



THE **I**NDPENDENT BUDGET

FOR THE **DEPARTMENT OF VETERANS AFFAIRS**

FISCAL YEAR **2011**

A COMPREHENSIVE BUDGET & POLICY DOCUMENT
CREATED BY VETERANS FOR VETERANS

The Independent Budget

Critical Issues Report

For Fiscal Year 2011

As the United States enters the ninth year of the global war on terrorism, and with service members continuing to be placed in harm's way in Iraq, Afghanistan, and foreign theaters, the Department of Veterans Affairs (VA) is facing growing pressure to meet their needs and the needs of the veterans of earlier service. The sacrifices these brave soldiers, sailors, airmen, marines, and coastguardsmen have made will leave them dealing with a lifetime of physical and psychological wounds. It is for these men and women and the millions who came before them that 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.

Whereas *The Independent Budget for Fiscal Year 2011* will be released in February 2010 concurrent with the release of the President's proposed budget for the Department of Veterans Affairs, this "Critical Issues" report is designed to alert the Administration, Members of Congress, VA, and the public to the issues concerning VA health care, benefits, and benefit delivery that we believe deserve special scrutiny and attention. We are releasing this report now as a guide to policy makers so they can confirm an adequate budget for FY 2011 and begin preparing the advance appropriation for the medical care accounts of VA for FY 2012. *The Independent Budget* will present specific funding recommendations for FY 2011 and medical care recommendations for FY 2012 in February. Through these efforts we believe VA will be better positioned to successfully meet the challenges of the future. We also hope that this document will provide direction and guidance for the Administration and Members of Congress.

As the war on terrorism grows longer and longer, the obligation that this country has to the men and women who have served and sacrificed grows as well. Additionally, we must be cognizant of the current fiscal realities in a time of turbulent and rapidly fluctuating economic conditions that may compel veterans of past service to seek VA care and benefits for the first time.

With this new reality ever present in our minds, we must do everything we can to ensure that VA has all the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve on the frontier of freedom need to know that they will come home to a nation that respects and honors them for their service, while also providing 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 this will mark the 24th year of *The Independent Budget*. We are equally proud of the respect and influence that it has gained during that time. 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 this “Critical Issues” report 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.

CRITICAL ISSUE 1

Sufficient, Timely, and Predictable Funding for VA Health Care

The Department of Veterans Affairs must receive sufficient funding for veterans health care and Congress must reform the funding process to ensure sufficient, predictable, and timely VA health-care funding.

With the end of the first session of the 111th Congress nearing, it is important to review and assess its efforts to provide sufficient, timely, and predictable funding for the Department of Veterans Affairs, particularly the health-care system. The actions of Congress this year, in general, reflect a commitment to maintaining a viable VA health-care system. More important, Congress showed real interest in reforming the budget process to ensure that VA knows in advance of the start of the new fiscal year exactly how much funding it will receive.

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations,* including the four coauthors of *The Independent Budget*, has advocated for reform in the VA health-care budget process. This year the Partnership made a concerted effort to effect real change in the budget process. By working with the leadership of the House and Senate Committees on Veterans' Affairs, the Military Construction and Veterans Affairs Appropriations Subcommittees, and key members of both parties, the Partnership was able to move advance appropriations legislation forward. At the beginning of the year, Representative Bob Filner (D-CA), chairman of the House Committee on Veterans' Affairs, and Senator Daniel Akaka (D-HI), chairman of the Senate Committee on Veterans' Affairs, introduced the Veterans Health Care Budget Reform and Transparency Act (H.R. 1016/S. 423). This legislation would, in fact, guarantee that VA health-care funding would be sufficient, timely, and predictable.

Although members of both committees appeared to have serious questions about how best to address the recurring funding problems for the VA health-care system, it is clear that the current process must be reformed in a manner that meets three key tests: *sufficiency*, *timeliness*, and *predictability*. Most important to consider is that as long as the VA health-care system remains part of the current annual discretionary funding process it will remain vulnerable to unrelated budget and partisan politics that threaten the quality of care for veterans.

Again this year Congress provided historic funding levels in the House and Senate versions of the Military Construction and Veterans Affairs appropriations bill for the Department of Veterans Affairs that matched, and in some cases exceeded, the recommendations of *The Independent Budget*. Unfortunately, as has become the normal process, the Military Construction and Veterans Affairs appropriations bill has yet to be completed, even though the start of the new fiscal year passed October 1. While the House passed the bill in the summer, the Senate was unable to approve the bill prior to the beginning of the new fiscal year. This fact serves as a continuing reminder that despite excellent funding levels provided over the past two years the larger appropriations process is in need of reform.

* *The Partnership for Veterans Health Care Budget Reform is made up of The American Legion, AMVETS, Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans of the USA, Military Order of the Purple Heart of the U.S.A., Inc., Paralyzed Veterans of America, Veterans of Foreign Wars of the United States, and Vietnam Veterans of America.*

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 veterans' health-care appropriations legislation on time continues to hamper and threaten health care. When VA does not receive its funding in a timely manner, it is forced to ration health care. Much-needed medical staff cannot be hired, medical equipment cannot be procured, waiting times for veterans increase, and the quality of care suffers.

Only through a comprehensive reform of the budget and appropriations process, such as advance appropriations, will Congress be able to ensure the long-term viability and quality of the VA health-care system. A review of recent budget cycles makes it evident that even when there is strong support for providing sufficient funding for veterans medical care programs, the systemic flaws in the budget and appropriations process continue to hamper access to and threaten the quality of the VA health-care system.

In February 2009, President Obama released a preliminary budget submission for the Department of Veterans Affairs for fiscal year 2010. This submission only projected funding levels for the overall VA budget. The Administration recommended \$55.9 billion for VA, approximately \$5.8 billion more than the FY 2009-appropriated level and nearly \$1.3 billion more than recommendations in *The Independent Budget for Fiscal Year 2010*.

In early May the Administration released its detailed budget blueprint that included approximately \$47.4 billion for medical care programs, an increase of \$4.4 billion over the FY 2009-appropriated level and approximately \$800 million more than the recommendations of *The Independent Budget*. The budget also included \$580 million in funding for Medical and Prosthetic Research, an increase of \$70 million over the FY 2009-appropriated level.

For FY 2010, *The Independent Budget* had recommended that the new Administration and Congress invest \$54.6 billion in the Department of Veterans Affairs—\$4.5 billion more than the FY 2009 operating budget—to adequately meet veterans' health-care and benefits needs. Recommendations included \$46.6 billion for health care and \$575 million for medical and prosthetic research.

The coauthors of *The Independent Budget* also remain concerned that despite significant increases in VA health-care funding in recent years, VA still has not dedicated the necessary resources to remove the prohibition on enrollment of priority group 8 veterans, who have been blocked from enrolling in VA since January 17, 2003. In response to this continuing policy, Congress continues to target additional funding to begin opening the VA health-care system to some priority group 8 veterans. In fact, the final approved FY 2009 appropriations bill included approximately \$375 million to increase enrollment of priority group 8 veterans by 10 percent. More important, the President committed to expanding the enrollment of priority group 8 veterans into the VA system by more than 500,000 by FY 2013.

However, as we have emphasized in the past, VA must have a clear plan for incrementally increasing the enrollment of this population. Otherwise, VA risks being overwhelmed by significant new workload. *The Independent Budget* is committed to working with the Department of Veterans Affairs and Congress to implement a workable solution to allow all eligible priority group 8 veterans to begin enrolling in the system.

Recommendations:

- Congress should enact the Veterans' Health Care Budget Reform and Transparency Act (H.R. 1016/S. 423) in order to reform VA's medical care appropriation to give it an advance appropriation status. This would guarantee timely and predictable funding without converting it to mandatory status or requiring it to meet Congressional pay-as-you-go rules for mandatory accounts.
- Congress should require VA's internal budget model, with the information audited by the Government Accountability Office, to be shared publicly to provide accurate estimates for VA health-care funding.
- The Administration and Congress must provide sufficient funding for VA health care to ensure that all eligible veterans are able to receive VA medical services without undue delays or restrictions.
- Once VA has calculated the cost to reopen the system to all veterans, the department should be fully funded to accommodate the priority group 8 veterans who choose to use the VA health-care system for their health-care needs.

CRITICAL ISSUE 2

The Continuing Challenge of Caring for War Veterans

The Departments of Defense and Veterans Affairs face unprecedented challenges in meeting the needs of a new generation of war veterans and their families while continuing to provide effective care for veterans injured or ill from earlier military conflicts.

Since October 2001 approximately 1.9 million military service members have deployed to Iraq and Afghanistan in Operations Enduring and Iraqi Freedom (OEF/OIF).¹ Because many service members participate in multiple deployments, they are subjected to a number of serious threats, including mortar attacks, suicide bombs, and exposure to repeated blasts from improvised explosive devices (IEDs). Current studies indicate that repeated exposure to IED blasts, along with the stress of these deployments, is exacting a heavy toll on the fighting force, resulting in a variety of seemingly “invisible” wounds, including post-traumatic stress disorder (PTSD), major depression, and cognitive impairments as a result of milder incidences of traumatic brain injury (TBI). Military medicine has advanced to unprecedented levels of excellence that have resulted in a 90 percent survival rate among wounded veterans.² However, within the DOD and VA health-care systems, gaps remain in the recognition, diagnosis, treatment, and rehabilitation of these less-visible injuries. These new veterans exhibit the same symptoms today that earlier generations of veterans experienced years, and even decades, ago.

The DOD and VA 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 postdeployment readjustment problems as a result of combat exposure and from chronic manifestations of older injuries and illnesses incurred in service. Without question, both agencies have done an extraordinary job in treating those who have suffered the most grievous polytraumatic injuries during current conflicts. But these deployments are also causing heavy casualties in what are considered the invisible wounds of war—PTSD, depression, substance-use disorders, family disruptions and distress, 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 the newest generation of combat 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. Congress must also remain apprised of how VA spends the significant new funds that have been provided and earmarked specifically for the purpose of meeting all enrolled veterans’ mental health and physical rehabilitation needs, whether acute or chronic.

