The Independent Budget

for the Department of Veterans Affairs

Fiscal Year 2010

Executive Summary

A Comprehensive Budget & Policy Document
Created by Veterans for Veterans

Prologue

As the global war on terrorism enters its eighth year and the conflict in Iraq approaches its sixth year, servicemen and -women continue to experience traumatic effects as they are placed in harm's way. Since fighting began in Afghanistan in October 2001, and in Iraq in March 2003, more than 4,000 service members have made the ultimate sacrifice and more than 40,000 more have been wounded. The sacrifices these brave soldiers, sailors, airmen, marines, and coast-guardsmen have made will leave them dealing with a lifetime of both visible and invisible wounds. It is for these men and women and the millions who came before them that we set out each year to assess the health of the one federal department whose sole task it is to care for them and their families.

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

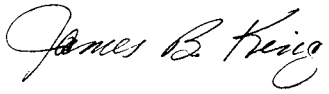
As it becomes more and more likely that the global war on terrorism will be long, with dangers from unexpected directions and enemies who are creative and flexible in planning and executing attacks on our citizens and on our friends, our nation must continue to provide for those who serve in our defense. Additionally, we must be cognizant of the current fiscal realities in a time of turbulent and rapidly fluctuating economic conditions that may compel veterans of past service to seek health care and benefits from the Department of Veterans Affairs (VA).

With this reality ever present in our minds, we must do everything we can to ensure that VA has *all* the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners of the world, keeping the forces of anarchy, hatred, and intolerance at bay, need to know that they will come home to a nation that respects and honors them for their service, while also providing them with the best medical care to make them whole, the best vocational rehabilitation to help them overcome employment challenges created by injury, and the best claims processing system to deliver education, compensation, and survivors' benefits in a minimum amount of time with the greatest accuracy to those most harmed by their service to our nation.

(Continued)

We are proud that *The Independent Budget* has gained the respect that it has over its 23-year history. The coauthors of this important document—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States—work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

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



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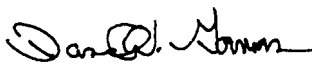

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Supporters

Administrators of Internal Medicine
African American Post Traumatic Stress Disorder Association
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United States Coast Guard CPOA/CGEA
United States Federation of Korea Veterans Organizations
US-Korea Allies Council
Veterans Affairs Physician Assistant Association
Vietnam Veterans of America
Washington State, Office of the Governor
Wisconsin Department of Veterans Affairs

Guiding Principles

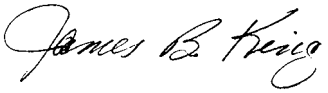
- Veterans must not have to wait for benefits to which they are entitled.
- Veterans must be ensured access to high-quality medical care.
- Veterans must be guaranteed timely access to the full continuum of health-care services, including long-term care.
- Veterans must be assured burial in state or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

Dedication

The veterans service organizations that collectively author *The Independent Budget* wish to acknowledge and express our deep appreciation to Mr. Richard Fuller for his guidance and many contributions to this document over the years. Richard, who worked for Paralyzed Veterans of America for almost 20 years, died in February 2008 after a prolonged illness.

A tireless advocate for veterans, Richard dedicated himself to ensuring that all men and women who have served in the uniform of this nation have access to the highest quality health care and receive the benefits to which they are entitled. For many years as the lead author of the Medical Care section of *The Independent Budget*, Richard worked to ensure the document reflected the highest degree of professionalism, technical expertise, and compassion.

Richard embodied the true meaning of "citizen soldier." A graduate of Duke University; a veteran of the United States Air Force with service in Vietnam, Thailand, and Okinawa as a Vietnamese linguist; and as an advocate for his fellow service members his entire professional life, he set a standard for excellence and dedication that will remain at the heart of *The Independent Budget*.



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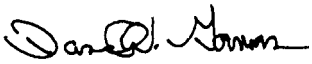

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Special Thanks to:

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

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Summary of Recommendations

Once again, the four veterans service organizations who coauthor *The Independent Budget (IB)*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—offer budget and program recommendations for the Department of Veterans Affairs (VA) 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) 2010. In fact, this FY 2010 issue of the *IB* represents the 23rd consecutive year that this partnership of veterans service organizations has joined together to produce a comprehensive budget document that highlights the needs of elderly veterans and those of the younger men and women who join their ranks each year as they return from the conflicts in Afghanistan and Iraq.

Thousands more men and women who have sacrificed themselves in the global war on terrorism are returning home. These brave men and women are relying on VA health-care and benefits systems to help rebuild their lives and become productive members of society. Currently, according to information released by the Department of Veterans Affairs on October 29, 2008, America's current veteran population is projected to be 23,442,000, which includes 1,802,000 females. Of the 23,442,000, 7.8 million veterans are enrolled in the VA health-care system. According to VA data, 5.5 million veterans are identified as unique individual patients who actually received care in VA facilities in 2007. Also, 2.95 million veterans receive disability compensation for injuries they received while on active duty. In addition, 333,196 spouses of deceased veterans rely on VA's dependency and indemnity compensation for the costs of everyday life.

The Veterans Health Administration, similar to private sector health-care providers and other federal health-care programs, including Medicare, Medicaid, and TRICARE, is facing growing demand for services, as the country ages and medical treatment and administrative costs spiral upward. In addition to increasing medical operational costs, almost 40 percent of America's veterans are 65 years of age or older. This group of elderly veterans has an increased demand for VA health and long-term-care services. Additionally, the influx of new, and often severely disabled, veterans entering the VA system brings new demands for care. These age-related, economic, and new patient factors make accurate resource forecasting difficult but more important each year.

Year after year, the coauthors of *The Independent Budget* review VA workload information and medical and administrative cost data and then call upon Congress to provide funding necessary to meet the health-care needs of veterans and to do so in a timely manner. Unfortunately, Congress has historically been unable to complete the VA appropriation process prior to the beginning of the new fiscal year. The *IB* offers reasonable solutions to this serious budget-timing problem—through either a mandatory or an advance appropriation process. The *IB*'s goal is to secure sufficient, timely, and predictable funding that allows VA to conduct effective planning and provide quality services.

With regard to veterans' benefits, the *IB* recommends that VA fast-track real steps that will help ameliorate nagging barriers to claims processing. Continuing studies to find solutions must be replaced by

real action plans that produce positive results. These action steps must be implemented before VA's claims system becomes further mired in its own red tape and ultimately collapses under its own weight. Veterans and their families deserve prompt decisions regarding the benefits for which they have shed their blood. 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 2010 provides recommendations for consideration by our nation's decision makers that are based on rigorous and rational methodology designed to support the Congressionally authorized VA programs that serve our nation's veterans. *The Independent Budget* veterans service organizations are proud that more than 60 veteran, military, medical service, and disability organizations have signed on in support of this *IB*. 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.

VA Accounts FY 2010 (Dollars in Thousands)

	FY 2009 Appropriation	FY 2010 IB
Veterans Health Administration		
Medical Services	30,969,903	36,572,421
Medical Support and Compliance	4,450,000	4,584,964
Medical Facilities	5,029,000	5,402,015
Subtotal Medical Care, Discretionary	**40,448,903**	**46,559,400**
Medical Care Collections	2,544,000	
Total, Medical Care Budget Authority *(including Medical Collections)*	**42,992,903**	**46,559,400**
Medical and Prosthetic Research	510,000	575,000
Total, Veterans Health Administration	**40,958,903**	**47,134,400**
General Operating Expenses		
Veterans Benefits Administration	1,466,095	1,629,230
General Administration	335,772	353,552
Total, General Operating Expenses	**1,801,867**	**1,982,782**
Departmental Admin and Misc. Programs		
Information Technology	2,489,391	2,713,058
National Cemetery Administration	230,000	291,500
Office of Inspector General	87,818	90,719
Total, Dept. Admin. and Misc. Programs	**2,807,209**	**3,095,277**
Construction Programs		
Construction, Major	923,382	1,123,000
Construction, Minor	741,534	827,000
Grants for State Extended-Care Facilities	175,000	250,000
Grants for Construction of State Veterans Cemeteries	42,000	52,000
Total, Construction Programs	**1,881,916**	**2,252,000**
Other Discretionary	158,926	163,217
Total, Discretionary Budget Authority *(Including Medical Collections)*	**50,152,821**	**54,627,676**
Cost for Priority Group 8 Veterans Denied Enrollment	**375,000***	**544,200****

*The FY 2009 Appropriations Bill provided $375 million to expand enrollment for Priority Group 8 veterans by 10 percent.

**Cost for Priority Group 8 veterans based on known total cumulative number denied enrollment since 2003 (approximately 565,000 veterans) and a utilization rate of approximately 25 percent.

Key *Independent Budget* Recommendations

CRITICAL ISSUE 1

Sufficient, Timely, and Predictable Funding for VA Health Care

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

With the end of the 110th Congress, it is important to review and assess its efforts to provide sufficient, timely, and predictable funding for the Department of Veterans Affairs, particularly the health-care system. The actions of Congress reflect the highest highs and the lowest lows of the current funding process. Although the new leadership in Congress elevated veterans' issues to the top of the priority list, Congress still faced a significant struggle to get its appropriations work done on time. Political wrangling continued to deadlock the federal budget process, and, in turn, complicate funding for veterans' health care.

Despite recent historic funding increases, today's VA health-care budget process itself has basically paralyzed VA officials from more properly managing, planning, and operating the VA system. Not knowing when or what level of funding it would receive from year-to-year, or how Congress would deal with policy proposals directly affecting the budget, severely impairs VA's ability to recruit and retain staff, contract for services, procure equipment and supplies, and conduct planning and administrative matters. Congress can fully solve this problem only by enacting real reform that results in sufficiency, predictability, and timeliness of VA health-care funding.

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations,* has advocated for reform in the VA health-care budget process. The Partnership has worked with both House and Senate veterans' leaders to craft legislation that would change VA's health-care funding process from a discretionary to a mandatory system. If enacted, such a change would be intended to guarantee that VA health-care funding would be sufficient, timely, and predictable. This would guarantee that funding is available on time every year, with automatic adjustments to account for medical inflation and enrollment changes. However, despite the fact that legislation has been introduced in recent years to shift VA health-care funding to a mandatory status, to date Congress has not shown interest in moving this legislation forward.

As a result, the Partnership worked with the Senate and House Committees on Veterans' Affairs this year to develop an alternative proposal (S. 3527/H.R. 6939) that would change VA's medical care appropriation to an "advance appropriation," guaranteeing funding for the health-care system up to one year in advance of the operating year. In fact, with bipartisan cosponsors, Senate VA Committee Chairman Daniel Akaka (D-HI) introduced S. 3527 and House VA Committee Chairman Bob Filner (D-CA) introduced H.R. 6939. Had this proposal already been in effect, Congress would have recently completed the FY 2010 appropriations bill for VA health care, and the FY 2009 appropriations for VA health care would already have been approved well in advance of the start of the fiscal year. This alternative proposal would ensure that the VA receives its funding in a timely and predictable manner. Furthermore, it would provide an option *The Independent Budget* veterans service organizations (IBVSOs) believe is politically more viable than mandatory funding, and is unquestionably better than the current process.

Moreover, to ensure sufficiency, our advance appropriations proposal would require that VA's internal budget actuarial model be shared publicly with Con-

gress to reflect the accuracy of its estimates for VA health-care funding, as determined by the Government Accountability Office (GAO) audit, before political considerations take over the process. This feature would add transparency and integrity to the VA health-care budget process.

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

As in years past, the FY 2008 appropriations process was not a seamless or efficient process. The IBVSOs were very disappointed when, for the 14th time in the past 15 years, VA did not receive its appropriation prior to the start of the new fiscal year on October 1. Although the appropriations bill was eventually enacted, it included budgetary gimmicks that *The Independent Budget (IB)* has long opposed. The maximum appropriation available to VA would match or exceed the *IB*'s recommendations; however, the vast majority of this increase was contingent upon the Administration making an emergency funding request for the additional money Congress approved. Fortunately, the Administration recognized the importance of this critical funding and triggered its release to VA. This emergency request provided VA with $3.7 billion more than the Administration had sought for VA in FY 2008.

The process leading up to FY 2009 was equally challenging. For the second year in a row, VA received historic funding levels that matched, and in some cases exceeded, the recommendations of the *IB*. Moreover, for only the second time in the past 21 years, VA received its budget prior to the start of the new fiscal year on October 1. However, this funding was provided through a combination continuing resolution/omnibus appropriations act. The underlying military construction and Veterans Affairs appropriations bill for FY 2009 was not actually completed by Congress in the regular order. While the House passed the bill in the summer, the Senate never brought its bill up for a floor vote. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past two years, the larger appropriations process is completely broken.

Although significant strides have been made to increase the level of VA health-care funding during the past several years, the inability of Congress and the Administration to agree upon and enact veterans' health-care appropriations legislation on time continues to hamper and threaten VA health care. When VA does not receive its funding in a timely manner, it is forced to ration health care. Much-needed medical staff cannot be hired, medical equipment cannot be procured, waiting times for veterans increase, and the quality of care suffers. Equally disturbing are reports that VA, following the close of FY 2008 is retaining as much as $800 million because VA was unable to spend it in time, despite the fact that thousands of veterans are waiting or unable to receive care.

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

On February 4, 2008, the President's budget submission for the Department of Veterans Affairs for FY 2009 was released, which included a total funding request of $41.2 billion for VA medical care, an increase of $2.1 billion over the FY 2008 funding level. This request included $38.7 billion in discretionary funding and $2.5 billion in medical care collections.

The Independent Budget for Fiscal Year 2009 recommended approximately $42.8 billion in total funding for medical care—an increase of $3.7 billion over the FY 2008 approved funding level and approximately $1.6 billion over the Administration's request. This funding recommendation would allow VA to reduce waiting times for medical services and keep up with the increasing demands placed on the system by returning and transitioning veterans.

