Prologue

As the United States reflects on the fateful date—September 11, 2001—that obligated millions of service members to be deployed into combat theaters, the Department of Veterans Affairs (VA) continues to face rising pressure to meet the needs of these veterans and of veterans before them. While the future of United States military deployments remains uncertain, the lasting impact of the physical and psychological traumas that some service members experienced during that time may require a lifetime of care. The sacrifices these brave soldiers, sailors, airmen, coastguardsmen, and marines 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 *The Independent Budget* veterans service organizations (IBVSOs)—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—set out each year to assess the status of the one federal department whose sole task it is to care for them and their families.

VA and the veterans it serves now face a new dynamic in which pressures resulting from the federal debt and deficit may dictate the level of services the agency can provide, whether arbitrary or not. In fact, these pressures may force VA to provide health-care services and benefits with fewer resources than might actually be necessary to meet full demand. This is a sobering proposition.

The Independent Budget is designed to alert the Administration, Members of Congress, VA, and the public to those issues concerning VA health care, benefits, and benefits delivery that we believe deserve special scrutiny and attention. This document provides a detailed funding analysis and recommendations to assist policy makers in assembling an adequate budget for fiscal year (FY) 2013, and developing the advance appropriation for the medical care accounts for FY 2014. Through these efforts, if Congress responds appropriately, the IBVSOs believe VA will be positioned to successfully meet the challenges of the future. We also hope that this report will provide direction and guidance to the Administration and Members of Congress to steer both policy and budget to the benefit of veterans served by VA.

The U.S. government confronts a number of challenges to our fiscal future. Rapid growth in federal spending, coupled with an economic recession that has had an impact on federal revenues, has set the nation on a course that appears unsustainable. Yet continued investment in VA's infrastructure and critical programs is imperative. The ongoing cost of maintaining VA's infrastructure and caring for veterans who honorably served this nation does not decline simply because financial times become challenging. With this new reality ever-present in our minds, we must take necessary steps to ensure that VA receives the

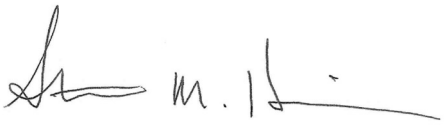
(Continued)

resources it needs to meet the challenges of today and the problems of tomorrow. In order to ensure that VA obtains these resources, *The Independent Budget* veterans service organizations offer a detailed analysis of the full funding needs of VA. *The Independent Budget* is based on a systematic methodology that takes into account changes in the size and age of the veteran population, the cost of living, federal employee staffing, wages, medical care inflation, construction needs, the aging health-care capital infrastructure, trends in health-care utilization, benefits needs, efficient and effective means of benefits delivery, and estimates of the number of veterans and their dependents who will be laid to rest in our nation's cemeteries.

Our sons, daughters, brothers, sisters, husbands, wives, and grandchildren 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, provides the best medical care to restore them, orchestrates the best vocational rehabilitation to help them overcome employment barriers created by injury, and furnishes a supportive claims-processing system that delivers education, compensation, and survivors' benefits with efficiency to those who sustained harm in their service to our nation.

We are proud that this year represents the 26th edition of *The Independent Budget*. We are proud of the respect and influence that *The Independent Budget* has attained during that quarter century. We endeavor 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 ask readers to approach this report with an open mind. War veterans should not be treated as war's refuse, but rather as proud warriors who served. Benefits and services for them are not gratuitous—they were earned, and payment is due in full.



Stewart M. Hickey
National Executive Director
AMVETS

Barry A. Jesinoski
Executive Director
Disabled American Veterans

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

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

Independent Budget Authors

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

AMVETS

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

Disabled American Veterans

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

Paralyzed Veterans of America

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

Veterans of Foreign Wars of the U.S.

The Veterans of Foreign Wars of the U.S. (VFW), founded in 1899 and chartered by Congress in 1936, is the nation's largest organization of combat veterans and its oldest major veterans service organization. Its 1.5 million members include veterans of past wars and conflicts, as well as those who currently serve in the active, Guard, and Reserve forces. Located in 7,900 VFW Posts worldwide, the VFW and the 600,000 members of its Auxiliaries are dedicated to "honoring the dead by helping the living." They accomplish this mission by advocating for veterans, service members, and their families on Capitol Hill as well as state governments; through local community and national military service programs; and by operating a nationwide network of service officers who help veterans recoup more than $1 billion annually in earned compensation and pension.

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

Supporters

African American Post Traumatic Stress Disorder Association
Air Force Association
Air Force Sergeants Association
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Military Retirees Association
American Military Society
American Psychological Association
American Thoracic Society
American Veteran Alliance
American Veterans for Equal Rights
Armed Forces Top Enlisted Association
Association for Service Disabled Veterans
Association of American Medical Colleges
Association of the United States Navy
Blinded Veterans Association
Catholic War Veterans, USA, Inc.
Combined KORUS Veterans
Easter Seals
Fleet Reserve Association
Gold Star Wives of America, Inc.
Governor of Washington
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the USA
Korea Veterans of America, Inc.
Louisiana Veterans Coalition
Lung Cancer Alliance

(Continued)

Mental Health America
Military Officers Association of America
Military Order of the Purple Heart
Minnesota Department of Veterans Affairs
National Alliance on Mental Illness
National Association for Uniformed Services
National Association of American Veterans, Inc.
National Association of Disability Representatives
National Association of State Head Injury Administrators
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Disability Rights Network
National Society of Cuban American Veterans
Navy Seabee Veterans of America, Inc.
Non Commissioned Officers Association of the USA
North Dakota Department of Veterans Affairs
Nurses Organization of Veterans Affairs
Society of Hispanic Veterans
Society of Military Spouses
Tennessee Department of Veterans Affairs
United Spinal Association
United States Coast Guard Chief Petty Officers Association
US Federation of Korea Veterans Organizations
US—Korea Allies Council
VetsFirst, A program of United Spinal Association
Veterans Affairs Physician Assistant Association, Inc.
Vietnam Veterans of America
Wyoming Veterans Commission

Guiding Principles

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

Acknowledgments

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

Adrian Atizado, DAV
Shane Barker, VFW
Carl Blake, PVA
Linda Blauhut, PVA
Denny Boller, AMVETS
Fred Cowell, PVA
Richard Daley, PVA
Daniel Elkins, VFW
Ryan Gallucci, VFW
Sherman Gillums, PVA
Jeff Hall, DAV
Michael Horan, PVA
Joy Ilem, DAV
Ray Kelley, VFW
Mark Lichter, AIA, PVA
Gerald Manar, VFW
Lana McKenzie, PVA
Teresa Morris, VFW
Blake Ortner, PVA
Alethea Predeoux, PVA
Susan Prokop, PVA
Kathy Wahlgren, PVA
John Wilson, DAV
Jennifer A. Zajac, PVA
Diane Zumatto, AMVETS

Advisors:

Heather Ansley, VetsFirst
John M.Bradley III, DAV Senior Advisor
Peter Dickinson, DAV Senior Advisor
John Driscoll, National Coalition for Homeless Veterans
Gary Ewart, American Thoracic Society
Amy Hogan, DAV Research Assistant
Heather Kelly, PhD, American Psychological Association
Tom Miller, Blinded Veterans Association
Robert Norton, Military Officers Association of America
Sheila Ross, Lung Cancer Alliance
Matthew Shick, Association of American Medical Colleges
Barbara West, National Association of Veterans Research and Education Foundations
Jennifer Zeitzer, Federation of American Societies for Experimental Biology
Tom Zampieri, Blinded Veterans Association

Special Thanks to:

Kelly Saxton, PVA, for editorial management
Lisa Bogle, DAV, for editorial assistance
DAV's Communication Department for the cover design

Table of Contents

Summary of Recommendations

With America finally transitioning away from a long war in Iraq, and as we begin to plan our withdrawal from an even longer war in Afghanistan, the number of new veterans and disabled veterans entering the Department of Veterans Affairs (VA) health-care and benefits systems increases steadily. Tens of thousands of soldiers, sailors, airmen, marines, and coastguardsmen have experienced injury or illness associated with their service during the global war on terrorism; meanwhile, the responsibility that this country has to take care of those men and women continues to grow.

It is against this dramatic backdrop of current military events that the four coauthors of *The Independent Budget*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—offer our budget and program recommendations based upon our unique expertise and experience concerning the resources that will be necessary to meet the needs of America's veterans in fiscal year (FY) 2013. These recommendations are designed to meet the needs of the thousands of veterans currently serving in America's armed services who will soon have earned and will require VA health-care and financial benefits, as well as the needs of the millions of veterans from previous conflicts and service who currently depend on VA.

We are proud of the fact that the *The Independent Budget for Fiscal Year 2013* represents the 26th consecutive year that our partnership of veterans service organizations has joined together to produce a comprehensive budget document that highlights the needs of every generation of veterans. During that time, *The Independent Budget* has improved significantly while gaining much more respect and recognition.

It is no secret that a difficult fiscal future lies ahead for this country, and we recognize that VA is not immune to this reality and will likewise face significant challenges. Following months of rancorous debate about the national debt and federal deficit during the summer of 2011, Congress agreed upon a deficit reduction measure—Public Law 112–25—that could lead to cuts in discretionary and mandatory spending for VA. While we ultimately believe that VA is exempted by law from any projected cuts in funding as a result of deficit reduction, the final decision on the impact on VA remains uncertain. *The Independent Budget* coauthors have serious concerns about the potential reductions in VA spending. While changes to benefits programs and cuts to discretionary programs have unique differences, the impact of these possibilities will be equally devastating for veterans and their families.

Additionally, as the Veterans Health Administration has adjusted to the implementation of advance appropriations, we must remain vigilant to ensure that VA is actually requesting and receiving the funding it requires to meet the health-care needs of millions of veterans. As has become the new norm, last year the enactment of advance appropriations shielded the VA health-care system from the political wrangling and legislative deadlock. Meanwhile, *The Independent Budget* veterans service organizations (IBVSOs) are concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on its health-care system. In fact, the FY 2012 and FY 2013 advance appropriations budget proposal released by the Administration last year included "management improvements," a popular gimmick used by previous administrations to generate savings and offset the growing costs to deliver care. Unfortunately, these savings were often never realized, leaving VA short of necessary funding to address ever-growing demand on the health-care system. Yet we believe that continued pressure to reduce federal spending will only lead to greater reliance on gimmicks and false assumptions to generate funding.

Year after year, the IBVSOs conduct comparative analysis of VA workload information and carefully review medical and administrative cost data that form the foundation of *The Independent Budget's* recommendations. The IBVSOs then call upon Congress and the Administration to provide sufficient funding to meet the health-care and financial benefit needs of veterans in a timely and predictable manner. This has proved to be a difficult, but welcome, challenge, particularly in light of recent economic conditions, as we seek to ensure that the needs of all veterans are properly met.

With regard to veterans' benefits, the IBVSOs believe VA must fast-track real steps that will help ameliorate nagging claims-processing barriers. Continuing studies to find solutions must be replaced by real action plans that produce positive results. We are pleased to see that real progress is finally being achieved to bring the claims process into the 21st century. Through implementation of reforms such as the Veterans Benefits Management System, the Veterans Benefits Administration may finally be on a path to ensuring that veterans' claims are decided in a timely fashion while also being decided correctly the first time. However, only time will tell if the myriad of reforms that the VBA is putting into place will have a significant and positive effect. Veterans and their families deserve prompt decisions regarding the benefits they have earned and deserve. These benefits are part of a covenant between our nation and the men and women who have defended it. Veterans have fulfilled their part of the covenant. Now VA must avoid further delay and move forward to meet its obligations in a timely manner.

The Independent Budget for Fiscal Year 2013 provides recommendations for consideration by our nation's elected leadership that are based upon rigorous and rational methodology designed to support the Congressionally authorized programs that serve our nation's veterans. The IBVSOs are proud that more than 60 veteran, military, medical service, and disability organizations have endorsed the FY 2013 edition of this document. Our primary purpose is to inform and encourage the United States government to provide the necessary resources to care for the men and women who have answered the call of our country and taken up arms to protect and defend our way of life.

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

	FY 2012 Appropriation	FY 2013 Administration**	FY 2013 *IB****	FY 2014 Advance Approp.
Veterans Health Administration				
Medical Services	39,649,985	41,519,000	46,041,363	43,557,000
Medical Support and Compliance	5,535,000	5,746,000	5,596,496	6,033,000
Medical Facilities	5,426,000	5,441,000	5,572,742	4,872,000
Subtotal Medical Care, Discretionary	50,610,985	52,706,000	57,210,601	54,462,000
Medical Care Collections*	2,767,000	2,966,000		3,051,000
Total, Medical Care Budget Authority *(including Collections)*	53,377,985	55,672,000	57,210,601	57,513,000
Medical and Prosthetic Research	581,000	582,674	611,000	
Total, Veterans Health Administration	53,958,985	56,254,674	57,821,601	
General Operating Expenses				
Veterans Benefits Administration	2,018,764	2,164,074	2,110,140	
General Administration	416,737	416,737	430,104	
Total, General Operating Expenses	2,435,501	2,580,811	2,540,244	
Departmental Admin. and Misc. Programs				
Information Technology	3,111,376	3,327,444	3,194,592	
National Cemetery Administration	250,934	258,284	280,000	
Office of Inspector General	112,391	113,000	115,608	
Total, Dept. Admin. and Misc. Programs	3,474,701	3,698,728	3,590,200	
Construction Programs				
Construction, Major	589,604	532,470	2,693,700	
Construction, Minor	482,386	607,530	1,069,000	
Grants for State Extended Care Facilities	85,000	85,000	85,000	
Grants for Construct of State Vets cemeteries	46,000	46,000	51,000	
Total, Construction Programs	1,202,990	1,271,000	3,898,700	
Other Discretionary	156,176	159,000	159,612	
Total, Discretionary Budget Authority (including Medical Collections)	61,228,353	63,964,213	68,010,357	

*Medical care collections estimates reflect revisions made by the Administration to the original projections included in the FY 2012 Budget Request submitted in February 2011.

**Amounts shown in FY 2013 Administration column reflect revised estimate for Medical Services. Recommendations for Medical Support and Compliance, and Medical Facilities accounts from the FY 2013 advance appropriation were unchanged in the newly released Budget Request.

***The recommendations of The Independent Budget (IB) for FY 2013 reflect the expectation for a 0.5 percent pay raise for all VA employees just as the Administration indicated its intention to recommend a similar pay raise in January 2012.

Key *Independent Budget* Recommendations

CRITICAL ISSUE 1

Protection of VA Health-Care and Benefits Programs

Congress and the Administration must ensure that as steps are taken to reduce federal spending that VA health-care and benefits programs are protected.