The *Independent Budget* veterans service organizations (IBVSOs) are grateful that VA has adopted the principles of the President’s New Freedom Commission on Mental Health. The commission’s ultimate goal is the eradication of the stigma that surrounds mental health challenges and the opportunity for full recovery for people facing those challenges. The commission’s framework for achieving this important goal should be the guiding beacon for VA mental health planning, programming, budgeting, and clinical care for veterans of OEF/OIF service and of all military service periods. Optimal recovery is also the goal for those with severe physical injuries.

¹*National Journal*, Vol. 41, No. 38, September 19, 2009, pp. 24–31.

²Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan: Hearing before the House Committee on Veterans Affairs, 110th Cong., 1 (2007) (Testimony of Matthew Goldberg, deputy assistant director for National Security, Congressional Budget Office).

Traumatic Brain Injuries

The RAND Corporation Center for Military Health Policy Research completed a comprehensive study in 2008 titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. RAND found that the effects of TBI are still poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it.³ The study evaluated the prevalence of mental health and cognitive problems of OEF/OIF service members; the existing programs and services available to meet the health-care needs of this population; the gaps that exist in these programs and what steps need to be taken to improve these services; and the costs of treating or not treating these conditions.

The study found rates of PTSD, major depression, and probable TBI are relatively high when compared to the U.S. civilian population.⁴ RAND estimated that approximately 300,000 of the 1.64 million OEF/OIF service members who had been deployed as of October 2007 suffer from PTSD or major depression and that about 320,000 individuals experienced a probable TBI during deployment.⁵ Additionally, about one-third of those previously deployed have at least one of those three conditions, and about 5 percent report symptoms of all three.

According to RAND, 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. Approximately 53 percent of those who met the criteria for PTSD or major depression sought help from a physician or mental health provider in the past year.⁶ However, it was noted that even when individuals sought care, too few received *quality* care—with only half having received what was considered minimally adequate treatment. A number of barriers to care were identified by survey participants as reasons for not getting treatment.⁷ RAND concluded that there is a need for increased access to confidential, evidenced-based psychotherapy and that the prevalence of PTSD and major depression will likely remain high unless efforts are made to enhance systems of care for these conditions.

Finally, the study evaluated the costs of these mental health and cognitive conditions to the individual and society. These conditions can impair relationships, disrupt marriages, affect parenting, and cause problems in veterans' children.⁸ RAND determined the estimated financial costs associated with mental health and cognitive conditions related to OEF/OIF service would be substantial (\$4 billion to \$6 billion over a two-year period for PTSD and major depression, and \$591 million to \$910 million for TBI within the first year of diagnosis).⁹

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, 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 powerful detonations. Symptoms can include chronic headaches, irritability,

³*Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary*, RAND Center for Military Health Policy Research, at XX (T. Tanielian & L. Jaycox eds., 2008).

⁴*Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary*, RAND Center for Military Health Policy Research, at XXI, (T. Tanielian & L. Jaycox eds., 2008).

⁵*Ibid.*

⁶*Ibid.*

⁷*Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary*, RAND Center for Military Health Policy Research, at XXII (T. Tanielian & L. Jaycox eds., 2008).

⁸*Ibid.*

⁹*Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary*, RAND Center for Military Health Policy Research, at XXIII, (T. Tanielian & L. Jaycox eds., 2008).

behavioral disinhibition, sleep disorders, confusion, memory problems, depression, and other behavioral conditions.

Emerging literature (including the RAND study) 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 mental health conditions. Additionally, TBI and PTSD can be coexisting conditions in one individual. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. The IBVSOs 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 veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. The medical and social histories of previous generations of veterans could be of enormous value to VA researchers interested in the likely long-term progression of brain 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-to-moderate TBI in combat veterans of the future.

The VA's Office of the Inspector General (OIG) issued an initial report on July 12, 2006, titled *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury 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. The OIG Office of Health Care Inspections conducted follow-up interviews to determine changes since the initial interviews conducted in 2006. The OIG concluded that three years after completion of initial inpatient rehabilitation many veterans with TBI continue to have significant disabilities and although case management has improved, it is not uniformly provided to these patients.¹⁰

Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, and progress is being made, gaps in services are still troubling. *The Independent Budget* veterans service organizations remain concerned about whether VA has fully addressed the long-term emotional and behavioral problems that are often associated with TBI and the devastating impact on both veterans *and* their families.

While a miraculous number of our veterans are surviving what surely would have been fatal wounds in earlier periods of warfare, many 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 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 consequence of their injuries. Immediate families of newly and severely injured veterans 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 and deal with the complexities of the systems of care that these veterans must rely on—all while struggling with disruption of their family life, interruptions of personal goals and employment, and often the dissolution of other “normal” support systems most people take for granted.

¹⁰Follow Up Health Care Inspection: *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*, VA Office of Inspector General Report No. 08-01023-119 at 8, (2008).

Better Case Management and Caregiver Support Are Essential

The IBVSOs believe that a strong case management system is necessary to ensure a smooth and transparent transfer of severely injured and ill veterans and their family caregivers from DOD to VA programs of care. This case management system should be held accountable to ensure uninterrupted support as these veterans and family caregivers return home and attempt to rebuild their lives. 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. Spouses must often give up their personal plans (resign from employment, withdraw from school, etc.) to care for, attend, and advocate for the veteran. They often fall victim to bureaucratic mishaps as a result of the shifting responsibility within conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation) on which they must rely for subsistence in the absence of other personal means. For many younger, unmarried veterans who survive their injuries, the primary caregivers remain their parents, who have limited eligibility for military assistance and have virtually no current eligibility for VA benefits or services of any kind.

Both the DOD and VA health-care systems are limited in authority as well as capacity to provide mental health and relationship counseling services to family members—an important component of the postdeployment rehabilitation process for veterans and their families. However, the IBVSOs have been informed by a few local VA officials that they are providing a significant amount of training, instruction, counseling, and other services 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 possible absence of legal authority to provide these services and that scarce resources are being diverted to these needs without recognition of their cost 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 and validity of this need.

The Independent Budget veterans service organizations believe Congress should authorize, and VA should provide, a full range of psychological counseling 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 burden of caring for a severely injured and permanently disabled veteran. Also, we believe VA should establish a new national program to make periodic and flexible respite services available to all severely injured veterans. Two bills are currently pending in Congress that would advance caregiver support services, but these bills are currently stalled and await further action by both chambers.

Substance-Use Disorder

Another issue having an impact on service members, veterans, and their families is substance-use disorders. There are multiple consistent indications from both the DOD and VA that the misuse of alcohol and other substances will continue to be a significant problem for many OEF/OIF service members and veterans. Likewise, ample evidence documents the severity and chronicity of substance-use disorder in earlier generations of war veterans. An untreated substance-use disorder can result in a number of health consequences for the veteran and family, including a marked increase in health-care expenditures, additional stresses on families, social costs from loss of employment, and additional, avoidable costs to the legal system. The IBVSOs urge VA and the

DOD to collectively continue research into this critical area and to identify the best treatment strategies to address substance-use disorder and other mental health and readjustment challenges.

Over the past decade VA drastically reduced its substance-use treatment and related rehabilitation services; however, it now appears some progress is being made in restoring them in the face of increased demand from veterans returning from OEF/OIF. The IBVSOs urge VA to closely monitor the implementation phase of its Uniform Mental Health Services policy to ensure a full continuum of care for substance-use disorders and include additional screening in all its health-care facilities and programs—and especially in primary care. Congress must provide continued oversight to ensure these specialized programs are fully restored, readily accessible, and focused on meeting the unique needs of this population.

Suicide

The IBVSOs are pleased that VA has developed a comprehensive strategy to address suicide prevention in the veteran population, but we encourage Congress to provide oversight to ensure proper focus and attention are paid to this issue. It is clear that without proper screening, diagnosis, and treatment, postdeployment mental health problems can lead distressed individuals to attempt to take their own lives. Ready access to robust mental health and substance abuse treatment programs, which must emphasize early intervention and routine screening, are critical components of any effective suicide prevention effort.

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. Additionally, Vet Centers, which provide readjustment counseling in almost 250 community-based centers, have reported rapidly growing enrollments in their programs. Although VA is increasing the number of Vet Centers, the IBVSOs believe that currently operating Vet Centers must also bolster their staffing to ensure that all the centers can meet the expanding caseload—now including not only traditional counseling but outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma.

Women Veterans

The number of women now serving in our military forces is unprecedented in U.S. history, and women are playing extraordinary roles in the conflicts in Iraq and Afghanistan. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, and military police officers and serve in other military occupational specialties that expose them to the risk of injury and death. To date, more than 100 women have been killed in action, and many have suffered serious mental health problems, including post-combat PTSD and grievous injuries, including multiple amputations, severe TBI, and burns. The current rate of enrollment of women in VA health care constitutes the most dramatic growth of any subset of veterans. According to VA, since 2002, 41 percent of women who deployed in OEF/OIF and have since discharged from military service have enrolled in VA health care.

Because of the expanded roles of women in the military and their broadened exposure to combat, the potential for them to carry the dual burden of combat experience and sexual assault, and the sheer numbers of women enrolling in VA health care, we encourage VA to continue to address, through its growing treatment programs and expanded research initiatives, the unique health-care needs of women veterans.