In the end, Congress provided approximately $43 billion for total medical spending in VA. This included $40.5 billion in discretionary budget authority and an additional $2.5 billion in medical care collections. While the IBVSOs have long opposed the use of collections in establishing the operating budget of VA, we recognize that a significant amount of funding is available

to VA each year from these collections. However, we would urge Congress to review the actual collections rates that VA achieves each year if it continues to use collections to increase the its operating budget. Our own analysis suggests that VA has only collected about 79 percent of its estimated collections rates dating back to FY 2004. This would suggest that VA will likely collect only approximately $2 billion for FY 2009, even though it will credit its estimate of $2.5 billion to offset budgetary needs.

The IBVSOs contend that despite the recent increases in VA health-care funding VA does not have the resources necessary to remove the prohibition on enrollment of priority group 8 veterans, who have been blocked from enrolling in VA since January 17, 2003. In response to this continuing policy, the Congress included additional funding to begin opening the VA health-care system to some priority group 8 veterans. In fact, the final approved FY 2009 appropriations bill includes approximately $375 million to increase enrollment of priority group 8 veterans by 10 percent. This will allow the lowest income and uninsured priority group 8 veterans to begin accessing VA health care. *The Independent Budget* provided a cost estimate for the total cost to reopen VA's health-care system to all priority group 8 veterans. We estimated that such a policy change would cost approximately $1.4 billion in the first year, assuming that about 375,000 such veterans would enroll in and use the system. This cost estimate is a total cost that does not reflect the impact of medical care collections. We believe that it is time for VA and Congress to develop a workable solution to allow all eligible priority group 8 veterans to begin enrolling in the system.

In its FY 2009 VA budget submission, the Administration once again included policy proposals to increase prescription drug copayments from $8 to $15 for a 30-day supply and add an enrollment fee for priority group 8 veterans that earn $50,000 or more annually that would range from $250 to $750. VA estimated that these proposals would generate $2.3 billion in receipts to the Treasury over five years; however, there would have been no guarantee that the funds would be used to improve or expand the delivery of health-care services to veterans. *The Independent Budget* opposes proposals requiring veterans to pay more for their own care, particularly when such revenues may not even be used for veterans' health care. As it had done numerous times in previous years, Congress roundly rejected these proposals this year.

Recommendations:

Congress should reform VA's Medical Care appropriation to give it an advance appropriation status, to provide funding for veterans' health care one year or more in advance of the operating year. This would ensure funding becomes timely and predictable, without converting it to mandatory status or requiring it to meet Congressional PAYGO (pay-as-you-go) rules for mandatory accounts.

Congress should require VA's internal budget model to be shared publicly to provide accurate estimates for VA health-care funding, with the information audited by the Government Accountability Office.

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. When VA has calculated the cost to reopen the system to all veterans, it should receive full funding to accommodate priority group 8 veterans who choose to use the VA system for their health-care needs.

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

CRITICAL ISSUE 2

The Challenge of Caring for Our Newest War Veterans

The Departments of Defense and Veterans Affairs face unprecedented challenges in meeting the needs of a new generation of war veterans and their families, including those who suffer from post-combat deployment readjustment challenges and who reveal cognitive impairments as a result of traumatic brain injury (TBI).

Since October 2001, approximately 1.7 million military service members have deployed to Afghanistan and Iraq in Operations Enduring and Iraqi Freedom (OEF/OIF). Because many service members participate in multiple deployments, they are subjected to a number of serious threats, including mortar attacks, suicide bombs, and exposure to repeated blasts from improvised explosive devices (IEDs). Current studies indicate that multiple exposures to IED blasts and the stress of these deployments in general are exacting a toll on the fighting force resulting in a variety of seemingly "invisible" wounds, including post-traumatic stress disorder (PTSD), major depression, and cognitive impairments due to milder forms of traumatic brain injury. Military medicine has advanced to unprecedented levels of excellence that have resulted in a 90 percent survival rate among wounded veterans. However, within the DOD and VA health-care systems, gaps remain in the recognition, diagnosis, treatment, and rehabilitation of these less-visible injuries.

The DOD and VA share a unique obligation to meet the health-care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from postdeployment readjustment problems as a result of combat exposure. Without question, both agencies have done an extraordinary job in treating those who have suffered the most grievous polytraumatic injuries. But these deployments are also causing heavy casualties in what are considered the invisible wounds of war—PTSD, depression, substance-use disorders, family disruptions and distress, and a number of other social and emotional consequences for those who have served. The DOD, VA, and Congress must remain vigilant to ensure that federal programs aimed at meeting the extraordinary needs of the newest generation of combat veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts. Congress must also remain apprised of how VA spends the significant new funds that have been provided and earmarked specifically for the purpose of meeting postdeployment mental health and physical rehabilitation needs.

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

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

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

According to RAND, 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. About 53 percent of those who met the criteria for PTSD or major depression had sought help from a physician or mental health provider in the past year. It

was noted, however, that even when individuals sought care, too few received *quality* care—with only half having received what was considered minimally adequate treatment. A number of barriers to care were identified by survey participants as reasons for not getting treatment. RAND concluded that there is a need for increased access to confidential, evidenced-based psychotherapy and that the prevalence of PTSD and major depression will likely remain high unless efforts are made to enhance systems of care for these conditions.

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

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, DOD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these powerful detonations. Symptoms can include chronic headache, irritability, behavioral disinhibition, sleep disorders, confusion, memory problems, depression, and other behavioral conditions.

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

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

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

While a miraculous number of our veterans are surviving what surely would have been fatal wounds in earlier periods of warfare, most now survive, but some are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal supports. Eventually most of these veterans will be able to return to their families, at least on a part-time basis, or be moved to an appropriate therapeutic residential setting—but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them substitute for the dramatic loss of physical, mental, and emotional capacities as a consequence of their injuries. Immediate families of newly and severely injured veterans face daunting challenges while serving in this unique role. They must simultaneously cope with the complex physical and emotional problems of the severely injured veteran, deal with the complexities of the systems of care that these veterans must rely on, all while struggling with disruption of their family life, in-

terruptions of personal goals and employment, and often the dissolution of other "normal" support systems most people take for granted.

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

The DOD and VA health-care systems have limited authorization and lack the capacity to provide mental health and relationship counseling services to family members—an important component of the rehabilitation process for veterans and their families. However, the IBVSOs have been informed by a few local VA officials that they are providing a significant amount of training, instruction, counseling, and other services to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the possible absence of legal authority to provide these services, and that scarce resources are being diverted to these needs without recognition of their cost within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency and validity of this need.

The Independent Budget veterans service organizations believe Congress should authorize, and VA should provide, a full range of psychological counseling and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and continuous burden of caring for a severely injured and permanently disabled veteran. Also, we believe VA should establish a new national program to make periodic respite services available to all severely injured veterans.

Another issue having an impact on service members, veterans, and their families is substance-use disorder. There are multiple consistent indications from both the DOD and VA that the misuse of alcohol and other substances will continue to be a significant problem for many OEF/OIF service members and veterans. An untreated substance-use disorder can result in a number of health consequences for the veteran and family, including a marked increase in health-care expenditures, additional stresses on families, social costs from loss of employment and additional, avoidable costs to the legal system. We urge VA and the DOD to continue research into this critical area and to identify the best treatment strategies to address substance abuse and other mental health and readjustment issues collectively.

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

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

VA operates a network of more than 190 specialized PTSD outpatient treatment programs throughout its system of care, including specialized PTSD clinical teams and/or a PTSD specialist at each VA medical center. Additionally, Vet Centers, which provide readjustment counseling in 232 community-based centers, have reported rapidly growing enrollments in their programs. Although VA has announced plans to increase the number of Vet Centers, the IBVSOs believe that currently operating Vet Centers must also bolster their staffing to ensure that all of them can meet the expanding caseload—including not only traditional counseling but outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma.

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

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

Recommendations:

The DOD and VA must invest in research for individuals who suffer from post deployment mental health challenges and traumatic brain injury, to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of traumatic brain injury and develop best practices in its screening, diagnosis, and treatment.

VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance-use disorders, in returning service members.

Congress should formally authorize, and VA should provide, a full range of psychological and social support services, including strong, effective case management, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.

The VA system must continue to improve access to specialized services for veterans with mental illness, posttraumatic stress disorder, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

VA should initiate surveys and other research to assess the variety of barriers to VA care for Operations Enduring and Iraqi Freedom veterans, with special emphasis on reservists and guardsmen returning to veteran status after combat deployments, rural and remote veterans, and female veterans. These surveys should assess barriers among *all* veterans of Operations Enduring and Iraqi Freedom—not only the subset who actually enroll or otherwise contact VA for health care or other services.

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

The DOD and VA should amend current policies to encourage service members and veterans to seek the care they need without fear of stigma.

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on new women veterans who have served in Iraq and Afghanistan.

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

CRITICAL ISSUE 3

MAINTAIN VA'S CRITICAL MEDICAL FACILITIES INFRASTRUCTURE

The Independent Budget ***veterans service organizations (IBVSOs) are concerned that the Department of Veterans Affairs has made attempts to back away from the capital infrastructure blueprint laid out by the CARES process and that its plans to begin widespread leasing of inpatient services through the "Health Care Center Facilities" program might not serve the best interests of veterans.***

With the completion of the Capital Asset Realignment for Enhanced Services (CARES) process, VA had a clear blueprint for the future—a comprehensive listing of necessary projects, including renovations and new construction that would bring VA infrastructure into the 21st century. So far, VA has completed 5 of those projects, with another 27 under construction.

Despite this progress, challenges remain. These projects, as well as the CARES-identified projects in the planning stage, still require at least $2.2 billion in future funding. At a March 24, 2008, briefing to several veterans service organizations, VA officials explained that between FY 2003 and FY 2009, the difference in the Department's capital needs and what Congress had appropriated was a shortage of nearly $5 billion. Further, VA estimated that its future capital needs would be approximately $2 billion per year over the next five years.

Given this fundamental mismatch between VA's infrastructure demands and funding, VA has begun studying the feasibility of establishing the Health Care Center Facilities (HCCF) program. In its HCCF study of replacing facility construction with leasing, VA may be signaling a push to circumvent the traditional construction process. VA's FY 2008 Asset Management Plan describes the HCCF studies as a "means of improving both the access and environment of care for its veterans. These studies will assist in determining whether VA should lease space in lieu of seeking construction funding to address the current and future *health-care* needs of veterans."

From a list of 75 potential projects, VA has narrowed down the number of sites that it would consider for this program to 22, and the FY 2008 Asset Management Plan explains that VA expects to have the site analysis finished during FY 2009, allowing the department to move forward on a pilot program shortly after that point. VA claims it retains the authority to conduct this program within the context of its existing leasing authority, and without specific authorization by Congress to initiate the program.

On the face of it, having VA lease space is not necessarily a bad idea. It has the advantage of being able to be done quickly, especially when compared to the drawn-out major construction process. It also allows VA flexibility, and it has been particularly valuable in establishing community-based outpatient clinics (CBOCs) and Vet Centers.

The IBVSOs' concern with the HCCF model is that it amounts to leasing in lieu of VA providing essential inpatient capacity. The leased VA facility would provide extensive outpatient services, including primary and specialty care services. Inpatient services, however, would be provided by local contract through an agreement with an affiliate or with a community hospital, privatizing many services we believe VA should continue to provide.

When combined with the recent trend of VA medical centers dropping inpatient services, the IBVSOs are becoming increasingly concerned. In Salisbury, North Carolina, the Hefner VA Medical Center is terminating inpatient, emergency, and surgical services. Michigan's Iron Mountain VA Medical Center has stopped performing inpatient surgeries and downgraded the emergency services it provides. There is suggestion that VA will contract out for some inpatient services at the Beckley, West Virginia, facility as well. Other still-unidentified facilities may follow this pattern.

One example of what can go wrong when VA abandons its inpatient services can be found in Grand Island, Nebraska. In 1997, the Grand Island VA Medical Center closed its inpatient facilities, contracting out with a local hospital for these services. Recently, the contract between the local facility, St. Francis Hospital, and VA was canceled. Veterans needing VA inpatient services can no longer receive care locally. They must travel great distances to other VA facilities, including the Omaha VA Medical Center. In some cases, when Omaha is unable to provide the necessary specialized care, VA is flying patients at its expense to other VA facilities, including the St. Louis and Minneapolis medical centers.

Further, with the canceling of that contract, St. Francis no longer provides the same level of emergency services that a full VA medical center would provide. With VA's restrictions on paying for emergency services in non-VA facilities, especially for those who may have some form of private insurance, this amounts to a cut in essential services to veterans. Given the expenses of air travel and medevac services, the current arrangement in Grand Island has likely not resulted in any cost savings for VA. Ferrying sick and disabled veterans great distances for inpatient care also raises patient safety and quality concerns.

The IBVSOs also have increasing concern over the changing of plans for the Denver VA Medical Center. The initial plans for the replacement Denver center were part of the 2004 CARES Commission recommendations. Congress authorized and appropriated funding for the project, but in April 2008 VA unveiled a revised plan that would dramatically change the size and scope of the project, taking it away from the blueprint CARES had laid out. Although VA has not identified it as one of its HCCF projects, it shares the characteristics of those proposals. VA's new proposal would shift its inpatient services to a shared facility built and maintained by the University of Colorado. VA would be responsible for a scaled-back outpatient clinic at the fringes of the Fitzsimons campus.

One example of the problems with the proposal in Denver pertains to the spinal cord injury/dysfunction (SCI/D) center. The new proposal inexplicably splits the SCI/D center into two separate buildings with the outpatient clinic providing 18 beds and the University's inpatient tower providing another 12 beds. These two facilities are separated by a distance of close to a mile—making coordination of care between the two locations difficult, especially given the mobility problems these patients have and harsh winter weather conditions in the Rocky Mountains. Worse, the design splits support spaces for these beds. With separate locations, some VA medical centers will need to duplicate support services at each facility, but with half the space VA originally determined was required. With regard to VA requirements, efficient staffing for an SCI/D unit dictates a minimum of 30 contiguous beds. If a SCI/D center is to function properly, it must be colocated with a full-service hospital and an SCI/D outpatient clinic.