As the country faces a difficult and uncertain fiscal future, the Department of Veterans Affairs likewise faces significant challenges ahead. Following months of rancorous debate about the national debt and federal deficit during the summer of 2011, Congress agreed upon a deficit reduction measure, P.L. 112–25, that could lead to cuts in discretionary and mandatory spending for VA. The coauthors of *The Independent Budget*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—have serious concerns about the potential reductions in VA spending. While changes to benefits programs and cuts to discretionary programs have unique differences, the impact of these possibilities will be equally devastating for veterans and their families.

VA discretionary spending accounts for approximately $62 billion. Of that amount, nearly 90 percent of that funding is directed toward VA medical care programs. VA is the best health-care provider for veterans. Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. Across the nation, VA is a model health-care provider that has led the way in various areas of medical research, specialized services, and health-care technology. The VA's unique system of care is one of the nation's only health-care systems that provides developed expertise in a broad continuum of care. Currently, the Veterans Health Administration serves more than 8 million veterans and provides specialized health-care services that include program specific centers for care in the areas of spinal cord injury/disease, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related polytraumatic injuries. Such quality and expertise on veterans' health care cannot be adequately duplicated in the private sector. Any reduction in spending on VA health-care programs would only serve to degrade these critical services.

Moreover, *The Independent Budget* veterans service organizations (IBVSOs) are especially concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on the VA health-care system. In fact, the FY 2012 and FY 2013 advance appropriation budget proposal released by the Administration in 2011 included "management improvements," a popular gimmick used by previous Administrations to generate savings and offset the growing costs to deliver care. Unfortunately, these savings were often never realized leaving VA short of necessary funding to address ever-growing demand on the health-care system. We believe that continued pressure to reduce federal spending will only lead to greater reliance on gimmicks and false assumptions to generate apparent but illusory funding. In fact, the Government Accountability Office (GAO) outlined its concerns with this budget accounting technique in a report released to the House and Senate Committees on Veterans' Affairs in June 2011. In its report, the GAO states:

> If the estimated savings for fiscal years 2012 and 2013 do not materialize and VA receives appropriations in the amount requested by the President, VA may have to make difficult trade-offs to manage within the resources provided.

This observation reflects the real possibility that exists should VA health care, as well as other programs funded through the discretionary process, be subject to spending reductions.

The IBVSOs also believe that VA benefits have no place in deficit reduction efforts. VA disability compensation is a benefit provided because an individual became disabled in service to the country. In addition, many ancillary benefits—particularly Specially Adapted Housing benefits, adaptive automobile assistance, and vocational rehabilitation—are provided to service-connected disabled veterans. Likewise, education benefits, such as the Post-9/11 GI Bill, are earned through service. Compensation reflects the debt of gratitude this nation owes the men and women who served in uniform and recognizes the challenges they will face every day as a result of their service. Any attempt to reduce or modify eligibility criteria would be considered an abrogation of the responsibility that this nation has to veterans and would be wholly unacceptable.

Meanwhile, we are concerned that because the Joint Select Committee on Deficit Reduction, originally created by P.L. 112–25, failed to agree on a bipartisan compromise to reduce the deficit and federal debt, an automatic "trigger" known as sequestration will occur that could lead to a potential reduction in spending on VA health care programs by two percent. While the IBVSOs believe all VA programs are excluded from automatic cuts by P.L. 111–139, the "Statutory Pay-As-You-Go Act of 2010," questions remain about whether or not VA health-care spending in particular could be included in broader discretionary spending reductions. In fact, Section 11 (Exempt Programs and Activities) of P.L. 111–139 specifically states:

> (b) VETERANS PROGRAMS—The following programs shall be exempt from reduction under any order issued under this part:
>
> "All programs administered by the Department of Veterans Affairs."

We believe this language is crystal clear in outlining the priority that Congress has placed on funding for VA programs, even in the face of pressure to reduce the deficit.

Finally, Congress once again failed to fulfill its obligations to complete work on appropriations bills funding all federal departments and agencies, including VA, by the start of the new fiscal year on October 1, 2011. Fortunately, as has become the new normal, last year the enactment of advance appropriations shielded the VA health-care system from the political wrangling and legislative deadlock. However, the larger VA system, particularly the management of claims processing, is still negatively affected by the incomplete appropriations work. VA still faces the daunting task of meeting ever-increasing health-care demand as well as demand for benefits and other services. The IBVSOs believe it is simply unacceptable that once again the operations of the VA were hampered by the inability of Congress to complete work on this critical funding measure prior to the start of the new fiscal year.

Recommendations:

Congress and the Administration must ensure that the health-care and benefits programs administered by VA are protected from any efforts to reduce spending as a result of sequestration or other deficit- and debt-reduction steps.

Congress and the Administration must work together to ensure that the advance appropriations amounts already provided for FY 2013 are sufficient to meet the projected demand for veterans' health care and ensure that sufficient resources will be provided in the advance appropriation for FY 2014 as well.

CRITICAL ISSUE 2

Reforming the Benefits Claims-Processing System

The Veterans Benefits Administration is at a critical juncture in reforming an outdated, inefficient, and overwhelmed disability claims-processing system, and strong leadership is required by both Congress and the Department of Veterans Affairs to ensure that this system is finally and truly reformed.

For the past two years, the Veterans Benefits Administration (VBA) has undertaken a comprehensive effort to reform its benefits claims-processing system. Under the weight of an outdated information technology (IT) system, increasing workload, and growing backlog, the VBA seeks to transform the way it processes claims, while simultaneously reducing the backlog of claims pending using its existing infrastructure. While there have been many positive and hopeful signs that the VBA is on the right track, over the next year critical choices will be made, and the results of those choices will determine whether this effort will be successful. Congress must provide careful and vigilant oversight of this transformation to ensure that the VBA achieves true reform, not only arithmetic milestones, such as a lowered backlog or decreased cycle times.

Launched by the Secretary of Veterans Affairs with the ambitious goal of deciding every claim in fewer than 125 days (currently more than 180 days) with a 98 percent accuracy rate (estimated as low as 78 percent), the VBA's transformation efforts are centered around three interconnected elements: people, processes, and technology. However, it is likely the critical path will be IT modernization, primarily the Veterans Benefits Management System (VBMS). Today, the VBA relies on a disjointed set of software applications and stovepipe databases designed only to manage, not automate, a very paper-intensive process. The logistical burden of maintaining and moving the VBA's mountain of paper within and among its 57 regional offices has significantly slowed the claims process and degraded the VBA's capacity to manage a growing workload. Further, the failure to take advantage of technology-driven automation has further stressed a workforce under pressure to produce decisions quickly, resulting in declining quality and accuracy, according to the VBA's own internal analyses.

The VBMS initiative, begun a couple of years ago, is now in pilot testing at VA Regional Offices in Providence, Rhode Island, and Salt Lake City, Utah. Additional rollouts are scheduled next year with full deployment promised by the end of 2012 or early 2013. While the early iterations of the VBMS appear to incorporate most of the essential functions required for a fully electronic and largely automated work process, questions remain about whether the VBMS will ultimately fulfill its objectives. What had originally been presented as a single, interconnected system to manage workflow now encompasses at least seven subcomponents: VBMS-E for "establishment," VBMS-D for "development, " VBMS-R for "rating," VBMS-A for "award," VBMS-C for "correspondence," VBMS-F for "folder," and VBMS-W for "workflow." In addition, a design team operating out of the Atlanta VA Regional Office has been moving forward rapidly with a new program called DENTT (Disability Evaluation Narrative Text Tool), which is being used to automate some elements of rating decisions and award letters. How and whether all of these components can or will be designed and deployed to create a single, unified IT system remains uncertain. Given the highly technical nature of such questions, it is essential for Congress to conduct vigorous oversight, including employing independent, third-party experts, to ensure that the VBA's IT transformation does not result in another, albeit different, set of IT acronyms that fail once again to provide a single integrated solution to address veterans' claims.

In addition to the VBMS, VA must also continue to develop both the e-Benefits and Veterans Relationship Management (VRM) systems. E-Benefits provides veterans with a modern Internet-based method of engaging with VA to apply for benefits, monitor claims, and make instant changes to user information. VRM is being designed to provide a fully integrated system of contact management for VA and veterans,

so that whether a veteran calls, emails, visits in person, or uses any other means to communicate with VA, the veteran will have the same timely and successful result. VRM and e-Benefits are both essential elements of the VBA's claims-processing reform that must be provided sufficient resources and time to be properly completed.

The past two years have been a time of change and experimentation for the VBA, with dozens of pilot programs and initiatives begun, ended, or continued. Among the most important are the Fully Developed Claim (FDC) program, Disability Benefits Questionnaires (DBQs), the I-Lab segmentation strategy, and the DENTT program. If designed and implemented with at least an equal emphasis on improving quality and accuracy, each of these initiatives offers opportunities for important improvements in the claims process. In particular, it is critical that the I-LAB being conducted in Indianapolis, which is seeking to combine the most successful pilots and initiatives into a new multipath claims process, evaluates success not only on reductions in cycle times, but equally on reductions in errors.

While not a central element of the VBA's transformation strategy, statutory and regulatory changes that are ongoing and proposed could have a significant effect on reform efforts. Proposals to streamline the Veterans Claims Assistance Act (VCAA) notice and duty-to-assist requirements must be carefully crafted to achieve the purpose of eliminating unnecessary overdevelopment while ensuring veterans' rights are fully protected, particularly for those veterans without representation. Also, changes are being developed to update the VA Schedule for Rating Disabilities (VASRD), which could have a profound effect on how and whether VA disability compensation benefits will achieve the purpose intended by Congress (to compensate disabled veterans for their average loss of earnings capacity). Although the VASRD update is being done as a regulatory process, Congress must ensure that VA's proposed new rules fully and faithfully meet Congressional intent.

While changes in the technology, processes, and legal framework will be crucial to the VBA's transformation, it is also essential that the people and culture at the VBA change with them. Regardless of how modern or automated the claims process may become, the VBA cannot be successful in the long run unless it has comprehensive training, testing, quality control, and accountability systems in place to match these developments. As long as incentives and penalties at all levels remain primarily focused on production and speed of processing, the long-term change in mind-set and behavior necessary to ensure lasting reform will remain elusive. The VBA and Congress must continue to look for ways to ensure that training, testing, quality control, and accountability are interrelated and form the core of the next claims-processing system in the VBA.

Finally, it is imperative that the VBA continue to develop new and expand existing collaborations and consultations with veterans service organizations (VSOs), which have tremendous expertise and lengthy experience with the claims process. Over the past two years, VBA leadership has made commendable outreach efforts to VSOs as VA has embarked on the current transformation effort. The new leadership at the VBA has not only continued that partnership, but enriched it with additional efforts to infuse VSO perspectives and ideas at the earliest stages of IT and process redesign. As the VBA continues to finalize its claims-processing transformation, VSOs and their service officers who represent veterans must be fully integrated into the final system design. Absent this involvement, success is doubtful.

Recommendations:

Congress and VA must ensure that the ongoing VBMS development and implementation be provided the resources and time necessary to ensure that the system is fully functional before it is rolled out nationally.

Congress must provide assertive oversight of the ongoing development of the VBMS, e-Benefits, VRM and other IT systems, including third-party, expert, independent reviews, to ensure that the IT modernization achieves the comprehensive solutions necessary to reform the claims process.

New regulatory, administrative, and procedural changes in the claims process—including Disability Benefits Questionnaires, Disability Evaluation Narrative Text Tools, and duty-to-assist reforms—must

be carefully developed and monitored to ensure that these innovations contribute to more accurate claims completed in a more timely manner, while fully ensuring veterans' statutory rights.

The VBA must also reform its training, testing, quality control, and accountability systems so that all employees, managers, and leaders throughout agency are incentivized or penalized in accordance with a clear goal of deciding each claim right the first time.

The VBA must continue and build upon its successful efforts over the past two years to partner with veterans service organizations during the design, development, and implementation of claims-process reforms.

CRITICAL ISSUE 3

Transition, Employment, and Training for Today's Veteran Population

Successful transition from military service to civilian life hinges on veterans' ability to be competitive in the workforce; therefore, it is imperative that Congress fund employment training, and education programs to meet increasing needs of those repatriating from overseas deployments.

Transition Programs

The Departments of Defense (DOD), Veterans Affairs (VA), and Labor (DOL) all devote considerable resources to aiding service members, and veterans' transition to civilian life. However, while less than 1 percent of our nation's population chooses to serve in the military, unemployment rates continue to skyrocket among veterans and are disproportionately high when compared to that of their nonveteran counterparts. The men and women who fight to protect our nation's safety and freedoms are then faced with the fight for employment when transitioning to civilian life. While there are numerous federal, state, and private sector programs designed to assist veterans during their transition, the fact remains that the unemployment rate among veterans continues to rise.

A recent report from the Government Accountability Office (GAO), GAO-11–92, explained that in fiscal year 2009 the federal government spent about $18 billion on 47 separate employment and training programs managed by nine different agencies.[1] All but three of those programs overlapped with at least one other program. Five programs that specifically target veterans provided seven similar types of services. As the GAO noted in its report, this overlap among programs could interfere with individuals seeking services and could frustrate employers as well. Additionally, most of these programs—including those serving veterans—had not completed analyses to determine whether positive employment outcomes resulted from their services, rather than from other factors. Three programs, including the Transition Assistance Program (TAP), do not track any outcome measures. *The Independent Budget* veterans service organizations (IBVSOs) believe that Congress and the Administration should resist "funding" additional programs and step back to evaluate existing programs, in order to identify strengths, weaknesses, and outcomes. Furthermore, evaluations and analyses for those established programs need to be developed in order to ensure they are providing proper services. It is the opinion of the IBVSOs that too many of the programs tasked with assisting veterans during their transitions have deviated far from their original intended purpose.

The path to a successful transition from military to civilian life begins with a thorough TAP class. TAP is a program designed by the DOD to provide transition and job search assistance to separating service members. Currently, TAP is a partnership between

the DOL, DOD, the Department of Homeland Security (DHS), and VA to provide employment assistance and counseling to members of the armed forces, and their eligible spouses, within one year of their separation or two years of their retirement from the military. TAP classes are often the only opportunity a service member, or qualifying family member, will have to receive this important information, vital to sustaining their quality of life after the military.

Programs for Disabled Veterans

According to a recent study performed by the DOL's Bureau of Labor Statistics, approximately 25 percent of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn veterans have a service-connected disability.[2] This statistic clearly illustrates the importance of programs designed to meet the transition and employment needs of today's returning service members. There are several programs tasked with training and preparing disabled veterans to reenter the civilian workforce. Examples of these federally funded programs include, but are not limited to, the Vocational Rehabilitation and Employment Service, Employment One Stop Integrated Resource Teams, and the Disabled Veterans' Outreach Program. *The Independent Budget* coauthors believe that with such a large number of federal and state-run programs being available to disabled veterans, there is absolutely no reason that the number of unemployed disabled veterans should continue to rise.