Recommendations:

- The DOD and VA must invest in research for individuals who suffer from postdeployment mental health challenges and TBI to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of TBI and develop best practices in its screening, diagnosis, and treatment.
- VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance-use disorders, in returning service members.
- Congress should formally authorize, and VA should provide, a full range of psychological and social support services, including strong, effective case management, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.
- The VA system must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.
- 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, veterans who live in rural and remote areas, and women veterans. These surveys should assess barriers among *all* OEF/OIF veterans—not only the subset who actually enroll or otherwise contact VA for health care or other services.
- The DOD and VA must increase the number of providers who are trained and certified to deliver evidenced-based care for postcombat PTSD and major depression.
- The DOD and VA should amend current policies to encourage service members and veterans to seek the care they need without fear of stigma.
- VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on those who have served in Iraq and Afghanistan. Congress should enact legislation to support VA improvements in women's health programs for all women veterans.
- The President and Congress should sufficiently fund DOD and VA health-care systems to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans, as well as continue to address the needs of previous generations of veterans with PTSD and other combat-related mental health challenges.

CRITICAL ISSUE 3

Claims Process Improvements Needed

While simultaneously enhancing training and increasing individual and managerial accountability, Congress and the Department of Veterans Affairs must take definitive steps to reduce delays in the disability claims process caused by policies and practices that were developed in a disjointed and haphazard manner.

The Independent Budget veterans service organizations (IBVSOs) commend Congress, acting without regard to party affiliation over the past few years, for addressing the critical staffing needs of the Veterans Benefits Administration (VBA). Inadequate staffing budgets over the past two decades directly and significantly contributed to the worst claims backlog in VA's history.

Although the recent focus of Congress and VA on hiring new personnel is critical to reducing the backlog, this action alone will not solve the problems inherent in the current disability claims-processing system. Adequate staffing alone will not allow the VBA to operate in an efficient, timely manner while producing quality decisions. The increase in the number and complexity of disability claims, and the time required for new employees to become proficient in processing claims, has left VA marking time as the claims backlog continues to grow.

On the surface, the disability claims process is simple: A veteran applies for compensation or pension; VA develops evidence necessary to decide the claim; VA evaluates the evidence, applies the facts to the law, and grants or denies benefits. However, as anyone who follows sports knows, the more you study the game the more you discover just how many variables go into scoring.

It is understandable that VA wants to be deliberative as it determines the next best course of action to address how to improve the claims process. After all, the VA estimates it will manage as many as 946,000 total claims this fiscal year and provide more than \$30 billion in compensation and pension benefits. The IBVSOs recognize that VA has a responsibility to administer these programs according to the law.

The claims process is simply a series of steps VA goes through to identify necessary evidence, obtain that evidence, and then make decisions based on the law and the evidence gathered. What fails here is the execution. While the rules are fairly clear, it is the overwhelming quantity of the work, inadequate training, lack of adequate accountability, and pressure to cut corners to produce numbers that result in an 18 percent substantive error rate (by VA's own admission). Congress and the Administration should seek to simplify, strengthen, and provide new structure to the VA claims process.

The converse of the underdevelopment problem plaguing the VA's claims process is its apparent propensity to overdevelop claims. One possible cause of this problem is that many claims require medical opinion evidence to help substantiate their validity. There are dozens of legal decisions on the subject of medical opinions (e.g., who is competent to provide them, when are they credible, when are they adequate, when are they legally sufficient, and which ones are more probative). There is anecdotal evidence that indicates that some rating specialists—rather than grant a claim based on the substantive evidence of record—request additional examinations and medical opinions.

There is ample room to improve the law in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assistance Act (VCAA) notice letter. Under current notice requirements and in applicable cases, VA's letter to a claimant normally informs the claimant that he or she may submit a private medical opinion. The letter also states that VA may obtain a medical opinion if VA decides to do so. However, these notice letters do not inform the claimant of what elements render private medical opinions adequate for VA rating purposes. To correct this deficiency, we recommend that when VA issues proposed regulations to implement the recent amendment of 38 U.S.C. § 5103 its proposed regulations contain a provision that will require it to inform a claimant, in a VCAA notice letter, of the basic elements that make medical opinions adequate for rating purposes.

The IBVSOs believe that if a claimant's physician is made aware of the elements that make a medical opinion adequate for VA rating purposes and provides VA with such an opinion, VA will no longer need to delay making a decision on a claim in order to obtain its own medical opinion. This would reduce the number of appeals that result from conflicting medical opinions—appeals that are frequently decided in an appellant's favor.

Congress should also consider amending 38 U.S.C. § 5103A(d)(1) to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request such evidence from a VA health-care facility. The language we suggest adding to section 5103A(d)(1) would not however require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for VA rating purposes.

In FY 2007 the Board of Veterans' Appeals (BVA) remanded more than 12,000 cases to obtain a medical opinion. In 2008 that number climbed to more than 16,000. In the view of the IBVSOs, many of these remands could have been avoided if VA had simply accepted sufficient medical opinions already provided by veterans. While recent court decisions have indicated that VA should accept private medical opinions that are credible and acceptable for rating purposes, we have seen no evident reduction in remands to obtain medical opinions.

Remands significantly lengthen the amount of time it takes for a veteran to receive a final decision. A remand adds about a year to the appellate process. Remands not only delay individual cases, but also divert resources from deciding new appeals. About 75 percent of cases remanded are returned to the BVA, increasing its workload and further degrading the timeliness of decisions. In addition, the BVA generally decides oldest cases first.¹ Processing of newer appeals is delayed when remanded appeals are returned to the BVA for readjudication. Thus, eliminating avoidable remands is a goal that will provide better service to veterans and their families and, ultimately, will help reduce the growing backlog.

The Independent Budget veterans service organizations have consistently maintained that VA must invest more in training adjudicators and decision makers and should hold them accountable for accuracy. VA has made improvements to its training programs in the past few years; nonetheless, much more improvement is required in order to meet quality standards that disabled veterans and their families deserve.

Training has not been a high enough priority in VA. The IBVSOs have consistently asserted that proper training leads to better quality decisions, and that quality is the key to timeliness of VA

¹BVA Dispositions by VA Program, page 5, Fiscal Year 2008 Report of the Chairman, Board of Veterans' Appeals, February 23, 2009.

decision making. VA will achieve such quality only if it devotes adequate resources to perform comprehensive and ongoing training and imposes and enforces quality standards through effective quality assurance methods and accountability mechanisms. The Administration and Congress should require mandatory and comprehensive testing designed to hold trainees accountable. This requirement should be the first priority in any plan to improve training. VA should not advance trainees to subsequent stages of training until they have successfully demonstrated that they have mastered the material.

VA can engineer an effective accountability system that holds each employee responsible for his or her work as a claim moves through the system while simultaneously holding all employees responsible. As errors are discovered, employees responsible for such errors must be held accountable. The IBVSOs recommend that this accountability be enforced by forfeiture of work credit.

The issues of quality of decisions, the timeliness of decisions, workload management, and safeguarding case files can be resolved by incorporating a robust information technology (IT) solution. And VA need not look further than the Social Security Administration (SSA) to benchmark an IT solution success story that may well fit its needs.

Organizations like the SSA and VA wrestle with a common set of challenges. Based on that insight, comprehensive, consistent business and system development models have been created to enhance such business operations. Building on the success of the SSA, VA should establish an imaging scanning center (ISC)/drop box-mail point and a datacentric claims management system as the backbone of its new IT solution. This would provide veterans who have the means and familiarity with digital approaches to file electronic claims using VONAPP (Veterans On Line Application) or other future digital claims filing options. The electronic records warehouse center could be housed centrally or regionally but must be accessible by all points in the VBA. Lost or incorrectly destroyed records would be a problem of the past, as would the need to transfer thousands of case files from one location to the next.

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

The IBVSOs propose an amendment to this process that will explain that evidence submitted after the appeal has been certified to the BVA will be forwarded directly to the BVA and not considered by the regional office *unless* the appellant or his or her representative elects to have additional evidence considered by the regional office. This opt-out clause merely reverses the standard process without removing any rights from an appellant. The IBVSOs believe this change should result in reduced appellant lengths, much less appellant confusion, and nearly 100,000 reduced VA work hours by eliminating in many cases the requirement to issue supplemental statements of the case. A legislative change, amending 38 U.S.C. § 7104 in a manner that would incorporate an automatic waiver of jurisdiction of regional office jurisdiction authorizing VA to

allow the veteran to instead opt out of having his or her case be transferred to the BVA would grant this flexibility.

Additional legislative modification could provide greater flexibility to the appeals process as well by substantially reducing the issuance of SSOCs.

The IBVSOs are confident these recommendations, if enacted, will help streamline the protracted claims process and drastically reduce undue delays. These recommendations will assist Congress and VA in taking deliberate steps aimed at making efficient an inefficient process without sacrificing a single earned benefit or right provided under the law.

Recommendations:

- VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence and require mandatory and comprehensive testing of the claims process and appellate staff. To the extent that VA fails to provide adequate training and testing, Congress should require mandatory and comprehensive testing, under which VA will hold trainees accountable.
- Congress should require the Secretary to report on how VA will establish a quality assurance and accountability program that will detect, track, and hold responsible employees who commit errors and modify the work credit program to remove or grant credits as appropriate.
- Congress should modify current “duty to assist” requirements that VA undertake independent development of the case, including gathering new medical evidence, when VA determines the claim already includes sufficient evidence to award all benefits sought by veteran.
- Congress should allow the Board of Veterans’ Appeals to directly hear new evidence in cases certified to it, rather than require VA’s regional offices to hear the evidence and submit supplemental statements of case.
- Congress and VA must develop and deploy a new electronic document management system, capable of converting all claims-related paperwork into secure, official electronic documentation that is easily accessible and searchable by all official personnel involved in the process.

CRITICAL ISSUE 4

Human Resources Needs Continue to Challenge the Department of Veterans Affairs

The Department of Veterans Affairs must strengthen and energize its human resources management efforts to recruit and retain highly qualified VA personnel and must redouble its efforts to advance succession planning to prepare the next generation of VA employees to assume their critical roles.