Paralyzed Veterans of America has traditionally had a strong working relationship with VA in developing these SCI/D centers, providing guidance and recommendations to optimize the care provided in a setting that is comfortable and efficient for the paralyzed patients VA serves. With regard to the planned change in the Denver project, veterans have not had a voice; therefore, VA may be making a major strategic error in establishing a suboptimal facility for this critical population of veterans.

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

The IBVSOs would like to see some justification for the changes in scope of this project. The CARES study used comprehensive demographic and health utilization data to support its recommendations. We would like to know what other information was used to develop this revised plan, especially in light of Congress's recent reauthorization of the project and its appropriation of an additional $20 million in FY 2009. The IBVSOs believe the Denver project must immediately move forward as initially envisioned.

CARES provided a sound data-driven assessment of VA's infrastructure needs, and VA seems to be backing away from it toward a model that includes much more privatization of care. The IBVSOs will be watching the process carefully and insist that VA provide us specific information and reasons for any changes in plans that deviate from the CARES blueprint. Also, we believe Congress should examine VA's new HCCF plan to determine whether VA retains the legal authority to proceed without specific Congressional authorization.

Recommendations:

VA must not move to a wide-scale leasing program that replaces critical inpatient capacity with contract or fee-basis care.

VA must immediately move forward with the initial plans for the Denver VA Medical Center, as *The Independent Budget* veterans service organizations believe a revised blueprint would not serve the needs of veterans, especially with respect to the split spinal cord injury/dysfunction clinics.

Congress must carefully examine VA's Health Care Center Facilities program and exercise its oversight authority to ensure that VA is caring for veterans in the best possible way.

CRITICAL ISSUE 4

Improvements Needed in the Claims Process

In order to make the best use of newly hired personnel resources, Congress must focus on the claims process from beginning to end. The goal must be to reduce delays caused by superfluous procedures, poor training, and lack of accountability.

During the past couple of years, the Department of Veterans Affairs hired a record number of new claims adjudicators. Unfortunately, as a result of retirements by senior employees, an increase in disability claims, the complexity of such claims, and the time required for new employees to become proficient in processing claims, VA has achieved few noticeable improvements.

The claims' process is burdensome, extremely complex, and often misunderstood by veterans and many VA employees. Numerous studies have been completed on claims-processing delays and the backlog created by such delays, yet the delays continue. The following suggestions would simplify the claims process by reducing delays caused by superfluous procedures, inadequate training, and little accountability. Other suggestions will provide sound structure with enforceable rights where current law promotes subjectivity and abuses rights.

The subjectivity of the claims process results in large variances in decision making, unnecessary appeals, and claims overdevelopment. In turn, these problems contribute to the duplicative, procedural chaos of the claims process. Congress and the Administration should seek to simplify, strengthen, and provide structure to the VA claims process.

In order to understand the complex, procedural characteristics of the claims process, and how these characteristics delay timely adjudication of claims, one must focus on the procedural characteristics and how they affect the claims process as a whole. Whether through expansive judicial orders, repeated mistakes, or variances in VA decision making, some aspects of the claims process have become complex, loosely structured, and open to the personal discretion of individual adjudicators. By strengthening and properly structuring these processes, Congress can build on what otherwise works.

These changes should begin by providing solid, nondiscretionary structure to VA's "duty to notify." Congress meant well when it enacted VA's current statutory "notice" language. It has nonetheless led to unintended consequences that have proven detrimental to the claims process. Many Court of Appeals for Veterans Claims (Court) decisions have expanded upon VA's statutory duty to notify, both in terms of content and timing. However, with the recent passage of P.L. 110-389, the "Veterans Benefits Improvement Act of 2008," Congress, with the Administration's support, took an important step to correct this problem. However, *The Independent Budget* veterans service organizations (IBVSOs) believe VA can do more.

The VA's administrative appeals process has inefficiencies. The delays caused by these inefficiencies force many claimants into drawn-out battles for justice that may last for years. Delays in the initial claims development and adjudication process are insignificant when compared to delays that exist in VA's administrative appeals process. The IBVSOs believe VA can eliminate some of the delays in this process administratively, and we urge VA to do so. For example, VA can amend its official forms so that the notice VA sends to a claimant

when it makes a decision on a claim includes an explanation about how to obtain review of a VA decision by the Board of Veterans' Appeals (Board) and provides the claimant with a description of the types of reviews that are available.

Another problem that seems to plague the VA's claims process is its apparent propensity to overdevelop claims. One possible cause of this problem is that many claims require medical opinion evidence to help substantiate their validity. There are volumes of *Veterans Appeals Reporters* filled with case law on the subject of medical opinions, i.e., who is competent to provide them, when are they credible, when are they adequate, when are they legally sufficient, and which ones are more probative, etc.

There is ample room to improve the law concerning medical opinions in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assistance Act (VCAA) notice letter. Under current notice requirements and in applicable cases, VA's letter to a claimant normally informs the claimant that he or she may submit a private medical opinion. The letter also states that VA may obtain a medical opinion. However, these notice letters do not inform the claimant of what elements render private medical opinions adequate for VA rating purposes. To correct this deficiency, we recommend to VA that when it issues proposed regulations to implement the recent amendment of title 38, United States Code, section 5103 that its proposed regulations contain a provision that will require it to inform a claimant, in a VCAA notice letter, of the basic elements that make medical opinions adequate for rating purposes. The IBVSOs believe that if a claimant's physician is made aware of the elements that make a medical opinion adequate for VA rating purposes, and provides VA with such an opinion, VA no longer needs to delay making a decision on a claim by obtaining its own medical opinion. This would reduce the number of appeals that result from conflicting medical opinions—appeals that are ultimately decided in an appellant's favor more often than not. If the Administration refuses to promulgate regulations that incorporate the foregoing suggestion, Congress should amend VA's notice requirements in section 5103 to require that VA provide such notice regarding the adequacy of medical opinions.

Congress should consider amending section 5103A(d)(1) to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request such evidence from a Department health-care facility. Some may view this suggestion as an attempt to tie VA's hands with respect to its consideration of private medical opinions. However, it does not. The language we suggest adding to section 5103A(d)(1) would not require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for VA rating purposes.

The IBVSOs also believe that other procedures add unnecessary delays to the claims process. For example, we believe VA routinely continues to develop claims rather than issue decisions even though evidence development appears complete. These actions result in numerous appeals and unnecessary remands from the Board and the Court. Remands in fully developed cases do nothing but perpetuate the hamster-wheel reputation of veterans law. In fact, the Board remands an extremely large number of appeals solely for unnecessary medical opinions. In FY 2007 the Board remanded 12,269 appeals to obtain medical opinions. Far too many were remanded for no other reason but to obtain a VA medical opinion merely because the appellant had submitted a private medical opinion. Such actions are, we respectfully submit, a serious waste of VA's limited and shrinking resources.

The suggested rulemaking actions and recommended changes to sections 5103 and 5103A(d)(1) may have a significant effect on ameliorating some problems. But to further improve these procedures, Congress should amend title 38, United States Code, section 5125. Congress enacted section 5125, for the express purpose of eliminating the former title 38, Code of Federal Regulations, section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report before VA could award benefits. However, Congress enacted section 5125 with discretionary language. This discretionary language permits, but does not require, VA to accept medical opinions from private physicians. Therefore, Congress should amend section 5125 by adding new language that requires VA to accept a private examination report if the VA determines that the report is (1) provided by a competent health-care professional; (2) probative to the issue being decided; (3) credible; and (4) otherwise adequate for adjudicating the claim.

The IBVSOs have consistently maintained that VA must invest more in training adjudicators and decision makers and should hold them accountable for higher

standards of accuracy. VA has made improvements to its training programs in the past few years; nonetheless, much more improvement is required in order to meet quality standards that disabled veterans and their families deserve.

Training has not been a high enough priority in VA. We have consistently asserted that proper training leads to better quality decisions and that quality is the key to timeliness of VA decision-making. VA will only achieve such quality when it devotes adequate resources to perform comprehensive and ongoing training and imposes and enforces quality standards through effective quality assurance methods and accountability mechanisms.

The VA's problems with accountability are not isolated to the claims process. In fact, they begin in the VA training process. Essentially, there is no distinction between VA's claims process and its training program when distinguishing unsatisfactory performance and outstanding performance. Both processes place too much emphasis on quantity rather than quality. It is simply the numbers game in full swing.

The Administration and Congress should require mandatory and comprehensive testing designed to hold trainees accountable. This requirement should be the first priority in any plan to improve training. VA should not advance trainees to subsequent stages of training until they have successfully completed such testing.

In addition to training, accountability is a key to quality and therefore to timeliness. However, almost everything in VA is production driven. VA should base personnel awards as equally on quality as it places on production. Therefore, VA must implement stronger accountability measures for quality assurance.

Congress should require the Secretary to report on how VA will establish a quality assurance and accountability program that will detect, track, and hold responsible those employees who commit errors. VA should generate the report in consultation with veterans service organizations most experienced in the claims process.

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

Such a cumulative accountability system would eliminate potential abuse of the system through the proverbial "good-old-boy's" club. One employee is far less likely to cover for errors or look the other way from errors committed by a fellow employee if he or she knew his or her performance measurement was equally at risk. This type of system will ensure personal accountability at every stage in the claims process without seriously disrupting or dismantling VA's current performance measurement system.

Recommendations:

VA should amend its notification forms to inform claimants of the procedures that are available for obtaining review of a VA decision by the Board of Veterans' Appeals along with providing an explanation of the types of reviews that are available to claimants.

VA should issue proposed regulations to implement the recent amendment of title 38, United States Code, section 5103 as quickly as possible. The VA's proposed regulations should include provisions that will require VA to notify a claimant, in appropriate circumstances, of the elements that render medical opinions adequate for rating purposes.

Congress should amend section 5103A(d)(1) to provide that when a claimant submits a private medical opinion that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request another medical opinion from a department health-care facility.

Congress should amend title 38, United States Code, section 5125, insofar as it states that a claimant's private examination report "may" be accepted. The new language should direct that the VA "must" accept such report if it is (1) provided by a competent health-care professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for adjudicating such claim.

VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence. In addition, to complement recent improvements in its training programs, VA should require mandatory and comprehensive testing of the

claims process and appellate staff. To the extent that VA fails to provide adequate training and testing, Congress should require mandatory and comprehensive testing, under which VA will hold trainees accountable.

Congress should require the VA Secretary to report on how the Department will establish a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit errors. VA should generate the report in consultation with veterans service organizations most experienced in the claims process. As errors are discovered, employees responsible for such errors must be held accountable by forfeiture of work credit percentage.

CRITICAL ISSUE 5

SEAMLESS TRANSITION FROM THE DOD TO VA

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

As service members return from the conflicts in Afghanistan and Iraq, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service to successfully integrate into the civilian community as veterans. Though improvements have been made, the transition from the DOD to the VA heath-care system continues to be a challenge for newly discharged veterans. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

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

The Independent Budget continues to stress the points outlined by the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report released in May 2003, and reinforced by the President's Commission on Care for America's Returning Wounded Warriors in September 2007, as well as four other major studies regarding transition of service members to veteran status. One of the 20 recommendations made by the PTF and those made by the President's Commission was for increased collaboration between the DOD and VA for the transfer of personnel and health information. Great progress has been made in this area by VA; however, this recommendation remains only partially implemented. A September 2008 Government Accountability Office (GAO) report noted that the DOD and VA are not sharing all electronic health information and that information is still being captured in paper records at many DOD facilities.

Health Information

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

tronic health information should also include an easily transferable electronic DD214 forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and other benefits.

The Joint Electronic Health Records Interoperability (JEHRI) plan as agreed to by both the DOD and VA through the Joint Executive Council and overseen by the Health Executive Council is a progressive series of exchanges of related health data between the two departments culminating in the bidirectional exchange of interoperable health information. While this has occurred at several levels, the current need is for a common standard. In May 2007, the DOD established the Senior Oversight Committee (SOC), chartered and cochaired by the Deputy Secretaries of the DOD and VA with the goal to identify immediate corrective actions and to review, implement, and track recommendations from a number of external reviews. As a result of the recognized need, one of the lines of action identified to be addressed was DOD-VA data sharing. The SOC approved initiatives to ensure health and administrative data are made available. The September 2008 GAO report indicates that the DOD and VA have agreed to numerous common standards and are working with federal groups to ensure adherence and alignment with emerging standards.

For example, the DOD and VA are sharing select health information at different levels of interoperability, such as pharmacy and drug allergy data on nearly 19,000 patients who seek care from both agencies. Such information can be shared electronically between the DOD and VA to warn the different clinicians of a possible drug allergy with a to-be prescribed medication. The Laboratory Data Sharing Interface Project is a short-term initiative that has produced an application used to electronically transfer laboratory work orders and retrieval of results between the departments in real time. Nonetheless, questions remain regarding the extent to which the DOD and VA will achieve full interoperability by next year when neither has not yet articulated an interoperability goal.

According to the GAO, the DOD-VA Information Interoperability Plan, recently completed by the Departments, is supposed to address these and other issues, including the establishment of schedules and benchmarks for developing interoperable health record capability. However, although an important accomplishment, on preliminary review the plan's high-level content provides only a limited basis for understanding and assessing progress toward full interoperability by the September 30, 2009, date mandated by the "National Defense Authorization Act for Fiscal Year 2008." Moreover, when fully established, a new interagency program office is to play a crucial role in accelerating efforts. Unfortunately, this office is not expected to be fully operational until the end of this year, and some milestones in the office's plan for achieving interoperability have yet to be determined.

Care Coordination

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

In October 2007, the DOD and VA partnered to create the Federal Recovery Coordination Program to improve care management by identifying and integrating care and services between the DOD and VA health-care systems, which subsequently served to satisfy provisions of the Wounded Warrior Act, title XVI of Public Law 110-181. With such resources as the newly developed Federal Individual Recovery Plan, National Resource Directory, Family Handbook, MyeBenefits, and Veterans Tracking Application, the IBVSOs are cautiously optimistic that these coordinators will be able to provide greater oversight for the seamless transition of severely injured service members. While there are only eight federal recovery coordinators serving about 120 severely injured service members across military treatment facilities, and one newly assigned at Dwight D. Eisenhower Army Medical Center, the President's Commission on Care of America's Returning Wounded Warriors reported that more than 3,000 seriously wounded veterans might need the assistance of these coordinators.

