony, Committee on Veterans' Affairs, United States Senate, Washington, DC, September 25, 2007.
[69] *Gulf War and Health: Volume 4. Health Effects of Serving in the Gulf War. National Academy Press,* Washington DC. September 2006.
[70] *Gulf War and Health: Vol. 6. Physiologic, Psychologic and Psychosocial Effects of Deployment-related Stress.* National Academy Press, Washington, DC November 2007.
[71] Hyams, K.C., Wignall, S., Roswell, R. War Syndromes and their Evaluation: From the U.S. Civil War to the Persian Gulf War. *Annals of Internal Medicine;* 125(5): 398–405.

LUNG CANCER SCREENING AND EARLY DISEASE MANAGEMENT PROGRAM:

VA should conduct a screening program for veterans at high risk for lung cancer.

Overall Impact

Lung cancer continues to be the number one cancer killer, causing 30 percent of all cancer deaths and taking more lives each year than breast, prostate, colon, kidney, melanoma, and liver cancers combined. More than half of all new cases are being diagnosed in former smokers, many of whom quit decades ago. Another 10 percent to 15 percent have never smoked. With higher smoking rates than the civilian population, as well as increased exposure to Agent Orange, asbestos, beryllium, nuclear emissions, propellants, and other environmental toxins, veterans are at higher risk.

High Mortality Rate

Since Congress passed the National Cancer Act of 1971, the five-year survival rates for the three other most com-

mon cancers—breast, prostate, and colon—have risen to 88 percent, 99 percent, and 65 percent, respectively. These greatly improved survival rates are reflective of the significant federal investment in research and early detection for those cancers and widely promoted screening tests (mammograms, PSA testing, and colonoscopies). By contrast, lung cancer research and early detection has been consistently underfunded, and its five-year survival rate is still only 15 percent. Lung cancer is a slow-growing cancer, the symptoms of which rarely become evident until late stage. Only 16 percent of lung cancers are being diagnosed at its earliest, most treatable stage.

Impact on Military and Veteran Populations

The DOD routinely distributed free cigarettes and included cigarettes in K-rations until 1976. The 1997 Harris Report to VA 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. More than 70 percent of Vietnam veterans have ever smoked, twice the civilian rate of 35 percent. Asbestos on submarines, Agent Orange, Gulf War battlefield emissions, and other toxins are also carcinogenic factors that add to the overall exposure burden. A 2004 report by the Health Promotion (HPDP) of the Institute of Medicine, titled “Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer,” concluded that the presumptive period for lung cancer is 50 years or more. Another HPDP report in 2005, *Gulf War and Health: Vol. 3, Fuels, Combustion Products and Propellants*, concluded that sufficient evidence existed for an association with lung cancer. Given that lung cancer is an indolent cancer that takes decades to develop, the burden of treatment will fall most heavily on VA. Without screening, more than 70 percent of lung cancer is being diagnosed at late stage, and most patients will die within a year. Late stage lung cancer is twice as costly to treat as early stage.

Department of Defense and Cancer Research

In 1991, Congress initiated the Congressionally Directed Medical Research Program. From FY 1992 to FY 2007, appropriations have totaled $4.36 billion, including $2.1 billion for breast cancer research, $810 million for prostate cancer, $111.7 million for ovarian cancer, and $22 million for leukemia. Smaller miscellaneous amounts have been occasionally earmarked for other cancers. In 2005, lung cancer biomarker research received $1 million in funding.

Department of Energy and Lung Cancer

Munitions plant workers have been routinely screened for lung cancer since the Worker Health Protection Program was authorized in the Department of Defense Authorization Act of 1993 and funded through the Office of Environment, Safety, and Health of the Department of Energy.

Justification

On October 26, 2006, the *New England Journal of Medicine* published the results of a 13-year study on screening for lung cancer with CT scanners of 31,500 asymptomatic people at high risk. The International Early Lung Cancer Action Project (I-ELCAP) was carried out by multidisciplinary groups at 40 centers in 26 states and 6 foreign countries. Lung cancer was diagnosed in 484 participants, 85 percent at stage 1 (versus 16 percent nationally), and those treated promptly had 10-year survival rates of 92 percent (versus the national 5-year survival rate of 15 percent). The study, now expanded to 44 sites in the United States and 8 foreign countries, is still ongoing, and data continue to be collected to validate the efficacy of screening. By partnering with those sites and utilizing the robust diagnostic protocol I-ELCAP has developed over the years, VA could expedite implementation of the pilot screening program for veterans at high risk with a broad geographic reach and with significant cost savings.

2007 Legislative History

On August 2, 2007, the Senate passed S. Res. 87, expressing the sense of the Senate that the President should declare lung cancer a public heath priority and implement a comprehensive interagency task force to reduce the mortality rate for lung cancer by 50 percent by 2015. The resolution specifically cited the serious problems of tobacco addiction and exposure among military personnel and veterans, and called for the DOD and VA to develop a lung cancer screening and disease management program.

On November 13, 2007, the House of Representatives passed H.R. 335, which also cited concerns about lung cancer risk among the military and supported the development of a screening program for the military and veterans. In addition, Senate Report 110-85 accompanying the FY 2008 appropriations bill for Military Construction and Veterans Affairs and Related Agencies included the following language:

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

Recommendations:

VA should request and Congress should appropriate at least $3 million in FY 2009 to conduct a pilot screening program for veterans at high risk of developing lung cancer.

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

Women Veterans Health and Health-Care Programs:

The number of women veterans will change dramatically over the next decade and is likely to double in less than five years. This demographic change will present challenges, and an important opportunity, for the VA health-care system. VA must consistently provide comprehensive, quality women's health services across the continuum of care at all its facilities.

Women have played a vital part in the military service since the birth of our nation. In the past 50 years, their roles, responsibilities, and numbers have increased. Current estimates indicate that there are 1.7 million women veterans comprising 7 percent of the United States veteran population. According to the DOD, women service members represent approximately 17 percent of active duty deployed forces and represent a rapidly expanding segment of the veteran population.

Historically, women have represented a small numerical minority of veterans who receive health care at VA facilities. However, if the women veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) continue to enroll at the current enrollment rate of 39 percent, it is estimated that the number of women using VA health-care services will double in less than five years. Women will still remain a numerical minority in VA, so the overall effect of these increases will be small; however, the impact on the programs and staff who serve the unique needs of women will be very heavy. Absent significant reforms, women veterans will be unable to maintain their current level of access. Women veteran program managers (WVPMs) are a key component to addressing the specialized needs of women veterans. At a minimum, VA should ensure that every VA medical center (VAMC) and large community-based outpatient clinic has a full-time WVPM. At present, only 8 percent of VAMCs meet this minimum standard, with the remainder of WVPMs serving in collateral roles. VA needs to develop a comprehensive strategy and action plan to address this projected exponential growth.

The women who served in the global war on terrorism make up an important and growing segment of the veterans population. Based on DOD rosters received through July 27, 2007, there are a total of 751,273 military members who served in Iraq or Afghanistan and have since separated from active duty. There are 83,593 women who have deployed to these combat theaters; 89 percent were enlisted personnel who served in almost equal numbers on active duty and National Guard/reserve components. Eighty-five percent of women who served in OEF/OIF are under the age of 40, and 40 percent are of nonwhite race or ethnicity.

During the past five years, 39 percent of separated women have used VA health-care services, with 82.7 percent having two or more VA clinic visits, and 35.3 percent being seen more than 11 times in ambulatory care. The top five diagnostic categories that brought these veterans to VA care were diseases of the musculoskeletal system and connective tissue; signs, symptoms, and ill-defined conditions; diseases of the digestive system; mental disorders; and diseases of the genitourinary system.[72] *The Independent Budget* veterans service organizations (IBVSOs) are pleased that VA is attempting to address the needs of women returning from combat theaters. However, the health consequences of service by women in a combat theater are largely unknown because no long-term women's health studies have been conducted that focus on these unique issues. Rare events, such as cancers and birth defects, cannot be investigated without a dedicated, longitudinal women's health study that has adequate sample size and representative population. The current deployment provides a unique opportunity to address these important questions, and we strongly urge that VA and Congress oversee and fund this research.

Recent research studies have demonstrated that women veterans use outpatient services more heavily than men, especially middle-aged women and those with comorbid mental health conditions. Women veterans who use VA health care are younger than men, averaging 50.1 years and 63.6 years, respectively, and are also more likely to be unmarried, have a service-connected disability, have a mental health diagnosis, use more outpatient care, and have higher outpatient and pharmacy costs. During FY 2002 only 6.6 percent of men used fee-basis care, compared to 19.4 percent of women; these differences likely reflect the variable ability of VA facilities to provide comprehensive women's health services. In addition, women are much more likely to have experienced sexual trauma while serving in the military, which has been shown to have significant long-term effects on burden of illness and health-care utilization.[73]

Despite the increasing number of women coming to VA for health care, fully 90 percent of eligible women veterans are not enrolled in VA's health-care system. Research finds that women who have not been using the VA health-care system experience many barriers to accessing VA care, the most significant ones being lack of knowledge about eligibility and benefits and the perception that VA's system is not "welcoming" to them. These initial results warrant further study to better understand women's reasons for seeking care elsewhere.

The VA system was designed to provide health care to the predominantly male population it has traditionally served. Despite concerted efforts by VA, privacy and safety issues have not been universally addressed to date. In 2003, VA issued Handbook 1330, and mandated minimum levels of women's health services to be provided by each VA facility, independent clinic, and community-based outpatient clinic: Unfortunately, a loophole exists in this policy, which states that these services shall be provided "where feasible." However, quality of care measures for both cervical cancer screening and breast cancer screening ensure that at least some gender-specific care is provided to women veterans at each Veterans Health Administration (VHA) facility. Today, women are receiving services in a variety of clinic settings, including physically separate, specialized comprehensive women's centers, partially integrated gender-neutral primary care, gender-specific care as separate clinic stops, and in "virtual" women's clinics.

The availability and the quality of this care vary widely across the VA health system, creating inequities in quality and service levels. Today's reality is that women veterans cannot be sure that their needs will be consistently met. In FY 2006, VHA survey results indicated that facilities were using the following models for provision of care to women veterans:

- Separate women's health center providing comprehensive, multidisciplinary care that includes primary care, gender-specific care, mental health services, and surgical services (i.e., breast clinic or gynecology/colposcopy clinic) within a designated space (14 percent).
- Separate women's health center providing primary care and gender-specific care within a designated space (19 percent).
- Separate gender-specific and/or gynecology clinic, primary care provided in a designated women's primary care team within the facility (8 percent).
- Separate gender-specific and/or gynecology clinic, primary care provided in mixed-gender primary care teams within the facility (43 percent).
- Integrated gender-specific and primary care provided in mixed-gender primary care teams within the facility (16 percent).

VA women's health researchers have also investigated which models of care deliver better quality and patient satisfaction. Results clearly indicate that women veter-

ans are significantly more satisfied with women's health providers, especially when care is provided by 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 that of 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. Given these findings, the IBVSOs strongly support providing training to dedicated VA staff to increase their expertise in women's health care. VA should have at least one provider with women's health care expertise at every medical facility.

The IBVSOs were distressed to learn that VA performance data indicate that currently women get lower quality care than men and are not consistently receiving the recommended evidence-based health-care services that meet current VA standards.[74] These are potentially serious deficiencies that increase the women veterans' risk of serious illness and death. We understand VA is working to address these identified health-care disparities faced by women veterans and urge VA leadership to devote additional resources and attention to this problem until it is resolved. In order to give the IBVSOs, veterans, and other stakeholders confidence that health-care quality and access issues are being addressed, VA should begin to provide Veterans Integrated Service Network facility-level quarterly performance reports that are stratified by gender and report them in an easily accessible, public, and transparent manner. VA has been lauded for the overall quality of its health-care services. All veterans should be actively engaged in their health care and track the quality of services that they receive. In order to ensure the highest quality of care, veterans and other stakeholders must have easy access to publicly reported performance measurement data.

The women veteran population is predominantly pre-retirement and of childbearing age. Birth defects and potential exposure to teratogenic agents (which cause developmental deformities) must be addressed as a critical health-care quality and safety issue for women veterans. VA health-care providers should question women about sexual function, reproductive issues, health promotion, and disease prevention issues, and prescribe folate, calcium, and vitamin D supplements as appropriate. 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 the pharmacy package to provide alerts for potential teratogens prescribed to women veterans under 50 years old. The IBVSOs believe strongly that VA must immediately add functionality to its electronic health record pharmacy package so that providers receive alerts concerning potential teratogenicity of pharmaceuticals being provided and so that alternative choices can be offered to women. Equally critical is that every VA facility should have the ability to obtain an urgent beta-HCG pregnancy test so that health care decisions can be made swiftly without endangering the veteran or fetus. VA health-care providers also need to be sensitized to the significant health-care access barriers that women face as often unmarried, employed heads of households, parents, and caregivers. VA should develop a pilot program to provide child care services to veterans who are the primary caregivers of children, while they receive intensive health care services for post-traumatic stress disorder (PTSD), mental health, and other therapeutic programs requiring privacy and confidentiality.

Given the increasing role of women in combat and with almost 40 percent of OEF/OIF veterans coming to VA for health care, access to quality mental health services is critical. These issues are especially important for women who deployed to a combat theater or those who suffered sexual trauma during military service. The scientific literature is clear that women veterans report higher rates of sexual assault than their civilian counterparts and that there is a high prevalence of sexual assault and harassment among women using VA services. VHA staff need to be sensitive, knowledgeable, and recognize the importance of environment of care delivery when evaluating women veterans for their physical and mental health conditions. We encourage the VHA to develop a military sexual trauma provider certification program, provide separate women's subunits for inpatient mental health and residential services, and improve the coordination with the DOD on transition of women veterans, especially those with behavioral health needs.

In 2007, VA's National Center for PTSD published the first-ever randomized controlled trial to assess PTSD treatment for active duty and veteran women. In this study the women who received prolonged exposure therapy had a greater reduction of PTSD symptoms, to no longer meet criteria for a diagnosis of PTSD and to

achieve complete remission of their PTSD. Prolonged exposure therapy is proven effective for women veterans with PTSD.[75] Current clinical practice guidelines for PTSD recommend prolonged exposure and other cognitive behavior therapies; however, these treatments are rarely used. This study has documented the importance of spreading this evidence-based practice throughout VA's system. Considering the high prevalence of PTSD in OEF/OIF as well as older veterans, VA needs to develop an efficient and effective program to train its mental health providers to provide prolonged exposure cognitive behavioral therapy.

Summary

Women's health care is fragmented. More than 37 percent of women veterans receive dual-use VA and non-VA care. VA should improve its case management and care coordination of women veterans, especially those with comorbid mental health conditions. VA should assess and develop a plan to enhance the provision of integrated primary care, specialty care, readjustment services, and related mental health services for women veterans at VA's Vet Centers. In addition, collaborative care models incorporating mental health providers should be piloted in the ambulatory care clinics where women receive their care.

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. VA must step up its planning efforts and develop a comprehensive plan to address the increased overall demands on ambulatory care, hospital and long-term care, gender-specific services, and mental health programs. As the population of women veterans undergoes exponential growth in the next decade, VA must act now to prepare to meet the specialized needs of the women who served. Increases in the number of WVPMs and training to increase staff knowledge of the state of the art in women's health and mental health care and treatment should be implemented this year. The IBVSOs also recommend that VA focus its women's health research agenda on a longitudinal health study of women who served in Iraq and Afghanistan. Such a study could prove invaluable as a source of information to help VA address a growing burden in the care of women who serve.

Recommendations:

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 enhance its health-care demand model to address women veterans' health. Recent studies of utilization patterns by women veterans suggest that the numbers of users of women veterans' health care will double in less than five years. VA should address these unprecedented increases by modeling demand for gender-specific health services and stratifying demand by gender.

VA needs to develop enhanced training programs for women health providers and support at least one full-time expert in women's health at every VA medical center (VAMC).

VA health-care providers should make every effort to reduce women's unnecessary exposure to radiation and pharmaceutical teratogens. VA should facilitate providers' ability to identify compounds associated with an increased risk of birth defects and immediately revise the pharmacy package to provide alerts for potential teratogens to prescribe to women veterans younger than 50 years of age.

Every VAMC should be provided sufficient resources to make VA women veterans program managers full-time positions.

VA should fund a study either under contract with a qualified independent entity or in collaboration with a university affiliate for a long-term study of women who served in OEF/OIF. The research would investigate the health consequences of service in Iraq and Afghanistan using both a telephone survey and health examinations of deployed and nondeployed women veterans.

VA should contract with a qualified independent entity for a comprehensive study of the barriers experienced by recently discharged women veterans. The study would explore their perceptions of, and experiences when accessing, health-care services at VA facilities.

VA should conduct a comprehensive assessment of its women veterans' health programs and report findings to Congress, along with an action plan to improve

quality and reduce disparities in health-care services for women receiving VA care. The Government Accountability Office should review and report to Congress on the results of VA's assessment.

VA's sexual trauma programs should be enhanced by requiring consistent training and certification of health-care personnel across all medical and mental health disciplines on techniques for screening women at risk for military sexual trauma, effective care and treatment options, and evidence-based clinical practice guidelines for victims of sexual trauma.

VA should assess and develop a plan to enhance the provision of integrated readjustment and related mental health care services for women veterans at VA's Vet Centers.

VA should develop a pilot program to provide child care services for veterans who are the primary caregivers of children, while these women receive intensive health care services for PTSD, mental health, and other therapeutic programs requiring privacy and confidentiality.

VA should develop a pilot program to provide counseling, transition assistance, and reintegration assistance for newly separated women veterans in a group retreat setting.

VA's Women Veterans Advisory and Minority Veterans Advisory Committees should include veterans who served in Afghanistan or Iraq.

[72] Kang, Han, VHA Office of Public Health and Environmental Hazards, Environmental Epidemiology Service. "VA Healthcare Utilization Among 85,539 Female OIF/OEF Veterans through 3rd Qtr FY2007," August 20, 2007.
[73] Frayne, S.M., Yu, W., Yano, E.M., et al. "Gender and Use of Care: Planning for Tomorrow's Veterans Health Administration." *Journal of Women's Health,* 2006; 16: 1188–1199.
[74] Personal communications with VHA staff.
[75] Schnurr, P.P., Friedman, M.J., Engel, C.C., et al. Cognitive Behavior Therapy for Post-traumatic Stress Disorder in Women. A Randomized Controlled Trial. *JAMA*, 2007; 297(8):820–830.

Ending Homelessness Among Veterans:

VA must provide a comprehensive array of services, including preventative services, to ensure that fewer veterans experience chronic homelessness.

In 2006, VA reported the number of homeless veterans on any given day increased by 0.8 percent from 194,254 in 2005 to 195,827. According to Department of Housing and Urban Development (HUD) Continuum of Care data, of the 495,400 homeless people in America, roughly 26 percent are veterans. The Government Accountability Office reports between 44,000 and 64,000 veterans are chronically homeless.