The Independent Budget veterans service organizations (IBVSOs) are becoming more concerned about the current status of human resource challenges faced in the Department of Veterans Affairs and the few tools available to VA to overcome them. Congress and VA must continue to work to strengthen and energize its human resources management programs to recruit, train, and retain qualified VA employees and to identify new tools to enable VA to gain equality with other employers in attracting a new generation workforce for veterans.

To adequately address the needs of veterans who rely on VA services and benefits, VA must work to maintain sufficient employment levels and retain a trained and qualified workforce. As veterans return home from the current combat deployments abroad and approach the VA system for services and benefits they so recently earned, veterans from previous wars and service periods, particularly veterans from the Vietnam era, are continuing to utilize VA services in record numbers. Given the age and seniority of its current workforce, VA's ability to sustain a full complement of skilled and motivated personnel requires aggressive and competitive hiring strategies to enable it to successfully compete in the local and national labor market. To be successful, human resources programs of both the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) require constant attention by the highest levels of VA leadership, as well as strong oversight by Congress.

In order for VA to continue to build a reputation as an "employer of choice," it must work to 1) refine human capital policies and procedures, specifically in the areas of recruitment, retention, and succession planning; and 2) provide and create satisfying work environments that encourage scholarship, professional development, and career advancement.

An Aging Workforce

The federal workforce is an older workforce. Approximately 60 percent of the federal workforce and an estimated 90 percent of the members of the Senior Executive Service will be eligible to retire within the next decade. At the end of FY 2008, 11 percent of the Veterans Health Administration (VHA) workforce was eligible for regular retirement, and between FY 2007 and FY 2013, 86,500 employees, or 39.4 percent of the VHA projected workforce will be eligible to retire. VA estimates that 49,600 will take regular retirement during that period. The average age of VHA employees is approaching 50 years. The average age of new registered nurse (RN) graduates today is 31 years; however, VA reports the average age range of new RNs hired in VHA is 45–54 years.

VA must create and implement a strategy that will focus on hiring, training, and retaining personnel to offset the changing demographics of the veteran population and the VA workforce. During such recruitment efforts, VA must also work to reach out to the trained and qualified community of veterans that are potential candidates for VA employment. Ultimately, VA must

provide efficient, safe, and productive work environments that attract high caliber professionals in order to successfully execute the VA mission: caring for America's veterans.

Veterans Health Administration

Given the VHA's leadership position as a health system, it is imperative that VA aggressively recruit health-care professionals in addition to emphasize the attractive opportunities within the VHA. In order to be a competitive employer, VA must strengthen its recruitment and retention programs, increase the timeliness of hiring processes, and work to improve the workplace environment for all medical staff. Today's health-care professionals and other staff who work alongside them need improved benefits, such as competitive salaries and incentives, child care, flexible scheduling, and generous educational benefits.

In the VHA between fiscal year 2002 and 2006, 108,620 new hires (21,724 per year) were needed to maintain the health-care workforce. Between FY 2007 and 2017, 163,308 new hires will be needed to maintain the VHA workforce (an average of 23,330 new hires per year). VA has recognized that the employment market is extremely competitive for some positions and is working to provide more professional development opportunities and programs to attract the new employees it will need to care for veterans.

With regard to RNs within the VA system, the United States is experiencing an unprecedented nursing shortage that is expected to continue well into the future.¹ The Health Resources and Services Administration projected in 2007 that the nation's nursing shortage will grow to more than 1 million nurses by the year 2020 and that all 50 states will experience shortages of nurses in varying degrees by the year 2015. According to the July 2006 Aging Workforce Survey conducted by the Nursing Management organization, 55 percent of surveyed nurses reported the intention to retire between 2011 and 2020.²

VHA Nurses: Turnover and New Employee Early Resignations

With respect to turnover for VHA nurses, the lowest rates occur in VA Central Office among nurses who perform administrative, policy, and management functions. The highest rates occur along the Pacific coast and in the Appalachian region along the Atlantic coast. Many RNs resign early in their VHA careers. For example in FY 2006, 16.3 percent resigned in the first year of employment, compared with VA physicians, 13.2 percent of whom departed VHA in their first year of employment. Overall in VHA, 12.9 percent of newly hired personnel resign in their first year.

In addition to the need for 30,211 RNs by 2013, the VHA turnover rate for registered nurses in 2006 was 8.5 percent (full- and part-time positions, not including trainees). VA must develop a recruitment strategy that provides employment incentives that attract and encourage nursing students and new nurse graduates to commit to VA employment. VA must also work to recruit and retain nurses that provide care in VA's specialized service programs, such as spinal cord injury/disease (SCI/D), blind rehabilitation, mental health, and brain injury, using compensatory benefits, such as specialty pay.

VA must couple its recruitment efforts with an emphasis on retention of its medical staff. In order to retain a well-trained and qualified nursing staff, it is important that VA work to provide a

¹Auerbach, Buerhaus, & Staiger, 2007.

²www.nursingmanagement.com.

stimulating work environment that provides educational opportunities and allows nurses, and all medical staff, a healthy work-life balance that ensures the delivery of efficient care to veterans. Particularly in an effort to improve the quality of working conditions for VA nurses, the IBVSOs strongly support proposed legislation pending in Congress that, if enacted, would enhance the capacity of the VHA to recruit and retain nurses and other critical health-care professionals. This legislation would prohibit nurses from being forced to work “mandatory” overtime, would improve VA’s employee incentive programs for educational loan repayments and enhance health-care scholarship payments, and other changes that would make VA a better employment prospect for new health professionals.

VHA Physicians

With respect to VA physicians, a key component of providing quality care and retaining a qualified physician workforce is maintaining a healthy patient workload. VA must make certain that medical centers are staffed with a sufficient number of physicians in relation to patients to ensure that veterans receive adequate medical attention. About 2,500 (16 percent) of VA physicians are currently eligible for voluntary retirement, and it is projected that by 2012 this number will grow to 2,909 (17 percent).³ VA must work to offset the loss of experienced personnel and employ recruitment tools that attract and retain high caliber physicians. Such recruitment strategies include guaranteeing that VA physicians have opportunities for continuing education, research, and fully utilizing existing academic partnerships.

At present, 130 VA medical centers have affiliations through which physicians represent half of approximately 100,000 VA health profession trainees. It is estimated that medical residents equate to approximately one-third of the total VA physician workforce. Although current resignation rates among VA physicians remain stable, a number of voluntary retirements will inevitably rise over time. Therefore, VA must take advantage of its training programs, a ready source of physician recruitment.

In 2004, Congress passed Public Law 108-445, the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004. The act is partially intended to aid VA in recruitment and retention of VA physicians (including scarce subspecialty practitioners) by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. VA has implemented the act, but the IBVSOs believe the act may not have provided VA the optimum tools needed to ensure that veterans will have available the variety and number of physicians needed in their health-care system. We urge Congress to provide further oversight and to ascertain whether VA has adequately implemented its intent or if VA needs additional tools to ensure full employment for qualified VA physicians as it addresses its future staffing needs.

Outmoded Human Resource Policies

VA must work aggressively to eliminate outdated, outmoded VA personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment. The IBVSOs have received recurring reports indicating that appointment of a new employee within the VHA can consume up to 90 days. In some professional occupations (especially physicians and nurses), many months can pass from the date of a position vacancy until the date a newly VA-credentialed and privileged professional caregiver is on board and providing clinical care to veterans. The lack of ability to make employment offers and confirm them in a timely manner, especially to new graduates it has helped to train, unquestionably affects

³Department of Veterans Affairs, Veterans Health Administration Workforce Succession Strategic Plan FY 2008–2012.

VA's success in hiring highly qualified employees and has the potential to diminish the quality of VA health care. Hiring delays depress current workforce morale and lead to overuse of mandatory overtime for nurses and others, greater workplace stress, and staff burnout. The VHA (especially including local facility managements) must be held accountable at all levels for improving human resources policies and practices. Congress should require VA to report its efforts to improve recruiting, retention, and environmental/organization practices to ensure veterans that VA will be a preferred health-care provider in the future and will continue to provide veterans an effective health-care system to meet their specialized needs.

VA Succession Planning, Recruitment, and Retention

Improving VA recruitment and retention efforts and more focused succession planning could help offset the inevitable loss of VA's experienced personnel. The VHA has identified the top 10 occupations that make up approximately 44 percent of the future new hires needed to stem attrition between FY 2007 and FY 2013. VA must implement an energized succession plan in VA facilities that utilizes the experience and expertise of current employees, as well as improve existing human resources policies and procedures to bring the next generation of VA caregivers onboard.

As employees exit VA employment over the next few years, it is imperative for VA to conduct exit surveys without regard to time in service or reason for resignation. Exit surveys in the top 25 critical VA occupations are particularly important to evaluate employees leaving these positions. With thorough surveys VA management can secure pertinent data to help refill positions as quickly as possible and to determine whether conditions of employment, human resources policies or other contributing factors to early departures of valued staff need revision. Exit surveys also provide valuable insight and information on the VA work environment and organizational culture. These are key elements to both retaining and recruiting high quality personnel in VA health care.

Existing VA loan repayment and scholarship programs were established by Congress to provide individuals interested in VA nursing with the financial support they need to enter and stay in the field. Both a recruitment and retention tool, the centrally funded Employee Incentive Scholarship Program (EISP)⁴ pays up to \$35,900 for "health care-related academic degree programs."⁵ VA testified that since its inception in 1999 through 2007, "approximately 7,000 VA employees have received scholarship awards for educational programs related to title 38 and "hybrid" title 5-title 38 VA occupations. About 4,000 employees have graduated from academic programs under these auspices. Scholarship recipients include registered nurses (93 percent), pharmacists, physical therapists, and other allied health professionals. A five-year VA analysis of program outcomes demonstrates this program's impact on VA employee retention."⁶

According to further testimony provided by VA in April 2008:

The VA Education Debt Reduction Program (EDRP) provides tax-free reimbursement of existing education debt of recently hired title 38 and hybrid employees. Centrally funded, the EDRP is the title 38 equivalent to the Student Loan Repayment Program administered by the Office of Personnel Management

⁴38 U.S.C. §§ 7671–7675. Established by Public Law 105-368, Title VIII, the Department of Veterans Affairs Health Care Personnel Incentive Act of 1998, and amended by Public Law 107-135, Department of Veterans Affairs Health Care Programs Act of 2001.