For those service members and veterans whose injuries allow for more outpatient recovery and rehabilitation, a more extensive network has been created, spanning the entire VA health-care system. The Veterans Health Ad-

ministration has assigned part-time and full-time social workers to major military treatment facilities (MTF) to serve as VHA liaisons between the MTF and VHA facilities. Each VHA facility has selected a point of contact and alternate who work closely with the VA-DOD social work liaisons detailed to MTFs and the Veterans Benefits Administration (VBA) representatives to ensure a seamless transition and transfer of care. While this initiative pertains primarily to military personnel returning from Afghanistan and Iraq, it also includes active duty military personnel returning from other combat theater assignments. It does not include active duty military personnel who are serving in noncombat theaters of operation.

Moreover, VA introduced the concept of transition patient advocates in March 2007 to focus specifically on the needs of severely wounded veterans from operations in Afghanistan and Iraq. The OIG then issued a follow-up report (May 1, 2008) to assess the extent to which VA maintains involvement with service members and veterans who had received inpatient rehabilitative care in VA facilities for TBI. According to the report, VA case management was determined to have improved, while long-term case management is not uniformly provided for these patients, and significant needs remain unmet.

Disability Evaluation

The Independent Budget likewise concurred with the President's Commission recommendation that the DOD and VA implement a single comprehensive medical examination, and we believe that this absolutely must be done as a prerequisite of promptly completing the military separation process. However, we would like to reiterate our belief that if and when a single separation physical becomes the standard, VA should be responsible for handling this duty because VA simply has the expertise to conduct a more thorough and comprehensive examination as part of its compensation and pension process. Moreover, the inconsistencies with the Physical Evaluation Board process from the different branches of the service can be overcome with a single physical administered from VA's perspective, and not the DOD's. A pilot project launched by the DOD and VA in November 2007 for service members from Walter Reed Army Medical Center, National Naval Medical Center at Bethesda, and Malcolm Grow Medical Center has more than 200 participants and is a step toward developing this single separation physical. While this separation physical is targeted primarily at those considered for medical discharge from the military, it should be considered for all separations. According to the GAO, the DOD and VA have not finalized their criteria for expanding the pilot project beyond the original sites. The IBVSOs believe the DOD and VA need to expand the pilot to more sites in preparation to fully implement the program.

The problem with separation physicals identified for active duty service members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists, and in some cases reservists are not made aware of the option. While the physical examinations of demobilizing reservists have greatly improved in recent years, there are still a number of service members who "opt out" of the physicals, even when encouraged by medical personnel to have them. Although the expense and manpower needed to facilitate these physicals might be significant, the separation physical is critical to the future care of demobilizing service members. We cannot allow a recurrence of the lack of information that led to so many issues and unknowns with Gulf War illnesses, particularly among our National Guard and Reserve forces. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by each to recognize, treat, and prevent illnesses and injuries resulting from military service.

In the past several years, the DOD and VA have made good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) handled by the Veterans Employment and Training Service (VETS) is generally the first service a separating service member will receive. In particular, local military commanders, through the insistence of the DOD, began to allow their soldiers, sailors, airmen, and marines to attend well enough in advance to take greatest advantage of the program. The programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then seek answers prior to discharge.

The TAP and DTAP programs continue to improve, but challenges continue at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service

members who wish to file a claim for VA compensation benefits and thus, other ancillary benefits, are dissuaded by the specter of being assigned to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in providing this information. Though individuals are receiving the information, the haphazard nature and quick processing time may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center despite still being on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. DTAP has not had the same level of success as TAP, and it is critical that coordination be closer between the DOD, VA, and VETS to improve this disparity.

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

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

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

Recommendations:

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

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

The DOD and VA must fully establish the Joint Interagency Program Office with permanent staff and clear lines of responsibility and finalize the draft implementation plan with appropriate milestones and timelines for defining requirements to support interoperable health records.

The DOD and VA must outline the requirements for assigning new or additional federal recovery coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service member's medical conditions.

The DOD and VA must develop a clear plan of rehabilitation for severely injured service members and veterans receiving care and must receive the necessary resources to accomplish these goals.

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

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

CRITICAL ISSUE 6

Human Resource Challenges Facing the Department of Veterans Affairs

The Department of Veterans Affairs must strengthen, energize, and expand programs to recruit and retain highly qualified VA employees, particularly in the Veterans Health Administration (VHA), and must redouble its efforts to advance succession plans to welcome the next generation of VA employees.

Addressing human resource issues within VA has never been more urgent than today with the ongoing conflicts in Afghanistan and Iraq and the aging of both the veteran population and the "Baby Boomer" generation. Service members are returning from conflicts abroad and seeking services from VA, and, at the same time, veterans from previous wars, particularly veterans from the Vietnam era, are aging, and their need for medical services and other VA benefits is steadily increasing. In this environment, sufficient staffing becomes more essential to ensuring that veterans receive adequate VA care.

VA's ability to sustain a full complement of highly skilled and motivated personnel will require aggressive and competitive employment hiring strategies that will enable it to successfully compete in the national labor market. VA's employment success within the VHA and Veterans Benefits Administration (VBA) will require constant attention by the very highest levels of VA leadership. Additionally, Members of Congress must understand the gravity of VA personnel issues and be ready to provide the necessary support and oversight required to ensure VA's success.

VA must prepare for future personnel challenges by refining human capital policies and procedures, specifically in the areas of recruitment, retention, and succession planning. The average age of a VA employee is nearly 50 years, and 41 percent of VA employees will be eligible for retirement by the year 2013. The estimated U.S. veteran population is 23,816,000, and 39 percent of the veteran population is 65 years of age or older. VA must create and implement a strategy that will focus on hiring, training, and retaining personnel to offset the changing demographics of the veteran population and the VA workforce. VA must work to ensure efficient, safe, and productive work environments that attract high caliber professionals to successfully execute the VA mission, caring for America's veterans.

Veterans Health Administration

The facilities of VA, like many other American health-care providers, are facing a looming and potentially dangerous shortage of available health-care personnel to meet the growing demands of sick and disabled veterans. The current documented national shortage of physicians, nurses, pharmacists, therapists of all disciplines, psychologists, and practitioners in several other professional disciplines is bound to impact the effectiveness of VA's recruitment and retention programs. VA estimates that 163,308 new hires will be needed to handle attrition and maintain VHA's workforce to 2013. VA must anticipate the effects of the national health-care workforce shortage and work to provide competitive employment packages and a more pre-

ferred workplace to ensure veterans continue to receive high quality and effective VA health care in the future.

The dwindling supply of trained and qualified health-care professionals cannot keep pace with the national growth in demand for health care. VA has recognized that the employment market is extremely competitive for some positions and is working to provide innovative professional development opportunities and programs to attract some of the new employees it will need to care for veterans. However, recruitment, retention, and succession planning can be fully successful only with sufficient, timely, and predictable funding from Congress for VA's overall health-care mission. After years of reacting to the current erratic funding process, achieving effective health-care budgetary reform can provide VA the confidence it needs to more effectively recruit, develop, and retain its health-care workforce to meet the needs of our nation's veterans.

With regard to registered nurses (RNs) within the VA system, the United States is experiencing an unprecedented nursing shortage that is expected to continue well into the future. The Health Resources and Services Administration projected in 2007 that the nation's nursing shortage will grow to more than 1 million nurses by the year 2020 and that all 50 states will experience shortages of nurses in varying degrees by the year 2015. According to projections from the U.S. Bureau of Labor Statistics (BLS) in the November 2005 *Monthly Labor Review*, 1.2 million new RNs will be needed by 2014 to meet job growth and replacement needs. According to the July 2006 Aging Workforce Survey conducted by the Nursing Management organization, 55 percent of surveyed nurses reported the intention to retire between 2011 and 2020. In addition to the need for 30,211 RNs by 2013, the VHA turnover rate for registered nurses in 2006 was 8.5 percent (full and part-time positions, not including trainees). VA must develop a recruitment strategy that provides employment incentives that attract and encourage nursing students and new nurse graduates to commit to VA employment. More specifically, VA must work to recruit and retain nurses that provide care in VA's specialized service programs, such as spinal cord injury/dysfunction (SCI/D), blind rehabilitation, mental health, and brain injury using compensatory benefits, such as specialty pay.

With respect to VA physicians, at present, 130 VA medical centers have affiliations through which physicians represent half of approximately 100,000 VA health profession trainees. VA estimates that medical residents equate to approximately one-third of the total VA physician workforce. About 2,500 (16 percent) of VA physicians are currently eligible for voluntary retirement, and it is projected that by 2012, this number will grow to 2,909 (17 percent). Notably, a 2007 survey assessed the impact of VA health profession training on VA physician recruitment. Prior to exposure to training in VA facilities, 21 percent of medical students and 27 percent of medical residents indicated they were "very" or "somewhat" likely to consider post-graduate VA employment. Following training at VA, these positive responses grew to 57 percent of medical students and 49 percent of medical residents. Although current resignation rates among VA physicians remain stable, VA projects the number of voluntary retirements will rise over time. Thus through its training programs VA is well positioned to take advantage of a ready source of physician recruitment.

In 2004, Congress passed Public Law 108-445, the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004. The act is partially intended to aid VA in both recruiting and retaining VA physicians (including scarce subspecialty practitioners) by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. In the intervening years VA has implemented the act, but the IBVSOs believe the act may not have provided VA the optimum tools needed to ensure that veterans will have available the variety and number of physicians needed in their health-care system. For example, a recent review of offered VA physician position vacancies on usajobs.gov revealed the following: Bay Pines VA Medical Center was recruiting an orthopedic surgeon at a maximum salary of $175,000 while the national average income of orthopedists is $459,000. Indianapolis VAMC was seeking an emergency room physician at a maximum of $175,000 while the national average for this category is $216,000. The Greater Los Angeles VA system was offering a maximum of $270,000 for an anesthesiologist while the average income for anesthesiologists is $311,000. We urge Congress to provide further oversight and to ascertain whether VA has adequately implemented its intent or if VA may need additional tools to ensure full employment for qualified VA physicians as it addresses its future staffing needs.

Given the VHA's leadership position as a health system, it is imperative that VA aggressively recruit health-care professionals in addition to emphasizing the

attractive opportunities within the VHA and work within established relationships with academic affiliates and community partners to recruit new employees. In order to make gains on these needs, VA must update and streamline its human resource processes and policies to adequately address the needs of new graduates in the health sciences, recruits, and current VA employees. Today's health-care professionals and other staff who work alongside them need improved benefits, such as competitive salaries and incentives, childcare, flexible scheduling, and generous educational benefits. VA must actively address the factors known to affect current recruitment and retention, such as fair compensation, professional development, and career mobility; benevolent supervision and work environment; respect and recognition; technology; and sound, consistent leadership, to make VA an employer of choice for individuals who are offered many attractive alternatives in other employment settings.

VA Human Resources Policies Are Outmoded

VA must work aggressively to eliminate outdated, outmoded VA personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment. It is reported that, on average, from the time a vacancy announcement is posted, appointment of a new employee within VHA takes 90 days. In some professional occupations (especially physicians and nurses) many months can pass from the date of a position vacancy until the date a newly VA-credentialed and privileged professional caregiver is on board and providing clinical care to veterans. Its lack of ability to make employment offers and confirm them in a timely manner, especially to new graduates it has helped train, unquestionably affects VA's success in hiring highly qualified employees and has the potential to diminish the quality of VA health care. Hiring delays depress current workforce morale and lead to overuse of mandatory overtime for nurses and others, greater workplace stress, and staff burnout. At all levels, the VHA (especially including local facility managements) must be held accountable for improving human resources policies and practices. Congress should require VA to report its efforts to improve recruiting, retention, and environmental/organization practices to assure veterans that VA will be a preferred health-care provider in the future and will continue to provide veterans an effective health-care system to meet their specialized needs.

Succession Planning Needs Improvement

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

As employees exit VA employment over the next few years, it is imperative for VA to conduct exit surveys without regard to time in service or reason for resignation. However, the opposite seems to be the case today. In 2007, the VHA's exit survey rate dropped from 27 percent to 20 percent, the lowest in three years. Exit surveys in the top 25 critical VA occupations are particularly important to evaluate employees leaving these positions. With thorough surveys VA management can secure pertinent data to help refill positions as quickly as possible and to determine whether conditions of employment, human resources policies, or other factors contributing to early departures of valued staff need revision. Exit surveys also provide valuable insight and information on the VA work environment and organizational culture. These are key elements to both retaining and recruiting high quality personnel in VA health care.

Existing VA loan repayment and scholarship programs were established by Congress to provide individuals interested in VA nursing with the financial support they need to enter and stay in the field. Both a recruitment and retention tool, the centrally funded Employee Incentive Scholarship Program (EISP) pays up to $32,000 for health care–related academic degree programs, with an average of $12,000 paid per scholarship. Since its inception in 1999 through 2007, approximately 7,000 VA employees have received scholarship awards for educational programs related to title 38 and "hybrid" title 5-title 38 VA occupations. About 4,000 employees have graduated from academic programs under these auspices. Scholarship recipients include registered nurses (93 percent), pharmacists, physical therapists, and other allied health professionals. A five-year VA analysis of program outcomes demonstrates this program's impact on VA employee retention. For exam-

ple, turnover of nurse scholarship participants is 7.5 percent compared to a nonscholarship nurse turnover rate of 8.5 percent. Also, less than 1 percent of participating nurses left VHA employment during their service obligation period (from one to three years after completion of degree).

The VA Education Debt Reduction Program (EDRP) provides tax-free reimbursement of existing education debt of recently hired title 38 and hybrid employees. Centrally funded, the EDRP is the title 38 equivalent of the Student Loan Repayment Program (SLRP) administered by the Office of Personnel Management for title 5 employees. More than 5,600 VA health-care professionals have participated in the EDRP. The maximum amount of an EDRP award is limited by statute to $44,000 in exchange for five years of service. As education costs have risen, the average award amount per employee has increased over the years from about $13,500 in FY 2002 to more than $27,000 in FY 2007. While employees from 33 occupations participate in the program, 77 percent are from three mission critical occupations—RN, pharmacist, and physician. The rate of losses from resignation of EDRP recipients is significantly less than that of nonrecipients as determined in a 2005 study. For physicians the study found the resignation rate for EDRP recipients was 15.9 percent compared to 34.8 percent for non-EDRP recipients.