VA reports that 97 percent of homeless veterans are male and 3 percent are female. The vast majority of homeless veterans are single, although service providers are reporting an increased number of veterans with children seeking their assistance. About half of all homeless veterans have a mental illness, and more than two-thirds suffer from alcohol or other substance abuse problems. Nearly 40 percent have both psychiatric and substance abuse disorders. Additionally, VA reports that the majority of women in homeless veteran programs have serious trauma histories, some life-threatening, and many of these women have reported experiencing physical harassment and/or sexual assault while serving in the military.

According to VA, male veterans are 1.3 times more likely to become homeless than their nonveteran counterparts, and female veterans are 3.6 times more likely to become homeless than their nonveteran counterparts. As compared to nonveterans, veterans are at high risk of homelessness as a result of having extremely low or no livable income, the extreme shortage of affordable housing, and a lack of access to health care. These factors put veterans at even greater risk of homelessness.

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. Veterans of the conflicts in Afghanistan and Iraq also likely suffer disproportionately from traumatic brain injury. These conditions can interrupt their ability to keep a job, establish savings, and, in some cases, main-

tain family harmony. Veterans' family, social, and professional networks may have been broken due to extensive mobility while in military service or lengthy periods away from their hometowns and their civilian jobs. Oftentimes these problems are directly traceable to their experience in military service or to their return to civilian society without having had appropriate transitional support.

While most Americans believe our nation's veterans are well-supported, the fact is that many go without the services they require but are eligible to receive. According to a Congressional staff analysis of 2000 U.S. Census data conducted in 2005, 1.5 million veterans—nearly 6.3 percent of the nation's veteran population—have incomes that fall below the federal poverty level, including 634,000 with incomes below 50 percent of poverty. Neither VA nor its state and county equivalents are adequately funded to respond to these veterans' health, housing, and supportive services needs. Moreover, community-based and faith-based service providers also lack sufficient resources.

VA reports its homeless programs serve 100,000 veterans annually. National Coalition for Homeless Veterans (NCHV) member community-based organizations serve 150,000 annually. With an estimated 400,000 veterans experiencing homelessness at some time during the year, and VA reaching only 25 percent and community-based organizations reaching approximately 35 percent of those in need, there are substantial numbers of veterans who do not receive the help they need to transition out of homelessness and reenter society as productive citizens. Likewise, other federal, state, and local public agencies—notably housing agencies and health departments—are not adequately responding to the housing, health-care, and supportive services needs of these vulnerable veterans. Indeed, it appears veterans fail to register as a target group for these agencies in many communities.

The reported increase in the number of homeless veterans in 2006 suggests the homeless veteran population in America may be experiencing significant changes. Homeless veterans receiving services today are aging and the percentage of women veterans seeking services is growing. The VA reports about 1,400 homeless veterans have been treated at VA medical centers—and of that number, 4 percent are women.

This new generation of war veterans is beginning to trickle into VA and community-based homeless veterans service provider organizations in search of such services as health care, substance abuse prevention, disability compensation, vocational rehabilitation, affordable housing, employment training, and job placement assistance. Poverty, lack of support from family and friends, and unstable living conditions in overcrowded or substandard housing may be contributing factors. Additionally, 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, new and more comprehensive services, housing, and child care services are needed. In the next 10 years, significant increases in services over current levels will be needed to serve aging Vietnam veterans, women veterans, and combat veterans of America's current operations in Afghanistan and Iraq.

Recommendations:

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

VA should improve its outreach efforts to help ensure homeless veterans gain access to VA health and benefits programs.

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

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

Congress should increase the authorization level of and appropriations for the Homeless Veterans Reintegration Program (HVRP). Funded by the U.S. Department of Labor-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 commu-

nity-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

Congress should increase appropriations for Veterans Workforce Investment Program (VWIP). Funded by the DOL, 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 establish a "veterans work opportunity tax credit" program. The program would, as an incentive to hiring veterans, provide employers a tax credit equal to a percentage of the wage paid to the homeless or other low-income veteran.

Congress should increase the authorization level of and appropriations for the VA Homeless Provider Grant and Per Diem program (GPD) to meet the demands for transitional housing assistance. GPD provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans. Special needs grant funding under this program should increase for women veterans, frail and elderly veterans, veterans with chronic mental illness, and those who are terminally ill.

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

Congress should establish additional domiciliary care capacity for homeless veterans within the VA system or via contractual arrangements with community-based providers when such services are not available within VA.

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

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

Congress should require applicants for HUD McKinney-Vento homeless assistance funds to develop specific plans for housing and services to homeless veterans. Organizations receiving HUD McKinney-Vento homeless assistance funds should screen all participants for military service and make referrals as appropriate to VA and homeless veterans service providers.

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

Congress should assess 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 provision of information about VA resources and assistance 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.

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

Long-Term Care Issues

Increasing Demand for VA Long-Term-Care Services

VA must be funded and mandated by law to provide long-term-care services (institutional and noninstitutional) to an aging veteran population and meet the needs of younger, catastrophically wounded veterans returning from Iraq and Afghanistan.

VA's Long-Term-Care (LTC) Strategic Plan

VA's Strategic Plan for Long-Term Care lacks specific detail regarding how it will align resources to meet the growing demand for institutional (nursing home) and noninstitutional (home and community-based) services.

If veterans were expecting a detailed roadmap with specific short-term solutions for current problems and clear waypoints along a longer path to meet the future demands for LTC services, they were disappointed. Instead of providing detailed information on alterations to existing programs and recommendations for innovative new services, VA's LTC plan focused instead on describing its array of existing programs and current policy approaches to service delivery.

Detailed action plans are usually the spine of any strategic planning initiative, but unfortunately they are not the backbone of VA's recent planning endeavor. The LTC plan lacks new policy initiatives and contains no VA directive action recommendations that require the field to close gaps in services. Additionally, VA's plan does not provide detailed (facility by facility) information regarding the location of catastrophically injured veterans. Population by Veterans Integrated Service Network (VISN) is not specific. The thrust of the Congressional mandate contained in PL 109-461 was designed to assist quality-of-care investigation and required a detailed report, not a VISN-by-VISN rollup. VA's Strategic LTC Plan is not a prescription for change but only a description of business as usual.

The Independent Budget veterans service organizations (IBVSOs) call upon the Committees on Veterans' Affairs to hold appropriate hearings on VA's LTC Strategic Plan. These Congressional hearings must include hard and specific LTC program questions designed to clearly understand how VA will move forward to meet current and future demand for services. For example: Exactly how will VA provide care to younger Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans who require nursing home care? How will VA long-term-care services interface with VA's new OEF/OIF care coordinator? Does VA ever expect to follow the Congressional average daily census (ADC) mandate for VA nursing home care? Can the state veterans' homes capacity continue to handle VA's shifted nursing home care workload? Does VA's new nursing home construction design set aside adequate accessible space for veterans with spinal cord injuries and other catastrophic disabilities? What is VA's long-range plan for new nursing home construction? Does VA have waiting lists for VA nursing home care? Are veterans receiving quality nursing home care in community facilities that contract with VA?

The Aging of America's Veteran Population

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

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

Despite this VA data, VA's FY 2006–2011 Strategic Plan does not identify the needs of an aging veteran population as one of the Secretary's priorities. *VA's plan has no specific objectives or performance measures directly related to long-term care*. Regarding long-term care, Dr. Michael J. Kussman, Under Secretary for

Health, says only, "The Veterans Health Administration (VHA) will expand its offerings of noninstitutional alternatives to nursing home care and the capabilities of home-based care programs."[76]

Disturbing VA Long-Term-Care Program Trend

Despite clear VA data that highlight the aging of the U.S. veteran population, VA's 2007 ADC data for its nursing home program reveals a reduction in the number of veterans served again this year. VA says little about the future direction of its nursing home care program in its strategic plan, but acknowledges it is working to shift more of its long-term-care workload toward its noninstitutional care programs. For many veterans this is a positive policy, but for many other elderly veterans it is not. VA must be judicial in its decisions that guide veterans to home and community-based options for care. *The Independent Budget* authors are concerned that a constrained VA budget is forcing VA to downsize its nursing home capacity and turn to less expensive noninstitutional care in order to meet the growing demand for services. *VA must not substitute noninstitutional care for institutional (nursing home) care just because it is less expensive to do so in order to serve a greater number of veterans.*

VA Institutional Care

VA Nursing Home Expenditures/Venues of Care

VA's 2008 budget requested $3,537 million to operate its three nursing home care programs (VA nursing homes, community nursing homes, and state veterans homes). The cost of nursing home care continues to trend upward despite VA's efforts to shift more of its nursing home care workload to the State Veterans Home Program.

extended-care facilities must be increased. VA must request and Congress must provide adequate funding for new construction and the necessary maintenance and repair of these facilities. The IBVSOs believe $200 million is needed to provide the necessary funding required to support state veterans' homes infrastructure in the 2009 budget grants line.

VA's Nursing Home Care Program

Today, VA's long-term-care program focus is concentrated on expanding noninstitutional care programs. It seems that VA is hoping the financial stress of providing nursing home care will simply go away. However, demand for nursing home care will continue to grow because of expanding life expectancies. Plus, many elderly veterans who are safely utilizing noninstitutional services today may not be able to tomorrow. VA must maintain a safe margin of nursing home beds that will meet the needs of America's oldest veterans and be capable of meeting the needs of other elderly veterans who can be expected to transition from VA noninstitutional care programs to nursing home care.

Average Daily Census (ADC) VA's Nursing Home Care Program	
1998	13,391 (Congressional mandated level)
2004	12,354
2005	11,548
2006	11,434
2007	10,926
ADC Decrease 2,465 (decrease from 1998 mandated level)	

VA Nursing Home Program Expenditure Comparison Chart (Dollars in Millions)				
Setting	**2005**	**2006**	**2007 CR***	**2008**
VA Home	$ 2,441	$ 2,351	$ 2,487	$ 2,608
Community Home	$ 352	$ 385	$ 402	$ 420
State Vet Home	$ 382	$ 440	$ 451	$ 509
Total	**$ 3,175**	**$ 3,176**	**$ 3,340**	**$ 3,537**

*Continuing Resolution

If VA plans to continue shifting more and more of its nursing home care workload, and recent trends reflect this intention, it must increase funding to support these alternatives. For example: VA's grants line item for state

VA is a nationally recognized leader in providing quality nursing home care, but its ADC is being reduced each year. Congress has mandated that VA must maintain its nursing home ADC at the 1998 level of 13,391,

but VA has not done so. VA's nursing home average daily census has continued to trend downward. VA has chosen to ignore the Congressional ADC mandate, and Congress has chosen to look the other way. Once again, VA has failed to meet the Congressional ADC mandate.

Special Programs for Younger OEF/OIF Combat-Injured Veterans

VA must move forward in the development of institutional care programming for young Operation Enduring Freedom and Operation Iraqi Freedom veterans whose combat injuries are so severe that they are forced to depend on VA for long-term nursing home care services.

An important factor to consider is that we are seeing extraordinarily disabled veterans coming home from Iraq and Afghanistan with levels of injury and disability unheard of in past wars. Our incredible military medical triage and its applied technology has saved them, and many of them are now in VA polytrauma centers or other acute care and rehabilitation facilities, but they present a medical and social challenge the likes of which VA has not seen before. We are fortunate that the numbers of these "polytraumatic" injured are relatively small, but we must be cognizant that some of them will need extraordinary care and shelter for the remainder of their lives. Neither VA nor these veterans' families are fully prepared today to deal with their longer-term needs, an issue we have addressed in other sections of this *Independent Budget*. In addition to establishing internal residential treatment and care capacity, the existing partnership between the states and VA might be the basis for the state veterans' homes to play a small but vital role in aiding some of these catastrophically injured veterans by providing them a homelike atmosphere, a caring environment, and the level of clinical services they are going to need for the remainder of their lives. Also, the state veterans' homes can offer a less intensive alternative to VA medical facilities in serving as a source of respite for families of these severely injured.

VA's current nursing home capacity is designed to serve elderly veterans, not younger ones. VA must make every effort to create an environment for these veterans that recognizes they have different needs. VA leadership and VA planners must work to bring a new type of long-term-care program forward to meet these needs.

Finally, the newest generation of veterans, from the first Gulf War until today, exhibits different expectations than their counterparts of the past. In general they are computer literate and well educated, want more involvement in their own care, and want to control their own destinies. As these veterans age into later life 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 surrounded by forward-thinking administrators and staff who can adapt 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 LTC Strategic Plan does not explain how VA will adjust services to care for younger OEF/OIF veterans.

Culture Change

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

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

VA's 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 com-

munity nursing home program represented 13 percent of VA's total nursing home workload. VA's CNH program often brings care closer to where the veteran actually lives, closer to his or her family and personal friends. Since 1965, VA has provided nursing home care under contracts or 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 CNHs.

Veterans Health Administration Handbook 1143.2 provides instructions for initial and annual reviews of community nursing homes and for ongoing monitoring and follow-up services for veterans placed in these facilities.

First introduced in 2002, the handbook updates new approaches to CNH oversight, first introduced in 2002, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

ADC VA's Community Nursing Home Program	
2004	4,302
2005	4,254
2006	4,395
2007	4,439
2007 ADC Increase over 2006: 141	

Institutional Care in State Veterans' Homes

The state veterans' home program currently encompasses 132 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 Government Accountability Office 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 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 made up from a mix of funding, including state support, Medicaid, Medicare, and other public and private sources. VA's authorized ADC for state veterans homes was 18,349 for FY 2007.

VA holds state homes to the same standards that are applied to the nursing home care units that VA operates. Teams of VA examiners inspect state homes annually, and VA's Inspector General (IG) also audits and inspects them when determined necessary. In addition, state homes that are authorized to receive Medicaid and Medicare payments are subject to unannounced inspections by the Centers for Medicare and Medicaid Services (CMS), and announced and unannounced inspections by the IG of the Department of Health and Human Services (HHS).

In Public Law 109-461, Congress authorized VA to reimburse state homes the full cost of care for seriously disabled service-connected veterans (those with a VA disability rated at least 70 percent disabling or more), and for veterans who receive state home care primarily for a service-connected disability at any VA rating. VA has been slow to implement this new mandate, which took effect in March 2007. Service-connected veterans should be the top priority for admission to state veterans' homes, but traditionally they did not consider state homes an option for nursing home services because of lack of VA financial support. To remedy this disincentive, Congress provided authority for full VA payment. The IBVSOs urge VA to move forward with implementation of this important authority.

ADC State Veterans' Homes	
2004	17,328
2005	17,794
2006	17,747
2007	18,349
2007 ADC Increase over 2006: 602	

In addition to per diem support, VA also helps cover the cost of construction, rehabilitation, and repair of state veterans' homes. VA provides up to 65 percent of the cost, with the states providing at least 35 percent. Unfortunately, in FY 2007, the State Home Construction Grant Program was funded at only $85 million, the same amount that Congress had provided in FY 2006. Based on a current backlog of nearly $1 billion in grant proposals (including $242 million in life and safety projects) and with thousands of veterans on waiting lists for state beds, the *FY 2008 Independent Budget* recommended no less than $150 million be appropriated for this program. The IBVSOs are grateful

that Congress responded and provided $165 million for FY 2008 in the recently enacted omnibus appropriations act.

For FY 2009, *The Independent Budget* recommends the State Home Construction Grant Program be funded at $200 million.

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

Continuing Concerns on VA's Inadequate Planning for Long-Term Care

The Government Accountability Office (GAO) has expressed a number of concerns about VA's nursing home program. In its November 2004 report (GAO-05-65) the GAO pointed out several problems that prevent VA from having a clear understanding of its program's effectiveness.

The GAO recommended that VA collect and report data for community nursing homes and state veterans' nursing homes on the numbers of veterans that have long and short stays. GAO also recommended that VA collect data on the number of veterans in these homes that VA is required to serve based on the requirements of the Veterans Millennium Health Care and Benefits Act, P.L. 106-117. The GAO believed that this information would assist VA to conduct adequate monitoring and planning for its nursing home care program.

Congress has shown its concern about VA's long-term-care planning as evidenced by its rejection of VA's proposals to halt construction and reduce per diem funding to state veterans' homes and to repeal the nursing home capacity mandate under P.L. 106-117. Also, in July of 2005, Congress was asked to provide VA with an additional $1.997 billion for higher than expected health-care needs. Of this amount, $600 million was to be used to correct for the estimated cost of long-term care (VA press release July 14, 2005). VA's lack of appropriate workload information gathering and data analysis has placed it in a weak position to do effective planning for the immediate and future long-term-care needs of America's veterans. While VA can only advise Congress about the program requirements necessary to meet these needs, it is its duty to do so. VA should be the advocate for veterans' long-term-care needs, not just the provider.

VA Noninstitutional Care (Home and Community-Based Services)

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

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

The Independent Budget supports the expansion of VA's noninstitutional long-term-care services and also supports the adoption of innovative approaches to expand this type of care.

Noninstitutional long-term-care programs can sometimes obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost-effective and extremely popular. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

ADC for VA Noninstitutional Care Programs					
	2004	2005	2006	2007	I/D Over 2006
Home-based Primary Care	9,825	11,594	12,641	13,222	1,581
Contract Skill Home Care	2,606	3,075	2,490	2,656	166
VA/Contract Adult Daycare	1,493	1,762	1,304	1,884	1,884
State Adult Daycare (New Service)				15	15
Homemaker Health Aid Services	5,580	6,584	5,867	6,631	764
Community Residential Care	5,771	6,810	3,692	5,069	1,377
Home Respite	84	99	118	254	136
Home Hospice	164	194	427	553	126
Total Noninstitutional Care Programs	25,523	30,118	26,539	30,284	3,745

Note: I/D = Increase/(Decrease) over 2006

Future Directions

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 choices. VA can be expected to modify existing programs and develop new alternatives as financial resources allow. New horizons for VA long-term care include the following:

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

VA's Care Coordination Program

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

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

There are also physicians who care-coordinate complex patients.

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

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

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

Both institutional and noninstitutional VA long-term-care services designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D.

Older veterans with SCI/D are especially vulnerable and require a high degree of long-term and acute care coordination. A major issue of concern is the fact that a recent VA survey indicated that in FY 2003 there were 990 veterans with SCI/D residing in non-SCI/D designated VA nursing homes. However, VA has not identified the exact locations of these veterans in its LTC 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's LTC Strategic Plan does not provide adequate and specific information to identify the location and facility of service for these veterans. The plan provides a VISN-by-VISN rollup but does not allow for quality-of-care tracking of individual catastrophically injured veterans. VA must develop a program to locate and identify veterans with SCI/D who are receiving care in non-SCI/D designated long-term-care facilities and ensure that their unique needs are met. In addition, these veterans must be followed by the nearest VA SCI center to ensure they receive the specialized medical care they require. Veterans with SCI/D who receive VA institutional long-term-care services require specialized care from specifically trained professional long-term-care providers in an environment that meets their accessibility needs.