Moreover, since veterans with significant disabilities often encounter multiple barriers when returning to competitive employment, the IBVSOs recommend that federal and state programs actively seek out and partner with similar programs designed to assist all people with disabilities. Specifically, veterans who have acquired significant disabilities must be able to benefit from all of the programs for which they are eligible, not just those for wounded warriors. The DOL's Office of Disability Employment Policy (ODEP) has worked to include the perspectives of veterans with significant disabilities in its employment initiatives for people with disabilities. Although employers may wish to hire disabled veterans, those who have significant disabilities face barriers similar to those faced by other people with disabilities. This includes misinformation about disability and misperceptions regarding required accommodations.

To ensure that veterans with significant disabilities have every opportunity to regain employment, the mission of ODEP and other programs to increase employment opportunities for all people with disabilities must be viewed as integral to the reintegration of these veterans. For example, partnerships between the DOL's Veterans' Employment and Training Service and ODEP must be required in the development and implementation of labor programs and policies to ensure that veterans with significant disabilities are specifically included in initiatives for people with disabilities. The IBVSOs recommend this include, but not be limited to, measuring the benefits for veterans with significant disabilities separately from those for nonveterans. Without these measurements, the results for veterans of various employment programs will be difficult to measure.

Private Sector Employers, Veterans, and Post-Service Credentials

Responding to the disproportionately high unemployment rates among veterans, in June 2010, the Society For Human Resource Management (SHRM) released the findings of its national survey, titled "Employing Military Personnel and Recruiting Veterans—Attitudes and Practices SHRM Poll." The survey examined pay and benefits that organizations provide to employees who have been mobilized to serve on active duty service either as a reservist or as a member of the National Guard, as well as the challenges organizations face when an employee has been mobilized to serve on active duty. The benefits and challenges of hiring military veterans were examined, as were the areas that would assist organizations in recruiting and hiring veterans. Unfortunately, the survey results simply confirmed what many veterans service organizations already suspected. Employers reported wanting to actively hire veterans but not knowing the appropriate channels to do so and reported they did not receive much assistance from local DOL or VA offices. The survey also found that only 13 percent of private sector companies offered any type of transition assistance to newly separated service members or active duty returning Guard and Reserve members.

The survey also examined the problems employers have experienced in the past when hiring veterans. Sixty percent of employers found they were unable to translate a veteran's military experience into a job's requisite skills. This finding illustrates the problem veterans have effectively translating their military qualifications and experiences to civilian employment. Due to the fact that the DOD establishes performance standards for every occupation within the armed forces, it is able to provide some of the best vocational training in the nation, yet transferability of military skills and training to civilian occupations is problematic and often dependent upon which state the service member chooses to reside in.

In an attempt to address this issue, the "Veterans Benefits Health Care and Information Technology Act of 2006" recommended that the DOL carry out a demonstration project on credentialing to facilitate the seamless transition of members of the armed forces to civilian life. However, since this was a recommendation, and not mandated by law, the study has not been carried out. Unfortunately, licensure and certification are often dependent on a veteran's state of residence. *The Independent Budget* veterans service organizations believe this issue should be examined to see if it would be feasible to establish a clear process in every state to grant a level of both military training equivalency and enhanced licensure or certification for civilian equivalent employment, thus smoothing the transition from military to civilian occupations.

Additionally, we believe that it is time for the DOD and other federal agencies tasked with assisting transitioning service members to do a better job reaching out to and educating private-sector employers on the value of employing veterans. This outreach must include engaging both large corporations as well as small businesses, which comprise approximately 98 percent of all American businesses.

We recognize that Congress alone cannot solve this epidemic of unemployment among our nation's veterans. It will take a collective effort between Congress, the Administration, federal agencies, private businesses, veterans service organizations, and the broader American public. Better preparing our service members for their transition to civilian life, as well as ensuring they are receiving all of the care and services necessary, is the only way to lower the unemployment rate and properly address adjustment issues today's veterans face.

Recommendations:

The DOD, VA, DOL, and DHS should start taking a "proactive" approach to fighting unemployment and other transition issues, beginning with mandatory Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) classes designed to meet the needs of today's transitioning service members.

The Independent Budget veterans service organizations strongly believe there needs to be more focus and education on the translation of military experience and training into a civilian skill set and résumé.

Congress should emphasize collaboration between programs targeted to veterans and those targeted to people with disabilities to ensure that veterans with significant disabilities benefit from the knowledge and expertise of both the veterans and disability communities.

All TAP classes must include in-depth VA benefits and health-care education sessions and time for a question and answer session.

The DOD, VA, the DOL, and the DHS must redesign and build upon the current transition assistance programs available to active duty National Guard and Reserve members.

The federal government should increase focus and education on the translation of military experience to civilian skill sets and provide guidance to new veterans on suggested areas of private employment potential.

TAP results must be tracked and measured to identify where the program is proving to be successful and where it is falling short. Outcome measures should be applied to determine the program's effectiveness.

TAP needs to be updated so that the government can better educate the families of service members on the availability of TAP classes to meet the needs of qualified spouses.

TAP should be a mandatory program, which all transitioning service members and their eligible family members attend before service members' release from the DOD.

The DOD, VA, the DOL, and the DHS must design and implement a stronger DTAP for wounded service members who are hospitalized or are receiving rehabilitation as their active duty period ends as well as for their families.

Congress must emphasize collaboration between programs targeted to veterans and those targeted to people with disabilities to ensure that veterans with significant disabilities benefit from the knowledge and expertise of both the veterans and disability communities.

Congress must ensure measurement of assistance available to wounded warriors, not just as people with disabilities but as veterans with significant disabilities.

The Administration and Congress should take necessary actions to encourage American businesses to do their part for veterans by enabling them to engage in meaningful employment.

[1] U.S. Small Business Administration: How important are small businesses to the U.S. economy? http://www.sba.gov/advocacy/7495/8420.
[2] The Bureau of Labor Statistics, *Employment Situation of Veterans* 2010, March 10, 2011. http://www.bls.gov/news.release/pdf/vet.pdf.

CRITICAL ISSUE 4

The Continuing Challenge of Caring for War Veterans and Transitioning Them to Civilian Life

A new generation of war veterans is repatriating. The Departments of Defense and Veterans Affairs face challenges in meeting the needs of these veterans and those of their families to make this crucial transition seamless and effective. VA must continue to find ways to work more collaboratively with the DOD while sustaining needed programs for older generations of war veterans and their dependents.

As conflicts overseas wind down, the DOD and VA are accountable for providing new combat veterans with a seamless transition of services and benefits to ensure their successful reintegration. More than 2 million U.S. service members have deployed to Iraq and Afghanistan since 2001, with many individuals serving several tours of duty. *The Independent Budget* veterans service organizations (IBVSOs) believe particular attention must be paid to this population, including the families of those severely injured during wartime service and to women veterans now serving in increasing numbers.

Advancements in military medicine have resulted in a 90 percent survival rate among the wounded, but within the DOD and VA health-care systems, gaps remain in recognizing, diagnosing, treating, and rehabilitating the less-visible injuries of mild-to-moderate traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and other post-deployment health issues.

According to the DOD, VA, and outside experts, even the "mild" version of brain injury can produce behavioral manifestations that mimic PTSD or other mental health conditions. TBI and other injuries can leave patients with long-term mental and physical health consequences. In addition to treatment and rehabilitation, the IBVSOs are concerned about the challenge and coordination of services for severely injured veterans and their families, especially those with TBI. Additionally, research has consistently

found that the effects of TBI and PTSD can coexist in one individual. Nevertheless, much about effective treatments for these conditions remains unknown. The IBVSOs believe VA and the DOD should conduct additional research into the long-term consequences of brain injury and PTSD and continue to develop best practices, not only in the care of these patients but also in supportive programs for their families.

What is clear is that without proper screening, diagnosis, and treatment, post-deployment mental health problems could eventually lead some distressed individuals to suicidal ideation. The IBVSOs are encouraged that VA has developed a comprehensive strategy to address suicide prevention in veterans. However, the DOD and VA need to continue cooperating to improve their responses to these at-risk combat veterans, including improvements in primary care to readily identify and develop early interventions for potential mental or emotional problems and to prevent suicide in this population.

The number of women now serving in our military is unprecedented in U.S. history, and women have played extraordinary roles in Afghanistan and Iraq, including serving in female engagement teams and other hazardous duties. Responding to the unique post-deployment health-care needs of women and the significant increases in the number of women is a daunting challenge for VA. The current rate of enrollment of women in VA health care has doubled in the past decade and now constitutes the most dramatic growth of any subset of veterans. For these reasons the IBVSOs encourage VA to concentrate on improving services and treatment programs for women and to continue research initiatives for female veterans to ensure they have access to high-quality comprehensive medical care at all VA facilities.

Many family members serve as lifelong caregivers to severely injured veterans. Until recently this crucial role has received little acknowledgment from the government. The IBVSOs are pleased that Public Law 111–163, the "Caregivers and Veterans Omnibus Health Services Act," is being thoughtfully developed and implemented. VA has created an array of supportive services; however, many family caregivers are not eligible for some of these benefits. The IBVSOs believe these services should apply to all service-disabled veterans on the basis of medical and financial needs. We appreciate Congressional oversight hearings that have clarified the intentions of the act so that VA could establish a program that is more responsive than originally proposed, but we urge Congress to authorize expansion of the program to cover family caregivers of all service-disabled veterans.

The IBVSOs believe that veterans should not be forced to wade through bureaucratic delays to obtain the VA benefits and health care that they have earned. To better assist these veterans and their families, we believe that strong case management is necessary as these veterans transfer from the responsibility of the DOD to VA. Congress created the Federal Recovery Coordination Program (FRCP) to coordinate DOD and VA care for severely injured and ill service members. We appreciate that authorization but remain concerned about the gaps observed in the FRCP and the need for dependable case management essential to coordinating complex components of care. The gaps that need to be addressed include better communication, education, and streamlining of the referral process. We thank Congress for the series of oversight hearings held over the past three years that highlighted these gaps and needs, and we encourage continuation of that oversight.

The IBVSOs continue to be concerned about the status of collaboration between the DOD and VA in the area of information technology management, incorporating both military personnel records (including the DD 214 service record) and the electronic health records each agency maintains. We acknowledge that progress has been made; however, the military service branches and VA are still not sharing electronic information on a broad or routine scale—a shortfall that can serve as a major barrier to achieving seamless transition for hundreds of thousands, perhaps millions, of service personnel and new veterans. Effective information exchange could increase health-care sharing between agencies and providers, laboratories, pharmacies, and patients; aid patients in transition between settings; reduce duplicative and unnecessary testing; improve safety and reduce errors; and increase general understanding of the value of health information technology.

The IBVSOs are pleased with the establishment of a pilot Virtual Lifetime Electronic Record program, including VA's recent announcement of its expansion beyond the two initial sites. However, it should be remembered that VA and DOD facilities are widely scattered and can be counted in the thousands, so the IBVSOs remain firm that the DOD and VA be held

accountable for completing a process of information flow that is national, computable, interoperable, and that can provide real-time electronic exchange of personnel, health, occupational, and environmental exposure information on millions of veterans. Today this goal is far from being achieved.

Recommendations:

As a general principle, Congress must conduct rigorous oversight to ensure that the DOD and VA ultimately provide service members a seamless transition from military to civilian life.

The DOD and VA must develop clear plans of effective rehabilitation for severely injured service members and veterans, with special attention to those with polytraumatic injuries and/or traumatic brain injury (TBI).

The DOD and VA must invest in research in TBI and post-deployment mental health to close gaps in care and develop best practices in screening, diagnosing, and treating brain injuries and mental health sequelae of exposure to war.

VA and the DOD should establish a program of early intervention services for treatment of war-related health problems, with a priority on mental health challenges and substance-use disorders.

The DOD and VA must increase the number of providers who are trained and certified to deliver evidence-based care for post-traumatic stress disorder and major depression and find new ways to encourage service members and veterans to seek care without fear of stigma.

VA should continue improvement of its health-care delivery model and expansion of programs for the treatment of the unique post-deployment health needs of women veterans.

Congress should continue to monitor VA to ensure that it faithfully implements the intent of Public Law 111–163 with respect to family caregiver needs and programs for women veterans.

Congress should expand eligibility for family caregiver supports to all generations of service-disabled veterans.

Congress should ensure that the DOD and VA improve the use of the Federal Recovery Coordination Program (FRCP) in military treatment facilities and VA medical centers caring for severely injured service members and veterans.

VA should periodically survey family members of veterans assigned to the FRCP to determine where improvements are needed.

CRITICAL ISSUE 5

Transformation of the Department of Veterans Affairs Health-Care Delivery Model—Patient-Centered Medical Home or Patient-Aligned Care Teams

The Veterans Health Administration is undergoing change in the way it delivers health care. As the VHA implements a patient-centered medical home model, Department of Veterans Affairs' leadership must ensure that the unique health-care needs of the veteran population are met while sustaining quality and satisfaction.

Over the past 15 years, VA has been transformed into a nationally recognized, first-rate, and comprehensive health-care system. To maintain its high standards of quality care, VA recently announced its intention to transition to a patient-centered medical home (PCMH) model using the patient-aligned care team (PACT) approach. *The Independent Budget* veterans service organizations (IBVSOs) believe that such a change has the potential to enhance the delivery of health services for veterans; however, to ensure that the expected positive outcomes are achieved, VA must include three critical factors as fundamental components of the medical home model: (1) the PACT approach must meet the unique needs of disabled veterans; (2) PACTs must be accessible and provide timely care to and communication with veterans and their advocates; and (3) the VHA's infrastructure needs must be aligned with the new model of care.

In January 2011, VA announced that the newly created Office of Patient Centered Care and Cultural Transformation would be primarily responsible for managing the implementation of all PACTs throughout the VHA. The PACTs are interdisciplinary teams with primary care providers, registered nurse case managers, clinical and administrative staffs, and medical professionals that are requested based on the health-care needs of individual veterans. As of July 2011, VA reported that 80 percent of VA medical facilities have elements of PACT in operation, and VA leadership further projects that all VA health-care sites will function as PACTs by 2015. The VA has identified the principles of the patient-centered medical home model as having—

- team-based care that emphasizes continuity of care over the lifespan of the veteran-patient;
- a larger role for nurses, nurse practitioners, and physician assistants in coordinating care;
- use of email, secure messaging, and other alternative forms of communication and telemetry with patients to monitor care;
- greater attention on behavioral and mental health issues; and
- increased focus on what patients want while increasing patient and practitioner satisfaction.

The five elements of PACT implementation include (1) assessment and readiness; (2) building staffing infrastructure; (3) training and education; (4) innovation and evaluation; and (5) measurement. Each of these elements constitutes a tool used by VA to define, assess, and develop the overall mission and responsibilities of PACTs. Most important, these elements must incorporate the principals of quality care that VA has successfully delivered to America's veterans.