Both the ESIP and EDRP initiatives need to be strengthened and expanded to new VA occupations, in particular among the 25 critical occupational categories that will be increasingly competitive as the health manpower shortage worsens. These programs have proven themselves to be cost-effective recruitment tools and to provide strong incentives for individuals to remain in VA employment rather than to go elsewhere.

Veterans Benefits Administration

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

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

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

Recommendations:

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

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

VA facilities must fully utilize recruitment and retention tools, such as relocation and retention bonuses, a locality pay system for VA nurses, and education scholarship and loan payment programs as employment incentives, in both the Veterans Health Administration and the Veterans Benefits Administration.

VA must conduct improved exit surveys as employees terminate employment to secure pertinent data that will help refill positions in a timely manner and to determine if conditions of employment, human resources policies, or other contributing factors need revision.

Congress must provide further oversight to ensure adequate implementation of Public Law 108-445.

Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA's specialized services areas, such as spinal cord injury and dysfunction, blind rehabilitation, mental health, and traumatic brain injury.

VA must develop a more aggressive recruitment strategy that provides employment incentives that attract and encourage affiliated health professions students, and new graduates in all degree programs of affiliate institutions, to commit to VA employment.

Congress should improve the provisions of VA's Employee Incentive Scholarship Program and Education Debt Reduction Program and make them available more broadly to all VA employees. VA must become more flexible with its work schedules to meet the needs of today's health-care and benefits professionals and must provide other employment benefits, such as child-care, that will make VA employment more attractive.

CRITICAL ISSUE 7

The National Cemetery Administration

The National Cemetery Administration (NCA) must ensure that burial in a national or state veterans cemetery is an option available for all veterans and their family members and must provide a dignified setting with perpetual care that honors veterans and exhibits evidence of the nation's gratitude for their military service.

VA's National Cemetery Administration maintains more than 2.8 million gravesites at 125 national cemeteries and 33 additional installations in 39 states and Puerto Rico. Currently there are more than 17,000 acres within established NCA installations. Just more than half of this land is undeveloped. Including available gravesites and the undeveloped land, there is a potential to provide more than 4 million resting places. In addition to the maintenance of these facilities, the NCA administers four programs: the State Cemetery Grants Program, the Headstone and Marker Program, the Presidential Memorial Marker Program, and outer burial receptacle reimbursements.

The purpose of the national cemetery is to honor the memory of America's servicemen and -women. Many of our nation's cemeteries are steeped in history, and the monuments, markers, and memorials that stand represent the very foundation of our country. Our nation's burial grounds are a national treasure deserving of the utmost care and protection. To achieve this high standard of preservation, the NCA faces serious challenges. The increase in the demand for interment and the need for continuous gravesite maintenance, including the repairs, upkeep, and other labor-intensive tasks involved in operating a cemetery, continue to rise. To meet these challenges, the NCA must have adequate funding to ensure it remains a world-class system that honors our veterans and recognizes their contribution and service to our nation. Therefore, *The Independent Budget* recommends a budget for the NCA that will both meet the growing demand and allow every man and woman who has worn the uniform of the United States armed forces to be treated with dignity and respect.

The NCA has done an exceptional job of providing burial options for 90 percent of all veterans who fall within the 170,000 veterans within a 75-mile radius threshold model. However, under this model, no new geographical area will become eligible for a National Cemetery until 2015. St. Louis, Missouri, will at that time meet the threshold due to the closing of Jefferson Barracks National Cemetery in 2017. Analysis shows that the five areas with the highest veteran population will not become eligible for a national cemetery because they will not reach the 170,000 threshold.

The NCA has spent years developing and maintaining a cemetery system based on a growing veteran population. In 2010 our nation's veteran population will begin to decline. Because of this downward trend, a new threshold model must be developed to ensure

more of our veterans will have reasonable access to their burial benefits. Reducing the radius to 65 miles would reduce the veteran population that is served from 90 percent to 82.4 percent, and reducing the radius to 55 miles would reduce the served population to 74.1 percent. Reducing the radius alone to 55 miles would only bring two geographical areas into the 170,000 population threshold in 2010, and only a few areas into this revised model by 2030.

Several geographical areas will remain unserved if the population threshold is not reduced. Lowering the population threshold to 110,000 veterans would immediately make several areas eligible for a national cemetery regardless of any change to the mile radius threshold. A new threshold model must be implemented so more of our veterans will have access to this earned benefit.

In addition to the day-to-day operations to develop, maintain, and improve the NCA cemeteries, the NCA run State Cemetery Grants Program is vital in establishing and maintaining veterans' gravesites in areas in which the NCA cannot fully respond to the burial needs of veterans. This program assists states by providing grant money to ensure veterans' burial needs are met in areas where there are no national cemeteries or the area is under represented due to the number of veterans who live in a given area. It is imperative that the State Cemetery Grants Program be funded at a level that ensures the states can continue to meet the needs of veterans who want to be buried closer to their homes and that meets the challenge of growing interest by states in providing burial services in areas not currently served.

In 1973 the NCA established a burial allowance that provided partial reimbursements for eligible funeral and burial costs. The current payment is $2,000 for burial expenses for service-connected death, $300 for nonservice-connected deaths, and $300 for plot allowance. At its inception, the payout covered 72 percent of the funeral cost for a service-connected death, 22 percent for a nonservice-connected death, and 54 percent of the burial plot cost. In 2007, these benefits eroded to 23 percent, 4 percent, and 14 percent, respectively. It is time to bring these benefits back to their original value.

To ensure the National Cemetery Administration's capability to maintain our national cemeteries in a dignified and respectful manner, a comprehensive effort must be made to greatly improve the condition, function, and appearance of these cemeteries. To assist in restoring the national cemeteries *The Independent Budget* recommends to Congress the establishment of a five-year, $250 million "National Shrine Initiative" to restore the character of NCA cemeteries.

The NCA honors veterans with a final resting place that commemorates their service to the nation. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans—they are hallowed ground to those who died in our defense and a memorial to those who survived.

Recommendations:

Congress must provide adequate resources to ensure that the National Cemetery Administration remains a world-class operation that honors veterans and recognizes their contributions and service to the nation.

Congress must fund the State Cemetery Grants Program at a level that ensures that states can meet the needs of veterans who want to be buried closer to their homes.

Congress should increase burial benefits to cover the cost of burial more adequately and expand the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

The NCA must continue to identify sites for the addition of new national cemeteries in areas that remain underserved.

Recommendations to Congress

Benefit Programs

Compensation and Pensions

Compensation

Congress should enact legislation that automatically adjusts compensation and dependency and indemnity compensation by a percentage equal to the increase received by Social Security recipients in order to offset the rise in the cost of living.

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

In the alternative, Congress should enact a one-time adjustment to ensure that veterans and the survivors of those who gave the ultimate sacrifice in service to our nation again receive the full value of benefits intended by a grateful nation.

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

Congress should clarify its intent by amending title 38, United States Code, section 1154(b), with respect to defining a veteran who engaged in combat for all purposes under title 38.

In the alternative, Congress should enact legislation that extends 38 U.S.C. section 1154(b) to anyone who served in a war zone. This action would ease the evidentiary burden on veterans and time-consuming development by the Department of Veterans Affairs while leaving in place the need for the veteran to prove the existence of a disability and medical evidence connecting the disability to service.

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

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

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

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

Pensions

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

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

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

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

Readjustment Benefits

Housing Grants

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

Congress should increase the allowance from $14,000 to $28,000 for those veterans meeting the criteria of the first group and increase the allowance from $2,000 to $5,000 for veterans meeting the criteria of the second group. Then it should provide for automatic annual adjustments in the future to keep pace with inflation.

Automobile Grants and Adaptive Equipment

Congress should increase the automobile allowance to 80 percent of the average cost of a new automobile in 2008 and then provide for automatic annual adjustments based on the rise in the cost of living.

Insurance

Government Life Insurance

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

Congress should enact legislation to authorize the Department of Veterans Affairs to revise its premium schedule for Service Disabled Veterans' Insurance to reflect current mortality tables.

Congress should enact legislation to increase the maximum protection under base Service Disabled Veterans' Insurance policies to $50,000.

Veterans' Mortgage Life Insurance

Congress should increase the maximum coverage under Veterans' Mortgage Life Insurance from $90,000 to $150,000.

General Operating Expenses

Veterans Benefits Administration

Compensation and Pension Service

Congress should amend section 5103A(d)(1) to provide that when a claimant submits a private medical opinion that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request another medical opinion from a Department health-care facility.

Congress should amend title 38, U.S.C., section 5125, insofar as it states that a claimant's private examination report "may" be accepted. The new language should direct that the Department of Veterans Affairs "must" accept such report if it is (1) provided by a competent

health-care professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for adjudicating such claim.

Should VA fail to undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence or fail to require mandatory and comprehensive testing of the claims process and appellate staff, Congress should require mandatory and comprehensive testing, under which VA will hold trainees accountable.

Investments in VBA Initiatives

Congress should provide the Veterans Benefits Administration adequate funding for its information technology initiatives to improve multiple information and information-processing systems and to advance ongoing, approved, and planned initiatives, such as those enumerated in this section. These IT programs should be increased annually by a minimum of 5 percent or more.

Congress should continue to monitor current staffing levels and ensure that they remain in place until such time as the backlog is eliminated.

Once the backlog is eliminated, Congress could consider staffing reductions in the VBA but only after ensuring that quality problems are fully and adequately addressed.

Congress should ensure through oversight that management and leadership reforms in the VBA are completed and permanent.

Vocational Rehabilitation and Employment

Congress should authorize 1,375 total full-time employees for the Vocational Rehabilitation and Employment Service for FY 2010.

Congress should amend title 38, United States Code, section 3108 (f)(1)(A) to include recipients of chapter 33 benefits.

Education Service

Congress should support VA requests for additional full-time employees at a level sufficient to minimize current claims backlogs and to fully manage the new workload they will incur with the addition of chapter 33 claims.

Judicial Review

The Court of Appeals for Veterans Claims

Scope of Review: Enforce Fairness in the Appeals Process

Congress should enact a joint resolution 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 the intent of Congress that the Court of Appeals for Veterans Claims provide a more searching review of the Board of Veterans' Appeals findings of fact, and that in doing so, ensure that it enforce 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: "(5) In conducting review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision."

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

Congress should enact a Judicial Resources Preservation Act as described herein to preserve the Court's limited resources and reduce the Court's backlog.

Congress should enact a joint resolution indicating that it is the sense of Congress that any new judges appointed to the Court be selected from the knowledgeable pool of current veterans law practitioners.

Court Facilities

Congress should enact legislation and provide the funding necessary to construct a courthouse and justice center for the 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. When the Department of Veterans Affairs has calculated the cost to reopen the system to all veterans, it should receive full funding to accommodate priority group 8 veterans who choose to use the VA system for their health-care needs.

Congress should reform VA's medical care appropriation to give it an advance appropriation status, to provide funding for veterans' health care one year or more in advance of the operating year. This would ensure funding becomes timely and predictable, without converting it to mandatory status or requiring it to meet Congressional PAYGO (pay-as-you-go) rules for mandatory accounts.

Congress should require VA's internal budget model to be shared publicly to provide accurate estimates for VA health-care funding, with the information audited by the Government Accountability Office.

Congress should approve legislation that reforms the VA health-care budget process by authorizing one-year advance appropriations for VA Medical Care Accounts: Medical Services, Medical Support and Compliance, and Medical Facilities. The legislation should also require the GAO to regularly audit, assess, and report publicly to Congress on the integrity and accuracy of VA's budget forecasting model and its estimates.

Congress should include language in the budget resolution that provides a waiver for points of order against advance appropriations for VA Medical Care Accounts without setting a dollar limitation on those accounts.

Congress should approve both the FY 2010 appropriations for all VA accounts and an FY 2011 advance appropriations bill for the three VA Medical Care Accounts during the FY 2010 budget cycle.

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

Congress should provide funds necessary in the Veterans Health Administration's FY 2010 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, funding for the fourth mission should be included as a separate line item in the Medical Care appropriation.

Mental Health Issues

Congress should provide oversight to ensure that the Department of Veterans Affairs maintains a full continuum of mental health-care services across the system and enhance its efforts for oversight of VA's mental health transformation and implementation of VA's National Mental Health Strategic Plan and Uniform Mental Health Services (UMHS) delivery initiative.

Given the urgency of ensuring the implementation of the UMHS package, consideration should be given to holding Congressional oversight hearings as soon as possible on the implementation strategy employed by the VA Central Office for this initiative. Congress should require VA to provide an assessment of resource requirements, as well as a completion date for full implementation of the UMHS package.

OEF/OIF Issues

Congress should formally authorize, and the Department of Veterans Affairs should provide, a full range of psychological and social support services, including strong, effective case management, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.

The President and Congress should sufficiently fund Department of Defense and VA health-care systems to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans and continue to address the needs of previous generations of veterans with post-traumatic stress disorder and other combat-related postdeployment mental health challenges.

Access Issues

Congress must exercise its oversight authority in determining the rationale for the departure from the Capital Asset Realignment for Enhanced Services and the implementation of the Health Care Center Facility initiative.

Congress must continue to adequately fund needed VA construction projects and work to eliminate the existing backlog of projects that are the result of previous years' underfunding.

Veterans designated by the Department of Veterans Affairs as being catastrophically disabled for the purpose of enrollment in health-care eligibility priority group 4 should be exempt from all health-care copayments and fees.

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

Congress should provide oversight on the claims processing for non-VA emergency care reimbursement to determine if claims are generally paid timely and if rates of denials for such claims are adjudicated similar to the claims applicable to the policies of the Centers for Medicare and Medicaid Services and other payers who 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 disabled veterans, including the latest advances in technology so that funding shortfalls do not compromise other programs.