⁵April 9, 2008, testimony of Marisa Palkuti, M. Ed., director, VA Health Care Retention and Recruitment Office.

⁶*Ibid.*

for title 5 employees. More than 6,000 VA health-care professionals have participated in the EDRP. The maximum amount of an EDRP award is limited by statute to \$48,000 in exchange for five years of service. As education costs have risen, the average award amount per employee has increased over the years from about \$13,500 in FY 2002 to more than \$29,000 in FY 2007. While employees from 34 occupations participate in the program, 75 percent are from three mission critical occupations—RN, pharmacist, and physician. The rate of losses from resignation of EDRP recipients is significantly less than that of nonrecipients as determined in a 2005 study.⁷

Both the ESIP and EDRP initiatives need to be strengthened and expanded to new VA occupations, in particular among the 25 critical occupational categories that will be increasingly competitive as the health manpower shortage worsens. Again, the IBVSOs strongly encourage passage of pending legislation, which, if enacted, would increase payment limitations on these two programs. Additionally, VA must ensure that the funds associated with both programs are delivered in a timely manner to guarantee availability to employees. These programs have proven themselves to be cost-effective recruitment tools and to provide strong incentives for individuals to remain in VA employment rather than to go elsewhere.

Veterans Benefits Administration

Over the past two years, and with Congressional authorization, the Veterans Benefits Administration has hired a record number of claims adjudication staff. Unfortunately, as a result of senior VBA officials retiring in the interim, an increase in disability claims received, rising complexity of such claims, and the time required for new employees to become proficient in processing accurate claims, VA has achieved little noticeable improvement in its claims work. The VBA has a major challenge under way in completing the complex training required to gain full productivity of several thousand new staff.

With the influx of these new benefits personnel, it is difficult for the IBVSOs as observers to predict that ongoing challenges faced by the VBA are still the result of staffing shortages. In fact, such is the size of the claims backlog that it would be naïve to expect an immediate reduction in the VBA workload. Such an expectation is defeated merely by the time required for new employees to gain necessary experience, and the drain on experienced employees who provide much of the current training to them. In order to make the best use of new resources, the VBA must focus on improving training and accountability while simplifying the claims process itself.

Many of the core human resource systems problems documented primarily for the VHA in this Critical Issue also pertain to the VBA. As VA approaches solutions to its human resource challenges in its health-care system, it should also incorporate those solutions where applicable in the human resource policies and practices of the VBA.

Veterans and VA Employment

VA has a long tradition of employing veterans, including service-connected disabled veterans who successfully complete VA vocational rehabilitation programs. In establishing the Veterans Employment Coordination Service last year, VA reiterated its commitment to “advance efforts to attract, recruit and hire veterans into the VA, particularly severely injured veterans returning from

⁷*Ibid.*

Operation Enduring Freedom and Operation Iraqi Freedom,” through a network of regional employment coordinators.

However, action is necessary in a number of areas to ensure that veterans have greater opportunities to enter and remain part of the VA’s workforce. First, VA should seek out jobless veterans for positions for which they are qualified. Second, Congress should amend either title 38, or title 5, United States Code, to reverse a federal appeals court decision holding that title 38 employees are not covered by the Veterans Employment Opportunities Act.⁸ Third, VA should ensure that veterans preference–eligible individuals are properly acknowledged and rated for their military occupational specialties when seeking VA employment (for example, medics or corpsmen applying for licensed vocational or practical nurse positions). Finally, to ensure that these protections are enforceable, VA human resources management officials should adopt a tracking system, similar to the system used to tracking employment discrimination data, to ensure qualified veterans are an employment priority for VA.

Recommendations:

- VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment.
- VA must implement an energized succession plan in VA medical and regional office facilities that utilizes the experience and expertise of current employees, as well as to improve existing human resources policies and procedures.
- VA facilities must fully utilize recruitment and retention tools, such as relocation and retention bonuses, a locality pay system for VA nurses, and education scholarship and loan payment programs as employment incentives, in both the VHA and VBA.
- VA must improve exit surveys so that as employees terminate employment it can secure pertinent data that will help refill positions in a timely manner and to determine if conditions of employment, human resources policies, or other contributing factors need revision.
- Congress must provide further oversight to ensure adequate implementation of Public Law 108-445 and enact into law pending legislation that would improve VA human resources management programs.
- Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA’s specialized services areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury.
- VA must develop a more aggressive recruitment strategy that provides employment incentives that attract and encourage affiliated health professions students, as well as new graduates in all degree programs of affiliate institutions, to commit to VA employment.

⁸ *Scarnati v. Dept of Veterans Affairs*, 344 F. 3d 1246 (Fed. Cir. 2003).

- Congress should improve the provisions of VA's Employee Incentive Scholarship Program and Education Debt Reduction Program to make them more broadly available to all VA employees. VA must become more flexible with its work schedules to meet the needs of today's health-care and benefits professionals and must provide other employment benefits, such as child care, that will make VA employment more attractive.
- Congress and VA should ensure veterans preference is emphasized in VA human resources management activities and that veterans remain important targets for VA recruitment.

CRITICAL ISSUE 5

Seamless Transition from the DOD to VA

The Departments of Defense and Veterans Affairs must ensure that all service members separating from active duty have a seamless transition from military to civilian life.

As service members return from the conflicts in Afghanistan and Iraq, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service to successfully integrate into the civilian community as veterans. Though improvements have been made, the transition from the DOD to the VA health-care system continues to be a challenge for newly discharged veterans. *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 DOD to VA were never more apparent than during the controversy surrounding Walter Reed Army Medical Center in 2007. While much of the media coverage misrepresented the problems at Walter Reed as 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 veterans service organizations (IBVSOs) continue 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, as well as four other major studies regarding transition of service members to veteran status. One of the 20 recommendations made by the PTF and those made by the President's Commission was for increased collaboration between the DOD and VA for the transfer of personnel and health information. Great progress has been made in this area by VA; however, this recommendation remains only partially implemented. Testimony in July 2009¹ to the House Committee on Veterans' Affairs by the Government Accountability Office (GAO) noted that the DOD and VA are still not sharing all electronic health information and that information is still being captured in paper records at many DOD facilities. While progress is being made in sharing of viewable social history data, physical exam data, and the operation of secure network gateways, demonstration of "initial" document scanning is expected to require substantial additional work beyond the September 2009 deadline to meet clinicians' needs.

Health Information

The IBVSOs believe the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and bidirectional, allowing for a two-way, real-time electronic exchange of health information and occupational and environmental exposure data. Such an accomplishment could increase health information sharing between providers, laboratories, pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase our knowledge and understanding of the clinical, safety, quality, financial, and organizational value and benefits of health information technology (IT). Lessons learned from current conflicts and previous wars also indicate that the DOD must accurately collect medical and environmental exposure data electronically while personnel are still in theater. But it is equally important that this information be provided to VA. Electronic health information should also include an easily

transferable electronic DD214 forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and other benefits.

The Joint Electronic Health Records Interoperability (JEHRI) plan, as agreed to by both the DOD and VA 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. While this has occurred at several levels, the current need is for a common standard. In May 2007, the DOD established the Senior Oversight Committee (SOC), chartered and cochaired by the Deputy Secretaries of the DOD and VA with the goal to identify immediate corrective actions and to review, implement, and track recommendations from a number of external reviews. As a result of this recognized need, one of the issues identified for action was DOD-VA data sharing. The SOC approved initiatives to ensure health and administrative data are made available. The July 2009 GAO testimony indicated that the DOD and VA had achieved three of the six objectives and would meet another by September 2009, but would not meet the other two by the September 2009 deadline.

The DOD and VA are sharing selected health information at different levels of interoperability, such as pharmacy and drug allergy data on patients that seek care from both agencies. Such information can be shared electronically between the DOD and VA to warn the different clinicians of a possible drug allergy with a to-be prescribed medication. The Laboratory Data Sharing Interface Project is a short-term initiative that has produced an application used to electronically transfer laboratory work orders and retrieval of results between the departments in real time.

According to the GAO, the DOD-VA Information Interoperability Plan has achieved three benchmarks. The DOD is sharing viewable social history data that provide VA with clinical information on shared patients. In addition, shared physical examination data allow VA to view DOD's medical data that support the physical examination process for service members who separate from active military service. Finally, five secure network gateways that support health information sharing between the departments have been established. The remaining three objectives are still in process. The departments have indicated that they anticipate meeting the requirement for expanded questionnaires and self assessment tools by the September 2009 deadline. However, two objectives will not be met and will require substantial additional work. The DOD expects to expand its Essentris system to at least one additional site for each military medical service but will only be sharing 70 percent of data electronically with VA. The DOD admits that further expansion is needed and it may meet only a 92 percent capability by September 2010. Regarding the scanning of medical records, neither the DOD nor VA will meet the September 2009 requirement. The departments expect to demonstrate an initial scanning capability by the deadline but will need additional work to expand the capability. Unfortunately, this failed to meet the Congressional requirement for full interoperability by the September 30, 2009, date mandated by the National Defense Authorization Act for Fiscal Year 2008.

Care Coordination

Severely injured service members and veterans whose care and rehabilitation is being provided by both the DOD and VA, or who are transferring from one health-care system to the other, must have a clear plan of rehabilitation and the resources needed to accomplish its goals. In response to the provisions of VA's Office of Inspector General (OIG) recommendations in a 2006 report examining the rehabilitation of OEF/OIF veterans suffering from traumatic brain injury (TBI), the Under Secretary for health stated, "...case managers will provide long-term case management

services and coordination of care for polytrauma patients and will serve as liaisons to their families.”