Because the PCMH model requires each PACT to be responsible for coordinating, managing, and developing health-care plans for a panel of veteran patients, there is great potential to improve the delivery of health-care services as it relates to continuity of care, communication with veterans, and comprehensive services. However, over the years VA has established specialized systems of care and primary care teams with specialty-trained practitioners for veterans who have experienced spinal cord injury or disease, blindness, amputations, polytraumatic injuries, and chronic mental illness challenges, and these specialized systems of care serve as excellent models for patient-centered care delivery and cannot be replaced or diluted by the advent of PACTs that focus on the basic outpatient model of care. While the IBVSOs understand the importance of the transition to a new model of care, PACTs may not be trained to adequately meet the specialized health-care needs of these populations.

VA leadership must make certain that PACT staffing is sufficient to provide quality care and addresses the individual medical needs of veterans. To guarantee the success of this health-care delivery model, and improve VA health-care services, Congress and VA must ensure that VA medical centers have adequate funding, as well as clearly prescribed patient-to-staff ratios for PACTs. Specifically, staffing levels at each medical center must be in direct alignment with the number of veterans seeking services. Funding must be made available to hire additional full-time medical staff, as well as make facility enhancements to support implementation of the PCMH model.

An important counterpart to the PACT approach is a supportive adjustment to the Veterans Equitable Resource Allocation model and to existing individual and organizational performance plans and measures, both of which incentivize a primary care system, not necessarily PACTs. The VHA should redesign management tools that modify behaviors of the health-care system so that the VHA can make a successful transition to PACTs.

As PACT implementation moves forward, the changes inherent in this cultural shift in health-care delivery must be taken into account in VA's infrastructure and capital investment policies. With the advent of PACTs, VA would no longer simply be replacing worn-out medical centers and clinics with like, but modernized, facilities; VA's evolution to the PACT approach in all likelihood will result in the need for VA to redesign its thinking for how a 21st century VA health-care system, based on the new PACT model of care, should be configured. Therefore, the IBVSOs strongly encourage VA to incorporate a sixth element of PACT implementation: building facility infrastructure and technology. As PACT implementation progresses, VA must assess the physical infrastructure and technology needs of its medical centers in order to fully support the transition to a PCMH model of care and utilize integral components of this new health-care system, such as the use of telemedicine and telemetry to help manage and coordinate veterans health care, as well as reach and treat certain patient populations.

VA must help veterans, family members, and caregivers understand the purpose and goals of VA's new culture to help them become true collaborators in the health-care decisions and care plans formulated to maintain veterans' health. In addition to the goal of better health outcomes and management of chronic diseases, the value of long-term, one-to-one relationships that are established and nurtured between patient and practitioner and the emphasis on enhanced access to care, quality, safety, and coordination of care are also important and beneficial. As PACTs are established in VA medical centers, the IBVSOs recommend that VA schedule frequent meetings to reach out to veterans and their advocates for input and feedback, as well as identify tools to monitor quality performance using measurable indicators to ensure that the intended health-care outcomes are achieved.

Recommendations:

VA must ensure that the specialized systems of care are not replaced or diluted by standard patient-aligned care teams (PACTs) that may not be trained to adequately meet the unique health-care needs of populations needing specialized care.

VA must implement policies to provide continuity of care throughout the Veterans Health Administration to ensure safe delivery of quality health care.

VA must use the data collected from its research efforts to bring all of the facets of the PACT plan into a cohesive and integrated whole.

VA must create and implement a comprehensive educational component for veterans and their advocates during the early stages of PACT implementation to increase the likelihood VA users understand how the new model serves them and represents an improvement.

VA must include *The Independent Budget* veterans service organizations as an integral part of the transformational process and keep them informed and involved in the changes to come in order to help serve and educate their memberships and the veterans VA serves.

VA capital investment planning, as well as VA's academic missions, must be accommodated as VA shifts its culture to that of PACTs.

VA must develop a sixth element of PACT implementation—building infrastructure and technology—to assess the current physical infrastructure and technology needs of medical centers and ensure efficient management of care.

VA must test and create clearly prescribed patient-to-staff ratios for PACTs to ensure timely health-care services at all medical centers.

The VHA should redesign the Veterans Equitable Resource Allocation model and make changes to existing performance measures that modify behaviors of the health-care system so that it can make a successful transition to the PACT approach.

CRITICAL ISSUE 6

Maintaining Critical Infrastructure in the Department of Veterans Affairs

The Department of Veterans Affairs must receive adequate funding to maintain current structures and reduce the backlog of critical infrastructure gaps in utilization, space, condition, and safety that are outlined in its Strategic Capital Investment Plan.

VA's infrastructure—particularly within its health-care system—is at a crossroads. The system is facing many challenges, including the average age of buildings (60 years) and a significant funding need for routine maintenance, upgrades, modernization, and new construction. This vast, growing, and aging infrastructure continues to create a burden on VA's overall construction and maintenance requirements. It must be remembered that these facilities are the instruments used to deliver the care to our injured and ill veterans. Every effort must be made to ensure these facilities have sufficient resources to remain safe environments to deliver that care. A VA budget that does not adequately fund facility maintenance and construction will reduce the timeliness and quality of care for our veterans.

VA manages a wide portfolio of capital assets throughout the nation. According to its latest Capital Asset Plan, VA is responsible for 5,500 buildings and almost 34,000 acres of land with a plant replacement value (PRV) of $85 billion. VA has identified in its 10-year Strategic Capital Investment Plan (SCIP) more than 4,800 critical infrastructure gaps that will cost between $53 billion and $65 billion to close, not including activation and operation costs.[1]

Under SCIP, VA provides gap and cost analysis for Nonrecurring Maintenance (NRM), which is budgeted through VA's Medical Facilities budgetary line item, Major and Minor Construction, and leases. The industry standard for medical facilities is for managers to spend between 2 percent and 4 percent for PRV. For VA to keep up with the industry standard, the NRM budget would need to be at least $1.7 billion annually. The $1.7 billion would only prevent the NRM backlog, which is currently at $21.5 billion,[2] from growing any larger. In order to more effectively reduce the backlog, additional funding would be needed.

VA's major construction account faces an equally daunting scenario. In order to finish existing projects and to close current and future gaps, VA will need to invest $21.4 billion[3] over the next 10 years. At current funding levels, it will take between 18 and 22 years to complete VA's 10-year plan and given currently proposed funding levels, completion will take twice as long.

To close all the minor construction gaps within its 10-year timeline, VA will need to invest $7.9 billion.[4] In past years, VA and Congress requested and

appropriated nearly 10 percent of the total needed to close the minor construction gaps. However, the Administration and Congress revised the funding course in recent years by proposing steep reductions in funding for minor construction. If these proposals are enacted and sustained, it will take VA 16 years to complete its 10-year minor construction plan.

An important cornerstone to SCIP is leasing. The current lease plan calls for approximately $3 billion over the next 10 years. The vast majority of these leases are for community-based outpatient clinics. Leasing these types of properties provides the advantage of providing quick, accessible health care. *The Independent Budget* veterans service organizations (IBVSOs) see the value and success of these types of leases. In the past, however, the IBVSOs have been cautious about some of VA's leasing concepts, which relied on contracting inpatient care. As SCIP is implemented, the IBVSOs will remain vigilant to ensure that the few planned leases that contain an inpatient component will not adversely affect veterans who utilize those facilities if the lease is abruptly ended.

Accessible and high-quality health care continues to be the focus for the IBVSOs. To achieve and sustain that goal, large capital investments must be made. Presenting a well-articulated, completely transparent capital asset plan is important, but funding that plan at nearly half of the prior year's appropriated level and at a level that is only 25 percent of what is needed to close the access, utilization, and safety gaps will not fulfill VA's mission.

Recommendations:

Congress must dramatically increase funding for nonrecurring maintenance to maintain current and future infrastructure, putting it in line with the industry plant replacement value standard of 2–4 percent, as well as invest in reducing the current $21.5 billion nonrecurring maintenance backlog.

Congress must increase funding for VA's major construction account. In order to close the gaps in major construction within 10 years, VA will need to invest more than $2.1 billion per year.

VA's minor construction account must be funded at a level of $840 million per year through 2021 to close gaps affected by the chronic underfunding of this account.

VA must continue its transparency in leasing and ensure that veterans' inpatient access needs will not be jeopardized if and when leases expire.

VA must include activation and operational costs in its construction plan to show the full costs of its major construction projects.

[1] Department of Veterans Affairs, FY 2012 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2011, p. 8.1–1.
[2] Ibid., 1–4.
[3] Ibid.
[4] Ibid.

Recommendations to Congress

Benefit Programs

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

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

Congress should carefully review any proposed rules that would change the *VA Schedule for Rating Disabilities*, particularly if such rules would change the basic nature of veterans' disability compensation.

Congress should make cost-of-living adjustments retroactive to the beginning of the year in which the inflation occurred. This change would ensure that veterans and survivors receive the full value of the benefit provided them to offset the loss of earnings capacity due to service-connected disabilities for veterans or the loss of a spouse or parent due to death caused in or by military service.

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

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

VA should amend 38 C.F.R. 3.304 to allow veterans to submit, and VA to accept, the diagnosis of post-traumatic stress disorder (PTSD) by a qualified private clinician along with confirmation that the stressor is directly related to PTSD and military service. In the alternative, Congress should mandate a study by VA to determine how often VA examiners have confirmed a diagnosis of PTSD and confirmation of an in-service stressor in cases where veterans previously submitted private medical evidence that contained a diagnosis of PTSD and confirmation of an in-service stressor.

Congress should enact legislation to repeal the inequitable requirement that veterans' military longevity retired pay be offset by an amount equal to their disability compensation if rated less than 50 percent.

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

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

Congress should change the dates of eligibility for Korea veterans who served in the Korean demilitarized zone at any time starting from April 1968.

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

Congress should authorize dependency and indemnity compensation eligibility at increased rates to survivors of service members who died on active duty, at the same rate paid to the eligible survivors of totally disabled service-connected veterans.

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

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

Congress should establish a supplementary housing grant that covers the cost of new home adaptations for eligible veterans who have used their initial, once-in-a-lifetime grant on specially adapted homes they no longer own and occupy.

Congress should make the temporary residence allowance grant permanent with no finite eligibility period date and automatic adjustments to keep pace with inflation.

Congress should direct VA to administer the temporary residence allowance grant as a stand-alone program, separate and apart from the specially adapted housing/special housing adaptation grants.

Congress should enact legislation that exempts the cash value of VA life insurance policies, and all dividends and proceeds therefrom, from consideration in determining veteran entitlement under other federal programs.

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

General Operating Expenses

Congress and the Veterans Benefits Administration must remain focused on and committed to reforming the claims-processing system, with the principal goal of enhancing quality and accuracy, rather than focusing on reducing the backlog.

Congress must provide sufficient oversight of VBA development of a new operating model to process claims for disability compensation and ensure that best practices are adopted and integrated based on their ability to help VA get claims done right the first time.

Congress and the VBA must ensure that the use of contractors to perform some or all of the development function in claims processing is carefully and comprehensively evaluated, with sufficient consideration given to the VBA's long-term workforce requirements.

Congress and the VBA must ensure that comprehensive metrics are established to assess whether proposed changes to the operating model being considered at the I-LAB will lead to more accurate and timely claims decisions.

Congress must aggressively evaluate and monitor the VBA's implementation strategy and plan to ensure that it remains focused on getting claims right the first time, not just reducing the backlog.

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

Congress should ensure that any legislation being considered to reduce VA's duty to notify or assist claimants does not endanger veterans' ability to receive the highest rating to which they are entitled within a reasonable time frame.

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

Congress and VA must ensure that the Veterans Benefits Management System (VBMS), as well as Veterans Relationship Management and e-Benefits, are provided full funding to successfully complete transformation of the claims-processing system.

Congress should consider an independent, outside, expert review of the VBMS system while it is still possible to make course corrections, should they be necessary.

Compensation Service

Congress should require the Veterans Benefits Administration to conduct a study to determine the actual number of full-time employees necessary to effectively manage its growing inventory of claims while ensuring that rating decisions are produced in an accurate and timely manner.

Vocational Rehabilitation and Employment

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

Congress should authorize at least 195 additional full-time employees for the VR&E Service for FY 2013 to reduce current case manager workload and allow for additional one-on-one dialogue for all veterans generally and for our most severely disabled veterans particularly.

Congress should authorize at least nine new full-time employees in FY 2013 to manage VR&E's expanding campus program.

Congress must provide the resources for VR&E to establish a maximum ceiling of 1:125 as the counselor-to-client workload and a new ratio of 1:100 as the standard.

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

Congress must ensure that funding for the Board of Veterans' Appeals (Board) rises at a rate commensurate with its increasing workload so that it remains properly staffed to decide veterans' cases in an accurate and timely manner.

To meet known and projected workload increases next year, Congress should authorize and fund an additional 40 full-time employee equivalents at the Board for FY 2012.

Judicial Review

Congress should reaffirm its intentions concerning changes made to Title 38, United States Code, section 7261, by the "Veterans Benefits Act of 2002," indicating that it was and still is its intent for the Court of Appeals for Veterans Claims to provide a more searching review of the Board of Veterans' Appeals findings of fact and, in doing so, ensure that it enforces a VA claimant's statutory right to the benefit of the doubt. Congress should amend 38 U.S.C. section 7261(a) by adding a new section, (a)(5), that states: "In conducting a review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision." Congress should require the Court to consider and expressly state its determinations with respect to the application of the benefit-of-the-doubt doctrine under section 7261(b)(1), when applicable.

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

Congress should provide all funding as necessary to construct a courthouse and justice center in a location of honor and dignity to the men and women who served and sacrificed so much to this great nation and befitting the authority and prestige of the United States Court of Appeals for Veterans Claims.

Medical Care

Finance Issues

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

Congress and the Administration must work together to ensure that advance appropriations estimates for FY 2013 are sufficient to meet the projected demand for veterans' health care and authorize those amounts in the FY 2013 appropriations act.

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

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

Congress should provide funds necessary in the Veterans Health Administration FY 2013 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, VA should request appropriate funding separately from the Medical Care appropriation to support its health-care–related emergency management, planning, education, and research.

Mental Health Issues

Congress should require VA to develop performance measures and provide an assessment of resource requirements, expenditures, and outcomes in its mental health programs, as well as a firm completion date for implementation of the components as well as the full Uniformed Mental Health Services (UMHS) package.

Congress should ensure that the new mandatory, person-to-person mental health screening process for post-deployed combat service members (including guardsmen and reservists) required by the "National Defense Authorization Act for FY 2010" is fully implemented for all service branches, and conducted by Department of Defense and VA personnel who are effectively trained to identify these veterans' problems. This responsibility should be jointly embraced by both Departments.