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

The Independent Budget veterans service organizations strongly support full implementation of VA's new amputation system of care and encourage Congress to provide adequate resources for staffing and training of this important program.

Congress must continue to work for increased funding for VA and the Department of Defense to prevent, treat, and cure tinnitus.

Special Needs Veterans

In implementing DOD/VA Vision Centers of Excellence and the joint eye trauma registry created by the National Defense Authorization Act of 2008, the Departments of Defense and Veterans Affairs must ensure electronic exchange of essential information between all eye care professionals in order to establish a seamless transition of eye care and improve long-term outcomes through vision research. As it included in FY 2009 MILCON-VA appropriations to establish this registry, Congress should again provide $2 million for FY 2010 to complete this eye trauma registry.

Defense appropriations for FY 2010 must include $6,780,000 for further implementation of the four Vision Centers of Excellence located at Bethesda National Naval Medical Center, Brooke Army Medical Center, Madigan Army Medical Center, and San Diego NNMC, and Armed Services/VA Committee hearings on this joint program for eye injured and hearing impaired must be held.

The Congressionally directed Peer Medical Research Program must continue to include eye and vision research in Defense appropriations, and DOD research funding on eye trauma must be increased in FY 2010 to $8 million.

Although the House of Representatives passed H.R. 6445 in the 110th Congress, Congress should reintroduce and enact legislation amending title 38, United States Code to prohibit the VA Secretary from collecting certain copayments from veterans who are catastrophically disabled.

Congress should amend title 38 to provide beneficiary travel reimbursement for catastrophically disabled veterans who need to attend an inpatient rehabilitation center.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for spinal cord injury/dysfunction nurses.

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

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

Congress should provide funding to conduct research on effective treatments for veterans suffering from Gulf War illness.

Congress must conduct oversight on the concerns raised in the November 2008 report by the Research Advisory Committee on Gulf War Veterans' Illnesses on the IOM's Gulf War and Health reports.

Congress should make permanent the presumptive period for undiagnosed illnesses, which is due to expire September 30, 2011.

VA should request and Congress should appropriate at least $3 million in FY 2010 to conduct a pilot screening program for veterans at high risk of developing lung cancer based on collaboration with the International Early Lung Cancer Action Program and should explore the most effective way to partner with the Department of Defense on its early detection program.

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

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

Congress should increase appropriations for the Homeless Veterans Reintegration Program (HVRP) *to the authorized level of $50 million*. Funded by the U.S. Department of Labor Veterans Employment and Training Service, HVRP is the only federal program wholly dedicated to providing employment assistance to homeless veterans and provides competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

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

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

Congress should increase the authorization level of and appropriations for the VA Homeless Provider Grant and Per Diem (GPD) program to *$200 million* to meet the need for additional transitional housing and service center programs assistance. GPD provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans. Special needs grant funding under this program should increase for women veterans, frail and elderly veterans, veterans with chronic mental illness, and those who are terminally ill.

Congress should revise the GPD payment program to allow payments to be related to service costs rather than a capped rate. Grantees should be allowed to use GPD funds, both in capital development projects and operating per diem payments, as a match to any other federal grant source. Grantees should also be allowed to use other available sources of income besides the GPD program to furnish services to homeless veterans.

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

Congress should provide and appropriate funding *for an additional 20,000 Section 8 vouchers* for the HUD-Veterans Affairs Supportive Housing Program, which provides permanent housing subsidies and case management services to homeless veterans with mental and addictive disorders, by appropriating additional funds for additional housing vouchers targeted to homeless veterans.

Congress should require applicants for Department of Housing and Urban Development McKinney-Vento homeless assistance funds to develop specific plans for housing and services to homeless veterans. Organizations receiving these assistance funds should screen all participants for military service and make referrals as appropriate to VA and homeless veteran service providers.

Congress should authorize and appropriate funds for a targeted permanent housing assistance program to prevent homelessness among low-income and formerly homeless veterans.

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

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

Long-Term-Care Issues

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

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

Congress must enforce and VA must abide by P.L. 106-117 regarding VA's nursing home average daily census capacity mandate.

VA and Congress must continue to provide the construction grant and per diem funding necessary to support state veterans homes. Even though Congress has approved full long-term-care funding for certain service-connected veterans in State Veterans Homes under P.L. 109-461, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure. To that end, Congress should provide state veterans homes $250 million in construction grant funds for FY 2010.

Congress must conduct oversight on VA's relationship and use of community nursing homes to provide long-term care to disabled veterans, and VA must do a better job of tracking the quality of care provided in VA contract CNHs. Unscheduled quality-of-care visits are a good first step but accreditation requirements are a better approach.

Given the evident growth in demand and to protect traditional VA institutional programs, Congress must provide additional resources and VA must increase its capacity for noninstitutional, home, and community-based care.

While assisted living is not currently a benefit that is available to veterans (outside the two pilot programs discussed above), *The Independent Budget* veterans service organizations believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care.

VA Medical and Prosthetic Research

To keep its research funding predictable and stable, VA requires at least $20 million per year to account for rising biomedical research costs. *The Independent Budget* veterans service organizations believe an additional $45 million in FY 2010 is needed for continued support of new research initiatives and to raise the restrictive cap on merit reviews. Thus, the President and Congress should provide an increase of $65 million for VA research in FY 2010, for a total of $575 million.

In keeping with VA's crucial need to have stable, predictable funding so that it can effectively manage critical multiyear proposals, the President and Congress should fund the VA Medical and Prosthetic Research Account at $596 million in FY 2011, and $617 million in FY 2012.

Administrative Issues

Congress must provide further oversight to ensure adequate implementation of Public Law 108-445.

Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA's specialized services areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury.

Congress should improve the provisions of VA's Employee Incentive Scholarship Program and Education Debt Reduction Program and make them available more broadly to all VA employees.

Congress must provide sufficient funding through regular appropriations that are provided on time and include resources to support programs to recruit and retain critical nursing staff in VA health care, in particular, to support enlargement of the Nursing Academy.

Congress should provide adequate funding to reestablish the Health Professions Scholarship Program.

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

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

If Congressional action is necessary to enable the Veterans Health Administration to control and supervise IT staff in VA health-care facilities and network offices (more than 1,400 locations), Congress should permit this change. If Congressional action is not required (as *The Independent Budget* veterans service organizations believe to be the case), the Secretary of Veterans Affairs should take administrative action to effect reassignments of field IT staffs to the respective VHA health-care facilities where they currently work.

Any strictures on VA's ability to shift funds in or out of IT financial accounts, whether by appropriations transfers or by reprogramming, should be examined by Congressional appropriations committee staffs to determine if more flexibility is needed within the VA to ensure continuity of operations of VA's IT systems—and particularly those affecting direct VA health care.

Congress should mandate a full-time chief consultant for Physician Assistant Services within the Office of the Under Secretary for Health. Implementation of this position should be required, with reports back to the chairmen of the Committees on Veterans' Affairs.

Congress should include the physician assistant occupation in any future legislation concerning health-care retention, and education, training, and debt-reduction programs.

Congress should formally authorize, and VA should provide, a range of transitional psychological and social support services to family caregivers of veterans with severe service-connected injuries or illnesses.

Congress should authorize a compensation system for family caregivers of severely disabled veterans, intended to make up for the loss of income resulting from full-time caregiving, and to provide supplemental financial support to maintain their homes.

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

Construction Issues

Congress and the Administration must ensure that there are adequate funds for VA's capital budget so that the Department can properly invest in its physical assets to protect their value and to ensure that it can continue to provide health care in safe and functional facilities long into the future.

Congress should consider the strengths of allowing the Department of Veterans Affairs to carry over some maintenance funding from one fiscal year to another so as to reduce the temptation some VA hospital managers have of inefficiently spending their nonrecurring maintenance money at the end of a fiscal year for fear of losing it.

The Independent Budget veterans service organizations anticipate VA's analysis will find a need for funding significantly greater than VA had identified in the 2004 Capital Asset Realignment for Enhanced Services report. As VA moves forward with its research facilities assessment, the IBVSOs urge Congress to require VA to submit the resulting report to the House and Senate Committees on Veterans' Affairs no later than October 1, 2009. This report will ensure that the Administration and Congress are well informed of VA's funding needs for research infrastructure so they may be fully considered at each stage of the FY 2011 budget process.

To address the current shortfalls, the IBVSOs recommend an appropriation in FY 2010 of $142 million, dedicated to renovating existing VA research facilities in line with the 2004 CARES findings.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs encourage the Administration and Congress to support a new appropriations account in FY 2010 and thereafter to independently define and separate VA research infrastructure funding needs from those related to direct VA medical care. This division of appropriations accounts will empower VA to address research facility needs without interfering with the renovation and construction of VA direct health-care infrastructure.

Congress must appropriate $20 million to provide funding for each medical facility to develop an architectural master plan.

Career and Occupational Assistance Programs

Vocational Rehabilitation and Employment

Congress must provide the funding level to meet the increasing veteran demand for VA Vocational Rehabilitation and Employment program services.

Congress needs to change the eligibility delimiting date for VA Vocational Rehabilitation and Employment services by eliminating the 12-year eligibility period for chapter 31 benefits and allow all veterans with employment impediments or problems with independent living to qualify for VR&E services.

Congress should eliminate the 30-month maximum requirement for providing Independent Living services and the statutory cap of 2,500 new Vocational Rehabilitation and Employment Independent Living program participants because the effect of the cap and the increasing veteran demand for services delays providing needed IL programs to severely disabled veterans.

Congress should provide VA with additional funding for the Center for Veterans Enterprise so it can meet the increasing veteran demand for entrepreneurial services.

Congress must fund the National Veterans Training Institute at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

National Cemetery Administration

National Cemetery Administration Accounts

Congress should fund the State Cemetery Grants Program at a level of $52 million.

Congress should establish two categories of veterans for the purpose of burial benefits: veterans within the accessibility model and veterans outside the accessibility model. Congress should increase the plot allowance from $300 to $1,150 for all eligible veterans and expand the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

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

Congress should enact legislation to adjust these burial benefits for inflation annually.

Recommendations to the Department of Veterans Affairs

Benefit Programs

Compensation and Pensions

Compensation

The Department of Veterans Affairs should propose a rule change in the *Federal Register* that would update the mental health rating criteria to more 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.

General Operating Expenses

Veterans Benefits Administration

VBA Management

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

Compensation and Pension Service

The Department of Veterans Affairs should issue proposed regulations to implement the recent amendment of 38, United States Code, section 5103 as quickly as possible. VA's proposed regulations should include provisions that will require it to notify a claimant, in appropriate circumstances, of the elements that make medical opinions adequate for rating purposes.

VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence. In addition, to complement recent improvements in its training programs, VA should require mandatory and comprehensive testing of the claims process and appellate staff. To the extent that VA fails to provide adequate training and testing, Congress should require mandatory and comprehensive testing, under which VA will hold trainees accountable.

The VA Secretary's upcoming report must focus on how the Department will establish a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit errors, while simultaneously providing employee motivation for the achievement of excellence. VA should generate the report in consultation with veterans service organizations most experienced in the claims process.

Investments in VBA Initiatives

The Veterans Benefits Administration should revise its training programs to stay abreast of IT program changes and modern business practices.

The Department of Veterans Affairs should ensure that recent funding specifically designated by Congress to support the information technology (IT) needs of the VBA, and of new VBA staff authorized in FY 2009, are provided to the VBA as intended, and on an expedited basis.

The chief information officer and Under Secretary for Benefits should give high priority to the review and report required by Public Law 110-389 and redouble their efforts to ensure these ongoing VBA initiatives are fully funded and accomplish their stated intentions.

The VA Secretary should examine the impact of the current level of IT centralization under the chief information officer on these key VBA programs and, if warranted, shift appropriate responsibility for their management, planning, and budgeting from the chief information officer to the Under Secretary for Benefits.

Medical Care

Finance Issues

The Department of Veterans Affairs should ensure that objectives and performance measures are directly related to each other and the strategic goal they support.

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

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

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

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

The DOD and VA must fully establish the Joint Interagency Program Office with permanent staff and clear lines of responsibility, and finalize the draft implementation plan with set milestones and timelines for defining requirements to support interoperable health records.

VA and the DOD must outline the requirements for assigning new or additional federal recovery coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service members' medical conditions.

Severely injured service members and veterans receiving treatment from the DOD and VA must have a clear plan of rehabilitation and the necessary resources to accomplish its goals.

VA and the DOD should make changes to the Disability Evaluation System Pilot Project to meet the needs and protect the rights of severely injured service members.

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

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

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

Mental Health Issues

The Department of Veterans Affairs should appoint a task group to study and recommend a budget appropriate to support the Uniform Mental Health Services (UMHS) initiative. The task group should determine whether the Veterans Equitable Resource Allocation (VERA) model will provide adequate funding for the full continuum of services mandated by the UMHS handbook and make recommendations for future funding of mental health services.

VA should provide frequent periodic reports that include a facility-level accounting of the use of mental health enhancement funds, as well as an accounting of overall mental health expenditures, to Congressional staff, veterans service organizations, and the Consumer Liaisons Council of the VA Advisory Committee on the Care of Veterans with Serious Mental Illness.

In keeping with the National Mental Health Strategic Plan, Medical Services funding to support the Mental Health Enhancement Initiative should be provided on a recurring "earmarked" basis, outside of the VERA system, until such time that VA is confident that the programs within the initiative are sustainable. At a minimum, the IBVSOs believe a five-year period for such protection is necessary.

Given the urgency of ensuring the implementation of the UMHS package, consideration should be given to holding Congressional oversight hearings as soon as possible on the implementation strategy employed by the VA Central Office for this initiative. Congress should require VA to provide an assessment of resource requirements, as well as a completion date for full implementation of the UMHS package.

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

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

A task force, composed of experts from the Veterans Benefits Administration, Veterans Health Administration mental health staff, veterans service organizations, and disabled veterans, should be assembled to explore potential barriers and disincentives to mental health care and the VA disability compensation system.