In October 2007, the DOD and VA partnered to create the Federal Recovery Coordination (FRC) Program to coordinate clinical and nonclinical care for severely injured and ill service members. By identifying and integrating care and services between the DOD and VA health-care systems, this program subsequently served to satisfy provisions of the Wounded Warrior Act, title XVI of Public Law 110-181. With such resources as the Federal Individual Recovery Plan, National Resource Directory, Family Handbook, MyBenefits, and Veterans Tracking Application, the IBVSOs are cautiously optimistic that these coordinators will be able to provide greater oversight for the seamless transition of severely injured service members.

For service members and veterans whose injuries allow for more outpatient recovery and rehabilitation, a more extensive network has been created spanning the entire VA health-care system. The Veterans Health Administration has assigned 27 part-time and full-time social workers to major Military Treatment Facilities (MTF) to serve as VHA liaisons between the MTF and VHA facilities. Each VHA facility has an OEF/OIF care management team to coordinate medical care and benefits. Members of the OEF/OIF Care Management Program team include a program manager, nurse and social worker case managers, a Veterans Benefits Administration (VBA) veterans service representative, and a transition patient advocate. These representatives are responsible for ensuring a seamless transition, transfer, and management of a patient’s care. While this initiative pertains primarily to military personnel returning from Afghanistan and Iraq, it also includes active duty military personnel returning from other combat theater assignments. It does not include active duty military personnel who are serving in noncombat theaters of operation.

However, under VA’s clinical and nonclinical case management strategy, veterans transitioning from the DOD to VA who are not assisted by the FRC program may interact with as many as five VA representatives, their primary and specialty care provider or team, and any DOD case manager. The IBVSOs are concerned that such an array of points of contacts can have a deleterious effect on assistance to veterans and their families at a critical juncture. Moreover, veterans suffering from cognitive impairment, such as mild TBI, who can experience such symptoms as behavioral or mood changes and trouble with memory, concentration, attention, or thinking, may easily perceive this as a fragmented arrangement, and thus it may hamper the veterans’ ability to communicate his or her needs or effectively participate in his or her care and rehabilitation. Notably, the OIG issued a follow-up report in May 2008 to assess the extent to which VA maintains involvement with service members and veterans who had received inpatient rehabilitative care in VA facilities for TBI. According to the report, VA case management was determined to have improved, while long-term case management is not uniformly provided for these patients, and significant needs remain unmet. While progress continues, the transition from active status to the VA care still needs improvement.

Disability Evaluation

The Independent Budget veterans service organizations likewise concurred with the President’s Commission recommendation that the DOD and VA implement a single comprehensive medical examination, and we believe that this absolutely must be 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 because VA 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 VA's perspective, and not the DOD. A Disability Evaluation System (DES) pilot project launched by the DOD and VA in November 2007 for service members from Walter Reed Army Medical Center, the National Naval Medical Center, and Malcolm Grow Medical Center had more than 200 participants and was a step toward developing this single separation physical. While this separation physical is targeted primarily at those considered for medical discharge from the military, it should be considered for all separations, whether active duty, National Guard, or Reserve. The DES has improved VA's ability to provide a disability rating shortly after military discharge. Unfortunately, one flaw of the DES is that service members are not encouraged to seek representation from a veterans service organization, instead relying on the services of military counsel. Since most service members undergoing the discharge evaluation process are unaware of the complexities of the system, it is to their benefit to have an educated and experienced representative. Obviously, the IBVSOs believe that all veterans should have benefit of representation by an advocate.

The problem with separation physicals identified for active duty service members is compounded when mobilized Reserve and Guard forces enter the mix. A mandatory separation physical is not required for demobilizing Reserve and Guard members, and in some cases they are not made aware the option is available to them. Although the physical examinations of demobilizing personnel have greatly improved in recent years, there are still a number of service members who "opt out" of the physicals, even when encouraged by medical personnel to have them. Although the expense and manpower needed to facilitate these physical exams might be significant, the separation physical is critical to the future care of demobilizing service members. The mistakes of the first Gulf War should not be repeated for future generations of war veterans particularly among our National Guard and Reserve forces. Mandatory separation physical examinations would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by each to recognize, treat, and 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 Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) handled by the Veterans Employment and Training Service (VETS) is generally the first service a separating service member will receive. In particular, local commanders, through the insistence of the DOD, began to allow their soldiers, sailors, airmen, marines, and coastguardsmen to attend well enough in advance to take greatest advantage of the program. The programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then seek answers prior to discharge.

The TAP and DTAP programs 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 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 disparity.

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

The issue of the transition from active duty status to veteran status should also be a subject of future study, and the IBVSOs look forward to participating in these discussions as well. These existing programs prove invaluable during this transition period, but they are in need of additional funding. Congress could act now by providing increased funding for TAP and DTAP. The transition from military service to civilian life is very difficult for most veterans, who must overcome many obstacles to successful employment. TAP and DTAP were created with the goal of furnishing separating service members with vocational guidance to assist them in obtaining meaningful civilian careers, and continuation of these programs is essential to easing some of the problems associated with transition. Unfortunately, the level of funding and staffing is inadequate to support the routine discharges per year from all branches of the armed forces.

Although the achievements of the DOD and VA have been good with departing active duty service members, there is a much greater concern with the large numbers of Reserve and National Guard service members moving through the discharge system. 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. If service members are uninjured, they may clear the demobilization station in a few days, and 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 soldiers through the site. Lack of space and facilities often restricts contact between demobilizing soldiers and VA representatives.

In October 2008, the DOD released a new version of "Compensation and Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces." This handbook is designed to help service members who are wounded, ill, and injured, as well as their family members, navigate the military and veterans disability system. The IBVSOs applaud this informative booklet as one more method to help service members understand the transition. Now it will be critical for the DOD to ensure the handbook gets to transitioning service members. Its availability on the Internet is a strong step toward this goal.

The IBVSOs believe the DOD and VA have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. If we are to ensure that the mistakes of the first Gulf War are not repeated during this extended global war on terrorism, 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. Service members exiting military service

should be afforded easy access to the health care and other benefits that they have earned. This can only be accomplished by ensuring that the DOD 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 environmental exposure data. These electronic medical records should also include an easily transferable electronic DD214.
- The DOD and VA ensure that the Joint Interagency Program Office finalizes the implementation plan with appropriate milestones and timelines for defining requirements to support interoperable health records.
- The DOD and VA must outline the requirements for assigning new or additional federal recovery coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service member's medical conditions.
- The DOD and VA must develop a clear plan of rehabilitation for severely injured service members and veterans receiving care and must receive the necessary resources to accomplish these goals.
- 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.
- The DOD and VA should encourage active duty service members to seek veterans service organization representation during outprocessing and discharge examination.
- Congress and the Administration must provide adequate funding to support the Transition Assistance Program and Disabled Transition Assistance Program managed by the Department of Labor's Veterans Employment and Training Service to ensure that active duty, as well as National Guard and Reserve, service members do not fall through the cracks while transitioning.
- The DOD, VA and Social Security Administration must continue to explore and implement the most effective practices for informing significantly disabled veterans and their families about the supports available to them under Social Security Disability Insurance.

¹ Statement of Valerie C. Melvin, director, Information and Human Capital Issues, U.S. Government Accountability Office before the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, July 14, 2009.

CRITICAL ISSUE 6

Maintaining VA's Critical Infrastructure

The Department of Veterans Affairs must receive increased funding to reduce the growing maintenance backlog in its medical facilities, as well as improve efforts to spend the resources it is given.

For the past few years, *The Independent Budget* veterans service organizations (IBVSOs) have emphasized the importance of maintenance funding within the Department of Veterans Affairs. We believe that maintenance funding, especially considering the growing backlog of maintenance projects, must be a point of emphasis in the budget, and that VA must efficiently and expeditiously obligate the funds appropriated for those purposes.

VA manages a wide portfolio of capital assets throughout the nationwide system of health-care facilities. According to the latest VA Capital Asset Plan, VA owns 5,405 buildings and almost 33,000 acres of land. It is a vast network of facilities that requires much time and attention from VA's capital asset managers. Unfortunately, VA's infrastructure is aging rapidly. Although Congress has funded a significant number of new facilities in recent years, the vast majority of existing VA medical centers and other associated buildings are on average more than 50 years old.

Aging facilities create an increased burden on VA's overall maintenance requirements. They must be maintained aggressively so that their building systems—electrical, plumbing, capital equipment, etc.—are up to date and that these facilities are able to continue to deliver health care in clean and safe environments. Older, out-of-date facilities do not just present patient safety issues. From VA's perspective, older buildings often have inefficient layouts and inefficient use of space and energy. This means that even with modification or renovation, VA's operational costs can be higher than they would be in a more modern structure.

VA is aware of the challenges it faces with respect to the maintenance backlog, and VA regularly surveys each facility as part of the Facilities Condition Assessment (FCA) process. Teams of professional engineers and cost estimators survey each medical facility at least once every three years. These surveys aim to assess all of a building's systems as well as issues related to the site (such as parking and mobility barriers and related issues). Each component of a facility is given a letter grade, A through F. Systems with a grade of F are items that require immediate attention. This could mean that an item, such as a heating or cooling unit, no longer functions or functions poorly or that the unit is well past its useful life and is in danger of imminent structural or systems failure. VA estimates the cost of repair for each item rated D or F, and it uses this cost estimate as a component of its Federal Real Property Report requirements.

According to VA's latest five-year capital plan, VA has estimated the total cost of repairing all D-rated and F-rated FCA deficiencies at a staggering \$8 billion, even as VA and Congress have greatly increased the amount of funding and resources devoted to this critical aspect of capital asset management.