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

OEF/OIF Issues

Congress should authorize and VA should provide a full range of medical, psychological, financial, and social support services to family caregivers of veterans, especially for those with brain and severe physical and polytraumatic injuries. In that connection, Congress should closely oversee VA's full implementation of caregiver benefits authorized by P.L. 111–163. Congress should expand the benefits afforded by this act to family caregivers of enrolled veterans, on the basis of need, rather than the period during which they served.

Congress should provide oversight to ensure that the DOD and VA improve the Federal Recovery Coordinator Program in military treatment and VA facilities caring for severely injured service members and veterans. VA should periodically survey the family members of veterans assigned to federal recovery coordinators to determine where improvements might be necessary to the services they provide these veterans and their families.

Access Issues

Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary automobile travel and should continue to work to develop a transportation strategy in rural and highly rural cases that takes into account alternatives, including greater use of telehealth coordination with available providers and VA mobile services when cost-justified.

Congress and the Administration should investigate to determine if Congressionally directed rural health funds for new innovations in rural and highly rural areas were diverted to underwrite new VA community-based outpatient clinics in nonrural areas and, if confirmed, should take appropriate action to address those deviations from Congressional intent.

Congress must provide real oversight to ensure that the full intent of Congress to exempt catastrophically disabled veterans from paying medical care and prescription copayments is accomplished.

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

Congress should provide oversight on claims processing for non-VA emergency care reimbursement to determine if claims are generally paid timely and if rates of denials for such claims are adjudicated similarly to the claims applicable to the policies of the Centers for Medicare and Medicaid Services and other payers that operate under "prudent layperson" standards.

Specialized Services

Prosthetics and Sensory Aids

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

Congress must continue providing funding for VA and the DOD to prevent, treat, and cure tinnitus.

Congress should change the visual acuity standard definition of legal blindness to 20/200 or less or to 20 degrees or less of peripheral field loss as a visual acuity standard for Specially Adapted Housing grants.

Congress should enact legislation to provide adequate transportation reimbursement for blinded veterans who are accepted into inpatient specialized residential rehabilitation programs.

Congress should provide oversight on the implementation of the Vision Center of Excellence, and should oversee the Defense and Veterans Eye Injury and Vision Registry for coordination information for all eye care professionals to improve care during a seamless transition.

Congress should oversee joint interoperable injury registries that have been mandated by Congress in the "National Defense Authorization Act" for hearing, vision, and limb extremity injuries so they become operational.

Congress should fund the Vision Center of Excellence in the amount of $18.8 million for FY 2013.

Congress should fund vision research in the amount of $10 million for FY 2013.

Congress should renew legislation to require the annual reporting requirement to measure capacity for VA spinal cord care and other specialized services as originally required by P.L. 104–262.

Congress should appropriate the funding necessary to provide competitive salaries for spinal cord injury/disorder (SCI/D) nurses.

Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.

Congress and VA must work together to identify SCI/D centers that are in need of critical resources and that are currently not able to care for referred veterans and make certain that all centers within the VA SCI/D system of care are fully capable of providing the services outlined in VA policy.

VA and Congress must work together to improve the travel reimbursement benefit to ensure that all catastrophically disabled veterans have access to the care they need.

Congress should reauthorize, through 2016, Title 38, United States Code, section 1118(e) affecting VA determinations of presumption of service connection associated with service in the Persian Gulf theater.

Congress should make permanent or, at a minimum, extend VA's "special treatment authority" for veterans who served in the Southwest Asia theater of operations during the Persian Gulf War.

Congress should conduct rigorous oversight of the federal research budget to ensure that VA and other federal agencies collaborate to prioritize and coordinate investigations in a progressive manner.

Congress should maintain its commitment to provide sufficient funding for VA's research program to permit it to resume robust research into the health consequences of Gulf War veterans' service and to conduct research on effective treatments for veterans suffering from Gulf War illnesses. The unique issues faced by Gulf War veterans should not be lost in the urgency to address other issues related to armed forces personnel who are currently deployed and to veterans more recently discharged.

Homeless Veterans

Congress should ensure sufficient and sustained resources to strengthen the capacity of VA health-care services for homeless veteran programs to enable VA to meet the physical, mental health, and substance-abuse rehabilitation needs of this population, including vision and dental care services.

Congress should increase appropriations for the Homeless Veterans' Reintegration Program to the authorized level of $50 million.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers when such services are not available within VA.

Congress should ensure that the DOD assesses all service members separating from the armed forces to determine their risk of homelessness and provide life skills training to help them avoid homelessness.

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

Congress should increase appropriations for the Veterans Workforce Investment Program.

Long-Term Care Issues

Congress must enforce its average daily census mandate for VA to provide institutional care and enact adequate funding to allow VA to expand its non-institutional care services to meet current and future demand.

Congress should conduct oversight in VA's long-term care programs, and VA must maintain a safe margin of community living center capacity to meet the needs of elderly veterans.

Congress should fund the state extended-care construction grant program at $85 million for FY 2013.

VA and Congress must work together to immediately proceed with opening additional SCI/D long-term care beds. This is imperative in order to provide quality long-term health care to the aging SCI/D veteran population and provide them with the specialized care required to meet their needs.

Congress should amend existing statutory authority to end any further fragmentation of VA's long-term care benefits provided under Section 1730, Title 38, United States Code.

Medical and Prosthetic Research

To keep VA research funding at current-services levels, the VA research program requires at least $20 million (a 3.1 percent increase over FY 2012) to accommodate biomedical research inflation. However, *The Independent Budget* veterans service organizations believe an additional $10 million or more in FY 2012, beyond inflationary coverage, is necessary for sustained support of the multiplicity of ongoing VA research initiatives and projects discussed herein. Thus, Congress should increase by at least $30 million the VA Medical and Prosthetic Research account for fiscal year 2013, for a total of $611 million, and more if feasible.

Pervasive problems in timely VA contracting, hiring, and procurement negatively affecting VA research should be the focus of a House or Senate Committee on Veterans' Affairs hearing to determine the exact nature of the causes and solutions. If legislative action is warranted, VA should work with the committees to develop the necessary legislative proposals to remedy this sensitive problem that can have the effect of canceling or significantly delaying VA research projects.

Congress should require VA to submit its research facilities' capital needs report to the House and Senate Committees on Appropriations and Veterans' Affairs as soon as possible. Further, correction of the known infrastructure deficiencies should not be further delayed. Therefore, *The Independent Budget* veterans service organizations recommend (1) a construction appropriation sufficient to address at least five of VA's highest priority research facility construction needs as identified in its facilities assessment report; and (2) a pool of $50 million in minor construction and maintenance and repair funds dedicated exclusively to renovating existing research facilities to address the current and well-documented shortfalls in research infrastructure. Further, Congress should require that research space be addressed as an integral component of planning for every new medical center and that such space plans be designed by architects and engineers experienced in research facility requirements.

The Administration and Congress should establish a new appropriations account in FY 2013 and thereafter to define and separate VA research infrastructure funding needs independently from capital and maintenance funding for direct VA medical care programs. The account should be subdivided for major and minor research construction and for maintenance and repair needs of VA's research programs. This revision in appropriations accounts would empower VA to address research facility needs without interfering with direct health-care infrastructure.

In summary, Congress should fund the VA Medical and Prosthetic Research program in FY 2013 as follows:

- for appropriate program growth, and to cover anticipated inflation, $611 million or more;
- for capital infrastructure, renovations, and maintenance, $150 million or more for research construction projects and $50 million for maintenance and repair (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).

Administrative Issues

Congress should implement an additional Title 38 specialty pay enhancement for medical professionals who provide care in VA's subspecialized services areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury programs.

Congress should enact legislation to reverse a federal appeals court decision holding that VA employees appointed under Title 38 authorities are not covered by the "Veterans Employment Opportunities Act."

The Administration and Congress should take appropriate actions to ensure that VA provides ample opportunities for veterans to secure VA employment.

Congress must provide sufficient funding and strong oversight to support programs to recruit and retain critical nursing staff in VA health care and, in particular, to support enlargement of the Nursing Academy if warranted by expected results in the existing pilot program.

Congress should support changes in per diem and travel requirements to ensure the viability of the VA Travel Nurse Corps program.

Congress should provide support to ensure sufficient nurse staffing levels to regulate and ultimately reduce to a minimum VA's use of mandatory overtime for nurses.

Congress should provide sufficient funding so that all VA facilities can participate in workforce environmental improvement programs, such as recommended by the Robert Wood Johnson Foundation's "Transforming Care at the Bedside."

Congress should support funding to continue and expand the Office of Nursing Services' registered nurse residency pilot program.

Congress should provide oversight and the necessary resources to facilitate development and implementation of an appropriate information technology infrastructure for VA's non-VA purchased care program.

Congress and VA must ensure that the use of non-VA purchased care supplements and does not undermine or supplant the VA health-care system.

Congress should closely monitor the Veterans Benefits Administration's decision making on reliance on IT solutions as the means to achieve claims-processing reform. Congress should also evaluate VA's prioritization of IT projects across administrations to ensure balance and fairness in application and execution.

Congress should request a specific VA plan on including physician assistants in the Locality Pay System or legislate special pay provisions to address this longstanding problem with physician assistant recruitment and retention.

Congress must correct the inequity in the eligibility of VA caregiver support benefits and services.

Congress must ensure and VA must demonstrate the required good faith and serious consideration of post-promulgation comments.

Congress should eliminate applicable respite care copayments.

Congress and VA should review the detailed findings of the "Caregivers of Veterans—Serving on the Homefront" survey and address the recommendations contained therein.

Congress should require the Government Accountability Office to examine the current Civilian Health and Medical Program of Veterans Affairs to ensure that the health coverage available to primary caregivers is adequate.

VA must request and Congress must provide sufficient funding to ensure proper implementation and administration of the caregiver program.

Construction Programs

Congress must appropriate $2.84 billion to adequately fund VA's major construction accounts.

Congress must appropriate $919 million to adequately fund VA's minor construction accounts.

Congress must appropriate $2.1 billion to begin reducing the nonrecurring maintenance backlog as well as invest between 2 percent and 4 percent per year to maintain the plant replacement value of VA's infrastructure.

Portions of the Nonrecurring Maintenance account should continue to be funded outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that have the greatest maintenance needs, rather than based on other criteria unrelated to the condition of facilities.

Congress should require VA to submit its research facilities' capital needs report to the House and Senate Committees on Appropriations and Veterans' Affairs as soon as possible. Further, correction of the known infrastructure deficiencies should not be further delayed.

Congress should authorize a construction appropriation sufficient to address at least five of VA's highest priority research facility construction needs as identified in its facilities assessment report (with an appropriation of $150 million for those purposes) and create a pool of $50 million in maintenance and repair funds dedicated exclusively to renovating existing research facilities.

Congress should require that research space be addressed as an integral component of planning for every new medical center.

The Administration and Congress should establish a new appropriations account in FY 2013 and thereafter to define and separate VA research infrastructure funding needs independently from capital and maintenance funding for direct VA medical care programs.

Congress must appropriate $15 million to provide funding for each medical facility to develop a 10-year comprehensive facility master plan. The master plan should include all services currently offered at the facility and should also include any projected future programs and services as they might relate to the particular facility. Each facility master plan is to be reviewed every five years and modified accordingly based on changing needs and technologies, new programs, and new patient care delivery models.

Education, Employment, and Training

Education

Congress must conduct appropriate oversight to ensure that VA is properly expanding and evaluating the VetSuccess on Campus program.

Congress should grant the Secretary of Veterans Affairs the authority to leverage all available information sources, including that of the state approving agencies and the Departments of Defense, Justice, and Education, to make an informed decision on program eligibility and institutions that will receive federal GI Bill funding.

Congress should grant the Secretary the authority to sanction schools when a federal agency or department cites an institution of higher learning for predatory or other questionable practices.

Congress must also revisit the funding mechanism for the state approving agencies to ensure that they have the resources necessary to properly carry out their mission of inspecting GI Bill-eligible programs.

Training and Rehabilitation Services: Vocational Rehabilitation and Employment

Congress must provide the resources for Vocational Rehabilitation and Employment (VR&E) to establish a maximum client to counselor standard of 125:1 and a new ratio of 100:1 to be the standard.

Congress should provide the resources to support the expansion of VR&E's quality assurance staff to increase the frequency of site visits.

Congress and the Administration must ensure that VR&E is provided the necessary resources to upgrade its legacy Corporate WINRS and the new VetSuccess information technology platform as part of the Veterans Benefits Administration's upgrade of its larger IT systems.

Congress must conduct oversight to ensure that VR&E program services are being delivered efficiently and effectively.

Congress must provide the necessary funding to carry out the longitudinal study over a period of at least 20 years as directed by P.L. 110–389, section 334.

Congress must eliminate the 12-year delimiting period for VR&E services to ensure that veterans with employment barriers or problems with independent living qualify for services for the entirety of their employable lives.

Congress should study changing the current program eligibility standards to determine if doing so would streamline the process for veterans to receive VR&E services by making all veterans eligible who have been assigned a service-connected disability rating, regardless of the percentage.

Congress should eliminate the 30-month maximum program participation for independent living services and the statutory cap of 2,700 new, per annum VR&E Independent Living Program participants.

Congress should provide child care vouchers, linked to cost-of-living increases, for veterans who have families and are undergoing vocational rehabilitation.

Employment and Entrepreneurship

Congress and the Administration must provide adequate funding to support the Transition Assistance Program and Disabled Transition Assistance Program to ensure that active duty as well as National Guard and reserve service members receive proper services during their transition periods.

Congress should monitor Department of Labor (DOL) implementation of the VOW to Hire Heroes Act provisions mandating the DOD, VA, and DOL to work together to identify equivalencies between military and civilian occupations and credentialing, licensing, and certification so that military training meets civilian certification and licensure requirements in each state.

Congress should engage in a national dialogue, working closely with the Administration generally, and the DOD, VA, and DOL specifically, as well as state governments, employers, trade unions, and licensure and credentialing entities at all levels, to establish a process so military training meets civilian certification and licensure requirements for states in which veterans choose to live once they leave the military.

Congress must give the Department of Labor Veterans' Employment and Training Service the tools and resources necessary to ensure that veterans are benefiting from labor programs targeted to addressing their particular employment needs.

Congress must provide increased funding to the Department of Labor for the National Veterans Training Institute to ensure that the professional training programs can be made available for state and federal employment representatives on a timely basis.

Congress should take the necessary actions to require all federal agencies to use a single-source database in all verifications of veteran ownership status before awarding contracts to companies on the basis of a claim of service-disabled veteran-owned small business or veteran-owned small business preference.

Congress must ensure that adequate resources are available to effectively monitor and recognize those agencies that are not meeting the 3 percent minimum goal and hold them accountable. The annual reports filed by all federal agencies reporting fiscal year percentage of goal achieved should serve as guidance on which agencies need the most assistance in the development and implementation of stronger contracting plans.

Congress must ensure that adequate resources are available in VA and other federal agencies to effectively monitor, identify, and prosecute businesses that commit or attempt to commit fraud when contracting with the government.