Currently, VA operates only four designated long-term-care facilities for patients with spinal cord injury or disease, and none of these facilities 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, Illinois (28 staffed beds); and Castle Point, New York (16 staffed beds). Unfortunately, these limitedly staffed (121 total) beds are usually filled, and there are waiting lists for admission. These four VA SCI/D long-term-care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

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

Recommendations:

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

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

Congress must provide the financial resources for VA to implement its Long-Term-Care Strategic Plan.

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

VA must swiftly implement new authorities provided in P.L. 109-461 dealing with veterans' needs in the state veterans' home program.

VA and Congress must continue to provide the construction grant and per diem funding necessary to support state veterans' homes. Even though Congress has approved full long-term-care funding for certain service-connected veterans in state veterans' homes under P.L. 109-461, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure. To that end, Congress should provide state veterans' homes $200 million in construction grant funds for FY 2009.

VA must do a better job of tracking the quality of care provided in VA contract community nursing homes. Unscheduled quality of care visits are a good first step but accreditation requirements are a better approach.

VA must increase its capacity for noninstitutional, home, and community-based care, but given the evident growth in demand, not at the expense of its traditional institutional programs.

VA must ensure that each noninstitutional program mandated by P.L. 106-117 is operational and available across the entire VA health-care system. VA's LTC Strategic Plan does not include an action VA directive to mandate field compliance.

Serious geographical gaps exist in specialized long-term-care services (nursing home care) for veterans with spinal cord injury or spinal cord disease. As VA develops its construction plan for nursing home construction, it must include provisions, to provide a minimum of 15 percent bed space, to accommodate the specialized spinal cord injury nursing home needs nationally. VA must start by implementing the CARES SCI/D long-term-care recommendations. 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 non-SCI/D long-term-care facilities.

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

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

---

[76] Department of Veterans Affairs Strategic Plan FY 2006–2011, p. 23.

Assisted Living

Assisted Living as an Alternative to Nursing Home Care:

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

In November of 2004, Secretary Principi forwarded a VA report to Congress concerning the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by P.L. 106-117. The Assisted Living Pilot Program (ALPP) was carried out in VA's Veterans Integrated Service Network (VISN) 20. VISN-20 includes Alaska, Washington, Oregon, and the western part of Idaho.

VA's ALPP was implemented in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Oregon; Roseburg, Oregon; White City, Oregon;

Spokane, Washington; and Puget Sound Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

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

Some of the main findings of the ALPP report include:

- ALPP veterans showed very little change in health status over the 12 months postenrollment. As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that the ALPP may have helped maintain veterans' health over time.
- The mean cost per day for the first 515 veterans discharged from the ALPP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.
- The mean cost to VA for a veteran's stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.
- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.
- The average ALPP veteran was a 70-year-old unmarried white male who was not service connected, was referred from an inpatient hospital setting, and was living in a private home at referral.
- ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment: 22 percent received assistance with between four and six ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with one to three ADLs; while 35 percent received no assistance.
- Case managers helped ALPP veterans apply for VA Aid and Attendance and other benefits to help cover some of the costs of staying in ALPP facilities at the end of the VA payment period.
- Veterans were very satisfied with ALPP care. Highest overall scores were given to VA case managers (mean: 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82).
- Vendors are quite satisfied with their participation in the ALPP, with a mean score of almost 8 (of 10).
- Case managers were very satisfied with the ALPP. Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall between the cracks."

Secretary Principi'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 Independent Budget* veterans service organizations (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 just part of the mix. VA already provides housing in its domiciliary and nursing home programs, and it should not prohibit an assisted living benefit on the basis of its housing component.

■ CARES and Assisted Living

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

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

The IBVSOs acknowledge and appreciate that Congress recently authorized a new VA assisted living pilot

project in Section 1705 of title 17, the National Defense Authorization Act for Fiscal Year 2008 (NDAA). We are hopeful that VA and the DOD will expedite the establishment of 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 elderly veterans.

Recommendations:

While assisted living is not currently a benefit that is available to veterans (outside the two pilot programs discussed above), the authors of *The Independent Budget* believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care.

VA's 2004 Assisted Living Pilot Program (ALPP) report seems most favorable, and assisted living appears to be an unqualified success. However, *The Independent Budget* authors believe that to gain further understanding of how the ALPP can benefit veterans, it should be replicated in at least three Veterans Integrated Service Networks with a high percentage of elderly veterans. We hope the new pilot program authorized by the National Defense Authorization Act for Fiscal Year 2008 can be a means of evaluating assisted living as an innovative option for meeting elderly veterans' long-term-care needs.

VA Medical and Prosthetic Research

VA research is a national asset. VA's Medical and Prosthetic Research Program is one of the nation's premier research endeavors and helps to ensure the highest standard of care for our nation's veterans.

Medical and Prosthetic Research (in millions)	
FY 2008	$480
FY 2009 Administration Request	$442
FY 2009 *Independent Budget* Recommendation	$555

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

The VA research program is exclusively intramural; that is, only VA employees holding at least a five-eighths salaried appointment are eligible to receive VA awards. Unlike other federal research agencies, VA does not make grants to non-VA entities. As such, the program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA health-care system. The resulting environment of medical excellence and ingenuity benefits every veteran receiving care in the VA health system and, ultimately, all Americans.

Funding for VA Medical and Prosthetic Research:

Funding for VA research must be timely, predictable, and sufficient in size to meet current commitments and allow for innovative scientific growth.

The VA Medical and Prosthetic Research Program leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other federal research funding agencies, for-profit industry partners, nonprofit organizations, and academic affiliates. The VA research program has done an extraordinary job leveraging its relatively modest annual appropriation into a $1.7 billion research enterprise that hosts multiple Nobel laureates and produces an increasing number of scientific papers annually, many of which are published in the most highly regarded journals. This highly successful enterprise demonstrates the best in public-private cooperation, but would not be possible without the VA's research opportunities. As such, a commitment to steady and sustainable growth in the annual research and development appropriation is necessary for maximum productivity.

Predictable and Sustainable Growth to Meet Current and Emerging Research Needs

Funding for VA research since FY 2004 has been unpredictable. In FY 2005, VA research was cut by $3.3 million (0.8 percent). In FY 2006, VA research received a less than inflationary $9.7 million (2.4 percent) increase followed by essentially flat funding ($413.7 million) under the FY 2007 joint funding resolution. The FY 2007 emergency supplemental appropriations provided an additional $32.5 million for VA research, thus increasing total research funding in FY 2007 to more than $446 million. In November 2007, the second continuing resolution temporarily funded VA health care at a rate equal to that proposed by the President for FY 2008. For FY 2008, the Administration proposed only $411 million for VA research, forcing VA research to temporarily reduce its annualized rate of spending by 7.9 percent.

Funding with arbitrary peaks and valleys impedes important VA research on national priorities, including studies on post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), amputations, polytrauma, burns, and many other acute and chronic health conditions long prevalent in the veteran population. VA researchers are understandably hesitant to expand their research endeavors as inconsistent and unpredictable funding can quickly devastate plans for growth. Furthermore, should the available research awards decline as a function of budgetary policy, the VA risks losing physician-researchers and other clinical investigators who are integral to providing direct care for our nation's veterans and for sustaining its quality.

VA research awards are typically three to five years in duration. However, scientific advancement can demand many more years and requires steady, sustainable funding. To maintain the current level of VA research activity over the next three years, biomedical research and development inflation is estimated at 3.6 percent for FY 2009 and 2010, and at 3.5 percent for FY 2011.

Beyond biomedical inflation, additional research funding is needed to take advantage of burgeoning opportunities to improve the quality of life for our nation's veterans through genomic medicine; address the critical needs of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans; and raise the VA-imposed cap on investigator-initiated awards.

VA is in a unique position to revamp modern health care and to provide progressive and cutting-edge care for veterans through genomic medicine. VA is the obvious choice to lead advances in genomic medicine. It is the largest integrated health-care system in the world, employs an industry-leading electronic health-record system, and has a dedicated treatment population for sustained research. VA combines these attributes with high ethical standards and standardized processing. Innovations in genomic medicine will allow the 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.

Additional funding is also needed to expand research on strategies for overcoming the devastating injuries

being suffered by OEF/OIF veterans. Improvements in prosthetics and rehabilitation, as well as better treatments for polytraumas, TBI, whole body burns, and PTSD are urgently needed. Funding more studies and accelerating ongoing programs could deliver results that make a difference in the quality of life for hundreds or even thousands of the nation's newest disabled veterans.

Since 2005, inadequate funding for VA research has forced the Department to cap many VA merit-review awards at a mere $125,000 annually. VA research awards have not been so modestly funded since the $100,000 cap in 1999 (more than $140,000 in 2009 dollars). Nearly a decade later, the current $125,000 cap, which has been in place since it was lowered from $150,000 in 2003, fails to keep pace with biomedical inflation and VA's commitment to scientific innovation.

The cap—which is significantly lower than the average award at comparable federal research programs—is a tradeoff that VA leadership has had to make to continue funding the same number of grants it has historically supported. This is a problem compounded by VA's need to expand its research portfolio to include research on conditions prevalent among veterans of OEF and OIF. *The Independent Budget* veterans service organizations support increasing the number of funded programs to meet these challenges, but as a secondary objective also support raising the cap on merit review programs in order to recognize inflation, maximize productivity, foster recruitment, and speed the translation of research from the bench to the bedside.

Recommendation:

To keep VA research funding predictable, VA requires approximately $20 million per year to account for biomedical research and development inflation. *The Independent Budget* authors believe an additional $55 million in FY 2009 is necessary for continued support of new VA research initiatives and for raising the cap on merit reviews. Thus, *The Independent Budget* recommends for FY 2009 an increase of $75 million over the FY 2008 appropriated level.

Research Facilities Consistent with Scientific Opportunity:

State-of-the-art research requires state-of-the-art technology, equipment, and facilities.

A state-of-the-art environment for research promotes excellence in teaching and patient care as well as science. It also helps VA recruit and retain the best and brightest clinician scientists. In recent years, funding for the VA medical and prosthetics research program has failed to provide the resources needed to maintain, upgrade, and replace aging research facilities. Over the past decade, only $50 million has been spent on VA research construction or renovation and at only 24 of the 97 major VA research sites across the nation. Many VA facilities have run out of adequate research space. Ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades along with space reconfiguration. One cause of this neglect is that VA research must compete with other facility needs for medical services infrastructure for funds under the minor construction appropriation.

In May 2004, then-Secretary of Veterans Affairs Anthony J. Principi approved the Capital Asset Realignment for Enhanced Services (CARES) Commission's report to upgrade and renovate VA facilities. While this panel found need for $87 million to renovate existing research space, it was not included in the Secretary's final report.

In House Report 109-95 providing appropriations for FY 2006, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program maybe be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." It noted, "more resources may be required to ensure that research facilities are properly maintained to support the Department's research mission." To assess VA's research facility needs, the committee directed VA to con-

duct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies."

The VA Office of Research and Development plans to examine (over a three-year period) all VA research infrastructure for physical condition, capacity for current research, as well as program growth and sustainability of the space to conduct research. A 23-page evaluation instrument will be used to develop cost estimates to correct deficiencies or replace each research building or facility. A preliminary questionnaire was designed to take an overall "snapshot" of the current quantity and quality of VA research space. Fifty-eight percent of respondents reported a lack of sufficient space. Following a three-site pilot program in 2006, VA fully implemented the evaluation program in September 2007. VA has already completed three site surveys and plans to conduct two surveys per month beginning in FY 2008.

Recommendations:

As it moves forward with its research facilities assessment, VA should submit regular reports to Congress following the completion of each site survey. These reports will ensure that the Administration and Congress are well informed of VA's funding needs for research infrastructure at each stage of the budget process.

To ensure that funding is adequate to meet both immediate and long-term needs, *The Independent Budget* recommends an annual appropriation of $45 million in the VA's minor construction budget dedicated to renovating existing research facilities and additional major construction funding sufficient to replace at least one outdated facility per year to address this critical shortage of research space.

ADMINISTRATIVE ISSUES

ATTRACTING AND RETAINING A QUALITY VHA NURSING WORKFORCE:

The Veterans Health Administration (VHA) must devote sufficient resources to avert the national shortage of nurses from creeping into and potentially overwhelming VA's critical health-care programs.

Recruitment and retention of high-caliber health-care professionals is critical to the VHA's mission and essential to providing safe, high-quality health-care services to sick and disabled veterans. Given the impact of the nationwide nursing shortage and ongoing reports of difficulty in filling nursing and other key positions in the VHA, this is a continuing challenge for VA.

Addressing the National Nursing Shortage—National Commission on VA Nursing

The environment of the VHA, like America's health-care enterprise in general, is ever-changing and confronted with continuing challenges. Since 2000, VA has been working to address the increasing demand for medical services while coping with the impact of a rising national nursing shortage. In 2001, VHA's Nursing Strategic Healthcare Group released "A Call to Action—VA's Response to the National Nursing Shortage." Since that time, health personnel shortages, and plans to address them, have been dominant themes of numerous conferences, reports by the Government Accountability Office (GAO), other reviewers, and Congressional hearings.

One part of the equation that has remained paramount in the discussion concerns VA's ability to compete in local labor markets, given the barriers that impede nursing recruitment and retention in general. In 2002 the National Commission on VA Nursing was established by Public Law 107-135. The commission was

charged to examine and consider VA programs and to recommend legislative, organizational, and policy changes to enhance the recruitment and retention of nurses and other nursing personnel, and to address the future of the nursing profession within VHA. The commission envisioned a desired "future state" for VHA nursing, and made recommendations to achieve that vision. In May 2004, the commission published its final report to Congress, "Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce."

Illustrative of the commission's findings and recommendations is this synopsis in its final report:

> Recruiting and retaining nursing personnel are priority issues for every healthcare system in America. VHA is no exception. With the aging of the population, including veterans, and the U.S. involvement in military activity around the world, VHA will experience increasing numbers of enrolled veterans. Consequently, as the demand for nursing care increases, the nation will grapple with a shortage of nurses that is likely to worsen as baby boomer nurses retire. VHA must attract and retain nurses who can help assure that VHA continues to deliver the highest quality care to veterans. Further, VHA must envision, develop, and test new roles for nurses and nursing as biotechnologies and innovations change the way healthcare is delivered.

The Office of Nursing Service in the VA Central Office developed a strategic plan to guide national efforts to advance nursing practice within the VHA and engage nurses across the system to participate in shaping the future of VA nursing practice. This strategic plan embraces six patient-centered goals that encompass and address a number of the recommendations of the commission, including leadership development, technology and system design, care coordination and patient self-management, workforce development, collaboration, and evidence-based nursing practice.

The commission's legislative and organizational recommendations served as a blueprint for the future of VA nursing. Having followed that blueprint, VHA's strategic plan serves as a solid foundation for the creation of a delivery system that meets the needs of our nation's sick and disabled veterans while supporting those who provide their care. *The Independent Budget* veterans service organizations (IBVSOs) urge Congress to continue to provide appropriations for, and oversight of, VA health care to enable the VHA to carry out an aggressive agenda to improve VA's abilities to recruit and retain sufficient nursing personnel while proactively testing new and emerging nursing roles.

Current Workforce—Future Needs

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.

VHA's Succession Strategic Plan for Fiscal Year (FY) 2006–2010 reports:

> VHA faces significant challenges in ensuring it has the appropriate workforce to meet current and future needs. These challenges include continuing to compete for talent as the national economy changes over time, and recruiting and retaining healthcare workers in the face of significant anticipated workforce supply and demand gaps in the healthcare sector in the near future. These challenges are further exacerbated by an aging federal workforce and an increasing percentage of VHA employees who receive retirement eligibility each year.

In April 2007, the VHA conducted a national conference titled "VHA Succession Planning and Workforce Development." The conference report indicated the average age of all VHA employees in 2006 to have been 48 years. It estimated that by the end of 2012, approximately 91,700 VHA employees, or 44 percent of current full-time and part-time staff, will be eligible for full civil service retirement, with approximately 46,300 VHA employees projected to retire during that same period. Additionally, a significant number of healthcare professionals in leadership positions would also be eligible to retire by the end of 2012. The report concluded that 97 percent of VA nurses in pay band "V" positions would be eligible to retire, and that 56 percent were expected to retire. In its assessment of current and future workforce needs, the VHA identified registered nurses (RNs) as its top occupational challenge, with licensed practical/vocational nurses and nursing assistants also among the top ten occupations with critical recruitment needs. Currently, VA employs more than 62,000 nursing personnel, including about

42,000 RNs, 11,400 licensed vocational or practical nurses, and 9,100 nursing assistants.

VA recognizes the supply of qualified nurses in the nation in the near term will be inadequate to meet increasing demand for services. According to the Health Resources and Services Administration, by 2015 all 50 states will experience a shortage of nurses to varying degrees. Likewise, current enrollments in schools of nursing are not going to meet the projected future demand. 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 for denying admission to qualified applicants. In 2005 (most recent data available) schools and colleges of nursing turned away 41,683 qualified applicants. Over the past several years, the VHA has been trying to attract younger nurses into VA health care and to create incentives to keep them in the VA system.

Last year, in an attempt to attain a more stable nursing corps, VA initiated a "nursing academy" pilot program known as "Enhancing Academic Partnerships." VA reports its nursing academy will be committed to nursing education and practice and will address the nursing shortages in VA while aiding the nation's need for nurses as well. VA's pilot program for fiscal years 2007–2012 will partner 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 four sites will be selected in 2008 and 2009, for a total of 12 sites during the five-year pilot program. Similar to VA's longstanding relationships with schools of medicine nationwide, VA nurses with qualified expertise will be appointed as faculty members at the affiliated schools of nursing. Academy students 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 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 nationwide shortage.

Nursing Workplace Issues

We continue to hear concerns from VA nurses about a number of issues they believe have an impact on nursing recruitment and retention. There are reports that VHA staffing levels are frequently so marginal that any loss of staff—even one individual in some cases—can result in a critical staffing shortage and present significant clinical challenges at a medical facility. Some nurses report they have been forced to assume non-nursing duties because of shortages of ward secretaries and other key support personnel. Budget-related "unofficial" hiring freezes and routine human resources delays in recruiting place additional stress on existing nursing personnel and impact patient programs. Staffing shortages or hiring freezes can result in the cancellation or delay of elective surgeries and closure of intensive care unit beds. These staff shortages can also cause avoidable referrals of veterans to private facilities—ultimately at greater overall cost to VA. This situation is complicated by the fact that the VHA has downsized inpatient capacity in an effort to provide more services on a primary care basis. The remainder inpatient population is generally more acute, often with comorbid conditions, lengthier inpatient episodes, complicated medical histories, and needs for more skilled nursing care and staff-intensive aftercare.

It has also been reported that in some locations, VA is overusing overtime, including "mandatory overtime"; reducing flexibility in tours of duty for nurses; and limiting nurse locality pay. We believe the practice of mandatory overtime places an undue burden on nursing staff and compromises the quality of care and safety of veterans in VA health care. Additionally, these actions create a working environment that fosters staff burnout and morale problems. These reports are especially disturbing given that VA has made so much progress in establishing the current national standard of excellence in providing care to its large veteran population. We believe many of these difficult working conditions continue to exist today for VA's nursing staff, despite the best efforts and intentions of local and central management. Therefore, we suggest Congress provide additional oversight in this area to ensure a safe environment for both patients and staff. Finally, we note that many of these workplace issues are driven by short financing and extremely tight local budgets, including the now routine continuing resolution, which restricts overall management discretion nationwide.