Although funding has increased for nonrecurring maintenance (NRM) recently, the funding levels have only touched the surface of the backlog. For far too long, NRM and other maintenance issues were underfunded, helping to create a massive backlog. In recent years, the funding has increased but has still only been in line with addressing the bare minimum for the current level of

maintenance needs, with very little to significantly reduce the backlog. We have repeatedly cited the PricewaterhouseCoopers study of VA's facility management program. Using industry standards as its benchmark, PricewaterhouseCoopers estimated that VA must spend 2 to 4 percent of the plant replacement value (PRV) to sufficiently maintain VA infrastructure.

The most recent estimate of VA's PRV is from the FY 2008 Asset Management Plan. In this plan VA estimated its PRV to be \$85 billion. Accordingly, using those industry standards, VA would need an NRM budget of at least \$1.7 billion, a significant increase over what it has received in recent years. Although the number may seem disproportionately high to some observers, it is in line with the total level of maintenance funding VA has received in each of the past two fiscal years, if funds from the American Recovery and Reinvestment Act (the Stimulus Act) and the recent emergency supplemental appropriation are included.

Nonrecurring maintenance is not the only way in which maintenance priorities are addressed. Recently, VA has begun using minor construction projects, in part, to address larger scale maintenance needs. VA estimates that as much as 30 percent of its minor construction funding is targeted towards FCA-identified needs. It is also likely that certain major construction projects would either eliminate the need for, or absorb, multiple small minor construction or NRM-focused projects as well. In other words, VA has some tools available other than NRM with which to address its \$8 billion capital backlog. The IBVSOs urge VA capital asset planners to take maximum advantage of all methods available in addressing VA's need to update, repair, and maintain its critical health-care capital assets. We also recommend that Congress provide improved oversight to ensure that VA is using all its tools to address the unfunded needs of capital maintenance.

Another area of concern is the rate of spending of maintenance funding. Although the adequacy of the overall budget has increased dramatically in recent years, the timeliness has not. A normal side effect of late budgets in VA is delay. VA facilities have often held back making critical improvements as a method of adjusting and even pre-planning for late and inadequate budgets. VA's medical centers have reserved funds on an emergency basis to use for the delivery of direct medical care. While it is unfortunate that they have delayed critical maintenance, given the budgetary realities they face on a regular and recurring basis, it has been an appropriate decision.

More recently VA has done a better job of encouraging its managers to spend maintenance money throughout the year on projects that improve the health and safety of veterans. Related to this has been the rate of spending with respect to the \$1.4 billion VA received as part of the Stimulus Act. About \$1 billion from the Act was targeted toward major VA maintenance needs, with another \$399 million directed to VA energy improvements. Despite having a long list of already-identified projects, thanks to VA's regular FCA survey process, the department has spent just a fraction of its total maintenance funding. The September 25, 2009, report published at recovery.gov states that VA has actually obligated only \$6.3 million in stimulus funding for VHA projects.

For a department with a self-identified \$8 billion backlog of capital improvement needs, this result so many months after enactment of the appropriation, is unacceptably low. These projects have already been clearly identified and singled out for this purpose. Now VA must do a better job to ensure that these projects are carried out in a timely manner. The IBVSOs urge Congress to monitor VA's rate of obligation of these funds to ensure the purposes of the Stimulus Act are met, and that the needs of the nation's sick and disabled veterans are addressed through VA's capital programs.

Recently VA has broached the idea of a new capital model for health-care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF concept, VA would begin leasing large outpatient clinics in lieu of major construction of VA-owned buildings. These large clinics would provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery. On the face of it, this model seems to be a good approach to solving some of VA's capital problems. Leasing has the advantage of being able to be completed quickly, as well as being adaptable, especially when compared to existing, and aging, VA major medical facilities. Leasing has been particularly valuable for VA as evidenced by the success of the community-based outpatient clinics and Vet Centers.

Despite these advantages, the HCCF program raises many concerns VA must address before proceeding, including the following:

- How VA will handle governance, especially with respect to the large numbers of non-VA employees who would be treating veterans in this new model of care?
- How will the non-VA facility deal with VA directives and rule changes that govern health-care delivery and that ensure safety and uniformity of the quality of care?
- Will VA apply its space planning criteria and design guides to non-VA facilities?
- How will VA's critical biomedical research activities, most of which improve the lives of all Americans and not only veterans, be affected if they are being conducted in shared facilities, and not a traditional part of VA's first-class research programs?
- What will this change mean for VA's electronic health record, which many have rightly lauded as the standard that other health-care systems should aim to achieve?
- Without the electronic health record, how will VA maintain its high quality of care standards and continuity for a veteran who moves to another area?

But, most important, the Capital Asset Realignment for Enhanced Services (CARES) process required years to complete and consumed thousands of hours of effort and millions of dollars of study. The IBVSOs believe it to be a comprehensive and fully justified roadmap for VA's infrastructure as well as a model VA can apply periodically to assess and adjust those priorities. Given the strengths of the CARES process and the lessons VA learned and has applied from it, why is the HCCF model, which to our knowledge has not been based on any sort of study of the long-term needs of veterans, the superior one? We have yet to see convincing evidence that VA has addressed these questions as it developed the HCCF vision.

Recommendations:

- VA capital asset planners must take maximal advantage of all methods available to address VA's need to update, repair, and maintain its critical health-care capital assets. Congress should provide improved oversight to ensure VA is using all its tools to address the unfunded needs of capital maintenance.
- VA must improve its performance in ensuring that Stimulus Act-authorized projects within VA's health-care system are carried out in a timely manner, in accordance with the intent of law. Congress should closely monitor VA's rate of obligation of Stimulus Act funds to ensure the purposes of the Stimulus Act are met, and that the needs of the nation's sick and disabled veterans are addressed through VA's capital programs.

- VA must better inform and address veterans' concerns with respect to the Health Care Center Facility program, especially with how its blueprint for health-care delivery is equal to or better than the roadmap laid out by the CARES process. Congress must utilize its oversight authority to ensure that VA's long-range infrastructure planning will serve not just the needs of veterans today, but the needs of veterans long into the future. Veterans must be assured that the HCCF program expands access to health care and does not just replace, scale back, or eliminate services available to them.

CRITICAL ISSUE 7

Education, Employment, and Training

Positive transition from military service to civilian life hinges on veterans' ability to be competitive in the workforce; therefore, it is imperative that Congress fund these programs to meet increasing needs.

Education

Education benefits have been the single greatest recruitment tool for the Department of Defense. Occasionally, Congress will provide a new benefit for our service members that coincides with the sacrifices that are made, such as the post-World War II and the peacetime Montgomery GI Bill (MGIB). Historically, educational benefits do not overlap to the point at which service members are eligible for multiple benefits. Today that has changed. Now enlisting service members must make benefit choices without understanding the full scope of the available options, and service members from the current era of conflict who have already separated from service are not receiving an equal benefit in relation to their counterparts who are still serving on active duty.

The Independent Budget veterans service organizations (IBVSOs) praise the passage of the Post-9/11 GI Bill. Even though this benefit represents the largest increase in educational assistance since World War II, there are several issues that need to be addressed to provide parity for our veterans. Under current provisions, certain veterans will receive reduced value with the new GI Bill. These issues include disproportionate payment under the Yellow Ribbon program because of tuition and fee caps within certain states, denial of living stipends for veterans who attend college solely online, absence of benefits under title 32 in regard to Active Guard Reserve (AGR) and Guard members who are called to active duty by their states, and exclusion of vocational, on-the-job training, apprenticeships, and certification programs from the benefit.

VA's current method for determining tuition and fees causes confusion, unpredictability and inequities in receipt of the benefit. Because of this complex and arbitrary method of calculating each state's baseline for the Yellow Ribbon program, veterans could be unexpectedly billed because of a misunderstanding of the tuition and fees payment system. Also, universities often change tuition and fee rates from year to year, making it difficult to predict how much assistance will be needed from one year to the next. In addition, this method does not take into account the varying cost of an education from state to state.

Often veterans decide to attend online universities to achieve their educational goals. This option is not solely used for convenience; it is used as a necessity. Many veterans have families and work obligations that prevent them from attending college in a traditional manner. However, veterans who opt for a degree track through strictly online courses or universities are denied a living stipend. Education benefits cannot be reduced or denied.

By virtue of their status, veterans who serve our country under title 32 do not receive any credit or benefit under the Post-9/11 GI Bill. National Guard members and certain members of the reserve who have decided to not only serve their nation, but have volunteered to serve their state or work within their community as well, do not qualify for any benefits under the new GI Bill. This affects nearly 45,000 Guard and Reserve members who have been called to serve in disaster relief or in domestic national security roles or who volunteer to have their Guard or Reserve status as active duty.

The original GI Bill provided benefits for more than 8 million World War II veterans, but just over 2 million of those went to a four-year, degree seeking institution. The other 6 million sought training through apprenticeships, on-the-job training (OJT), and vocational training. Today's veterans are not provided the same benefit. The Post-9/11 GI Bill only provides benefits to veterans who seek a degree. The remaining veterans must continue to use the Montgomery GI Bill. Veterans seeking these nondegree careers are being penalized by being forced to pay into the MGIB to later receive a lesser benefit. Veterans, regardless of their post-military occupational desires, should have access to the Post-9/11 GI Bill.

In addition, the IBVSOs are concerned that veterans who are eligible for both the Post-9/11 GI Bill and traditional VA Vocational Rehabilitation (Chapter 31) due to service connected disability will choose to receive Post -9/11 benefits because the living allowance is significantly higher than under Chapter 31. In many cases, this is not the best option, since Chapter 31 participants are entitled to a wider range of services through the Vocational Rehabilitation & Education (VR&E) Service, including counseling, skills assessments, and job placement assistance. Congress should act to authorize subsistence allowances for veterans participating in Chapter 31 at the same rates as those eligible for the Post-9/11 GI Bill benefits.