Congress should provide for a reasonable transition period for all service-disabled veteran-owned small businesses (SDVOSBs) not covered by the limited provisions of P.L. 109–461 to retain their SDVOSB status with the federal government following the death of the disabled veteran, via a surviving spouse, children, or heirs.

National Cemetery Administration

Congress should fund the State Cemetery Grants Program at a level of $51 million for FY 2013. *The Independent Budget* veterans service organizations believe this small increase in funding will help the National Cemetery Administration meet the needs of the State Cemetery Grants program, as its expected demand will continue to rise through 2017. Furthermore, this funding level will allow the NCA to continue to expand in an effort to reach its goal of serving 94 percent of the nation's veteran population by 2015.

Congress should divide the burial benefits into two categories: veterans within the accessibility model and veterans outside the accessibility model.

Congress should increase the plot allowance from $700 to $1,150 for all eligible veterans and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected burial benefits from $2,000 to $6,160 for veterans outside the radius threshold and to $2,793 for veterans inside the radius threshold.

Congress should increase the nonservice-connected burial benefits from $300 to $1,918 for all veterans outside the radius threshold and to $854 for all veterans inside the radius threshold.

The Administration and Congress should provide the resources required to meet the critical nature of the National Cemetery Administration's mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.

Recommendations to the Department of Veterans Affairs

Benefit Programs

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

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

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

VA should amend 38 C.F.R. 3.304 to allow veterans to submit, and VA to accept, the diagnosis of post-traumatic stress disorder by a qualified private clinician along with confirmation that the stressor is directly related to PTSD and military service.

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

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

VA should provide a supplementary auto grant to eligible veterans in an amount equaling the difference between their previously used one-time entitlement and the increased amount of the grant.

General Operating Expenses

The VBA must continue to build upon its successful efforts over the past two years to partner with veterans service organizations during the design, development, and implementation of claims process reforms.

The VBA and Congress must remain focused on and committed to reforming the claims-processing system, with the principal goal of enhancing quality and accuracy rather than focusing on reducing the backlog.

The VBA should continue to review employee performance standards and its work credit system to ensure that it creates sufficient and proper incentives and accountability to achieve quality and accuracy.

The VBA should develop a systematic way to measure average work output for each category of its employees in order to establish more accurate performance standards, which will also allow the VBA to better project future workforce requirements.

The VBA should continue to work with veterans service organizations to expand participation in the Fully Developed Claims program, fine-tune the Disability Evaluation Narrative Text Tool process, and develop new disability benefits questionnaires (DBQs) as the *VA Schedule for Rating Disabilities* is updated and revised.

The VBA must ensure that DBQs are given the proper weight, as one piece of evidence among many, as ratings decisions are being made, and that veterans service organizations that hold power of attorney for claimants have full and immediate access to DBQs submitted electronically.

The VBA and Congress must ensure that the use of contractors to perform some or all of the development function in claims processing is carefully and comprehensively evaluated, with sufficient consideration given to VBA's long-term workforce requirements.

Congress and the VBA must ensure that comprehensive metrics are established to assess whether proposed changes to the operating model being considered at the I-LAB will lead to more accurate and timely claims decisions.

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

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

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

The VBA must ensure that existing and new quality assurance and quality control programs, including the Systematic Technical Accuracy Review (STAR) program and Quality Review Teams (QRTs), are sufficiently funded and staffed.

The VBA should make service on a QRT unit a required step along the career path of employees seeking to reach the highest positions within the VBA.

The VBA should ensure that the Veterans Benefits Management System (VBMS) is able to systematically aggregate and analyze the information that comes from QRTs, the STAR program, "coaches" reviews, Inter-Rater Reliability reviews, employee certification testing, and data from remands from the Board of Veterans' Appeals and the Court of Appeals for Veterans Claims to identify error trends and emerging issues that indicate a need for process improvements or additional training of employees or managers.

The VBA should develop real-time, in-process quality control mechanisms as a core component of the VBMS.

Congress and VA must ensure that the VBMS, as well as Veterans Relationship Management and e-Benefits, are provided full funding to successfully complete transformation of the claims-processing system.

The VBA must continue to support incorporation of rules-based decision support in the VBMS, recognizing that such automation will not be perfect and must be continually evaluated and improved.

The VBMS must include real-time quality control as a core component of the system in order to build a system capable of providing accurate and timely decisions, which is the key to reducing the backlog for the long term.

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

The VBA should continue seeking regular and ongoing input from veterans service organizations during VBMS development and deployment.

Vocational Rehabilitation and Employment

VA should require the Board of Veterans' Appeals to develop and implement an acceptable plan to increase focus on the performance of mission-critical activities, reduce the processing time for appeals, and improve the quality of its decision making.

Medical Care

Finance Issues

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

The VA Under Secretary for Health should establish and enforce a national policy describing the required action(s) a VA facility must take when a veteran identifies inappropriate billing as having occurred. When such actions are taken, their resolution(s) must be reported to a central database for oversight purposes.

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

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

The VHA must establish a performance measure for copayment accuracy rates and to periodically assess the accuracy and completeness of its copayment charges.

Because the fourth mission is increasingly important to our national interests, VA should request appropriate funding separately from the Medical Care appropriation to support its health-care–related emergency management, planning, education, and research.

The VHA should evaluate the need for the four emergency preparedness centers authorized in P.L. 107–287, the "Department of Veterans Affairs Emergency Preparedness Act," and incorporate the funding requirements for those centers in future budget requests.

Mental Health Issues

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

VA should focus intensive efforts to improve and increase early intervention and the prevention of substance-use disorders in the veteran population.

VA should provide training, evaluate the provider skills, and monitor the treatment outcomes of veterans who receive treatment for substance-use disorder from patient-aligned care teams.

VA should conduct health services research on effective stigma reduction, readjustment, prevention, and treatment of acute post-traumatic stress disorder (PTSD) in combat veterans and increase funding and accountability for evidence-based PTSD treatment programs.

VA should conduct an assessment of the current availability of evidence-based care, including services for PTSD, identify shortfalls by sites of care, and allocate the resources necessary to provide universal access to evidence-based care.

VA should ensure that all professional staff are provided specialized training and orientation to the current roles and experiences of women returning from combat theaters and their unique post-deployment mental health challenges.

VA should implement the Congressional requirement to employ veterans of Operations Enduring and Iraqi Freedom and Operation New Dawn at VA medical centers to provide both direct one-on-one peer outreach to other new veterans of Iraq and Afghanistan who might not otherwise seek treatment and peer-to-peer support to help sustain veterans in treatment.

VA should increase staffing at Vet Centers and expand the number of Vet Center sites, with emphasis on locating new Vet Centers near military facilities, and should substantially improve patient-care coordination among Vet Centers, medical centers, and community-based outpatient clinics.

VA should develop and carry out education and training programs for clinical staff on military culture and combat exposure to help forge a more effective connection with young veterans returning from combat theaters.

VA should increase its efforts to provide needed mental health and counseling services to immediate family members whose own mental health issues may diminish their capacity to provide emotional support for returning veterans.

VA should establish pilot programs to improve continuity of care and retention of veterans in evidence-based PTSD treatment programs.

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

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

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

OEF/OIF Issues

VA and the DOD should coordinate efforts to better address mild and moderate traumatic brain injury (TBI) and concussive injuries and establish a comprehensive rehabilitation program, including establishment of therapeutic residential facilities and deployment of standardized protocols utilizing appropriately formed clinical assessment techniques to recognize and treat neurological and behavioral consequences of all levels of TBI and all generations of veterans who suffer the lingering effects from earlier injuries.

Any TBI studies or research undertaken by VA and the DOD for the current generation of TBI-injured veterans should include older veterans of past military conflicts who may have suffered similar injuries that went undetected, undiagnosed, and untreated.

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

Congress should authorize and VA should provide a full range of medical, psychological, financial, and social support services to family caregivers of veterans, especially for those with brain and severe physical and polytrauma injuries. In that connection, Congress should closely oversee VA's full implementation of caregiver benefits authorized by P.L. 111–163. Congress should expand the benefits afforded by this act to family caregivers of enrolled veterans on the basis of need rather than the period during which they served.

The DOD and VA should provide all military personnel going through the Integrated Disability Evaluation System the option to choose between the legal counsel offered by the military and that available at no cost through national service officers of chartered veterans service organizations.

Access Issues

The Veterans Health Administration (VHA) should make every effort to establish external comparisons, such as the Institute for Healthcare Improvement's outcome measures, to gauge its performance in providing timely access to care.

The VHA should make public its Missed Opportunities Report, Completed Appointments Report, Electronic Waiting List Report, and the Access Waiting List Report used to track and manage waiting times.

The VHA should certify the validity and quality of waiting time data from its 50 high-volume clinics to measure the performance of networks and facilities.

VA must ensure that schedulers receive adequate annual training on scheduling policies and practices in accordance with the recommendations of its Office of Inspector General (OIG).

The OIG should conduct a follow-up evaluation of VA's outpatient scheduling processes and procedures, compliance, training, monitoring, and oversight.

VA should complete development of the replacement system for HealtheVet scheduling.

The VHA should also include the timeliness of care standards for veterans who receive non-VA purchased care.

VA must ensure that the specialized systems of care are not replaced or diluted by standard patient-aligned care teams (PACTs) that may not be trained to adequately meet the unique health-care needs of the populations needing specialized care.

VA must implement policies to provide continuity of care throughout the VHA to ensure safe delivery of quality health care.

VA must use the data collected from its research efforts to bring all of the facets of the PACT plan into a cohesive and integrated whole.

VA must create and implement a comprehensive educational component for veterans and their advocates during the early stages of PACT implementation to increase the likelihood that VA users will understand how the new model serves them and represents an improvement.

VA must include *The Independent Budget* veterans service organizations as an integral part of the transformational process and keep them informed and involved in changes to come so as to help serve and educate their memberships and the veterans VA serves.

VA capital investment planning and its academic missions must be accommodated as it shifts its culture to that of PACTs.

VA must develop a sixth element of PACT implementation—building infrastructure and technology—to assess the current physical infrastructure and technology needs of medical centers and ensure efficient management of care.

VA must test and create clearly prescribed patient-to-staff ratios for PACTs to ensure timely health-care services at all medical centers.

VA should enhance its efforts with added training of VA providers, patient-centered communication, implementation of shared decision-making tools, increased infrastructure support and use of technology, and home telehealth to increase continuity of care.

VA should mandate establishment of veterans' and family councils at every VA medical facility to ensure that veterans, families, and veterans service organizations are integrated into these efforts. Should the Office of General Counsel determine that VA is restricted by the "Federal Advisory Committee Act" from taking this action, legislation should be enacted to exempt these councils from such restrictions.

The VHA should redesign the Veterans Equitable Resource Allocation model and make changes to existing performance measures that modify behaviors of the health-care system so that it can make a successful transition to the PACT approach.

VA should improve specialty care offered at community-based outpatient clinics (CBOCs) and should aggressively enhance mental health services at all CBOCs, both VA-staffed and contracted.

VA must improve oversight for CBOCs to eliminate discrepancies in care, thereby ensuring consistently high-quality care at all CBOCs.

VA should concentrate on improving the oversight of contract CBOCs and should consider consolidating contract CBOCs at VA medical center or network levels. More aggressive oversight is necessary to ensure consistent requirements and performance measurements while also simplifying contract administration. Such a move could also ensure more aggressive pricing, but should be based on regional costs and rates within contract CBOCs.

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

VA should enhance telemedicine infrastructure and use of technology to deliver specialty services at CBOCs.

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

VA must ensure that the distance veterans travel, as well as other hardships they face, are considered in VA policies in determining the appropriate location and setting for providing direct VA health-care services and the benefits they have earned by their service to the nation.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans. In each of the past four fiscal years, Congress has provided VA $250 million to fund rural health initiatives; this dedicated funding stream should be maintained for FY 2013.

The Veterans Health Administration, as well as the VA departmental level, collaborating with the Office of Rural Health (ORH), should seek and coordinate the implementation of novel methods and means of communication, including use of the Internet and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health-care services, providers, technologies, and therapies, including greater access to their electronic health records, prescription medications, and primary and specialty appointments.

Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary automobile travel and should continue to work to develop a transportation strategy in rural and highly rural cases that takes into account alternatives, including greater use of telehealth coordination with available providers and VA mobile services when cost-justified.

The ORH should be organizationally elevated in VA's Central Office to be closer to VA resource allocators and executive decision makers.

The ORH should establish at least one full-time rural staff position as a Rural Health Coordinator in 20 Veterans Integrated Service Networks, and more if appropriate.

The Veterans Rural Health Resource Centers should be established permanently with full-time career staff elements, to properly execute the important function of field-based satellite offices providing operational field support and pertinent rural health analysis.

VA should ensure that mandated outreach efforts in rural areas required by P.L. 109–461 are closely coordinated with the ORH or sponsored by the ORH directly.

VA should establish additional mobile Vet Centers where needed to provide outreach and readjustment counseling for veterans in rural and highly rural areas, based on analysis and cost-effectiveness of current mobile services deployed by the Readjustment Counseling Service. VA should report the findings of its analysis to the Veterans Rural Advisory Committee and to Congress.

Given VA's affiliations with schools of health professions, the VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative or initiatives, aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations and to supply additional health manpower to rural America in general. Section 306 of P.L. 111–163 is illustrative of a model for such a policy initiative.

VA should rapidly implement section 401 of P.L. 111–163, which authorizes active duty service members and National Guard and reserve component veterans of Operations Enduring/Iraqi Freedom to be counseled in VA Vet Centers for readjustment problems.

Recognizing that in some areas of particularly sparse veteran population and absence of VA facilities travel to them is impractical, the ORH and its satellite Veterans Rural Health Resource Centers should sponsor and establish demonstration projects with available providers of mental health and other health-care services for enrolled veterans, taking care to observe and protect VA's role as the coordinator of care. The projects should be reviewed and guided by the Rural Veterans Advisory Committee. Funding should be made available by the ORH to conduct these demonstration and pilot projects, and VA should report the results of these projects to *The Independent Budget* veterans service organizations and the Congressional Committees on Veterans' Affairs.

At rural VA CBOCs, VA should establish a staff function of "rural outreach worker" serving to coordinate potentially fragmented care, collaborating with rural and highly rural non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available, or to VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs.

Rural outreach workers in VA's rural CBOCs should receive funding and authority to enable them to purchase and provide transportation vouchers and other mechanisms to promote rural veterans' access to VA health-care facilities that are distant from their rural residences. This transportation program should be inaugurated as a pilot program in a small number of facilities. If successful as a cost-effective tool for rural and highly rural veterans who need access to VA care and services, it should be expanded accordingly.

VA must continue to monitor implementation of the provisions of P.L. 111–163 to ensure that catastrophically disabled veterans are not still being billed for the medical care or prescriptions.