In October 2007, the House Committee on Veterans' Affairs Subcommittee on Health held a hearing on re-

cruitment and retention of VA health-care professionals. Testimony from the American Federation of Government Employees and the Nurses Organization of Veterans Affairs outlined a number of key issues believed to have an impact on VA's ability to recruit and retain qualified nursing personnel. Issues discussed included flaws in the current credentialing and boarding process for title 38 employees; increasing reliance on contract nurses and its impact on quality of care; impact of the budget on hiring practices; lack of use of authorized pay incentives by some medical facility managers; reluctance of medical center directors to offer scheduling incentives, such as the popular compressed work schedule; the need to strengthen current overtime policies in all VHA facilities; lack of human resources support; delays in hiring caused by the lengthy process involved for security and background checks; information technology issues; and a number of pay-related issues. We urge Congress to review the aforementioned testimonies by these organizations made up of frontline providers for specific recommendations on how to improve recruitment and retention of VA nursing personnel.

Like other health-care employers, the VHA must actively address those factors known to affect recruitment and retention of all health-care providers and nursing staff and take proactive measures to stem crises before they occur. While we applaud what VA is trying to do in improving its nursing programs, competitive strategies are yet to be fully developed or deployed in VA. The IBVSOs encourage the VHA to continue its quest to deal with shortages of health personnel in ways that keep the VHA at the top of the standards of care in the nation.

Recommendations:

Congress must provide sufficient funding through regular appropriations that are provided *on time,* and include resources to support programs to recruit and retain critical nursing staff in VA health care.

VA should establish recruitment programs that enable the Veterans Health Administration to remain competitive with private-sector marketing strategies.

Congress should provide oversight to ensure sufficient nursing staffing levels, and to regulate, and reduce to a minimum, VA's use of mandatory overtime for VA nurses.

VOLUNTEER PROGRAMS:

VA needs to provide a dedicated staff person at each VA medical center to promote volunteerism and coordinate and oversee voluntary services programs.

Since its inception in 1946, volunteers have donated in excess of 689.3 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 program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of 60 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and seven of their subordinate organizations, which report to the VA Under Secretary for Health.

Veterans Health Administration (VHA) 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, and veterans' outreach centers. With the expansion of VA health care for patients in the community setting, additional volunteers have become involved. During fiscal year 2007, VAVS volunteers contributed a total of 11,616,428 hours to VA health-care facilities. This represents 5,585

full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $223.8 million it would have cost VA to staff these volunteer positions with FTEE employees.

At national cemeteries, VAVS volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on grave sites for Memorial Day and Veterans Day. Hundreds of thousands of hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The combined annual contribution made in 2007 to VA is estimated at $54 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 being placed on VA health-care staff. The way health services are provided is changing, which provides opportunities for new and less-traditional roles for volunteers. Unfortunately, many of our 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 VHA keep pace with utilization of this national resource.

Recommendation:

Each Veterans Health Administration medical center should designate a staff person with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.

Contract Care Coordination:

The Veterans Health Administration (VHA) should develop an integrated program of contract care coordination for veterans who receive care from private health-care providers at VA expense, but should maintain vigilance in implementing a new contract care initiative that may have unintended consequences that diminish VA health care.

Current law authorizes VA to contract for non-VA health care (on a fee or contractual basis) and for scarce medical specialists only when VA facilities are incapable of providing necessary care to veterans, when VA facilities are geographically inaccessible to veterans, and in certain emergency situations. *The Independent Budget* veterans service organizations (IBVSOs) believe that contract care should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. We have consistently opposed proposals seeking to expand contracting to non-VA providers on a broader basis than this. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serving larger veteran populations, ultimately only dilute the quality and variety of VA services for new as well as existing patients.

Currently, VA spends more than $2 billion annually to purchase private care for eligible veterans. Unfortunately, VA does not track this care, its related costs, outcomes, or veteran satisfaction levels. Therefore, the IBVSOs be-

lieve VA should implement a consistent process for veterans receiving contracted-care services to ensure that:

- care is delivered by fully licensed and credentialed providers;
- continuity of care is monitored and that patients are directed back to the VA health-care system for follow-up when necessary;
- VA records of care are properly annotated with clinical information from contractors; and
- the process is part of a seamless continuum of services for enrolled veterans.

The IBVSOs believe it is critical that VA implement a program of contract care coordination that includes integrated clinical, record, and claims information for veterans VA refers to community-based providers. VA's current Preferred Pricing Program allows VA medical centers (VAMCs) to save funds when veterans use non-VA medical services by receiving network discounts through a preferred pricing program. However, VA currently has no system in place to direct veteran patients to any participating preferred provider organization (PPO) so VA could:

- receive a discounted rate for the outsourced services rendered;
- use a mechanism to refer patients to credentialed and certified providers; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VAMCs, when a veteran inadvertently uses a PPO, 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, we were pleased that VA made participation in its Preferred Pricing Program mandatory for all VAMCs in 2005. VA established a savings goal of $47 million from this program for fiscal year 2008. Despite the significant overall savings achieved through this program (more than $113 million gross to date), there are several major changes that can be made to improve the access, quality, and cost of contract VA care.

We believe the Preferred Pricing Program is a foundation upon which a more proactive managed care program could be established that would not only save significantly more funding when purchasing care, but, more important, could provide the VHA a mechanism to fully integrate contract care into its health-care system. By partnering with an experienced managed-care contractor(s), 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 the VA.

Currently, many veterans are 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 believe it is important for VA to develop an effective care coordination model that achieves both its health-care and financial objectives. Doing so will improve patient care quality, more wisely use VA's increasingly limited resources, and reduce overpayments.

Components of a coordinated care program should include the following:

- Care and case management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical needs, the care coordination contractor could address both appropriateness of care and continuity of care. The result could be a truly integrated seamless health-care delivery system; and
- Provider networks that complement capabilities and capacities of each VAMC. Such contracted networks should address timeliness, access, and cost-effectiveness. Additionally, the care coordination contractor could require private providers to meet specific VA requirements, such as timely communication of clinical information to VA, proper and timely submitting of electronic claims, meeting VA established access standards, and complying with other applicable performance measures.

If properly implemented, a care coordination system also could improve veteran satisfaction with contract services and optimize workload for VA facilities and their academic affiliates.

Approximately two years ago, VA announced an initiative titled "Healthcare Effectiveness through Resource Optimization," also known as "Project HERO." At that time VA indicated its goal to be consonant with the ideas

expressed previously and still now by the IBVSOs in improving VA contract care coordination. On closer examination, we concluded this initiative as originally conceived to be ill-considered, too loosely constructed, and thus dangerous to the continued integrity and availability of specialized VA health-care services. Accordingly, we expressed our concern and ultimately opposed that project, which was subsequently withdrawn.

In 2007, VA revamped the Project HERO solicitation, and awarded a contract to a national managed care corporation that is also a major intermediary and private network manager under the Department of Defense TRICARE program. Since this matter first emerged in the fiscal year 2006 Congressional appropriations arena, it has remained a significant concern of the IBVSOs that Project HERO not become a basis to downsize or to privatize VA health care.

The IBVSOs' concern remains that this initiative could become a method to contract out VA services beyond the current extent of that program. Early in our discussions with VA, we requested that spending under Project HERO be capped so as not to exceed total contract care during the previous year for each network selected to participate. This limitation would have ensured that Project HERO would become an incentive to *reduce* contract care spending, as originally envisioned. VA chose not to accept our recommendation, and, in fact, expanded contract maximum spending in some cases upward of 500 percent; thus, we remain concerned about the intent of this project.

The IBVSOs urge VA to establish monitoring mechanisms to ensure that the contract services provided under Project HERO meet the same expectations put forth above in our quest for improved contract care coordination. However, our fears remain that under this new pilot project VA will pay significantly more for contract care without the safeguards of VA's high quality standards.

Recommendations:

VA should establish a contract care coordination program that incorporates the preferred pricing program discussed above, based on principles of sound medical management and tailored to VA and veterans' specific needs.

Veterans who receive private care at VA expense and authorization should be required to participate in the care coordination program, with limited exceptions.

VA and any care coordinator should jointly develop identifiable measures to assess program results and share results with Congress and stakeholders, including *The Independent Budget* veterans service organizations. Care should be taken to ensure inclusion of important VA academic affiliates in this program.

The components of a care coordination program should include claims processing, health records management, and centralized appointment scheduling.

The following recommendations apply specifically to VA's Project HERO pilot program:

- VA should establish a mechanism to track contract expenditures within the selected pilot networks that include cost comparisons to existing contract costs.
- VA should develop a set of quality standards that contract care providers must meet that are equivalent to the quality of care veterans receive within the VA system. Any Project HERO provider should be held to this standard.
- VA should provide Congress and make publicly available the results of the first year of operations under the pilot project, including both quality and cost data.

Federal Supply Schedule for Pharmaceuticals:

VA must maintain and protect the ability to achieve pharmaceutical discounts through the Federal Supply Schedule for Pharmaceuticals (FSS-P).

A number of states and the District of Columbia have recently considered legislation that would tie Medicaid drug prices to the discounted prices now contained in the FSS-P. Passage of any legislation mandating that FSS-P pricing be opened to Medicaid programs could threaten VA's ability to receive discounted pricing because vendor contracts contain a clause allowing their cancellation in this event. Legislation considered during recent sessions of Congress that would tie the new Medicare Part D Prescription Drug Benefit to the FSS-P and VA drug discounts by referencing these reduced prices as a target for obtaining Part D drugs is of even greater concern.

Prior experience, most notably with Medicaid drug provisions contained in the Omnibus Budget Reconciliation Act of 1990 (PL 101-508), has demonstrated that if these types of legislative initiatives are enacted, VA's pharmaceutical discounts could be diluted and costs increased, harming both the VA health-care system and veterans.

Under the FSS-P, VA purchases, on behalf of itself and other federal entities through contracts with responsible vendors, approximately 24,000 pharmaceutical products annually. These purchases are made at discounts ranging from 24 to 60 percent below drug manufacturers' most favored nonfederal, nonretail customer pricing. As VA's pharmaceutical purchases are now roughly $4 billion annually, the loss of these discounts would dramatically increase the costs of pharmaceuticals, as well as the cost of providing care, to an already underfunded health-care system. These added costs could also be passed on to veterans in the form of dramatically higher copayments.

Recommendation:

Congress and the Administration need to address pharmaceutical cost-related issues in a manner that does not result in a reduction of veterans' benefits or threaten discounts VA currently receives under the Federal Supply Schedule for Pharmaceuticals.

Fee-Basis Care:

The extent of its decentralized structure, complex legislative authority, and the inadequate funding to local VA facilities for fee-basis care continue to erode the effectiveness of this necessary health-care benefit.

Current law allows the Department of Veterans Affairs to contract for private health-care services through fee basis when VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when a 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. Veterans who are authorized fee-basis care are also allowed to choose their own medical providers.

Veterans who are approved by VA to utilize fee-basis care are sometimes unable to secure treatment from a community provider because of VA's regulated level of payment for medical services. We are especially concerned that service-connected disabled veterans who are authorized to use fee-basis care are at times required by the only provider in their community to pay for the care up front. In these instances, health-care providers frequently charge a higher rate than VA is authorized to pay, resulting in veterans having to pay for the medical care they need and then seek reim-

bursement from VA. Furthermore, 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, veterans who seek reimbursement from VA are paying for part of their care.

We applaud VA for addressing existing variability in processing a fee-basis claim, which affects the timeliness to pay a claim, by initiating improvements to its business practice. While software improvements to increase program efficiency and regulatory changes to improve program effectiveness have been delayed, we believe VA leadership must continue to provide the support needed to achieve the goals of these initiatives.

Recommendations:

When VA preauthorizes fee-based care for a veteran, it should coordinate with the chosen health-care provider for both the veteran's care and payment of medical services. Service-connected veterans should not be required to negotiate payment terms with private providers for authorized fee-based care or pay out-of-pocket for such services.

VA should continue to pursue the regulatory changes needed for its payment methodology to provide equitable payments for the care veterans receive in the community.

With support from VA leadership, a standard business practice for efficient and timely processing of claims for fee-based care should be established.

VA Physician and Dentist Pay Reform and Clinical Workforce Morale:

***The Independent Budget* veterans service organizations (IBVSOs) remain concerned with the VA physician and dentist pay system and its relationship to deteriorating morale in the clinical care workforce.**

In 2004, Congress passed the Department of Veterans Affairs Personnel Enhancement Act, Public Law 108-445. This act reformed the pay and performance system used by VA in employment and supervision of VA physicians and dentists. This proposal was one of VA's top legislative goals in the 108th Congress. Enactment of this proposal was supported by the IBVSOs. We had expressed concern that VA needed new authority to attract and retain the best physicians and dentists for the care of enrolled veterans—particularly at a time of ongoing military engagements in Iraq and Afghanistan. VA implemented this new authority as required by the act in January 2006 and has established new pay plans and other governing policies for VA physicians under its terms. This act is the most significant reform of pay systems for VA employees since the enactment of the Civil Service Reform Act in 1978, and represents the first significant change in VA physician pay since 1991.

The Independent Budget veterans service organizations (IBVSOs) believe the appropriate committees should use their oversight authority to study the impact of Public Law 108-445 on recruitment and retention of VA physicians and dentists—especially those who practice in some of the more scarce specialties, including internal medicine and surgical subspecialties, anesthesiology, pathology, and other fields. These subspecialties are very scarce, and VA has historically had great challenges recruiting these highly paid practitioners to full-time employment (one of the goals of the legislation). VA's motivation to secure this new authority was driven by the exorbitant cost of procuring contract services of scarce medical specialists, reportedly more than $800 million annually at the time of enactment. One of the purposes of the act was to give VA the tools to enable it to attract even some of these specialists to VA employment on a full-time basis. Also, the new pay system was designed to attract to VA young physicians first entering their professional practices after residencies and to provide them meaningful financial and professional incentives to encourage them to pursue full careers in the VA health-care system.

The IBVSOs believe the responsible committees should investigate whether the act is resulting in VA's improving its ability to achieve these goals. Physicians are essential caregivers, educators, and key biomedical researchers in the VA health-care system. This act was intended for their benefit, to attract them to VA careers and to keep them providing outstanding care to veterans. We would hope these purposes would be transparent and that VA would have moved toward implementing these goals, but we believe the Committee should confirm those intended results.

VA Physician Workplace and Clinical Workforce Issues

The IBVSOs are also concerned about the stressful working environment now confronting the VA physician workforce and other direct care providers who work with them. While the variety of matters brought to our attention over the past few years, as VA clinical workloads have grown and VA has come under major strains, might be dismissed as anecdotal and not indicative of the general national environment, they are no less disturbing to us. We have learned from several sources that a number of VA medical center directors have established arbitrary "caps" on total financial bonuses VA physicians may receive under the performance element of pay. While the act gave the VA Secretary discretion by regulation to determine appropriate pay levels, the act allowed for annual performance pay up to $15,000 or not to exceed 7.5 percent of combined base and market pay amounts for a given tier of pay. While we are sensitive to VA's continuing dire financial straits, given the intent of Congress in establishing these limitations in law, directors should not be permitted to set arbitrary performance pay amounts of as little as $1,000 to meet those purposes (we have been told this to be the case in some facilities), or nothing at all, thereby frustrating that intent.

A recent letter written by a group of VA physicians concerning workplace environment is illustrative of how pay contributes to working conditions. This was a signed letter written in 2007 to the clinical manager of a VA network. We excerpt only a few of the concerns it expresses, but we fear these may be indicative of deteriorating workplace morale across the VA system:

> *First, we are understaffed. Over the past 1½ years, we have lost a net of three physicians and one nurse practitioner at the [ ] site. We all have had to absorb those provider panels into our own, at a rapid pace. You stated that we had grown by fewer than 200 new patients since January; however, that statistic misses how we have added literally thousands of our former colleagues' patients into our own panels. Our CBOC [community-based outpatient clinic] colleagues are suffering from similar provider shortages and turnover; in a single month this spring the [ ] CBOC lost two out of seven providers. At [ ], half of us are at or above full panel, and the other half of us are virtually at full panel. We have had no success so far at recruiting new providers, and we do not see evidence of strong administration commitment to recruitment. Further, it was known many, many months in advance that we would be losing a Women's Clinic provider to her deployment to Iraq, yet there was no leadership in making sure a temporary provider was ready to step into her place. In fact, there seemed to be obstruction to an on-site willing provider starting work in Women's Clinic. Again, current providers have had to absorb the workload of the absent provider.*
>
> *We are not only understaffed in terms of providers; we are also working without adequate numbers of support staff. Specifically, within the past year, we at [ ] lost two pharmacists who used to work directly with us in the clinic; to date these positions have not been filled. Our CBOC colleagues are overwhelmed by the extra work that an understaffed pharmacy creates. At the CBOCs, the providers spend inordinate amounts of time writing and documenting prescriptions for veterans to fill locally, when our pharmacy does not fill the medications in a timely fashion. At both [ ] and the CBOCs we now have fewer nurses as well.*

The IBVSOs certainly hope these are isolated incidents, but we believe we could obtain similar concerns from other VA physician groups in primary care and elsewhere, now shouldering a very heavy workload burden and individual caseloads, in caring for veterans. If the general situation in clinical care across the VA is anything like that portrayed here, VA has a very serious and rising morale problem that eventually may interfere with health-care quality, safety, efficiency, and effectiveness. We ask the Congress to consider conducting a survey of VA facilities to gauge conditions of employment and especially to assess the current morale of the VA physician workforce. We believe this examination could be very in-

formative to the Committees on Veterans' Affairs and on Appropriations, to the VA Central Office, and to the IBVSOs, all of whom are concerned about sustaining quality VA health care.

Recommendations:

Appropriate Congressional committees should use their oversight authority to study the impact of Public Law 108-445 on recruitment and retention of VA physicians and dentists.

Congress should investigate whether P.L. 108-445 is resulting in VA's improving its ability to achieve its goals in recruitment and retention of physicians and dentists, including members of scarce specialties in great demand in both the private and public sectors.

Congress should consider conducting a survey of VA facilities to gauge current conditions of employment in VA health care and especially to assess the current morale of the VA physician workforce.

Challenges in VA Information Technology:

The Independent Budget ***veterans service organizations (IBVSOs) remain deeply concerned about the impact of centralization of information technology (IT) on clinical care and research functions within the Veterans Health Administration (VHA).***

The VA health-care system has been iteratively developing and perfecting a unique VA electronic health record (EHR) system for more than 30 years. The most important, impressive, and lasting value of the VHA's EHR system is that it was conceived and developed internally by thousands of VA clinicians, administrators, managers, biomedical and health services researchers, and clinical informatics experts—those same professionals who actually deliver VA health care in VA facilities. The current version of this EHR system, based on VHA's self-developed VistA public-domain software, sets the standard for EHR in the United States and has been publicly touted by the President and other federal officials as a model for all health-care providers nationwide to emulate. In fact, a commercial form of VistA is being imported into the patient-care systems of a number of U.S. and foreign health-care providers and networks, including state mental health facilities in West Virginia and long-term-care facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and systems in a number of foreign nations, including one that is in the process of implementing VistA as its national EHR. More are expected to adopt VistA as time goes along and a reliable means of financing EHR systems becomes more readily available.