Employment and Training

Employment policy is vital to veterans and veterans with disabilities in today's environment in which work is critical to independence and self-sufficiency. 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, entitlement programs cannot keep pace with the current and future demand for benefits.

The Department of Defense indicates that each year approximately 25,000 active duty service members are found "not fit for duty" due to medical conditions that may qualify for VA disability ratings and eligibility to VR&E services.

The VA Vocational Rehabilitation and Employment (VR&E) program is authorized by Congress under title 38, United States Code, and is better known as Chapter 31 benefits. The program provides services and counseling necessary to enable service-disabled veterans to overcome employment barriers and allow them to prepare for, find, and maintain gainful employment in their communities. The program also provides independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their reentry back to private life. The program further offers educational and vocational counseling to service-disabled veterans recently separated from active duty and helps to expedite their reentry into the labor force. These services are also available to dependents of veterans who meet certain eligibility requirements.

The Office of Management and Budget (OMB) estimates the average cost of placing a service-connected veteran in employment at \$8,385, calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, the 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.

The number of veterans in the various phases of VR&E programs is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Even though the focus of the VR&E program has drastically changed to career development and employment, it is not clear, despite VR&E's addition of 83 employment coordinators, whether VA is able to meet the current and future demand for employment services. It is just not good enough to say the program's focus is on employment when the data demonstrate that only 9,000 veterans were placed in employment out of 90,000 active cases.

Performance reporting for the VR&E Chapter 31 benefits program that is used by VA and Congress to authorize funding and staffing needs must be improved. For example, in fiscal year 2006, VA reported a rehabilitation rate of 73 percent in their Performance and Accountability Report and Budget Submission. However, VA excluded veterans who discontinued participating in the program without implementing a written rehabilitation plan, even though these veterans represent a majority of veterans served by the program. Recalculating the rehabilitation rate including all participants, the VR&E success rate would be 18 percent. As a result, decision makers and Congress are not totally aware of the overall performance rate when making decisions on needed resources.

The period of eligibility for VR&E benefits is 12 years from the date of separation from the military or the date the veteran was first notified by VA of a service-connected disability rating. Unfortunately, many veterans are not informed of their eligibility for VR&E services or do not understand the benefits of the program. In addition, veterans who later in life may become so disabled that their disabilities create an employment barrier would benefit from VR&E services well beyond the 12-year delimiting date.

Many veterans with significant disabilities are turning to state vocational rehabilitation and workforce development systems because of these and other impediments to accessing VR&E. Almost all state vocational rehabilitation agencies have entered into memoranda of understanding with VA to serve veterans. Disabled Veterans Outreach Program and Local Veterans' Employment Representative Program personnel are often housed in state One-Stop Career Centers, and these positions are often praised as a model that should be emulated by the broader workforce system. However, all of these vocational programs are under considerable resource distress and their ability to serve veterans who are unserved by VR&E is hindered by their own personnel and budgetary limitations.

Veteran entrepreneurship programs allow veterans to use their training and skills to establish small businesses. Veterans need assurances that support for their business will be available. That is why federal agencies must be held accountable to meeting the federal procurement goals outlined by Executive Order 13360 and sections 15 (g) and 36 of the Small Business Act. As more and more service-disabled military members' begin to transition into civilian life, they are choosing to start their new lives as entrepreneurs. Recent studies of our newly returning and current veteran population show a 33 percent increase in the formation of new business entities over the past five years. Currently there are more than 18,000 service-disabled veteran-owned small businesses (SDVOSBs) registered in the Central Contractor Registration (CCR) database. Astoundingly this number does not accurately reflect the true number of SDVOSBs and veteran-owned small businesses (VOSBs) that may not yet be registered or have their statuses verified, or the number of veterans who may not be familiar with how to register for inclusion in federal procurement databases.

As VOSBs and SDVOSBs continue to rise, it is vital that the Center for Veterans Enterprise be ready and able to meet the growing demand for their services. Veteran-owned businesses face many obstacles to success. For this reason VA established the Center for Veterans Enterprise (CVE) program with the passage of the Veterans Entrepreneurship and Small Business Development Act of 1999.

The CVE is a subdivision of the Office of Small and Disadvantaged Business Utilization that extends entrepreneur services to veterans who own or who want to start a veteran-owned small business. It also helps federal contracting offices to identify veteran-owned small businesses in response to Executive Order 133600 calling for federal contracting and subcontracting opportunities for SDVOSBs. In addition, the CVE works with the Small Business Administration (SBA) 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 VOSBs and SDVOSBs. Unfortunately, the funding for this program is insufficient to meet the ever-increasing needs of our nation's veterans.

At present, vendors desiring to do business with the federal government must register in the Central Contractor Registration (CCR) database, and those who indicate they are veterans or service-disabled veterans, self-certify their status without verification. P.L. 109-461 required VA to establish a Vendor Information Page (VIP) database to accurately identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. This database was supposed to give all federal agencies a single source in the identification of possible SDVOSBs and VOSBs for consideration during their procurement processes. However, because of a lack of oversight in this area the database has failed to fulfill its purpose.

Employment Issues Affecting Veterans on Pension

Many veterans, who served this country honorably and were discharged in good health, later acquire significant disabilities. If their income is low enough, they will qualify for the Veterans Pension Program. VA pension is often likened to Supplemental Security Income (SSI) under Social Security. However, unlike that latter program, VA pensioners face a "cash cliff" in which benefits are terminated when an individual crosses an established earnings limit. Because of a modest work record, many of these veterans or their surviving spouses may receive a small SSDI benefit that supplements their VA pension. If these individuals attempt to return to the workforce, not only is their SSDI benefit terminated but their VA pension benefits are reduced dollar for dollar by their earnings.

More than 20 years ago, under P. L. 98-543, Congress authorized VA to undertake a four-year pilot program of vocational training for veterans awarded VA pension. Modeled on the Social Security Administration's trial work period, veterans in the pilot were allowed to retain eligibility for pension up to 12 months after obtaining employment. In addition, they remained eligible for VA health care up to three years after their pension terminated because of employment. Running from 1985 to 1989, this pilot program achieved some modest success. However, it was discontinued because most catastrophically disabled veterans were reluctant prior to VA eligibility reform to risk their access to VA health care by working.

The VA Office of Policy, Planning and Preparedness examined VA's pension program in 2002 and, though small in number, 7 percent of unemployed veterans on pension and 9 percent of veteran spouses on pension cited the dollar-for-dollar reduction in VA pension benefits as a

disincentive to work.¹ Now that veterans with catastrophic nonservice-connected disabilities retain access to VA health care, work incentives for VA's pension program should be reexamined and policies toward earnings should be changed to parallel those in the SSI program.

Recommendations:

- VA must fully cover tuition and fees at all public undergraduate schools, while setting a national standard for private and graduate schools.
- VA must provide a living stipend that is equal to the stipend for traditional students based on the zip code in which the veteran lives.
- VA must include title 32 service as acceptable service under the Post-9/11 GI Bill.
- VA must grant Post-9/11 GI Bill benefits to veterans who enroll in apprenticeships, on-the-job training, and vocational programs.
- Congress must provide the funding level to meet the increasing veteran demand for VA Vocational Rehabilitation & Employment program services.
- VA needs to strengthen its VR&E program to meet the demands of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce and providing placement follow-up with employers for at least six months.
- The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.
- The VR&E Service must place 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 initiate a nationwide study to reveal the reasons why veterans discontinue participation in the VR&E program and use the information to design interventions to reduce the probability of veterans dropping out of the program.
- The VR&E service must report the true number of veterans participating in the program and accurate performance data for budgetary and other resource decisions.
- Congress should change the eligibility delimiting date for VR&E services by eliminating the 12-year eligibility period for Chapter 31 benefits and allow all veterans with employment impediments or problems with independent living to qualify for VR&E services.

¹ Evaluation of VA Pension and Parents' DIC Programs – VA Pension Program Final Report, ORC Macro, Economic Systems Inc., Hay Group, Dec. 22, 2004. www1.va.gov/op3/docs/pension.pdf.

- Until changes are made in the law to broaden access to VR&E, Congress must ensure that all vocational systems to which veterans with significant disabilities must turn have adequate resources to serve those veterans.
- Congress should authorize identical subsistence allowance rates under VA Vocational Rehabilitation (Chapter 31) benefits and the Post-9/11 GI Bill.
- Congress should eliminate the 30-month maximum requirement for providing Independent Living services and the statutory cap of 2,500 new VR&E Independent Living program participants because the effect of the cap and the increasing veteran demand for services delays providing needed IL programs to severely disabled veterans.
- Congress should establish stronger oversight and outreach to all federal agencies by the Office of Small Business Programs, Small Business Administration, and all other federal agencies tasked with protecting and promoting service-disabled veteran-owned small businesses, to assist in the development and implementation stronger strategies/plans to reach the 3 percent goal. The annual reports filed by all federal agencies reporting the prior fiscal years' actual percentage of goal achieved should serve as guidance on which agencies need the most assistance in developing stronger plans.
- Congress must provide the Department of Veterans Affairs with additional funding for the Center for Veterans Enterprise so they can adequately meet the increasing veteran demand for entrepreneurial services. These additional funds should also be appropriated for the employment of more staff at CVE to meet the growing veteran entrepreneur population.
- VA must help eliminate the barriers that veterans face in regard to the formation and development of their business ventures.
- All federal agencies should be required to certify veteran status and ownership through the VA's Vendor Information Page program before awarding contracts to companies claiming to be veteran or service-disabled veterans who own small businesses.
- Congress should take appropriate steps to require all agencies to use the VIP to certify veteran status and ownership before awarding contracts to companies claiming to be veteran owned or service-disabled veteran owned.
- Work incentives in the VA pension program should be reexamined and consideration given to changes that would reduce benefits as earned income rises, as occurs with recipients of Supplemental Security Income.



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