Specialized Services

Prosthetics and Sensory Aids

The Veterans Health Administration (VHA) must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

VHA senior leadership should continue to hold field managers accountable for ensuring that data are properly entered into the National Prosthetics Patient Database.

VA should require the Office of Acquisition and Logistics to develop a tracking mechanism to measure the timeliness of the purchasing process. This system should enable veterans to inquire about the status of their prescribed prosthetic items and trigger automatic notifications when orders are delayed.

VA must develop policy guidance for employees within the Office of Acquisition and Logistics to work closely with VA Prosthetic and Sensory Aids Service (PSAS) leadership to identify those standardized prosthetic devices that are clinically adequate and proven to be durable, quality products.

VA must work closely with stakeholders in the veteran community and keep veterans and their families apprised of changes that affect their VA benefits and services.

VA must make certain that Veterans Integrated Service Network (VISN) prosthetics representatives have a direct line of authority over all prosthetics' employees throughout the VISN, including all prosthetics and orthotics personnel.

The VHA should review the current policy on VHA clinical appeals as outlined under VHA Directive 2006–057 and enact procedures that ensure adequate due process for veterans who are denied a prosthetics request.

The VHA should continue the Prosthetics Clinical Management Program (PCMP), provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

VA must implement safeguards to make certain that the issuance and delivery of prosthetic devices and equipment will continue to be provided based on the unique needs of veterans and to help veterans maximize their quality of life. Such protections will ensure that such principles are not lost during any VHA reorganization. The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

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

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

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent with the expected standard of care for defined services, including prescribing, ordering, and purchasing items based on patients' needs—not cost considerations.

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

The VHA must keep prosthetics standardization separate from other standardization efforts within the VHA since this program deals with items (many uniquely designed) prescribed for individual patients.

VA should provide the necessary resources to Prosthetics and Sensory Aids Service information technology systems to ensure that these functions are enhanced in a timely manner.

VA must fully fund and support its National Prosthetics Representative Training Program, expanding it to meet current shortages and future projections, with responsibility and accountability assigned to the chief consultant for the Prosthetics and Sensory Aids Service (PSAS).

With two national training programs in the PSAS, VA must establish a full-time national training coordinator for the PSAS to ensure standardized training and development of personnel for all occupations within the Prosthetics service line. This assignment will ensure successful educational programs and career development.

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

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

The VHA must ensure that the PSAS Program Office and VISN directors work collaboratively to select candidates for vacant VISN prosthetic representative positions who are competent to carry out the responsibilities of these positions.

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

VA must maintain its role as a world leader in prosthetics research and ensure that the VA Office of Research and Development and the Prosthetics and Sensory Aids Service work collaboratively to expeditiously apply new technologic development and transfer to maximally restore veterans' quality of life.

VA must improve outreach and education to veterans on the benefits and prosthetic options available to them and educate VA staff on the proper uses of service and guide dogs.

We urge VA to permanently remove the hurdle to care being experienced by many disabled veterans using service dogs when accessing VA care.

The VHA must rededicate itself to programs for treatment of tinnitus.

The Independent Budget veterans service organizations urge the DOD and VA to provide better education to service members and veterans on the importance of protective gear and preventative actions.

VA must maintain the current bed capacity and full staffing levels in the blind rehabilitation centers to the level that existed at the time of the passage of P.L. 104–262.

VA must improve yearly training and require the networks to increase the number of full-time Visual Impairment Service Team coordinators, to include blind rehabilitation outpatient specialists in new recruitment, scholarship, and employee retention programs and continue succession planning and development for specialized rehabilitation programs.

VA should create contemporary qualifications standards for ophthalmic technicians.

The VHA should ensure that the spinal cord injury/dysfunction (SCI/D) continuum of care model is available to all SCI/D veterans nationwide. VA must also continue mandatory national training for the SCI/D "spoke" facilities.

VA should develop a directive to enforce *VHA Handbook 011.06, Multiple Sclerosis System of Care Procedures.*

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

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

VA must enforce its policy which requires staff at SCI/D clinics (spokes) to refer veterans in need of acute care to SCI/D Centers (hubs). VA and Congress must also work to provide all VA SCI/D Centers with the resources needed to care for veterans with SCI/D.

Congress and VA must work together to identify SCI/D centers that are in need of the critical resources and currently not able to care for referred veterans, and make certain that all centers within the VA SCI/D System of Care are fully capable of providing the services outlined in VA policy.

VA and Congress must work together to improve the travel reimbursement benefit to ensure that all catastrophically disabled veterans have access to the care they need.

VA and other federal agencies funding Gulf War illness (GWI) research must ensure research proposals are of high quality based on such considerations as the quality of the design, the validity and reliability of measures, the size and diversity of subject samples, and similar considerations of internal and external validity.

VA, in collaboration with other federal agencies funding GWI research, must create a research program with a comprehensive research plan and management structure, prepared to answer questions most relevant and unique to Gulf War illnesses and injuries.

VA should commission the National Academy of Sciences' Institute of Medicine (IOM) to update the *2001 Gulf War Veterans: Treating Symptoms and Syndromes* report to determine whether treatments are effective in veterans suffering from GWI and whether these veterans are receiving appropriate care.

VA should issue a report containing practical information on utilization and trends of health care and diagnostic data, as well as other helpful information that would allow the Department to tailor its healthcare programs to meet the unique needs of ill Gulf War veterans.

VA should review and revise the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues* and the IOM Committee Reports—*Gulf War and Health* to include the latest research findings and clinical guidelines.

To properly assess and tailor existing VA benefits for ill Gulf War veterans, VA should gather more meaningful data that will result in a more accurate database than that currently available from the Gulf War Veterans Information System.

VA should move with all deliberate speed to include the list of those conditions in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* that were found to have at least met the limited or suggestive evidence criteria as presumptive conditions. These conditions should also be listed separate and distinct from those disabilities due to undiagnosed illnesses.

The VHA should establish post-deployment health clinics, enhance exposure assessment programs, and improve the quality of disability evaluations for the Veterans Benefits Administration's Compensation & Pension Service. To deliver high-quality occupational health services, VA should consider establishing at every VA medical center a holistic, multidisciplinary post-deployment health service led by occupational health specialists.

VA should initiate low-dose computed tomography screening programs based on the International Early Lung Cancer Action Program protocol at selected sites in order to bring the benefits of screening immediately to veterans at high risk for lung cancer and to enable VA to develop a rigorous, efficient, and cost-effective regimen tailored to the needs of the VA system.

Women Veterans

VA should enhance its programs to ensure that women veterans receive high-quality comprehensive primary care services (including gender-specific care) in a safe and sensitive environment at every VA health-care facility.

VA should redesign and implement an appropriate health-care delivery model for women veterans and establish an integrated system of health-care delivery that covers a comprehensive continuum of care.

VA needs to ensure that every woman veteran gains and keeps access to a qualified, concerned primary care physician who can provide gender-specific care for all basic physical and mental health conditions prevalent in women veterans.

Using the patient-aligned care team model, and to improve the quality and continuity of care, VA should establish collaborative approaches for women who use a combination of VA and VA-authorized contract and fee-basis care. Systems should be put in place to coordinate care to ensure continuity, quality, safety, and patient satisfaction.

VA should adopt a policy of transparent information sharing and initiate quarterly public reporting of all quality, access, and patient satisfaction data, including a report on quality and performance data from VA facilities stratified by gender.

VA should continue its program to educate all VA employees about the contributions of women veterans and their unique health-care needs and preferences. VA efforts to transform the internal culture of VA that obstructs integration of women as equals should be accelerated, measured, and reported.

VA should make every effort to reduce unnecessary exposure of women of childbearing age to radiation, chemical, and pharmaceutical teratogens; identify compounds associated with an increased risk of birth defects, fetal exposure, injury, and death; and immediately revise polypharmacy software to provide alerts and protections for potential teratogens prescribed to women veterans under 50 years of age.

VA should enhance its military sexual trauma treatment programs by mandating consistent, sufficient, and continuing training of health-care personnel across primary care and mental health disciplines and disseminating evidence-based clinical practice guidelines to clinicians who care for veterans with a history of military sexual trauma.

VA should monitor and report on its pilot program to provide child care services for veterans who are the primary caregivers of children while they receive treatment for post-traumatic stress disorder and other mental health services requiring privacy and confidentiality.

VA should concentrate on improving services for women with serious physical disabilities and evaluate all of VA's specialized services to ensure women have equal access to these programs and receive responsive services and support to help them properly rehabilitate.

VA should reform its capital investment planning and construction design guidelines to include criteria and standards to ensure that new construction projects and ongoing maintenance efforts in VA facilities meet privacy, dignity, safety, and security standards for women patients, visitors, and staff.

VA should enhance its outreach efforts to help ensure homeless veterans gain access to necessary VA health and benefits programs—including a national media campaign aimed at prevention for at-risk veterans.

Long-Term Care Issues

VA should expand its transformation efforts in all of its community living centers and continue studying the measurable outcomes of cultural transformation and participate in the nursing home quality campaign.

VA should continue its efforts to develop and disseminate a Handbook of Uniform Services in Geriatrics and Extended Care.

VA's adult day health care program (ADHC) should include amending VA's beneficiary travel regulations to provide veterans greater access to ADHC, provide ADHC outside normal business hours, revise current policy to foster broader development of VA-ADHC and community adult day health care, and should amend current regulations for state ADHC to provide greater flexibility in offering ADHC to veterans.

VA must develop a program to locate and identify veterans with spinal cord injury/disorder (SCI/D) who are receiving care in non-SCI/D long-term care facilities.

VA and Congress must work together to immediately proceed with opening additional SCI/D long-term care beds. This is imperative in order to provide quality long-term health care to the aging SCI/D veteran population and provide them with the specialized care required to meet their needs.

VA should expand the current 60 Geriatric Evaluation and Management programs to 150 sites.

VA should expand home-based primary care capacity and the home-baed primary care programs in its community-based outpatient clinics beyond current levels.

VA should enhance respite capacity and services to reduce the variability across the continuum of care.

VA should expand its provision of home care programs for veterans enrolled in VA health care. VA should study models of home care provided to veterans in other coalition nations, such as Canada.

VA should provide facilities with sufficient funds to ensure eligible veterans are provided Care Coordination/Home Telehealth services.

Medical and Prosthetic Research

Pervasive problems in timely VA contracting, hiring, and procurement negatively affecting VA research should be the focus of a House or Senate Committee on Veterans' Affairs hearing to determine the exact nature of the causes and solutions. If legislative action is warranted, VA should work with the committees to develop the necessary legislative proposals to remedy this sensitive problem that can have the effect of canceling or significantly delaying VA research projects.

Administrative Issues

VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process, and avoid recruitment delays that serve as barriers to VA employment.

VA must implement an energized succession plan in VA medical and regional office facilities and other VA offices that utilizes the experience and expertise of current employees, and improve existing human resources policies and procedures that promote succession.

VA should adopt performance measures that tie the results obtained by human resources staffs, managers, and facility executives—to meet service recruitment goals and needs, for elements that provide direct services to veterans—to their own performance evaluations, awards, performance bonuses, and performance sanctions.

VA facilities must fully utilize recruitment and retention tools, such as hiring, relocation, and retention bonuses; equitable locality pay for VA nurses; physician compensation improvements; reimbursement for continuing medical education and scholarship;

and educational loan repayment programs, as broad-based employment incentives, in both the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA).

VA should expand information technology efforts in nursing informatics and promote opportunities for VA physician-nurse collaborations in clinical and academic research and leadership.

VA should require each VHA medical center to designate sufficient staff with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions. The positions must also include experience in maintaining, accepting, and properly distributing donated funds and donated items for the medical center.

Each VHA medical center should develop nontraditional volunteer assignments, including assignments that are age appropriate and contemporary.

VA should provide Congress and the veteran community a final analysis and evaluation of Project HERO to address both the concerns raised in Congressional hearings as well as the instructions provided in House Report 109–305, the conference report to accompany P.L. 109–114, and its implications in developing an integrated care-coordination model.

VA should develop an effective integrated care-coordination model for all non-VA purchased care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to the VA, preserves agency interests, and, most important, preserves the level of service veterans have come to rely on inside VA. As part of the integrated care coordination model, VA should assign the coordination of all non-VA purchased care to a single individual of a veteran's VA health-care team.

VA should fund an integrated care management pilot program for veterans requiring dialysis. The program should leverage proven, existing approaches to prevention, coordination of care, and patient activation for end-stage renal disease and utilize a multidisciplinary team made up of the veteran's dialysis provider and VA and non-VA providers. VA should establish process, clinical outcome, and metrics to ensure the program improves the quality of care.

VA should establish clear and reportable national standards for fee care and, in particular, short-term fee-basis consults, that require care coordination, health information sharing, patient satisfaction and safety, and as well as quality of care standards (such as timeliness of referral, access to care, follow-up care, and patient notification) for both the VA and non-VA provider. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should also establish and develop a mechanism for keeping a current inventory of fee services and contracts in all states. This would serve to (1) assist the veteran in choosing a community provider; (2) identify needs and gaps in services provided in the communities, and (3) minimize barriers for VA to timely develop contracts with select entities as the need arises. Such contracts would serve as a vehicle to facilitate care coordination between VA and the community provider to enhance the quality of and access to care while reducing cost.

As VA shifts fee staff toward care and case management, it should work with key stakeholders before this event unfolds to ensure a smooth transition to retain a full complement of skilled and motivated personnel.

VA should provide the necessary support and place a higher priority on a long-term solution to standardize business practices in the non-VA purchased care program to address vulnerabilities, such as overpayments and efficient and timely processing of claims.

For care acquired through contract, VA should develop a set of quality standards that these providers must meet that promote care coordination and ensure that the care they provide is equivalent to the quality of care veterans receive within the VA system.

VA should develop identifiable measures to assess its integrated care-coordination model for all non-VA purchased care. The evaluation should be shared with Congress and the veteran community.

Congress and VA must ensure that the use of non-VA purchased care supplements and does not undermine nor supplant the VA health-care system.

VA should consider the patient-aligned care team model in developing and integrating non-VA purchased care coordination.

The Assistant Secretary of VA's Office of Information & Technology should continually improve and actively address effective OI&T-Administration collaboration and important interagency coordination challenges.

VA should modernize and update the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record system to provide an electronic health record that meets national health information technology standards, relying on public domain, open source programming code, assuming that is the most appropriate way to proceed.

VA should improve participation rates of VA's 6 million enrolled veterans in its Blue Button initiative in personal electronic health records, with the goal of participation of a majority of VA's enrolled veterans and 100 percent of new veterans.

VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records and medical images.

While VA has ramped up concern about the efficiency, cost-effectiveness, and success of IT projects through use of the Performance Management and Accountability System mechanism, it has allowed myriad needed IT infrastructure upgrade projects to languish. When a given project being monitored by the Project Management Accountability System fails or runs under projected cost, VA should shift the funds associated with that project (or with underages) to infrastructure so that its IT system receives proper maintenance and upgrades in preparation for new VistA technologies to be developed.