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

The VA Advisory Committee on the Care of Veterans with Serious Mental Illness should be redesignated as a secretarial-level committee on mental health, armed with independent reporting responsibility to Congress.

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

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

OEF/OIF Issues

The Department of Defense and Department of Veterans Affairs must invest in research for individuals who suffer from postdeployment mental health challenges and traumatic brain injury, to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of traumatic brain injury and develop best practices in its screening, diagnosis, and treatment.

VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance-use disorders, in returning service members.

Congress should formally authorize, and VA should provide, a full range of psychological and social support services, including strong, effective case manage-

ment, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.

The VA system must continue to improve access to specialized services for veterans with mental illness, posttraumatic stress disorder, and substance-use disorders, commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

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

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

The DOD and VA should increase outreach efforts to include Internet options and amend current policies to encourage service members and veterans to seek the care they need without fear of stigma.

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on women who have served in OEF/OIF.

The DOD and VA should align policies and procedures to maximize information sharing while protecting the privacy and confidentiality of service members' and veterans' health records.

Access Issues

The Veterans Health Administration should make external comparisons to measuring its performance in providing timely access to care.

The VHA should fully implement complementary aspects of the Institute for Healthcare Improvement's Advanced Clinic Access principles and measures for primary and specialty care to maximize productivity of clinical care resources by identifying additional high-volume clinics that could benefit.

The Department of Veterans Affairs should consider implementing complementary recommendations contained in the Booz Allen Hamilton "Patient Scheduling and Waiting Times Measurement Improvement Study."

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

The VHA should complete implementation of the eight recommendations for corrective action in the July 8, 2005, report by VA's Office of Inspector General.

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

The VHA should consider consolidating contracted community-based outpatient clinics at the VA medical center or network levels. This would ensure consistent requirements, pricing, and performance measurements, along with simplified contract administration. Aggregating CBOC contracting would allow VAMCs and the VHA to derive increased efficiencies within the CBOC program while simultaneously furthering VHA efforts to ensure clinical excellence in contracted CBOCs. Moreover, this approach would deliver a number of benefits to veterans including enhanced access, greater continuity of care, and a more standardized primary care benefit.

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

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

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

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

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

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

The ORH should be organizationally elevated in VA's Central Office and be provided staff augmentation commensurate with its responsibilities and goals.

The VHA should establish at least one full-time rural liaison position in each Veterans Integrated Service Network, and more if appropriate, with the exception of VISN 3 (urban New York City).

In cognizance of section 213 of Public Law 109-461, VA should be required to report to Congress the degree of its success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans.

VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with the ORH.

Additional mobile Vet Centers should be established to provide outreach and counseling for veterans in rural and highly rural areas.

Through its affiliations with schools of the health professions, VA should develop a policy to help supply health profession clinical personnel to rural VA facilities and practitioners to rural areas in general. The VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

Recognizing that in areas of particularly sparse veteran population and absence of VA facilities, the VA ORH should sponsor and establish demonstration projects with available providers of mental health and other health-care services for enrolled veterans, taking care to observe and protect VA's role as coordinator of care. The projects should be reviewed and guided by the Rural Veterans Advisory Committee. Funding should be made available to the ORH to conduct these demonstration and pilot projects outside of the Veterans Equitable Resource Allocation system, and VA should report the results of these projects to the Committees on Veterans' Affairs.

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

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 to their rural residences. This transportaion program should be inaugurated as a pilot program in a small number of facilities. If successful as an effective access tool for rural and highly rural veterans who need access to VA care and services, it should be expanded.

VA must establish a more transparent and open system that involves all stakeholders in addressing future construction initiatives.

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

SPECIALIZED SERVICES

Prosthetics and Sensory Aids

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

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

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the National Prosthetics Patient Database (NPPD), as well as program expansion needs.

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

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.

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 standard practices of care and defined services including prescribing, ordering, and purchasing items based on patient's 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 should continue ongoing evaluation of the purchasing and inventory guidelines necessary to provide timely and appropriate appliances for female veterans.

VA should increase funding for Prosthetics and Sensory Aids Service (PSAS) information technology systems projects. VA should consider dedicating full-time resources to PSAS IT systems to ensure these functions are enhanced in a timely manner.

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

The VHA should ensure that VISN prosthetics representatives do not have collateral duties as prosthetics representatives for local VA facilities within their VISNs.

The VHA must provide a single VISN budget for prosthetics and ensure that the VPR has control of and responsibility for that budget.

The VHA should set and enforce a five-day notification for a denial of prosthetics requests to the veteran.

VA must fully fund and support its National Prosthetics Representative Training Program, expanding the program to meet current shortages and future projections, with responsibility and accountability assigned to the chief consultant for 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 will ensure successful career path development.

The VHA must work to increase the number of training slots in the National Prosthetics Training Program to keep pace with the number of vacancies within the VHA for prosthetics representatives.

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 training 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 assess functional statements of all hybrid title 38 prosthetics employees to meet the complexities of programs throughout the VHA and must attract and retain qualified individuals.

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

VA should expeditiously implement the proposed system of amputation care providing proper staffing levels and training to ensure VA provides superior health services for aging and newly injured veterans who need these unique services.

The VHA must rededicate itself to the excellence of program for hearing loss and tinnitus as well as other auditory processing disorders.

The VHA must continue its work with networks, to restore clinical staff resources in both inpatient and outpatient audiology programs, and develop tinnitus components to existing audiology facilities.

Special Needs Veterans

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

The VHA must continue its three-year plan for full continuum of care outpatient programs for blinded and low-vision veterans that Secretary Nicholson promised in January 2007. Congress should ensure the program's implementation by providing $9.5 million in FY 2010 for completion of 54 new sites.

In implementing DOD/VA Vision Centers of Excellence and the joint eye trauma registry created by the National Defense Authorization Act of 2008, the Department of Defense and Department of Veterans Affairs must ensure electronic exchange of essential information between all eye care professionals in order to establish a seamless transition of eye care and improve long-term outcomes through vision research.

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

The VHA should ensure that the spinal cord injury/dysfunction continuum of care model is available to all veterans across the country with spinal cord injury or dysfunction. VA must also continue mandatory national training for "spoke" facilities.

The Department of Veterans Affairs should develop a comprehensive continuum of care model for SCI/D patients that includes other diseases of the neurological system, such as multiple sclerosis and amyotrophic lateral sclerosis.

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

VA should cease work on the revised plan involving the division of the SCI service in Denver and continue moving forward with the plan outlined by the Capital Asset Realignment for Enhanced Services (CARES) process.

VA should commission the National Academy of Sciences' Institute of Medicine to update the "2001 Gulf War Veterans: Treating Symptoms and Syndromes" report determine whether there are effective treatments for veterans suffering from Gulf War illness and whether these veterans are receiving appropriate care.

VA should change the current direction of its Gulf War illness research and separate its focus on ill Gulf War veterans and their health concerns from its focus on the health concerns of veterans of Operations Enduring and Iraqi Freedom.

VA should provide a more timely Gulf War Veterans Information System report and delineate Operations Enduring and Iraqi Freedom veterans from Gulf War veterans.

VA should issue regulations to add brucellosis, campylobacter jejuni, Q fever, malaria, mycobacterium tuberculosis, nontyphoid salmonella, shigella, visceral leishmaniasis and West Nile fever as presumptive conditions based on service in the Persian Gulf War.

VA should request and Congress should appropriate at least $3 million in FY 2010 to conduct a pilot screening program for veterans at high risk of developing lung cancer based on collaboration with the International Early Lung Cancer Action Program and should explore the most effective way to partner with the Department of Defense on its early detection program.

VA should conduct a comprehensive assessment of its women veterans' health programs and report the findings to Congress, along with an action plan to improve quality and reduce disparities in health-care services for women receiving VA care. The Government Accountability Office should review and report to Congress on the results of VA's assessment.

VA should redesign its women veterans care-delivery model and establish an integrated system of health-care delivery that covers a comprehensive continuum of care and serves as a best practice in the field.

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

VA should ensure that women veterans have access to comprehensive primary care services (including gender-specific care) at every VA facility. Collaborative care models incorporating mental health providers into women veterans' primary care teams should become the norm rather than the exception.

VA should implement and support at least one full-time women veterans program manager in women's health at every VA medical center and large multispecialty community-based outpatient clinic.

VA should fund a prospective, longitudinal long-term research study of the health consequences of women veterans' service in Afghanistan and Iraq. The research should include both telephone surveys and periodic health examinations of deployed and nondeployed women veterans.

VA should complete and report to Congress its comprehensive study of the barriers to health care experienced by recently discharged women veterans. The study should explore the perceptions and experiences of women who have tried to access health-care services at VA facilities.

VA health-care providers should make every effort to reduce women's unnecessary exposure to radiation and pharmaceutical teratogens. VA should facilitate providers' ability to identify compounds associated with an increased risk of birth defects and immediately revise the pharmacy package to provide alerts for potential teratogens to prescribe to women veterans less than 50 years of age. Women veterans should be offered a sexual function and safe-sex-practices screen annually.

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

VA should develop a pilot program to provide child care services for veterans who are the primary caregivers of children, while they receive intensive health-care services for post-traumatic stress disorder, mental health, and other therapeutic programs requiring privacy and confidentiality.

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

VA should concentrate on improving services for women with serious physical disabilities and evaluate all VA's specialized services to ensure women have equal access to these programs.

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

VA should expand its continuing and graduate medical education programs for women's health.

VA should establish a new program of Women Veterans Research, Education, and Clinical Centers modeled after the Geriatric Research, Education, and Clinical Centers.

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

Long-Term-Care Issues

The Department of Veterans Affairs must develop a more robust Long-Term Care Planning Model to ensure that strategic planning, program management, policy decisions, budget formulation, and oversight are able to meet the growing need of veterans of all ages for long-term care.

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

VA must develop a more detailed comprehensive strategic plan for long-term care that includes milestones for oversight purposes and such a plan must ensure that it meets the current and future needs of America's veterans.

Congress must enforce and VA must abide by P.L. 106-117 regarding VA's nursing home average daily census capacity mandate.

VA and Congress must continue to provide the construction grant and per diem funding necessary to support state veterans homes. Even though Congress has approved full long-term-care funding for certain service-connected veterans in state veterans homes under P.L. 109-461, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure. To that end, Congress should provide state veterans homes $250 million in construction grant funds for FY 2010.

Congress must conduct oversight on VA's relationship and use of community nursing homes to provide long-term care to disabled veterans, and VA must do a better job of tracking the quality of care provided in VA contract community nursing homes. Unscheduled quality-of-care visits are a good first step but accreditation requirements are a better approach.

Given the evident growth in demand and to protect traditional VA institutional programs, Congress must provide additional resources and VA must increase its capacity for noninstitutional, home, and community-based care.

The Veterans Health Administration must update its noninstitutional extended care directive and information letter to ensure that each noninstitutional long-term-care program mandated by P.L. 106-117 is operational and available across the entire VA health-care system.

VA should continue the "culture change" transformation; ensure that VA medical center executive staff and the community living center nurse manager and staff are involved and committed to this initiative; and issue a report measuring the expected increased satisfaction in VA community living centers.

VA should ensure all veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be provided, at a minimum, all services within the VA medical benefits package regardless of the payer of services.

VA should ensure all dependents of veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be made aware of all ancillary VA benefits to which they may be entitled.

VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days of respite care provided to veterans and their caregivers, and eliminating applicable copayments.

VA should expand the care coordination program to reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

VA should not require veterans to use personal funds, such as their service-connected disability benefits, to avail themselves of the type of noninstitutional long-term care provided by the medical foster homes program.

VA's Office of Geriatrics and Extended Care should encourage veterans to use VA's MyHealtheVet website.

Serious geographical gaps exist in specialized long-term-care services (nursing home care) for veterans with spinal cord injury or spinal cord disease. As VA develops its construction plan for nursing home construction, it must provide a minimum of 15 percent bed space to accommodate the specialized spinal cord injury nursing home needs nationally. VA must start by implementing the Capital Asset Realignment for Enhanced Services spinal cord injury/dysfunction (SCI/D) long-term-care recommendations. VA must develop a more detailed facility by facility mechanism to locate and identify veterans with SCI/D and other catastrophically injured veterans residing in non-SCI/D long-term-care facilities.

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

While assisted living is not currently a benefit that is available to veterans (outside the two pilot programs discussed above), *The Independent Budget* veterans service organizations believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care.

VA's 2004 Assisted Living Pilot Program report seems most favorable and assisted living appears to be an unqualified success. However, to gain further understanding of how the ALPP can benefit veterans, it should be replicated in at least three Veterans Integrated Service Networks with a high percentage of elderly veterans. The IBVSOs hope the new pilot program authorized by the National Defense Authorization Act for Fiscal Year 2008 can be a means of evaluating assisted living as an innovative option for meeting long-term-care needs of elderly veterans.

VA Medical and Prosthetic Research

To keep its research funding predictable and stable, the Department of Veterans Affairs requires at least $20 million per year to account for rising biomedical research costs. *The Independent Budget* veterans service organizations believe an additional $45 million in FY 2010 is needed for continued support of new research initiatives and to raise the restrictive cap on merit reviews. Thus, the President and Congress should provide an increase of $65 million for VA research in FY 2010, for a total of $575 million.

In keeping with VA's crucial need to have stable, predictable funding so that it can effectively manage critical multiyear proposals, the President and Congress should fund the VA Medical and Prosthetic Research Account at $596 million in FY 2011, and $617 million in FY 2012.

Administrative Issues

The Department of Veterans Affairs 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 its medical and regional offices that utilizes the experience and expertise of current employees as well as improves existing human resources policies and procedures.

VA facilities must fully utilize recruitment and retention tools, such as relocation and retention bonuses, a locality pay system for VA nurses, and education scholarship and loan payment programs as employment incentives, in both the Veterans Health Administration and the Veterans Benefits Administration.

VA must provide adequate oversight to ensure that all medical facilities correctly and consistently administer locality pay in accordance with VA policy.

VA must develop a more aggressive recruitment strategy that provides employment incentives that attract and encourage affiliated health professions students, and new graduates in all degree programs of affiliate institutions, to commit to VA employment.