Additionally, VHA leaders who helped bring this remarkable system into being are now major participants in efforts at the Department of Health and Human Services to markedly improve the quality, safety, and efficiency of health care in the United States, a goal that requires the same pervasive use of EHRs in routine care throughout the nation that VHA has already accomplished with VistA. VHA's remarkably successful integration of EHR into its health-care delivery process has been a critical factor in VHA's transformation since 1995 to become recognized as a national leader for health care quality, safety, and efficiency.

Private health-care facilities and networks are trying to achieve what the VHA has done already, but much more still needs to be done. Currently, only about 11 percent of the nation's private hospitals use advanced EHRs with any clinical decision support capability, and only about 15 percent claim significant physician use of computerized provider order entry systems, whereas in the VHA these processes are almost universally automated through VistA.

As discussed previously, the existence of automated records enables the VHA to provide higher quality, safer, and more efficient health care to veterans. VistA

empowers VA—uniquely—to avoid medical mistakes routinely being made by other providers in the private and public sectors. Given that the Institute of Medicine has estimated that preventable medical mistakes cost 90,000 or more lives annually, it is no exaggeration to say VistA saves veterans' lives. For example, for every prescription medication administered in a VA facility to an inpatient, a nurse uses VistA's optical character recognition (OCR) software, for bar code medication administration, to verify a patient's identify and validate that patient's proper dosage and type of medication—before it is administered. This procedure, a very simple one but with a complex VistA applications program underwriting it, has virtually eliminated medication errors in VA inpatients—the type of error that kills or sickens patients in private hospitals on a regularly occurring basis. It should also be noted that what started as an idea from a VA nurse at the VA Medical Center in Topeka, Kansas, has become an industry standard, sparking numerous commercial products that follow the same principles including adoption of the VA's term "bar code medication administration," or BCMA, a generally recognized term for the use of this OCR technology in health care.

At another level, VA more than proved the value and power of its EHR during the 2005 Gulf Coast storms when a large number of private providers in that area lost their paper records while the VHA simply transferred veterans' electronic records to other VA facilities. While VA shuttered and evacuated the New Orleans Medical Center and the Gulfport center, which was demolished, as well as a number of its community-based outpatient clinics, *not a single VA patient care record was lost* because VA's records are not stored on paper but in cyberspace. Whether veteran patients were evacuated to Houston or Minneapolis, their records were transferred electronically and were reactivated in their new treatment locations with no loss of data and no disruption of care. Also, it is important to note that not a single VA patient died as a result of the catastrophe. The 2005 reported annual cost of $87 per VA electronic record seems a pittance compared to the incalculable cost of the loss of millions of paper records by other institutions and practices, and the unfortunate effects those losses are still having on the health of millions of citizens of Mississippi and Louisiana, and parts of Texas, Florida, and Alabama.

The VHA's health-care quality improvements over more than a decade have been lauded by many independent and outside observers, including the Institute of Medicine of the National Academy of Sciences, the Joint Commission on Accreditation of Healthcare Organizations, the National Quality Forum, and the Agency for Health Care Quality and Research of the Department of Health and Human Services. For the first time in history, mainstream media and press are reporting VA health care's high quality as a news item. While its IT accomplishments alone certainly did not improve VA health care, the electronic integration of enrollment, computerized provider order entry, laboratory, radiology, nuclear medicine, pharmacy, surgical, scheduling, human resources, logistics, management, and reporting systems enables the VHA to operate, coordinate, and plan health care for veterans as never before—and to do so at a level well beyond the capabilities of other public and private practitioners. The VHA's IT system is part of the fabric of how the VHA provides clinical care. The VHA must stay in control of the methodology by which it documents and communicates its care for veterans and distributes, enforces, and measures quality, safety, and effectiveness throughout the clinical environment of care. That system *is a component of* VA health care no less crucial than VA physicians and nurses. In the judgment of the IBVSOs, the VHA is the essential place where this management and governance responsibility for health IT should lie.

Within the past year, former VA Secretary R. James Nicholson made a decision to restructure IT to give a departmental-level chief information officer complete governance authority over all IT functions (including the VHA's IT systems), as well as the agency IT budget. This action was motivated by the theft of a VA laptop computer from the home of a VA management analyst. That computer, which was later recovered intact, contained personal information on every living American veteran and most of the serving members of the U.S. armed forces. This was not a VHA laptop, was not VHA clinical information, and the analyst was not a VHA employee (he was employed by the Secretary's Office of Policy and Planning). It should also be noted that this was primarily a breach of office security policy, not IT security policy. The medium by which the offending employee removed the sensitive information from VA was electronic, rather than paper, and this theft event was not a breach of an IT security system. In the aftermath of the theft, the Secretary acted on VA IT systems *as a whole* in an effort both to satisfy Congress that VA was taking serious action to solve a chronic and serious problem in information security, about which many critics had complained for years, and to reassure veterans that VA would use all means at its disposal to protect their personal information.

All VA IT resources have since been gathered under the new Office of Information and Technology, reporting to the Secretary. Both the positive and negative effects of that centralization are now emerging. While the IBVSOs absolutely support the idea that sensitive veteran-specific information in the hands of the government needs close protection and security, the IBVSOs are concerned that focusing on information security as a problem that can be solved exclusively by IT centralization will retard the creative and crucial organizational elements that might be important in sustaining a culture of organizational vigilance in information protection. The VHA and the entire U.S. health-care community are subject to privacy and security regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), an act that comprehensively prescribes the vigilance required to protect health information. HIPAA is legislation that covers health information within the VHA, and is used by all VHA employees to guide their privacy activities related to health information on veterans.

Nationally and internationally, private sector and governments turn to the VHA to learn what is unique about its health-care system that would enable it to create and so extensively implement a transformational tool as powerful as VistA. It is ironic that, within VA now, the environment has been changed, with the possible result of jeopardizing the unique circumstances in the VHA that fostered the successful enhancement, improvement, and evolution of VistA from predecessor health and research IT activities. The future viability and sustainability of these technology advancements, now integrally intertwined with VHA's health-care delivery processes, are threatened.

VHA clinicians have high motives toward investigation, research, and teaching, and we encourage those laudable motives because they lead to higher quality, efficiency, and outcomes in health care. The VHA's IT environment feeds innovation and creative applications to solve difficult and often complex problems in clinical care, particularly in the university-affiliated environment. How long could such a delicate and balanced environment be sustained if all decisions on IT would need to be made in Washington and permission obtained for development, planning, procurement, and other key functions be granted through a centralized bureaucracy? The dampening effect would creep across the system and could well stymie creativity and alter the career choices of thousands of creative VA clinical professionals. This, in turn, would erode VA's rich programs in health professions education, clinical care, and biomedical research, in addition to frustrating the routine delivery of good health care. Such erosion places veterans' health in jeopardy. Impediments to the VHA's ability to determine the rate and scope of change in its health IT solutions embedded within the care delivery processes endanger the VHA's ability to deliver the high-quality health care our nation's veterans deserve. Such impediments delay or prevent VHA from rapidly incorporating advancements derived from its own research activities as well as from the exponentially increasing medical literature, and obstruct the VHA from continuing to transform the care delivery processes themselves.

Special Concern about IT Security and Priorities in VA Research Programs

Evolving policies of the Office of Information and Technology on data security, consequent to the laptop theft event, are already creating nearly intolerable conditions in VA's research and development programs. By its nature, VA biomedical research is a collaborative effort involving a veteran patient, the investigator, and other investigators with common interests, all of whom may or may not be working within a given VA facility, a VA network, or within the same community. While the IBVSOs are firmly in agreement that veteran privacy and data security must be safeguarded, data and systems security requirements should not defeat the patient's intent to volunteer to participate in VA-funded biomedical research, or be made to overwhelm the research itself.

By long-standing convention, a patient signs an informed consent and privacy authorization allowing the use of personal information for research purposes. Every VA-funded proposal is peer reviewed by experts in the field of the endeavor, including expertise on the maintenance of privacy and safety. Each volunteer's interest (including sensitive information) must be protected by the investigator as well as by the institutional review board that oversees research in each VA medical center where research is conducted. Nor should security requirements operate to prevent the essential transmission of data among research collaborators within an approved, funded project. Confiscating laptops, "supergluing" USB ports to prevent the use of "thumb drives," and encrypting software that freezes a hard drive if the encryption is not renewed each 30-day period by overburdened VA IT staff (these are current practices reported to the IBVSOs by VA researchers) are not approaches that provide answers to IT security needs in VA's sensitive research programs. These are examples of officials trying to solve an organizational policy issue through the limited lens of a technology-based "fix."

Given the degree of success evident in the VHA today, not only in its clinical care but also in its world-renowned biomedical research programs, the authors of *The Independent Budget* see no defensible justification for VA having centralized VHA IT governance and budgetary authority to a non-VHA environment that lacks health-care expertise. The success of VHA IT is critically linked to documented improvements in VA health-care quality. VA health-care officials, who are accountable for maintaining quality, have controlled and managed the VHA IT policy, planning, and budget functions. Thousands of clinical and other VA personnel who actually deliver health care to veterans also serve as software developers and testers, subject matter experts on IT technical evaluation panels, and daily users of VA's IT system. This symbiotic relationship of the IT system and its users supports the delivery of high-quality coordinated VA clinical care-care that these providers and managers directly control. Without this degree of health IT sophistication and integration with health-care delivery itself, we contend that the VHA would never have been able to double enrollment since 1995, significantly reduce the cost of care, and improve quality for America's veterans. With centralization, we fear these gains are in dire jeopardy.

The IBVSOs believe the VHA can best manage its own IT operations, planning, and budgeting. We feel certain that this will be true with respect to the next generation of VHA software, My HealtheVet, a web-enabled system already well into development by VHA clinicians. We acknowledge that centralization of any governmental or business function can be made to save dollars; however, these savings in the case of the VHA may come at a cost of eroded quality of care to sick and disabled veterans, with an inevitable overlay of bureaucracy that is endemic to centralization. Removing field facility personnel, especially clinical caregivers, investigators, and IT personnel, from the planning and development aspects of IT could doom future development and investments to mediocrity and the ultimate decline of VA health care.

While we recognize that IT centralization may make sense for many administrative functions in the Veterans Benefits Administration, various staff offices to the Secretary in Central Office, and functions of the National Cemetery Administration, the IBVSOs oppose centralization of IT in the VHA. Those offices' functions can be compared favorably to many other federal activities that rely on automated server systems and laptop or desktop applications, such as those offered by Microsoft, Computer Associates, and other commercial vendors of IT business platforms and systems.

We believe turning the VHA's 30-plus-year creative authority on its head and forcing the VHA to compete with other elements of the VA for IT resources for VistA, and soon for My HealtheVet, while satisfying a number of external requirements unrelated to health-care delivery, rather than permitting the VHA to continue on its successful journey of creating the next generation of health-promoting and life-saving software systems, is a potential strategic mistake of monumental proportions that should be reversed as soon as practicable. VHA's IT and its health-care delivery system are one and the same; therefore, the IBVSOs cannot support continuation of a cavalier policy that assumes VHA's IT needs are not materially different from any other type of administrative organization's—that VHA's is a simple and even pedestrian system of servers and networks that require "routine" maintenance at the point of service. Nothing could be further from the truth.

Recommendation:

The Veterans Health Administration, with the Under Secretary for Health in the lead, should regain full authority for health-related IT systems used within the fabric of the VA health-care environment, encompassing the authority for all plans, programs, operations, and budget in IT matters affecting the direct delivery of VA health care and affecting the conduct of VA's biomedical research and development programs. In regaining this responsibility, the VHA should establish designated processes to ensure coordination with the agency VA IT official to ensure that federally mandated IT security requirements are met in congruence with the VHA responsibilities as a Health Insurance Portability and Accountability Act "covered entity" for security of health information in general, and for protecting privacy and security of veterans' personal health information in particular.

Full-time Director of Physician Assistant Services:

The position of physician assistant advisor to the Under Secretary for Health should be a full-time equivalent employee (FTEE).

VA is the largest single federal employer of physician assistants (PAs), with approximately 1,574 full-time PA FTEE positions, and it has utilized PAs since 1969 when the profession started. However, since the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the Under Secretary of Health appoint a PA advisor to his office, the VHA has continued to assign this duty as a part-time field FTEE, as collateral administrative duties to their clinical duties. *The Independent Budget* has requested for the past six years that this be a full-time FTEE within the VHA and has requested a plan for bringing this key position into Washington—and all requests have been ignored.

This is the fourth Under Secretary of Health who has resisted to establish this important FTEE as full time, and, again, despite numerous requests from members of Congress, *The Independent Budget*, and professional PA associations, the Under Secretary has maintained this position as part time, field-based, with limited PA-specific clinical or personnel issues. During the time that the current part-time PA advisor was authorized, the number of PAs has grown from 1,195 to approximately 1,600. Despite this 34 percent increase, this important clinical representative has not been appointed to any of the major health-care VA strategic planning committees; has been ignored in the entire planning on seamless transition, polytrauma centers, traumatic brain injury planning, and staffing; and has not participated in new office of Rural Health Care or been utilized for emergency disaster planning—even though 36 percent of all VA-employed PAs are veterans or currently serve in the military reserves and could bring vital experiences to new initiatives for improving veterans health-care access.

PAs in the VA health-care system are essential primary care providers for millions of veteran outpatient and inpatient encounters in FY 2006, and PAs work in both critical ambulatory care clinics, emergency medicine, and in 22 other medical and surgical subspecialties. *The Independent Budget* believes that PAs are a critical component of VA health-care delivery and the coauthors urge that the position be changed to PA director, be included in VA headquarters' Office of Patient Care Services, and be a full-time FTEE in Washington, DC. We strongly urge Congress to enact H.R. 2790 and fund this FTEE within the VHA budget for FY 2009 and to ensure the PA director position is in Washington, DC.

Recommendation:

Congress should legislatively mandate the director of Physician Assistant Services as a full-time position within the office of the Veterans Health Administration Under Secretary for Health and monitor this position's implementation with reports to the Committees on Veterans' Affairs.

FAMILY AND CAREGIVER SUPPORT ISSUES AFFECTING SEVERELY INJURED VETERANS:

Given the prevalence and severity of polytrauma in the newest generation of disabled veterans, VA and the DOD should establish a series of new programs to provide support and care to their immediate family members who are committed to providing these veterans with lifelong personal care and attendance.

In "The Challenge of Caring for Our Newest Generation of War Veterans," *The Independent Budget* veterans service organizations (IBVSOs) describe the nature, prevalence, and degree of injuries veterans have suffered in Operations Enduring and Iraqi Freedom (OEF/OIF). While a miraculous number of our veterans are surviving what surely would have been fatal events in earlier periods of warfare, many now survive but are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal supports. Eventually, most of these veterans will be able to return to their families, at least on a part-time basis, or be moved to an appropriate therapeutic residential care setting—but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them substitute for the dramatic loss of physical, mental, and emotional capacities as a result of their injuries.

Immediate families of severely injured veterans of OEF/OIF face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical and emotional problems of the severely injured veteran plus deal with the complexities of the systems of care that these veterans must rely on, while struggling with disruption of family life, interruptions of personal professional goals and employment, and dissolution of other "normal" support systems because of the changed circumstances resulting from the veteran's injuries and illness.

Complex problems of the severely injured veteran

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 Iraq and Afghanistan, resulting in traumatic brain injuries that compromise cognitive functions and memory, and often result in inability to inhibit certain behaviors that are self-harming, such as domestic violence and substance misuse, 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 in many of these severely wounded veterans. In addition to the physical challenge, all these factors must be dealt with in the home as a part of the caregiving role immediate family members are expected to play.

Complexities of the systems of care

The OEF/OIF severely injured and ill veteran benefited from the military's advanced system for battlefield trauma care and expeditious transport to state-of-the-art treatment facilities in theater, at Landstuhl Air Force Medical Center in Germany, and then by aero medical evacuation to the continental United States for intensive care at Walter Reed Army Medical Center, the National Naval Medical Center in Bethesda, or in other premier military medical treatment facilities. The veteran may then be transferred to a VA polytrauma center for further care and initial rehabilitation.

Eventually the veteran is transferred for ongoing care nearer to where his or her family resides, but many of them have been shuttled back and forth from those home locations to military treatment facilities in Washington and elsewhere for follow-up services, procedures, evaluations, and even acute and chronic rehabilitative services. As this transition progresses, a complex set of overlapping and changing entitlements comes into play. This results in challenges to the coordination of care and communication of treatment and rehabilitation plans among various providers and treatment teams. Military treatment providers or contractors, TRICARE providers, VA medical staff, VA fee and contract providers, and community providers all become potentially involved in a severely injured veteran's care over the course of time. Eligibility rules, copayment requirements, and covered services often do not mesh across these systems of care, resulting in a state of confusion for providers and families, potentially degrading the optimal course of care for the severely ill veteran.

The IBVSOs believe that as early as practicable every severely injured or ill veteran evacuated from OEF/OIF

should be assigned a trained, knowledgeable, and professional advocate. The advocate's essential function should be to coordinate all military, VA, and other federal programs that provide services, benefits, and family support services, including inpatient, specialty and primary care, mental health care and counseling for veterans and family caregivers, rehabilitation, transition and community reintegration assistance, home care, respite care, vocational services, financial services, and child care services. The advocate should be assigned to support each severely disabled veteran for as long as services are required for the family.

We believe that a strong case management system should be designed to promote a smooth and transparent handoff of severely injured and ill veterans and their family caregivers between DOD and VA facilities. This case management system should be held accountable to ensure uninterrupted support as these veterans and family caregivers return home.

Disruption of family life and support systems

A severely injured veteran's spouse 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. An increasing number of the severely injured are from reserve components (primarily Army and Marine) and National Guard units. Their families likely have never lived on military bases and do not have access to the vibrant social support services and networks connected with military life. Spouses must often give up their own employment (or withdraw from school in many cases) to care for, attend, and advocate for the veteran. They often fall victim to bureaucratic mishaps in the shifting responsibility for conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation) that they must rely on for subsistence in the absence of other personal income. For many younger, unmarried veterans, their primary caregivers remain their parents, who have limited eligibility for military assistance, often are on limited incomes, and have no current eligibility for VA benefits or services of any kind. They, too, face the same dilemmas as spouses of severely injured veterans.