VA and the Navy must strongly support the efforts of the joint VA North Chicago-Great Lakes Navy health facility consolidation with continued significant IT funding and oversight so that currently incomplete IT projects, which may become critical to the ultimate operational success of the joint facility, will be accomplished at the earliest possible date.

The DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees, should continue monitoring the IT management aspects of the merged North Chicago health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Also, the North Chicago pilot test and its accomplishments may move the federal IT interoperability goals in a significant new and positive direction.

VA should continue to seek a national leadership role in developing crucial health information technology efforts prompted by the "American Recovery and Reinvestment Act" and by health insurance reform legislation (P.L. 111–148), now in its late implementation phase.

VA and the DOD, in conjunction with other federal and private sector partners, should develop a virtual lifetime electronic record (with inclusion of an electronic DD 214).

VA and the DOD, with the assistance of strong Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have been barriers to past efforts in formulating the virtual lifetime electronic record.

The VA Assistant Secretary for Information Technology, in conjunction with the VHA chief research and development officer, should find ways to speed procurements of IT equipment and software that support VA's Medical and Prosthetic Research program to avoid the loss of funds and to ensure that these IT procurements associated with time-sensitive and important biomedical research are dealt with in an expeditious manner.

VA should implement recruitment and retention tools targeting Employee Incentive Scholarship Program and Employee Debt Reduction Program funding to include physician assistants (PAs) and provide succession plans to Congress for this occupation.

VHA human resources should update and issue new personnel employment policies for PAs.

The VHA should strengthen academic affiliations and expand new agreements to provide clinical rotation sites for PA students.

VA should include the PA as a critical occupation in view of this occupation's vital role in providing a variety of primary clinical services.

VA should allow for the provisional or predetermination granting of access to caregiver support benefits and services to caregivers of service members who are found medically unfit for duty but awaiting medical discharge.

VA should re-evaluate its current assessment instrument to ensure that it reflects the real-world requirements for caring for severely injured veterans.

VA should eliminate the 40-hour limit used in determining the stipend amount. It is an arbitrary limitation for which VA has not provided any evidence in support.

VA should establish clear policies outlining the expectation that every VA nursing home and adult day health-care program will provide appropriate facilities and programs for respite care for severely injured or ill veterans. These facilities should be restructured to be age appropriate, with strong rehabilitation goals suited to the needs of a younger population, rather than expecting younger veterans to blend with the older generation typically resident in VA nursing home care units and adult day health-care programs. VA must adapt its services to the particular needs of this new generation of disabled veterans and not simply require these veterans to accept what VA chooses to offer.

VA should revise its respite care handbook to include the new requirement of P.L. 111–163, "Caregivers and Veterans Omnibus Health Services Act of 2010."

VA should explore the Aged/Disabled Medicaid Home and Community-Based Services waiver program as it has done in its emerging Medical Foster Home program to provide noninstitutional respite care services to caregivers of veterans.

VA should work with state veterans' homes in reviewing its relationship, including the referral and payment processes, to gain needed capacity and increase the likelihood caregivers will use respite care.

VA should expand the number of voluntary service specialists throughout its Veterans Integrated Service Networks and VA medical centers to expand the Volunteer Caregiver Support Network program.

VA should seek feedback from all caregivers of veterans to ensure its online communication, outreach, and information resource remains pertinent to caregivers' individual needs.

VA must provide evidence-based guidelines in determining the amount of caregiver support and types of services that should be used to ensure the veteran is able to remain at home as long as possible and improve the quality of life of the veteran and caregiver.

VA must ensure that workload credit is assigned and is captured in its resource allocation system for all caregiver support services provided by VA health-care providers.

VA should provide severely disabled veterans and family members residential rehabilitation services to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans.

VA must ensure that there is standard availability and accessibility of caregiver support services, with particular consideration for veterans residing outside a VHA catchment area.

Congress and VA should review the detailed findings of the "Caregivers of Veterans—Serving on the Homefront" survey and address the recommendations contained therein.

VA should develop a stronger social and advocacy support for caregivers of severely injured veterans, including peer support groups, facilitated and/or assisted by committed VA staff members; appointment of caregivers to local and VA network patient councils and other advisory bodies within the VHA and the Veterans Benefits Administration; and a monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled veterans of Operations Enduring and Iraqi Freedom, through My HealtheVet or another appropriate web-based platform.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys to assess the caregiver population being served, their challenges, needs, and whether existing programs are meeting those needs. The study

should be designed to yield statistically representative data for policy and planning purposes.

VA must request and Congress must provide sufficient funding to ensure proper implementation and administration of the caregiver program.

Construction Programs

VA must develop a comprehensive plan for addressing its empty, underutilized, or excess space in nonhistoric properties so that it can be used for other purposes if it is not suitable for medical or support functions because of its age or location.

VA must have greater transparency when initiating its Building Utilization Review and Repurposing plan and an earlier, more extensive community involvement when planning for underutilized space and infrastructure needs.

VA must establish a category system that ranks design/construction project types by complexity. This system should be used to determine if the project is a candidate for the design-build method of project management.

The design-build method of project delivery should only be used on projects that have a low complexity, such as parking structures and warehouses. For health-care projects, VA must evaluate the use of architect-led design-build as the preferred method of project delivery in place of contractor-led design-build project delivery.

VA must institute a program of "lessons learned." This would involve revisiting past projects and determining what worked, what could be improved, and what did not work. This information should be compiled and used as a guide to future projects. This document should be updated regularly to include projects as they are completed.

VA must continue to develop a comprehensive program to preserve and protect its inventory of historic properties.

VA must allocate funding for adaptive reuse of historic structures and empty or underutilized space at medical centers.

Education, Employment, and Training

Education

VA should seek to partner with other student services to act as a liaison between veterans and other assistance programs open to the nonveteran student population, particularly individuals with disabilities.

VA must expand the VetSuccess on Campus by strategically determining new campuses based on a student veteran population standard of between 800 and 1,200 per campus, geographical location in comparison to VA medical care, and other resources available to veterans.

VA must continually evaluate the success of the VetSuccess on Campus program by measuring student veterans' use of the program and the role the program plays in their completion of educational programs.

VA should ensure that VetSuccess on Campus staff gain the essential knowledge and skill set necessary to meet the needs of the general student veteran population, including guidance in navigating through the Post-9/11 GI Bill.

The Veterans Benefits Administration must quickly develop methods to monitor GI Bill usage similar to those being used by Department of Education to survey Title IV–funded schools. In this manner, VA will be able to detect trends among schools that may not be delivering the kinds of outcomes expected by taxpayers.

Training and Rehabilitation Services: Vocational Rehabilitation and Employment

VA needs to strengthen its Vocational Rehabilitation and Employment (VR&E) program to meet the demands of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq. It must provide a more timely and effective transition into the workforce and provide placement follow-up with employers for a minimum of six months.

VR&E must place a higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

VR&E must develop and implement metrics that can identify problems and lead to solutions that effectively remove barriers to veteran completion of VR&E programs.

VR&E should be given additional professional full-time employment slots with specialist counselors who are fully trained in all program options offered by VR&E, including independent living.

VA should require VR&E to inform each veteran enrolled in independent living services of the option to request an enrollment extension.

VA should conduct additional training within the VR&E program so each VR&E counselor is knowledgeable of the Independent Living Program.

VA must work in concert with the Department of Labor, the Small Business Administration, and applicable state agencies to develop and implement a single-source database and employer outreach interface geared toward facilitating contact between veterans seeking jobs and employers.

VA should improve its partnership with state agencies by incorporating the services of non-VA counselors and constituent-specific vocational assistance programs (those that cater to women, combat-exposed, paralyzed, blind, amputee, traumatic brain injured, etc.) to ensure that all veterans, regardless of demographic status, receive the full array of benefits and level of customization necessary for meaningful and effective vocational intervention.

VA must ensure that vocational rehabilitation counselors have appropriate training and certification, whether through either an outside accrediting body or through a VA-specific accreditation process.

VA must implement a targeted training program that familiarizes Vocational Rehabilitation and Employment staff with the special needs and vocational challenges inherent to key segments of the veteran demographic.

Employment and Entrepreneurship

All Transition Assistance Program (TAP) classes should include in-depth VA benefits and health-care education sessions and time for question and answer sessions.

The Departments of Veterans Affairs, Defense, Labor, and Homeland Security should design and implement a stronger Disabled Transition Assistance Program for wounded service members who have received serious injuries and for their families.

The DOD, VA, DOL, and DHS must do a better job educating the families of service members on the availability of TAP classes, along with other VA and DOL programs regarding employment, financial stability, and health-care resources.

The DOL and VA must improve oversight and outreach to all federal agencies, the Small Business Administration, and all other federal agencies tasked with protecting and promoting service-disabled veteran-owned small businesses, to assist in the development and implementation of stronger strategies/plans to reach the minimum 3 percent goal.

VA must place increased effort on the certification process to ensure veteran-owned businesses that depend on, or are waiting for, a government contract can be assured that excessive wait times on VA's administrative processes will not hinder the veterans' success in conducting their business.

Work disincentives in the VA pension program should be re-examined and consideration given to changes that would parallel Social Security work incentives, such as a trial work period and reduction in benefits as earned income rises.

Recommendations to the Administration

Medical Care

Finance Issues

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

Congress and the Administration must work together to ensure that advance appropriations estimates for FY 2013 are sufficient to meet the projected demand for veterans' health care and authorize those amounts in the FY 2013 appropriations act.

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.

Access Issues

Congress and the Administration should investigate to determine if Congressionally directed rural health funds for new innovations in rural and highly rural areas were diverted to underwrite new VA community-based outpatient clinics in nonrural areas, and, if confirmed, should take appropriate action to address those deviations from Congressional intent.

Medical and Prosthetic Research

The Administration and Congress should establish a new appropriations account in FY 2013 and thereafter to define and separate VA research infrastructure funding needs independently from capital and maintenance funding for direct VA medical care programs. The account should be subdivided for major and minor research construction and for maintenance and repair needs of VA's research programs. This revision in appropriations accounts would empower VA to address research facility needs without interfering with direct health-care infrastructure.

Administrative Issues

The Administration and Congress should take appropriate actions to ensure VA provides ample opportunities for veterans to secure VA employment.

Construction Programs

The Administration and Congress should establish a new appropriations account in FY 2013 and thereafter to define and separate VA research infrastructure funding needs independently from capital and maintenance funding for direct VA medical care programs.

Education, Employment, and Training

Training and Rehabilitation Services: Vocational Rehabilitation and Employment

Congress and the Administration must ensure that Vocational Rehabilitation and Employment is provided the necessary resources to upgrade its legacy Corporate WINRS and the new VetSuccess information technology platform as part of the Veterans Benefits Administration's upgrade of its larger information technology systems.

Employment and Entrepreneurship

Congress and the Administration must provide adequate funding to support the Transition Assistance Program and Disabled Transition Assistance Program to ensure that active duty as well as National Guard and reserve service members receive proper services during their transition periods.

National Cemetery Administration

The Administration and Congress should provide the resources required to meet the critical nature of the National Cemetery Administration's mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.

Recommendations to the Department of Defense

Medical Care

Mental Health Issues

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

OEF/OIF Issues

VA and the DOD should coordinate efforts to better address mild and moderate traumatic brain injury (TBI) and concussive injuries and establish a comprehensive rehabilitation program, including establishment of therapeutic residential facilities, and deployment of standardized protocols utilizing appropriately formed clinical assessment techniques to recognize and treat neurological and behavioral consequences of all levels of TBI and all generations of veterans who suffer the lingering effects from earlier injuries.

Any TBI studies or research undertaken by VA and the DOD for the current generation of TBI-injured veterans should include older veterans of past military conflicts who may have suffered similar injuries that went undetected, undiagnosed, and untreated.

The DOD and VA should provide all military personnel going through the Integrated Disability Evaluation System the option to choose between the legal counsel offered by the military and that available at no cost through national service officers of chartered veterans service organizations.

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

The DOD mandatory separation physical examination should be required not just for active duty personnel but for all demobilizing National Guard and reserve members.

Specialized Services

Prosthetics and Sensory Aids

The Independent Budget veterans service organizations urge the DOD and VA to provide better education to service members and veterans on the importance of protective gear and preventative actions.

The DOD should maximize use of VA blind rehabilitation and low-vision services for new combat veterans rather than referring those cases to private agencies.

Administrative Issues

VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records and medical images.

The DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees, should continue monitoring the information technology management aspects of the merged North Chicago health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in

establishing joint electronic records management at hundreds of health-care facilities in each department. Also, the North Chicago pilot test and its accomplishments may move the federal IT interoperability goals in a significant new and positive direction.

VA and the DOD, in conjunction with other federal and private sector partners, should develop a virtual lifetime electronic record (with inclusion of an electronic DD 214).

VA and the DOD, with the assistance of strong Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have been barriers to past efforts in formulating the virtual lifetime electronic record.

Employment and Entrepreneurship

The Departments of Veterans Affairs, Defense, Labor, and Homeland Security should design and implement a stronger Disabled Transition Assistance Program (DTAP) for wounded service members who have received serious injuries and for their families.

Chartered veterans service organizations should be directly involved in the Transition Assistance Program and DTAP or, at minimum, serve as an outside resource to TAP and DTAP.

The DOD, VA, DOL, and DHS must do a better job educating the families of service members on the availability of TAP classes, along with other VA and DOL programs regarding employment, financial stability, and health-care resources.

Recommendations to the Department of Labor

Education, Employment, and Training

Training and Rehabilitation Services: Vocational Rehabilitation and Employment

VA must work in concert with the Department of Labor, the Small Business Administration, and applicable state agencies to develop and implement a single-source database and employer outreach interface geared toward facilitating contact between veterans seeking jobs and employers.

Employment and Entrepreneurship

The Departments of Veterans Affairs, Defense, Labor, and Homeland Security should design and implement a stronger Disabled Transition Assistance Program (DTAP) for wounded service members who have received serious injuries, and for their families.

The DOD, VA, DOL, and DHS must do a better job educating the families of service members on the availability of Transition Assistance Program classes, along with other VA and DOL programs regarding employment, financial stability, and health-care resources.

The Department of Labor Veterans' Employment and Training Service (DOL VETS) the tools and resources necessary to ensure that veterans are benefiting from labor programs targeted to addressing their particular employment needs.

DOL VETS must work collaboratively within the DOL to increase employment opportunities for veterans with the most significant barriers to employment.

The Departments of Labor and Veterans Affairs must improve oversight and outreach to all federal agencies, the Small Business Administration, and all other federal agencies tasked with protecting and promoting service-disabled veteran-owned small businesses, to assist in the development and implementation of stronger strategies/plans to reach the minimum 3 percent goal.