VA must become more flexible with its work schedules to meet the needs of today's health-care and benefits professionals and must provide other employment benefits, such as child care, that will make VA employment more attractive.

VA should establish recruitment programs that enable the Veterans Health Administration to remain competitive with private-sector marketing strategies.

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

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

VA should establish a contract care coordination program that incorporates the Preferred Pricing Program discussed herein, based on principles of sound medical management, and tailored to VA and veterans' specific needs. The Preferred Pricing Program should also be enhanced and leveraged to develop pilots to address the needs of rural veteran access issues as well as a formal surge capability. Veterans who receive private care at VA expense and authorization should be required to participate in the care-coordination program, with limited exceptions.

VA and any care coordinator should jointly develop identifiable measures to assess program results and share results with Congress and stakeholders, including *The Independent Budget* veterans service organizations. Care should be taken to ensure inclusion of important VA academic affiliates in this program.

The components of a care-coordination program should include claims processing, health records management, and centralized appointment scheduling.

VA also should develop a series of tailored pilot programs to provide VA-coordinated care in a selected group of rural communities. As part of these pilots, VA should measure the relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, as compared to similar measurements of a like group of veterans in VA health care. In addition, the national Preferred Pricing Program's network of providers should be leveraged in this effort. Each pilot also should be closely monitored by the VA's Rural Veterans Advisory Committee. These same pilots can in turn be tailored to create a more formal surge capability addressing future access needs.

VA should establish a mechanism to track contract expenditures within the Project HERO pilot network that include cost comparisons to existing contract costs.

VA should develop a set of quality standards that contract care providers must meet that are equivalent to the quality of care veterans receive within the VA system. Any Project HERO provider should be held to this standard.

VA should provide Congress, and make publicly available, the results of the first year of operations under the Project HERO initiative, including both quality and cost data.

When VA preauthorizes non-VA medical care for a veteran, it should coordinate with the chosen health-care provider for both the veteran's care and payment of medical services. Service-connected veterans should not be required to negotiate payment terms with private providers for authorized fee-basis care or pay out-of-pocket for such services.

VA should continue to pursue the regulatory changes needed for its payment methodology to provide equitable payments for the care veterans receive in the community.

VA should provide the necessary support and place a higher priority for a long-term solution to standardize business practice in the non-VA purchased care program to allow efficient and timely processing of claims.

The VHA should regain at least partial—if not total—authority over health care-related information technology used within the VA health-care systems clinical, research, and education environment. The VHA should regain its authority for planning, programming, operat-

ing, and budgeting information technology matters that directly affect delivery of health care to enrolled veterans, and those directly affecting the conduct of VA's sensitive biomedical research and development programs. In regaining some management responsibility, the VHA should establish policies and procedures that ensure coordination with the VA chief information officer to guarantee compliance with all federally mandated information technology security requirements, in a manner congruent with the VHA responsibilities as a direct health-care service provider.

Because of its critical nature and tie to quality of health care, the HealtheVet next-generation IT development should be provided a dedicated contracting and legal review team to expedite decisions that move this key project forward.

The case management system should be seamless for veterans and family caregivers. Case manager advocates must be empowered to assist with medical benefits and family support services, including vocational services, financial services, and child care services.

VA should provide psychological support services to the family caregivers of severely injured and ill veterans. This support must include relationship and marriage counseling, family counseling, and related assistance to the family in coping with the inevitable stress and discouragement of caring for a seriously disabled veteran. These services should be made available at every VA facility that cares for severely disabled veterans of Operations Enduring and Iraqi Freedom.

VA should establish clear policies outlining the expectation that every VA nursing home and adult day health-care program provide appropriate facilities and programs for respite care for severely injured or ill veterans. These facilities should be restructured to be age-appropriate, with strong rehabilitation goals suited to the needs of a younger population, rather than expecting younger veterans to blend with the older generation typically residing 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 develop support materials for family caregivers, including the following:

- A "Caregiver Toolkit" available in hard copy and from the Internet—to supplement the recently published "National Resource Directory," which may not be fully responsive to their needs. This should include a concise "recovery road map" to assist families in understanding, and maneuvering through, the complex systems of care and resources available to them.
- Social support and advocacy support for the family caregivers of severely injured veterans, including:
  - Peer support groups, facilitated and assisted by committed VA staff members;
  - Appointment of caregivers to local and VA network patient councils and other advisory bodies within the Veterans Health Administration and Veterans Benefits Administration; and
  - A monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled OEF/OIF veterans, through My HealtheVet or another appropriate web-based platform.

VA should enhance its respite care services to reduce the variability across a veteran's continuum of care by allowing the veteran's primary treating physician to approve respite care in excess of 30 days; making the benefit more flexible by increasing the number of hours/days, overnight respite, and weekend respite care provided to veterans and their caregivers; and by eliminating applicable copayments.

Clarification is needed regarding the application of the Family and Medical Leave Act to address the special needs of the families of severely injured veterans, including increasing the duration of family leave time that is authorized by that act and adding additional employment protections for parents who are caregivers of severely disabled veterans of OEF/OIF.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys of caregivers of seriously injured veterans that will yield statistically representative data for policy and planning purposes.

VA should conduct caregiver assessments to identify the particular problems, needs, resources, and strengths of family caregivers of severely injured service members and determine appropriate support services and help the caregiver maintain her or his health and well-being.

Construction Issues

The Department of Veterans Affairs must dramatically increase funding for nonrecurring maintenance in line with the 2 percent to 4 percent total that is the industry standard so as to maintain clean, safe, and efficient facilities. VA also requires additional maintenance funding to allow it to begin addressing the substantial maintenance backlog of facility condition assessment-identified projects.

Portions of the nonrecurring maintenance account should be continued to be funded outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that actually have the greatest maintenance needs.

VA must not implement the Health Care Center Facility model without fully addressing the many questions raised in *The Independent Budget*, and VA must explain how the program would meet the needs of veterans, particularly as compared to the road map the Capital Asset Realignment for Enhanced Services laid out.

Each facility master plan should include the areas omitted from CARES: long-term care, severe mental illness, domiciliary care, and polytrauma programs as they relate to a particular facility.

The VA Central Office must develop a standard format for these master plans to ensure consistency throughout the VA health-care system.

Completed architectural master plans should be considered as VA develops future major medical construction budget requests.

VA must continue to monitor and develop short- and long-term plans with respect to the disposal of unnecessary space in nonhistoric properties that otherwise are not suitable for medical or support functions because of the structure's permanent characteristics or its location.

VA must continue to maintain and update the space-planning criteria and the VA Space and Equipment Planning System tool. It also must continue the process of updating the design guides to reflect current delivery models for patient care. VA must regularly review and update all of these space-planning tools as needed, to reflect the highest level of patient care delivery.

VA must evaluate the use of design-build as a method of construction delivery to determine if design-build is an appropriate method of project delivery for VA health-care projects.

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. VA should compile and use this information as a guide to future projects. VA must regularly update this document to include projects as they are completed.

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

Career and Occupational Assistance Programs

Vocational Rehabilitation and Employment

The Department of Veterans Affairs needs to strengthen its Vocational Rehabilitation and Employment (VR&E) program to meet the demands of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce and providing placement follow-up with employers for at least six months.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

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

The Independent Budget veterans service organizations recommend that the Vocational Rehabilitation & Employment Service initiate a nationwide study to reveal the reasons why veterans discontinue participation in the VR&E program and use the information to design interventions to reduce the probability of veterans dropping out of the program.

The VR&E Service needs to report the true number of veterans participating in the program and accurate performance data for budgetary and other resource decisions.

The VR&E Service must develop an aggressive outreach program to inform veterans of the benefit of participating in the VR&E program.

VA needs to streamline eligibility and entitlement to VR&E programs to provide earlier intervention and assistance to disabled veterans.

Vocational Rehabilitation & Employment Service staff must follow up with veterans after being referred to other agencies for self-employment to ensure that veterans' entrepreneur opportunities have been successfully achieved.

The VA Vocational Rehabilitation and Employment Service should improve its national acquisition strategy to make it easier for qualified vocational rehabilitation providers to offer services to veterans with disabilities.

VR&E Service staff must improve the oversight of non-VA counselors to ensure veterans are receiving the full array of services and programs in a timely and effective manner.

The VR&E Service should improve case management techniques and use state-of-the-art information technology to track the progress of veterans served outside VR&E.

The VR&E Service should follow up with rehabilitated veterans for at least six months to ensure that the rehabilitation and employment placement plan has been successful.

VA needs to utilize more effectively those resources within the nation's workforce development system that focus on obtaining and maintaining gainful employment for veterans. Until such time as the Vocational Rehabilitation & Employment Service's resources can accommodate the full range of services needed by veterans with disabilities, better coordination with state vocational rehabilitation programs, One-Stop Career Centers, and private sector vocational rehabilitation programs can help prepare veterans for interviews, offer assistance creating résumés, and develop proven ways of conducting job searches.

VA must help eliminate the barriers that veterans face when trying to establish and/or maintain a veteran- or service-disabled veteran-owned small business.

VA must expedite the overdue implementation of P.L. 109-461 so veteran entrepreneurs can receive set-aside and sole source contracts. Further delays in approving policy and regulation endanger the success and longevity of recently established service-disabled veteran-owned small businesses.

VA needs to establish a shared bonding process in conjunction with the Small Business Administration and provide a process to increase bonding limits upward to $15 million, which is necessary for service-disabled veterans to compete in today's construction market. VA should also develop a program for service-disabled veterans to teach them how to prepare their companies to overcome the obstacles that preclude them from obtaining surety bonding in a timely and efficient manner.

All federal agencies should be required to certify veteran status and ownership through the VA's Vendor Information Page program before awarding contracts to companies claiming to be veteran-owned or service-disabled veteran-owned small businesses.

Recommendations to the Administration

Benefit Programs

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. When the Department of Veterans Affairs has calculated the cost to reopen the system to all veterans, it should receive full funding to accommodate priority group 8 veterans who choose to use the VA system for their health-care needs.

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

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

Mental Health Issues

The President and Congress should sufficiently fund DOD and VA health-care systems to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans and continue to address the needs of previous generations of veterans with post-traumatic stress disorder and other combat-related postdeployment mental health challenges.

Specialized Services

Prosthetics and Sensory Aids

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

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

VA Medical and Prosthetic Research

To keep its research funding predictable and stable, the Department of Veterans Affairs requires at least $20 million per year to account for rising biomedical research costs. *The Independent Budget* veterans service organizations believe an additional $45 million in FY 2010 is needed for continued support of new research initiatives and to raise the restrictive cap on merit reviews. Thus, the President and Congress should provide an increase of $65 million for VA research in FY 2010, for a total of $575 million.

In keeping with VA's crucial need to have stable, predictable funding so that it can effectively manage critical multiyear proposals, the President and Congress should fund the VA Medical and Prosthetic Research Account at $596 million in FY 2011, and $617 million in FY 2012.

Construction Issues

Congress and the Administration must ensure that there are adequate funds for VA's capital budget so that the Department can properly invest in its physical assets to protect their value and to ensure that it can continue to provide health care in safe and functional facilities long into the future.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs encourage the Administration and Congress to support a new appropriations account in FY 2010 and thereafter to independently define and separate VA research infrastructure funding needs from those related to direct VA medical care. This division of appropriations accounts will empower VA to address research facility needs without interfering with the renovation and construction of VA direct health-care infrastructure.

Recommendations to the Department of Defense

Benefit Programs

Finance Issues

The Department of Defense and the Department of Veterans Affairs must ensure that service members have a seamless transition from military to civilian life.

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

The DOD and VA must fully establish the Joint Interagency Program Office with permanent staff and clear lines of responsibility, and finalize the draft implementation plan with set milestones and timelines for defining requirements to support interoperable health records.

VA and the DOD must outline the requirements for assigning new or additional federal recovery coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service members' medical conditions.

Severely injured service members and veterans receiving treatment from the DOD and VA must have a clear plan of rehabilitation and the necessary resources to accomplish its goals.

VA and the DOD should make changes to the Disability Evaluation System Pilot Project to meet the needs and protect the rights of severely injured service members.

A task force, composed of experts from the Veterans Benefits Administration, Veterans Health Administration mental health staff, veterans service organizations, and disabled veterans, should be assembled to explore potential barriers and disincentives to mental health care and the VA disability compensation system.

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

The VA Advisory Committee on the Care of Veterans with Serious Mental Illness should be redesignated as a secretarial-level committee on mental health, armed with independent reporting responsibility to Congress.

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

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

VA should conduct an assessment of the current availability of evidence-based care for PTSD, identify shortfalls by site of care, and calculate the resources necessary to provide universal access to these specialized treatments.

OEF/OIF Issues

The Departments of Defense and Veterans Affairs must invest in research for individuals who suffer from post-deployment mental health challenges and traumatic brain injury (TBI), to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of TBI and develop best practices in its screening, diagnosis, and treatment.

VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance-use disorders, in returning service members.

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

The DOD and VA should increase outreach efforts to include Internet options and amend current policies to encourage service members and veterans to seek the care they need without fear of stigma.

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on women who have served in Operations Enduring and Iraqi Freedom.

The DOD and VA should align policies and procedures to maximize information sharing while protecting the privacy and confidentiality of service members' and veterans' health records.

The DOD should declassify information on military occupational exposures, especially those experienced during combat deployments. The DOD should immediately release data on blast events and injuries that could result in TBI.

In implementing DOD/VA Vision Centers of Excellence and the joint eye trauma registry created by the National Defense Authorization Act of 2008, the Department of Defense and VA must ensure electronic exchange of essential information between all eye care professionals in order to establish a seamless transition of eye care and improve long-term outcomes through vision research. As it included in FY 2009 MILCON-VA appropriations to establish this registry, Congress should again provide $2 million for FY 2010 to complete this eye trauma registry.

In implementing DOD/VA Vision Centers of Excellence and the joint eye trauma registry created by the National Defense Authorization Act of 2008, the Department of Defense and VA must ensure electronic exchange of essential information between all eye care professionals in order to establish a seamless transition of eye care and improve long-term outcomes through vision research.

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