Immediate family caregivers (including parents) must cope with tremendous personal stress as well. The support systems they need are limited or restricted, often informal, and clearly inadequate for the long term. Within the military itself, TRICARE mental health benefits are inadequate and do not include relationship counseling. Under current law, the spouse of an enrolled veteran is eligible for limited VA mental health services and counseling only as a so-called "collateral" of the veteran; such services are spotty to nonexistent across the VA system. The IBVSOs have been informed by local VA officials that they are providing a significant amount of training, instruction, counseling, and health care to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the absence of legal authority to provide these services and that scarce resources that are needed elsewhere are being diverted to those needs, without recognition within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency of this need.

The authors of *The Independent Budget* believe Congress should formally authorize, and VA should provide, a full range of psychological and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and continuous psychological burden of caring for a severely injured and permanently disabled veteran. VA should develop plans to deploy such services in every location in which VA treats OEF/OIF disabled, and at a minimum should provide such services at every Veterans Health Administration (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 telemental health technology and the Internet. 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.

The IBVSOs believe practice makes perfect and that families of severely disabled veterans need practice before they are saturated with responsibilities in caring for their extraordinary veterans. To this end, VA should establish a pilot program immediately for providing 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, the pilot program should focus on helping the veteran and other family members restarting, or "rebooting," their lives after surviving devastating injury. An integral part of this program should include family counseling and family peer groups so they can share solutions for common problems.

Today, VA's system for providing respite care for severely injured veterans, to provide needed rest for a family caregiver, is fragmented and unpredictable, and governed by local VA nursing home care unit (NHCU) and adult day health-care (ADHC) policies. Understandably, these programs are targeted to older veterans with chronic illnesses, whereas veterans who survived horrific injuries in Iraq and Afghanistan are still in the early parts of their lives. Thus, VA's NHCU and ADHC programs remain unattractive to OEF/OIF veterans. They need to be adapted to become more acceptable and attractive to this new generation of disabled war veterans.

The IBVSOs believe VA should establish a new national program to make periodic respite services available to all severely injured veterans. This program should be designed to meet the needs of younger severely injured or ill veterans, in contrast to the generally older veteran population now served by VA programs. Where appropriate VHA 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.

Given the nature of these issues, and the unique situation that confronts our newest generation of severely disabled war veterans, the IBVSOs believe Congress and the Administration need to address a number of observed deficits to make a family caregiver's tasks and roles more manageable over the long term. This is in the best interests of these families, whose absence as personal caregivers and attendants for these seriously disabled veterans would mean even higher costs to the government to assume total responsibility for their care, and would lower the quality of life for the very veterans for whom VA was established as a caring agency.

Recommendations:

Congress should formally authorize, and VA should provide, a full range of psychological and social support services as an earned benefit to family caregivers of veterans with severe service-connected injuries or illnesses.

VA should assign an accountable advocate and case manager to each severely injured or ill veteran's family. The case management system must be seamless for veterans and family caregivers. Case manager advocates must be empowered to assist with medical benefits and family support services, including vocational services, financial services, and child care services.

VA should provide psychological support services to the family caregivers of severely injured and ill veterans. This support must include relationship and marriage counseling, family counseling, and related assistance to the family in coping with the inevitable stress and discouragement of caring for the veteran. These services should be made available at every VA medical center and all CBOCs that care for severely disabled OEF/OIF veterans.

VA should establish clear policies expecting every VA nursing home and adult day health dare program to 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 NHCUs and ADHC programs. As we have indicated in prior *Independent Budgets* and in testimony, we believe VA must *adapt* its services to the particular needs of this new generation of disabled veterans and not simply require these veterans to accept what VA chooses to offer.

VA should develop support materials for family caregivers, including the following:

- A "Caregiver Toolkit" that is available both in hard copy and from the Internet. This should include a concise "recovery roadmap" to assist families in understanding and maneuvering through the complex systems of care and resources available to them; and

- Social support and advocacy support for the family caregivers of severely injured veterans, including:

    - Peer support groups, facilitated and assisted by committed VA staff members;
    - Appointment to local and VA network patient councils and other advisory bodies to local and regional Veterans

Health Administration and Veterans Benefits Administration managements; and,

- 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 amend the Family and Medical Leave Act to address the special needs of the families of severely injured veterans, including increasing the duration of family leave time that is authorized by that act, and adding additional employment protections for immediate family members who are caregivers of severely disabled veterans of OEF/OIF.

Construction Programs

One of the strengths of the Capital Asset Realignment for Enhanced Services (CARES) process was that it was not just a one-time snapshot of needs. As part of the CARES process, the Department of Veterans Affairs (VA) developed a health-care model to estimate current and future demand for health-care services and to assess the ability of its infrastructure to meet this demand. VA uses this model throughout its capital planning process, basing all projected capital projects upon demand projections from the model.

This model, which drives many of the health-care decisions VA makes, produces 20-year forecasts of the demand for services. It is a complex model that adjusts for numerous factors, including demographic shifts, changing needs for health care as the veterans' population ages, projections for health-care innovation, and many other factors.

VA's testimony in a November 2007 House Veterans' Affairs Committee hearing summed up the process: "Once a potential project is identified, it is reviewed and scored based on criteria VA considers essential to providing high-quality services in an efficient manner. The criteria VA utilizes in evaluating projects include service delivery enhancements, the safeguarding of assets, special emphasis programs, capital asset priorities, departmental alignment, and financial priorities. VA considers these new funding requirements along with existing CARES decisions in determining the projects and funding levels to request as part of the VA budget submission. Appropriate projects are evaluated for joint needs with the Department of Defense and sharing opportunities."

VA uses these evaluation criteria to help prioritize its projects each year, releasing these results in its annual five-year capital plan. The most recent one, covering fiscal years 2007–2012, is part of the Congressional budget submission in "Volume III: Construction Activities." This plan is central to VA's funding requests and clearly lists the Department's construction priorities for the current year, as well as for the immediate future.

In developing the current fiscal year's request, VA uses the criteria listed above in developing a prioritization score. The current year priority projects are then ordered, but they fall behind previous years' projects that Congress only partially funded—perhaps because of the multistage planning process or because of changes in construction cost estimates.

For fiscal year 2007, for example, there were 10 partially unfunded projects from previous fiscal years.

Partially Unfunded Projects					
	FY Priority Ranking	Cost	Funded Amount To Date	FY '08 Budget Request	Unfunded Amount
Pittsburgh, PA	FY04–03	$ 248,000	$ 102,500	$ 40,000	$ 105,500
Denver, CO	FY04–10	$ 646,000	$ 102,000	$ 61,300	$ 477,700
Orlando, FL	FY04–12	$ 553,900	$ 25,000	$ 35,000	$ 493,900
Las Vegas, NV	FY05–06	$ 600,400	$ 259,000	$ 341,400	$ 0
San Juan, PR	FY05–20	$ 178,100	$ 10,880	$ 0	$ 167,220
Syracuse, NY	FY05–21	$ 77,700	$ 53,900	$ 23,800	$ 0
Los Angeles, CA	FY05–25	$ 111,800	$ 7,936	$ 0	$ 103,864
Lee County, FL	FY05–26	$ 109,400	$ 10,498	$ 9,890	$ 89,012
Fayetteville, AR	FY06–05	$ 65,700	$ 5,800	$ 0	$ 59,900
St Louis, MO	FY07–07	$ 99,000	$ 7,000	$ 0	$ 92,000
TOTAL BALANCE					**$1,589,096**
(All Dollars in Thousands)					

Unfortunately, the $560 million request for Veterans Health Administration (VHA) construction for FY 2008 does not even meet the needs of previous fiscal years with four of the 10 previous years' funding priorities receiving no funding. Consequentially, because projects from previous years take priority over the current year, not one of the FY 2008 priority projects received a funding request, including the highest priority projects in Tampa, Florida; Seattle, Washington; or Bay Pines, Florida.

VA's estimates of these top three FY 2008 projects indicate that they would cost a total of $334 million. The 10 partially funded projects have a balance of $1.6 billion. That represents almost $2 billion in construction priorities that lack funding, and that total only includes those three new projects. Clearly, VA needs more funding.

One of the reasons for such a large backlog of construction is because Congress allocated so little funding during the CARES process. The Appropriations Committees provided few resources during the initial review phase, preferring to wait for the results of CARES, something *The Independent Budget* veterans service organizations (IBVSOs) repeatedly argued against. We argued that the de facto moratorium on construction was unnecessary because of our conviction that a number of these projects needed to go forward and that they would be fully justified through any plans developed by CARES. The House agreed with our views as evidenced by their passage of the Veterans Hospital Emergency Repair Act, which passed unanimously on March 27, 2001. Congress, however, never appropriated funding and the construction backlog grew.

Upon completion of the CARES decision document, former VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans Affairs in July 2004. His testimony noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next five years to modernize VA's medical infrastructure and enhance veterans' access to care."

According to VA's November 2007 testimony before that same Committee, Congress has appropriated just $2.83 billion for CARES projects, far below the need to which the Secretary had testified. Further, this includes a sizeable amount for rebuilding facilities after the Gulf Coast hurricanes—amounts we have argued that Congress should have provided as separate emergency funding, outside of VA's regular planning process.

With just $560 million requested for fiscal year 2008, which is far below VA's demonstrated needs, it is clear that VA is falling short. After that five-year de facto moratorium and without additional funding coming forth, VA and veterans have an even greater need than they did at the start of the CARES process. Accordingly, we urge the Administration and the Congress to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the 21st century needs of veterans.

Construction Issues

Major Construction Account

The Major Construction budget includes funding for projects estimated to cost $10 million or more. The IB-VSOs recommend a total of $1.275 billion in funding.

Category	Funding (Dollars in Thousands)
Veterans Health Administration	$ 1,100,000
National Cemetery Administration	$ 75,000
Advanced Planning	$ 45,000
Master Planning	$ 20,000
Historic Preservation	$ 20,000
Asbestos	$ 3,000
Claims Analyses	$ 2,000
Facilities Security	$ 5,000
Judgment Fund	$ 5,000
TOTAL	**$ 1,275,000**

- VHA—Funds previous fiscal year's backlogged priority projects and begins funding current year priorities through initial steps of the design and build process.
- NCA—Fully funds a number of national cemeteries from VA's priority list on Page 7-132 of VA's 2008 Five-Year Capital Plan.
- Advanced Planning—Used for developing the scope of a project and for studying items specific to a site.
- Master Planning—See following text.
- Historic Preservation—See following text.
- Asbestos—Used for abatement of asbestos and other contaminants.
- Claims Analyses—Assists with legal claims against VA.
- Facilities Security—Used for studying vulnerability of VA facilities and conducting related projects.
- Judgment Fund—Used to settle claims against VA.

Minor Construction Account

VA's Minor Construction Account funds projects that are less than $10 million, but more than $500,000. The IBVSOs recommend a total funding amount of $621 million, the bulk of which to go to funding construction of and improvements to medical facilities.

Category	Funding (Dollars in Thousands)
VHA	$ 545,000
NCA	$ 50,000
VBA	$ 20,000
Staff	$ 6,000
TOTAL	**$ 621,000**

- VHA—VA's 2008 Five-Year Capital Plan details hundreds of potential projects that require funding with approximately 200 that were specifically set aside for fiscal year 2009. These projects are listed starting on page 7-86 of that report.
- NCA—VA's 2008 Five-Year Capital Plan provides nearly 500 potential minor construction projects within the National Cemetery Administration for the fiscal years 2008–2012, starting on page 7-134.
- VBA—VA's 2008 Five-Year Capital Plan lists several minor construction projects for the Veterans Benefits Administration (VBA), including the roughly $2 million annually it transfers to the U.S. State Department for security related to the VBA office in the Philippines.
- Staff—VA's 2008 Five-Year Capital Plan identifies numerous potential construction projects for various other staff offices within the Department, starting on page 7-153.

INADEQUATE FUNDING AND DECLINING CAPITAL ASSET VALUE:

VA does not have adequate provisions to protect against deterioration and declining capital asset value.

The last decade of underfunded construction budgets has led to a reduction in the recapitalization of VA's facilities. Recapitalization is necessary to protect the value of VA's capital assets by renewing the physical infrastructure to ensure safe and fully functional facilities. Failure to adequately invest in the system will result in its deterioration, creating even greater construction costs down the road.

As in past years, *The Independent Budget* veterans service organizations cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). We note that in the period from 1996 to 2001, VA's recapitalization rate was 0.64 percent, which corresponds to an assumed building life of 155 years. When factoring maintenance and restoration into VA's major construction budget, VA annually invests less than 2 percent of plant replacement value in the system. Citing a PricewaterhouseCoopers study of VA's facilities management programs, the PTF observed that a minimum of 5 percent to 8 percent per year is necessary to maintain a healthy infrastructure and that failure to adequately fund construction and maintenance needs could lead to unsafe, dysfunctional settings.

Recommendation:

Congress and the Administration must ensure that there are adequate funds for major and minor construction so that VA can properly reinvest in its capital assets to protect their value and ensure that the Department can continue to provide health care in safe and functional facilities long into the future.

INCREASE 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 highlighted the need for increased funding for the nonrecurring maintenance (NRM) account. NRM consists of small projects that are essential to the proper maintenance of and preservation of the lifespan of VA's facilities. NRM projects are one-time repairs, such as maintenance to roofs, repair and replacement of windows and flooring, or minor upgrades to the mechanical or electrical systems. They are a necessary component of the care and stewardship of a facility.

These projects are so essential because if ignored, they can really take their toll on a facility, leading to more costly repairs in the future, and the potential of a need for a costly minor construction project. Beyond the fiscal aspects, facilities that fall into disrepair can create access difficulties and impair patient and staff health and safety, and if things do develop into a larger construction projection because early repairs were not done, it creates an even larger inconvenience for veterans and staff.

The Washington Post's reports in spring 2007 on the deplorable conditions at Walter Reed Army Medical Center highlighted the importance of NRM funding. While not a VA facility, the problems our wounded warriors faced are the worst-case scenario of what happens when NRM projects are not carried out. It is a national disgrace that our servicemen and -women, especially those who have paid such a heavy price, were forced to live in substandard conditions amidst mold and leaky plumbing and in rooms with rotting floors and holes ripped in walls.

In the immediate aftermath of the Walter Reed story, former VA Secretary Nicholson on March 7 ordered an immediate review of VA's maintenance needs. VA released the 83-page report on May 21. It showed that the majority of VA's facilities were in good condition and that most of the deficiencies that this "National Roll Up of Environment of Care Report" identified were, in VA's words, "normal wear and tear."

The IBVSOs, however, have some concerns with the report's findings as well as with what they represent. A March 22, 2007, article in *The Washington Post* reported that VA officials concluded that 90 percent of the problems identified were routine, such as walls needing paint, but that VA deemed 10 percent as critical, including the following:

- Amarillo—problems with the fire alarm and smoke-barrier system.
- Fayetteville—fixtures, such as handrails and pipes exposed, creating a patient safety threat in mental health units.
- Saginaw—carpeting more than 15 years old and stained from "patients' personal accidents."
- Manchester—old carpeting stained, worn out, and, in some cases, installed over asbestos floor tiles.
- White City—local colony of Mexican wing-tailed bats occasionally infiltrating the interior portions of the facility and not just the attics.

Numerous other facilities reported issues with mold, leaky pipes, and roofs as well as with more cosmetic issues, such as discolored or defective ceiling tiles, peeling paint, and holes in walls, as well as issues with the quality of or appearance of flooring.

VA could correct every single problem identified in its report using NRM funding. Congress appropriated $1.2 billion in April 2007 to fix the aforementioned problems. The IBVSOs are certainly appreciative of VA's efforts to identify and correct these deficiencies, but we believe it should not have come to this. VA should have should have identified and cleaned up these problems before political pressure and media attention forced its hand.

In previous editions of *The Independent Budget*, we have identified full and proper funding of the NRM account as one of the largest challenges facing VA's facilities managers. These conditions only highlight what we have for years argued in favor of.

The industry standard for medical facilities is for managers to spend from 2 percent to 4 percent of plant replacement value (PRV) on upkeep and maintenance. The 1998 PricewaterhouseCoopers study of VA's facilities management practices argued for this percentage of funding.

The most recent estimate of VA's PRV, according to its Asset Management Plan, is approximately $40 billion. Accordingly, that same document agrees with the PricewaterhouseCoopers' percentages, leading to a recommended appropriate level of NRM funding from $800 million to $1.6 billion.

The IBVSOs would note that the level of NRM funding in the past few years of appropriations has fallen far below that. For fiscal year 2008, for example, the Administration recommended only a paltry $573 million for NRM. Over the previous two fiscal years, Congress appropriated only about $1 billion total for this critical account, far below what VA itself had identified as a need. It is no wonder, then, that the thorough review of VA's facilities showed so many critical issues or the great number of less critical but nontrivial instances of disrepair.

Not only had funding for NRM been below VA's demonstrated needs, but because it is allocated under the Medical Care account (as part of the Medical Facilities budget) and not the Construction Account, VA's facilities managers, when pressed with difficult health-care options, have in the past used funding for health-care delivery. This is especially true with the recent inability of Congress to pass an on-time appropriation and with the growing demand for health care, especially among Operation Enduring Freedom and Operation Iraqi Freedom veterans.

We also have concerns with how VA apportions NRM funding. Because it falls under the Medical Care account, VA has traditionally apportioned NRM funding using the Veterans Equitable Resource Allocation (VERA) formula. This model works when divvying up health-care dollars, targeting money to those areas with the greatest demand for health care. When dealing with maintenance needs, though, this same formula may actually intensify the problem, moving money away from older hospitals, such as in the Northeast, to newer facilities where patient demand is greater, even if the maintenance needs are not as high. The IBVSOs were happy to see that the House and Senate Appropriations Committees reports to the recent VA appropriations

bills required VA to apportion NRM funding outside the VERA formula, and we would hope that this continues into the future.

Another issue related to apportionment of funding came to light in a May 2007 Government Accountability Office (GAO) report. The GAO found that VA does not actually apportion the bulk of NRM funding until September, the final month of the fiscal year. In September 2006, for example, the GAO found that VA allocated 60 percent of that year's NRM funding. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and because NRM funding is year to year, this could lead to wasteful or unnecessary spending as hospital managers rush in a flurry to spend their apportionment before forfeiting it back. We cannot expect VA to perform a year's worth of maintenance in a month. It is clearly poor policy and not in the best interest of veterans.

Recommendations:

In accordance with industry standards and its own "Asset Management Plan," VA should spend 2 percent to 4 percent of its plant replacement value—$800 million to $1.6 billion—on nonrecurring maintenance (NRM) to ensure that its facilities are clean and safe for patients and staff.

VA must resist the temptation to dip into NRM funding for health-care needs as backlogging maintenance could lead to far greater expense in the future.

VA must give its hospital managers access to NRM funding consistently throughout the year, not just a lump sum in the final part of the year. Apportioning funding evenly throughout the year would allow them to better plan for necessary repairs and reduce waste and inefficiency in NRM use.

Congress must continue to ensure that NRM funding is not subject to the VERA formula and that funding goes to the hospitals and clinics with the greatest maintenance needs, not simply those with the most patients.

Timeliness of Construction Must Improve:

Congress and VA must do a better job in speeding up the construction process from its initial planning stages through the opening of a facility.

From planning to completion, the construction or renovation of a VA facility can take many years. There are many reasons for this delay, and a number of issues that could help speed up the process. The nature of the appropriations/authorization funding cycle creates much of the delay. Congress often funds VA major construction projects in a multistage process, usually consisting of three separate steps: the design phase, land acquisition and site preparation, and the actual construction and completion of the facility. The design phase often takes 18 months or longer. Land acquisition can be a complicated and drawn-out process, and construction takes a few years. Further, the appropriations cycle for each stage takes at least one year. Add it up, and it can take a decade from the initial proposal of a building until the date of completion.

When there are appropriations delays, the process bogs down even further. In fiscal year 2008, the VA funding bill was late once again, impairing the Department's ability to properly plan for, budget for, and enter into contracts related to the design, site preparation, and construction of its facilities. Without a steady stream of funding, construction cannot go forward and VA must push projects off into the future. This is doubly troublesome in that construction delays lead to dramatically increased costs, especially since 2004. As in all facets of the Department, it is essential that VA's construction managers receive on-time funding to best manage the department's priorities.

One possibility for improvement is the expansion of VA' s use of design-build contracts. Design-build con-

tracts award one contract to an architect/engineer and construction contractor team who take VA's initial designs, complete them, and construct the project, combining two of those steps and speeding up the process. Federal highway contracts, for example, are often given to design-build firms to minimize disruptions to commuters. VA currently executes about one-third of its projects with the design-build method. It would be worthwhile for VA to study the effectiveness of this method, the impact it has on the cost projection, the actual cost of the project, and what a project slowed by an extra delay for an additional appropriation would cost, as well as the facilities and construction projects that best work with this methodology.

Recommendations:

VA must receive an on-time appropriation to speed up the planning and design process and to minimize construction delays.

VA should study the effectiveness of awarding more design-build contracts, which could streamline the scope of the construction process, reducing some delays and potentially reducing costs.

Establishing a Program for Architectural Master Plans:

Each VA medical center needs to develop a detailed master plan.

The VA construction budget should include at least $20 million to fund architectural master plans. Without these plans, hasty and shortsighted construction planning could jeopardize Capital Asset Realignment for Enhanced Services (CARES) medical benefits.

The Independent Budget veterans service organizations believe that each VA medical center should develop a facility master plan to serve as a clear roadmap to where the facility is going in the future. It should be a document that includes multiple projects in a cohesive strategy.

In some cases, VA plans construction in a reactive manner. Projects are funded first and then fitted onto the site. VA plans each project individually and not necessarily with respect to other ongoing projects or ones planned for the future. It is essential that each medical center have a plan that looks at the big picture to efficiently utilize space and funding. If all VA does not simultaneously plan all projects, for example, VA may build the first project on the best site for the second project. Master plans would prevent shortsighted construction that restricts, rather than expands, future options.

Every new project in the master plan is a step in achieving the long-range CARES objectives. VA must develop these plans so that all future projects can be prioritized, coordinated, and phased. They are essential to efficiently use resources, but also to minimize disruption to VA patients and employees. For example, VA must often adjust medical priorities for construction sequencing. If infrastructure changes must precede new construction, master plans will identify this so that VA can plan for changes in schedules and budgets. Careful phasing is essential to avoid disrupting the delivery of medical care, and the correct planning of such will ensure that cost estimates of this phased-construction approach will be more accurate.

There may be cases, too, where master planning will challenge the original CARES decisions, whether due to changing demand, unidentified need, or other cause. For example, if CARES calls for the use of renovated space for a relocated program and a more comprehensive examination, as part of a master plan, later indicates that the site is impractical, different options should be considered. Master plans will help to correct and update invalid planning assumptions.

VA must be mindful that some CARES plans involve projects constructed at more than one medical center. Master plans, as a result, must coordinate the priorities of both medical centers. Construction of a new spinal cord injury facility, for example, might be a high priority for the "gaining" facility, but a lower priority for

the "donor" facility. It may be best to fund and plan the two actions together, even though the CARES plan splits them between two different facilities.

Another essential role of master planning is its use to account for three critical programs VA left out of the initial CARES process: long-term care, severe mental illness, and domiciliary care. Because CARES left them out, there is a strong need for a comprehensive plan, and a full facility master plan will help serve as a blueprint for each facility's needs in these essential areas. VA has since made efforts to account for long-term care in a separate plan that interfaces with the health-care projection model the department uses, in part, to assess construction needs, and they have made great strides in assessing the need for mental-health service, but VA must continue to focus on and address these issues.

VA must ensure that each medical center develops and continues to work on long-range master plans to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruptions to patient care.

Recommendations:

Congress must appropriate $20 million to allow each VA medical facility to develop architectural master plans to serve as roadmaps for the future.

Each facility master plan should address long-term care, including plans for those with severe mental illness, and domiciliary care programs, which the CARES process omitted.

VA must develop a format for these master plans so that there is standardization throughout the system, even though local contractors will perform planning work in each Veterans Integrated Service Network.

Empty or Underutilized Space at Medical Centers:

VA must not use empty space inappropriately.

Studies have suggested that the VA medical system has extensive amounts of empty space it could reuse for medical services. Reports have suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships not only for function but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. For example, VA likely cannot use unoccupied rooms on the eighth floor 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 of everything around it; these secondary impacts greatly increase construction expense, and they can disrupt patient care.

Some features of a medical facility are permanent. Contractors and architects cannot alter floor-to-floor heights, column spacing, light, and structural floor loading. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent a similar new space. When factoring in the aforementioned domino or

secondary costs, the renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for needs that are more modern. The government built and designed most of these Bradley-style buildings 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. They also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise VA would have previously renovated or demolished it 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 it to retain the proceeds from the sale, transfer, or exchange of certain properties in their Capital Asset Fund (CAF). Further, that law required VA to develop short-term and long-term plans for the disposal of facilities, and to provide these to Congress annually. VA must continue to develop these plans, working in concert with its architectural master plans and the long-range vision for a site.

Recommendation:

VA should develop a plan for addressing its excess space in nonhistoric properties that are not suitable for medical or support functions due to their permanent characteristics or locations.

VA Space Planning Criteria/Design Guides:

VA must remain committed to state-of-the-art methods of health-care delivery.

VA uses Space Planning Criteria and Design Guides to program space and design considerations for all new health-care projects, including new construction and renovation. VA developed these guides using input from VA advisory groups as well as outside consultants in order to develop standards that are consistent with the VA model of health-care delivery as well as methods used in the private sector.

VA is currently in the process of updating the Space Planning Criteria and Design Guides for its health-care services. To date, VA has updated all 60 chapters of the Space Planning Criteria, and the department has entered these criteria into a computer database called SEPS II. VA is also updating the lists of associated equipment. VA is currently working on updating the associated design guides for each chapter. When completed, these components, together, will provide a comprehensive and up-to-date tool with which to determine space needs, project design, and equipment specification.

All of this has been a monumental task and *The Independent Budget* veterans service organizations commend VA for this effort. We would note, however, that methods of health-care delivery are constantly changing. The Department should be cognizant of these changes and adjust its methods of health-care delivery accordingly. VA must regularly update the Space Planning Criteria and Design Guides.

Recommendation:

VA must remain committed to state-of-the-art methods of health-care delivery. VA needs to regularly review and update the Space Planning Criteria and Design Guides to reflect delivery of the highest level of health care.

Preservation of VA's Historic Structures:

VA has a large inventory of historic structures that must be protected and preserved.

VA 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 and who helped to develop this great nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected, and preserved because they are an integral part our nation's history.

Most of these historic facilities are not suitable for modern patient care. As a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services (CARES) process. As a first step in addressing its responsibility to preserve and protect these buildings, VA must develop a comprehensive program. For the past five years, *The Independent Budget* has recommended that VA conduct an inventory of these properties, classifying their physical condition and their potential for adaptive reuse. Medical centers, local governments, nonprofit organizations, or private-sector businesses could potentially find a use for these important structures. VA has been moving in that direction and the department now identifies historic properties on its website. VA has placed many of these buildings in an "Oldest and Most Historic" list, and they require immediate attention.

The cost for saving some of these buildings is not very high considering that they represent a part of history that enriches the texture of our landscape and once gone cannot be recaptured. For example, VA could restore the Greek revival mansion in Perry Point, Maryland, built in the 1750s, for use as a training space for about $1.2 million. VA could also restore the Milwaukee Ward Memorial Theater, built in 1881, as a multipurpose facility at a cost of $6 million. This is much less than the cost of a new facility.

The Independent Budget veterans service organizations recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. Their expertise would be helpful in implementing a preservation program.

As part of its adaptive reuse program, VA must ensure that the new owners of facilities that the department leases or sells maintain the sites properly. VA could address its legal responsibilities, for example, through easements on property elements, such as building exteriors or grounds. We would point to the partnership between the Department of the Army and the National Trust for Historic Preservation as an example of how VA could successfully manage its historic properties.

We encourage the use of P.L. 108-422, the Veterans Health Programs Improvement Act, which authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property.

Recommendation:

VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

Career and Occupational Assistance

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to their entry or reentry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties, in turn, contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

In recent years there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, cumbersome, and unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training in their particular field while on active duty, yet in most cases these learned skills and trades are not recognized by nonmilitary organizations. Efforts to enhance civilian awareness of the qualities and depth of military training should be made to reduce or eliminate licensing requirements and employment barriers. We are encouraged by the continued emphasis now being placed on employment and not just the counseling portion of vocational rehabilitation.

In response to criticism of the Vocational Rehabilitation and Employment (VR&E) Service, former Department of Veterans Affairs Secretary Anthony Principi formed the Vocational Rehabilitation and Employment Task Force. The Secretary's intent was to conduct an "unvarnished top to bottom independent examination, evaluation, and analysis." The Secretary asked the task force to recommend "effective, efficient, up-to-date methods, materials, and metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment. In March of 2004, the task force released its report recommending needed changes to the VR&E services. *The Independent Budget* continues to support the recommendations of the Vocational Rehabilitation and Employment Task Force, and the IBVSOs look forward to monitoring the continued implementation of these recommendations.

Career and Occupational Assistance Programs

Vocational Rehabilitation and Employment

Vocational Rehabilitation and Employment Funding:

Congressional funding for VA Vocational Rehabilitation and Employment (VR&E) services must keep pace with veteran demand for VR&E services.

The VR&E program provides services and counseling necessary to enable service-disabled veterans with employment handicaps to prepare for, find, and maintain gainful employment in their communities. The program also provides independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their reentry back to private life. The program future offers educational and vocational counseling to service members and veterans recently separated from active duty. These services are also available to dependents of veterans who meet certain eligibility requirements.

The Office of Management and Budget (OMB) evaluates the average cost of placing a service-connected veteran in employment at $8,385 as calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, OMB calculations do not include a provision for inflation, increased student tuition costs, and the numbers of veterans who drop out of the VR&E program or enter interrupt status of their rehabilitation plan. Comparisons to other vocational programs are not appropriate since nonfederal dollars are excluded when calculating their cost to place an individual in employment status.

Many veterans are facing significant challenges when they return home from the current global war on terror. These large numbers of regular military, National Guard, and Reserves are creating tens of thousands of new veterans, many of whom are eligible for VR&E programs. At present funding levels, VR&E programs cannot keep pace with the current and future demands for VR&E benefits.

Recommendation:

Congress must provide the funding level to meet veteran demand for VA Vocational Rehabilitation and Employment programs.

VR&E Staffing Levels Are Inadequate:

Staffing levels of the VA's Vocational Rehabilitation and Employment (VR&E) Service are not sufficient to meet the needs of our nation's veterans in a timely manner.

The VR&E Service is charged with the responsibility to prepare disabled veterans for suitable employment and provide independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their entry into the program. VR&E must begin to strengthen its program due to the increasing number of service members returning from Afghanistan and Iraq with serious disabilities. These veterans require both vocational rehabilitation and employment services. There is no VA mission more important during or after a time of war than to enable injured military personnel to have a seamless transition from military service to a productive life after serving their country.

Success in the transition of disabled veterans to meaningful employment relies heavily on VA's ability to provide vocational rehabilitation and employment services

in a timely and effective manner. Unfortunately, the demands and expectations being placed on the VR&E Services 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 delay in providing VR&E services to disabled veterans, thus reducing the veteran's opportunity to achieve successful rehabilitation.

To increase emphasis on employment, the service has begun an initiative titled "Coming Home to Work" as an early outreach effort to provide VR&E services to eligible service members pending medical separation from active duty at military treatment facilities. This and other new programs will require additional staff to maintain efforts nationwide. It is imperative that VA increase VR&E staffing levels to meet the increasing demand our nation's veterans have for services. The following facts further confirm these programs.

Currently, there are approximately 94,500 veterans in the various phases of VR&E programs compared to 70,000 in FY 2000. This number is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Nineteen thousand veterans have ended their participation in the VA rehabilitation program. Of these, 73 percent successfully completed the program. This is a marked increase from years past; however, only 74 percent of those service members who were found eligible to receive VR&E benefits signed rehabilitation plans and pursued the benefits. It is a positive sign that 3 percent of service members who sign up for the program complete it, but it is discouraging to find placement into the program is 8 percent below the program's target.

For many years, *The Independent Budget* veteran service organizations have criticized VR&E Service programs and complained that veterans were not receiving suitable vocational rehabilitation and employment services in a timely manner. Many of these criticisms remain 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;
- declaring veterans rehabilitated before suitable employment is retained for at least six months; and
- inconsistent tracking of electronic case management information system.

Recommendation:

VA needs to strengthen its Vocational Rehabilitation and Employment 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.

VA Center for Veterans Enterprise:

The Center for Veterans Enterprise (CVE) needs additional funding to assist veterans and service-disabled-veteran–owned small business enterprises, the mission for which it was established.

There are approximately 5 million veteran-owned small businesses in the United States according to the Department of Veterans Affairs. In February 2001, a new program entitled the Center for Veterans Enterprise was established by the passage of the Veterans Entrepreneurship and Small Business Development Act of 1999.

The CVE, a subdivision of the Office of Small and Disadvantaged Business Utilization, extends VA services to include veterans who own or who want to start a veteran-owned small business. It also helps federal contracting offices to identify veteran-owned businesses in response to Executive Order 133600 calling for federal contracting and subcontracting opportunities for service-disabled-veteran–owned small businesses. In addition, the CVE works with the Small Business Administration's Veterans Business Development centers nationwide regarding veteran business financing, management, bonding, and providing technical support for veteran entrepreneurs with the goal of increasing

the number of veteran and service-disabled-veteran–owned small businesses. Unfortunately, the funding for this program is inefficient to meet the ever-increasing needs of our nation's veterans.

Recommendation:

Congress must provide VA with additional funding for the Center for Veterans Enterprise so that it can meet the increasing veteran demand for entrepreneurial services.

Veteran Entrepreneurship:

More than one-third of both new veteran entrepreneurs and current veteran business owners have gained skills from their military service that are relevant to business ownership.

Increasing attention has been called to the entrepreneurial needs of American veterans, particularly those who have service connected disabilities. Not since the Vietnam War have American veterans experienced such high rates of disabilities, which include larger numbers of amputees. For many of these veterans, self-employment will be the only alternative to employment and successful reintegration back into society.

More than one-third of both new veteran entrepreneurs and current veteran business owners have gained skills from their military service that are relevant to business ownership. Several government reports indicate that approximately 22 percent of America's war fighters returning from the war on terrorism are purchasing, starting, or considering starting a small business. Unfortunately, there are many obstacles for them to overcome. There are major issues that veterans face including financing, bonding, and access to federal contracts. These necessary business segments have become so restrictive that it has become impossible for many veterans to establish or maintain their own small business enterprises.

Recommendation:

VA must help eliminate the barriers that veterans face when trying to establish and/or maintain a veteran-owned or service-disabled-veteran–owned small business.

VA's Failure to Implement P.L. 109-461 Contracting:

VA has yet to approve any policy or procedures to guide its contracting officers on how to set aside and/or award sole-source contracts for service-disabled-veteran–owned small businesses.

Public Law 109-461, The Veterans Benefits, Health Care and Information Technology Act of 2006, was signed into law by President Bush on December, 22, 2006, and required the law to take effect by 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.

Unfortunately, at the time of this writing, VA has failed to implement the law. Acquisition and Material management staff, in conjunction with VA attorneys, have yet to approve any policy or procedures to guide VA contracting officers on how to set aside and/or award sole-source contracts for service-disabled-veteran–owned small businesses. Without specific guidance and changes to the Federal Acquisition Regulations (FAR), existing acquisition policy will continue to apply. We have been informed that the process could take several years before approval if not expedited. VA personnel involved in the acquisition process need to become familiar with the new authorization and their responsibilities under P.L. 109-461. Our service-disabled veterans who own small businesses cannot afford to wait years for VA to become compliant with the law.

Recommendation:

VA must expedite implementation of P.L. 109-461 so veteran entrepreneurs can receive set-aside and sole-source contracts. Further delays in approving policy and regulation dangers the success and longevity of recently established service-disabled-veteran–owned small businesses.

Business Financing:

Veterans, particularly veterans who are service disabled, have difficulties obtaining financial support to establish or maintain a small business.

In an effort to assist veterans with financing a business, the Small Business Administration (SBA) has established a new loan program entitled "The Patriot Express Loan Initiative." Under this program, veterans can obtain business loans up to $500,000 and qualify for SBA's maximum loan guarantee of up to 85 percent of the loan value of $150,000 or less and 75 percent guarantee for loans more than $150,000. Unfortunately, lenders require collateral to secure the 15 percent to 25 percent of the loan not covered by the SBA guarantee. This collateral requirement actually restricts most recently discharged veterans from obtaining small business loans due to insufficient collateral.

Recommendation:

VA should establish a loan-guarantee program similar to its current VA Home Loan Guarantee program to provide recently discharged veteran entrepreneurs the security needed to establish a small business after they have left the military service even though they may be starting with little or no income or collateral.

Veteran Surety Bonding:

Surety bonding levels provided by the Small Business Administration (SBA) are inadequate for veteran entrepreneurs to compete in today's construction field.

Surety bonding continues to be a major problem for service-disabled-veteran–owned small businesses working in the construction field. Surety bonding levels currently guaranteed by the SBA at $2 million are grossly inadequate for today's federal construction process. Service-disabled-veteran small business owners find it difficult to obtain surety bonding required by federal contracting officers to compete for government contracts. Service-disabled-veteran small business owners also have difficulties preparing their businesses to withstand the scrutiny of the surety bonding process, especially when working on other construction projects.

Recommendation:

VA needs to establish a shared bonding process in conjunction with the Small Business Administration and provide a process to increase bonding limits upward to $15 million, which is necessary for service-disabled veterans to compete in today's construction market. VA should also develop a program for service-disabled veterans to teach them how to prepare their companies to overcome the obstacles that preclude them from obtaining surety bonding in a timely and efficient manner.

VA's Vendor Information Page Database:

Government agencies need a one-stop access to identify veteran and service-disabled-veteran–owned small businesses and verify their veteran status.

At the present time, vendors wanting 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 must self-certify their status without verification. P.L. 109-461, required VA to establish a vendor information page database designed to identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. Congress should take appropriate steps to require all agencies to use the VA's VetBiz Vendor Information Pages (VIP) to certify veteran status and ownership before awarding contracts to companies claiming to be veteran- or service-disabled-veteran–owned small businesses.

Recommendation:

All federal agencies should be required to certify veteran status and ownership through the VA's Vendor Information Pages (VIP) program before awarding contracts to companies claiming to be veteran- or service-disabled-veteran–owned small businesses.

Follow-up on Referrals to Other Agencies for Entrepreneurial Opportunities:

VA Vocational Rehabilitation and Employment (VR&E) Service staff should follow up with veterans who are referred to other agencies to ensure the veteran's entrepreneurial opportunities have been achieved.

VR&E has expanded its effort toward fostering awareness and opportunities for self-employment by signing memorandums of understanding with the Department of Labor, Small Business Administration, and the Veterans Corporation and SCORE. They have also implemented the Five Track Employment Process, which places emphasis on self-employment as a potential for gainful employment. VR&E has further included self-employment in standardized operation materials, online employment sources, and information guides. However, VR&E must follow up with veterans who were referred to other agencies for entrepreneurial opportunities and reassess their employment needs if they were not successful.

Recommendation:

Vocational Rehabilitation and Employment Service staff must follow up with veterans after being referred to other agencies for self-employment to ensure that the veteran's entrepreneurial opportunities have been successfully achieved.

VR&E Revision of Procedural Manuals:

The Vocational Rehabilitation and Employment (VR&E) Service must continue to revise its procedural manuals to keep current with changes in laws and regulations.

VR&E is currently working on revising its procedure manuals, which have been neglected for several years. Four of the seven chapters have been revised leaving three parts still to be updated. In addition to revising the content of the manual, VR&E must establish an ongoing routine for revising its manuals to be consistent with changes in laws, regulations, and policies.

Recommendation:

The Vocational Rehabilitation and Employment manual must be routinely revised to remain current with present as well as future changes in laws, regulations, and policies.

VR&E Contract Counselors:

VA needs to improve the oversight of contract counselors to ensure that veterans are receiving the full array of Vocational Rehabilitation and Employment (VR&E) programs and services in a timely and compassionate manner.

VA's Strategic Plan for FY 2006–2011 reveals that VA plans to continue the utilization of contractors to supplement and complement services provided by VR&E staff. However, *The Independent Budget* veterans service organizations are concerned about the quality of services provided by contract counselors, which may be contributing to the problem of veterans dropping out of their VR&E program before completion or going into interrupt status in their rehabilitation plan.

A survey conducted by the Veterans Benefits Administration Office of Performance Analysis & Integrity conducted in 2003 supports this concern. The survey concluded that "VA staff counselors were consistently rated higher than contractor counselors on the majority of issues addressed by their survey." VA counselors were viewed to be more concerned about the individual's needs and goals and were likely to be more caring and compassionate.

Recommendations:

Vocational Rehabilitation and Employment Service staff must improve the oversight of contract counselors to ensure veterans are receiving the full array of services and programs in a timely and compassionate manner.

The VR&E Service should improve case management techniques and use state-of-the-art information technology.

The VR&E Service must increase the success rate of their program above the current 67 percent to meet its goal of 80 percent by 2011.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

VA needs to streamline eligibility and entitlement to VR&E programs to provide earlier intervention and assistance to disabled veterans.

The VR&E Service needs to identify and address why veterans drop out of its VR&E program prior to completion or choose to interrupt their rehabilitation plans.

The VR&E Service must place higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

The VR&E Service should follow up with rehabilitated veterans for at least two years to ensure that the rehabilitation and employment placement plan has been successful.

VA needs to develop resource centers that focus on obtaining and maintaining gainful employment for veterans. The program needs to prepare veterans for interviews, offer assistance creating résumés, and develop proven ways of conducting job searches.

Transition Assistance Programs Inadequate:

The Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) do not adequately serve service members.

The Departments of Defense, Labor, and Veterans Affairs provide transition-assistance workshops to separating military personnel through TAP and DTAP. These programs generally consist of a three-day briefing on employment and related subjects, and veterans' benefits.

DTAP, however, has been largely relegated to a "stand-alone" session. Typically, a DTAP participant does not benefit from other transition services, nor does he or she automatically see a Vocational Rehabilitation and Employment (VR&E) Service representative.

The number of military members being separated annually remains high (more than 200,000 as projected by the DOD). These numbers continue to grow as large numbers of separating service members are returning from the global war on terrorism. Many have been on "stop loss," prevented from leaving military service on their scheduled date, and they depart military service soon after their return. It is imperative that these soon-to-become veterans are not overlooked during their rapid transition to civilian life. Additionally, tens of thousands of National Guardsmen and reservists have been called to active duty for the current conflict. No coherent program exists for them to receive transition services at demobilization. In some ways, they face even more difficult employment problems after being ripped from their civilian employment to serve the nation. Though protections exist, separating service members need detailed information on these protections and the benefits of service as well as information on other opportunities they may have available. *The Independent Budget* veterans service organizations (IBVSOs) believe TAP/DTAP must continue to provide their important services as recommended by the VR&E Task Force in March 2004 and expand them to Guardsmen and Reservists returning from combat.

The IBVSOs are encouraged that the VR&E Service is in the process of restructuring DTAP. However, we are concerned that too little is still being done for transitioning disabled veterans and we will continue to monitor the changes and progress in DTAP.

Recommendations:

Congress should pass legislation ensuring the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.

VA should assign primary responsibility for the Disabled Transition Assistance Program within the Veterans Benefits Administration to the Vocational Rehabilitation & Employment Service and designate a specific DTAP manager.

The DOD should work closely with the DOL to ensure detailed transition services are provided at the demobilization station or other suitable site for demobilizing National Guardsmen and reservists.

The DOD should ensure that separating service members with disabilities receive all of the services provided under the Transition Assistance Program as well as the separate DTAP session provided by the VR&E Service.

Whenever practical, the DOD should make preseparation counseling available for members being separated prior to completion of their first 180 days of active duty unless separation is due to a service-connected disability when these services are mandatory.

The House and Senate Veterans' Affairs Committees should conduct oversight hearings regarding the implementation of P.L. 107-288 to ensure the President's National Hire Veterans Committee fulfills the following purposes:

> Raise employer awareness of the advantages of hiring separating service members and veterans; facilitate the employment of separating service members and veterans through America's Career Kit, the National Electronic Labor Exchange; and direct and coordinate departmental, state, and local marketing initiatives.

Congress should provide the DOL adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act provisions.

Licensing and Certification:

Recently separated service members should have the opportunity to take licensing and certification examinations without a period of retraining.

Men and women of the armed forces acquire extensive knowledge and job skills, via military training and work experience, which are transferable to an array of civilian occupations. Along with technical proficiencies, service members offer intangible qualities like leadership skills and strong work ethics that are eagerly sought in the national job market as well as in other branches of government.

Yet an untold number of separating service members miss immediate opportunities to obtain good, high-paying jobs because of civilian licensure and certification requirements. Much of the lengthy and expensive training necessary for such certification is redundant to, and in some cases modeled on, military training.

This inefficient and costly waste of valuable human resources is unfair to veterans, an impediment to businesses that need skilled workers, and ultimately a burden upon the national economy due to delayed job creation, consumer spending, and unnecessary unemployment compensation insurance payments.

Recommendation:

To eliminate such artificial hurdles to employment in the private sector, the Department of Defense in partnership with the Department of Labor should develop programs that track military training requirements and how they compare to those needed for licensing and certification in the civilian workforce. Additionally, the DOL should work with states and local governments and the private sector to enhance civilian awareness of the quality and depth of military training and to eliminate superfluous licensing requirements and employment barriers.

Training Institute Inadequately Funded:

The National Veterans' Training Institute (NVTI) lacks adequate funding to fulfill its mission.

The National Veterans' Training Institute was established to train federal and state veterans' employment and training service providers. Primarily, these service providers are Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) specialists. DVOP/LVER specialists are located throughout the country at various locations, such as state workforce centers, VA Vocational Rehabilitation and Employment (VR&E) Service offices, VA medical centers, Native American trust territories, military installations, and other areas of known concentrations of veterans or transitioning service members.

DVOP/LVER specialists help veterans make the difficult and uncertain transition from military to civilian life. They help provide jobs and job training opportunities for disabled and other veterans by serving as intermediaries between employers and veterans. They maintain contacts with employers and provide outreach to veterans. They also develop linkages with other agencies to promote maximum employment opportunities for veterans.

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. It is administered by the Department of Labor Veterans Employment and Training Service through a contract with the University of Colorado at Denver. The NVTI curriculum covers an array of topics that are essential to DVOP/LVER specialists' ability to assist veterans in their quest to obtain and maintain meaningful employment. Such topics include courses to develop the following:

- core professional skills,
- media marketing skills,
- case management skills,
- investigative techniques,
- quality management skills, and
- grants management skills.

Certain DVOP/LVER specialists may be required to participate in employment programs involving other state and federal agencies. The NVTI helps prepare DVOP/LVER specialists for their roles in such programs as the VR&E Service and the Transition Assistance Program (TAP). The NVTI curriculum also includes information and training on the Uniformed Services Employment and Reemployment Rights. The NVTI offers Department of Defense employees TAP management training through reimbursable agreements under the Economy Act (at actual cost of training). The NVTI also offers a Resource and Technical Assistance Center, a support center, and repository for training and resource information related to veterans' programs, projects, and activities. *The Independent Budget* veterans service organizations are concerned that, after several years of level funding, appropriations for the NVTI for FY 2005 actually decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

Recommendation:

Congress must fund the National Veterans' Training Institute at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

PERFORMANCE STANDARDS:

Performance standards in the Veterans Employment and Training Service (VETS) system need to be uniform and consistent.

The enactment of the Jobs for Veterans Act (P.L. 107-288) has resulted in significant improvements in employment services to veterans and is showing a positive impact on veteran employment outcomes. However, while progress is being made, there are still no clear and uniform performance standards that can be used to compare one state to another or even one office to another office within one state.

In 2002, VETS began reporting performance outcomes that measured the "entered employment rate" and "employment retention rate" of veterans by state. However, the report lists percentages only, not actual numbers of veterans hired or served. Federal contractors must also file a "veterans hired" report annually. However, this report does not include all veterans employed and is only applicable to employers with federal contracts exceeding $25,000. The Bureau of Labor Statistics also has a number of reports available on the Department of Labor (DOL) website; however, none of them differentiate between disabled veterans, nondisabled veterans, and nonveterans. It is clear that the DOL needs to develop a standardized performance measure system and develop a centralized, national research database with this information.

Furthermore, despite these reporting requirements, the VETS headquarters and regional administrators have almost no authority to reward a good job or impose sanctions for poor performance. The only real authority is the seldom-used power to recapture funds when a state has acted in a way contrary to law. VETS is authorized to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly disabled veterans, to find work. However, this recognition is only for individuals and not entities. It would be practical if Congress would amend the Jobs for Veterans Act so entities (such as career one-stops) can be recognized and rewarded for exceeding the standards by providing them with additional funding.

In 2004, VETS performance measures were applied to veterans served by the Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) staff members as well. For several years, many have expressed a need for qualification standards to be put in place for both DVOP and LVER staff. In 2005, there was draft legislation proposed that would require the Secretary of the Department of Labor to establish such professional qualifications for employment in the two programs. While this concept is certainly welcomed and broadly supported, the legislation did not explain exactly how VETS would implement the new qualification standards.

The heart and soul of VETS efforts is the dedicated DVOPs and LVERs tasked with facing the employment challenges of hard-to-place veterans. For decades, DVOPs and LVERs have been the cornerstone of employment services for veterans. It is important for states to continue to be required to hire veterans for these positions. Part of this reason is that these individuals are veterans advocating for veterans. After all, DVOP and LVER staff are the front-line providers for services to veterans. They are the individuals who provide a smooth transition of service members from the military to the civilian workforce.

We must never lose sight of the fact that veterans continue to need the special job training and services that VETS provides within the DOL. Shifting VETS to VA will not improve the employment and training needs of veterans. The DOL knows the job market and skills required to fill jobs beyond any other executive department. Furthermore, it is unclear as to exactly how VA would effectively run the program that so naturally suits the DOL. VA does not have the capacity or the assets to support employment programs. Therefore, *The Independent Budget* veterans service organizations recommend that VETS remain a function of the Department of Labor.

Recommendations:

The Veterans Employment and Training Service should compile, and make available to the public, a state-by-state, standardized performance measure system on the hiring of veterans on all levels.

Congress should amend the Jobs for Veterans Act so that entities (such as career one-stops) can be recognized and rewarded with additional funding.

Congress needs to continue work on crafting legislation that will provide meaningful Disabled Veterans' Outreach Program and Local Veterans' Employment Representative qualification standards, provide the Secretary with the authority and direction to implement the standards, and keep VETS within the Department of Labor.

National Cemetery Administration

The Department of Veterans Affairs National Cemetery Administration (NCA) maintains more than 2.8 million gravesites at 125 national cemeteries and 33 additional installations in 39 states and Puerto Rico. Currently, there are more than 17,000 acres within established NCA installations. Just more than half of this land is undeveloped. Including available gravesites and the undeveloped land, there is a potential to provide more than 4 million resting places. In addition to the maintenance of these facilities, the NCA administers four programs: the State Cemetery Grants Program, the Headstone and Marker Program, the Presidential Memorial Marker Program, and Outer Burial Receptacle reimbursements.

VA estimates that approximately 24 million veterans are alive today. These veterans served in wars and conflicts ranging from World War I to the global war on terrorism, as well as service in peacetime. The age of our veteran population has peaked and is starting to decline, and as a correlation to this peak, the annual number of veteran deaths is beginning to decline. In 2008, nearly 683,000 veterans are expected to die; this number is expected to slowly decrease over the years. However, with the anticipated opening of new national cemeteries and an increase to the State Cemetery Grants Program, annual interments are projected to increase to more than 105,000 in 2008 with en estimated peak of 115,000 in fiscal year 2009.

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 would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families despite funding shortfalls, aging equipment, and the increasing workload of new cemetery activations. We again call on the Administration and Congress to provide the resources needed to meet the critical nature of NCA's mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

National Cemetery Administration (NCA) Accounts

The Independent Budget (IB) recommends an operations budget of $252 million for the NCA for fiscal year 2009 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations. The NCA is responsible for five primary missions:

- to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites;
- to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application;
- to administer the state grants program in the establishment, expansion, or improvement of state veterans cemeteries;
- to award a presidential certificate and furnish a United States flag to deceased veterans; and
- to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf, and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, functions, and appearance of the national cemeteries. Therefore, in accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a five-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the fiscal year 2009 operations budget. Volume 2 of the independent study identified 928 improvement projects in its then 119 national cemeteries. NCA has expended $99 million to complete work on 269 of these projects. These projects include gravesite renovation, repair, upgrades, and maintenance. Headstones and markers must be cleaned, realigned, and set. Stone surfaces of columbaria require cleaning, caulking, and grouting, and the surrounding walkways must be maintained. Grass, shrubbery, and trees in burial areas and other land must receive regular care. Additionally, cemetery infrastructure, i.e., buildings, grounds, walks, and drives must be repaired as needed.

According to the study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options and maintenance programs. The IBVSOs were encouraged that the NCA earmarked $28.2 million for the National Shrine Commitment for fiscal year 2008. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but there is a long way to go to get our national cemeteries to where they need to be. By enacting a five-year program with dedicated funds and an ambitions schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

In addition to the management of the national cemeteries, the NCA has responsibility for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

The Independent Budget veterans service organizations call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

FY 2009 National Cemetery Administration

FY 2009 National Cemetery Administration (dollars in thousands)	
FY 2008 Administration Request	$166,809
FY 2008 *IB* Recommendation	$213,335
FY 2009 *IB* Recommendation	
Administrative Services	$201,975
Shrine Initiative	$ 50,000
Total FY 2009 *IB* Recommendation	**$251,975**

THE STATE CEMETERY GRANTS PROGRAM:

Heightened interest in the State Cemetery Grant Program (SCGP) results in stronger state participation and complements the National Cemetery Administration's (NCA) mission.

The State Cemetery Grants Program complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

The SCGP faces the challenge of meeting a growing interest form states to provide burial services in areas that are not currently served. The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits 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 not currently served by a national cemetery.

States remain, as before the enactment of the Veterans Benefits Improvement Act of 1998, totally responsible for operations and maintenance, including additional equipment needs following the initial funeral purchase of equipment. The program allows states, in concert with the NCA, to plan, design, and construct the highest-quality cemeteries to honor veterans.

To help provide reasonable access to burial options for veterans and their eligible family members, *The Independent Budget* recommends $42 million for the SCGP for fiscal year 2009. The availability of this funding will help states establish, expand, and provide state-owned veterans cemeteries, and help the NCA reach its goal of providing veteran burial options for veterans within a 75-mile radius or a population threshold of 170,000.

Recommendations:

As a result of the interest and continued state participation, Congress should fund the State Cemetery Grants Program (SCGP) at a level of $42 million to adequately fund the planning, design, construction, and equipment expenses.

The National Cemetery Administration should continue to effectively market the SCGP.

Veterans Burial Benefits:

The burial benefit, now only 6 percent of what was provided when the National Cemetery Administration (NCA) started paying this benefit, must be increased to a level proportionate to the original benefit.

In 1973 the federal government started paying burial benefits to assist in the funeral cost for our veterans. Over the years the value of these benefits has been greatly reduced due to inflation. It was never the intent of Congress to cover the full cost of burial; however, the benefits now pay only a small fraction of what was covered 34 years ago.

In 2001 the plot allowance was increased for the first time in more than 28 years, to $300 from the original amount of $150. This higher figure covers approximately 6 percent of funeral costs. *The Independent Budget* recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

The 108th Congress increased the allowance for service-connected deaths from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. Clearly, it is time this allowance is raised to make a more meaningful contribution to the costs of burial for our veterans. *The Independent Budget* recommends increasing the service-connected benefits from $2,000 to $4,100, bringing it back up to a level proportionately level to the original benefit.

The nonservice-connected benefit was last adjusted in 1978, and today it covers just 6 percent of funeral costs. *The Independent Budget* recommends increasing the nonservice-connected benefit from $300 to $1,270.

Recommendations:

Congress should increase the plot allowance from $300 to $745 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected benefit from $2,000 to $4,100.

Congress should increase the nonservice-connected benefit from $300 to $1,270.

Congress should enact legislation to adjust these burial benefits annually for inflation.

AMVETS
4647 Forbes Boulevard
Lanham, MD 20706
301.459.9600
www.amvets.org

DISABLED AMERICAN VETERANS
807 Maine Avenue, SW
Washington, DC 20024-2410
202.554.3501
www.dav.org

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, NW
Washington, DC 20006-3517
202.872.1300
www.pva.org

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
200 Maryland Ave, NE
Washington, DC 20002
202.543.2239
www.vfw.org

www.independentbudget.org