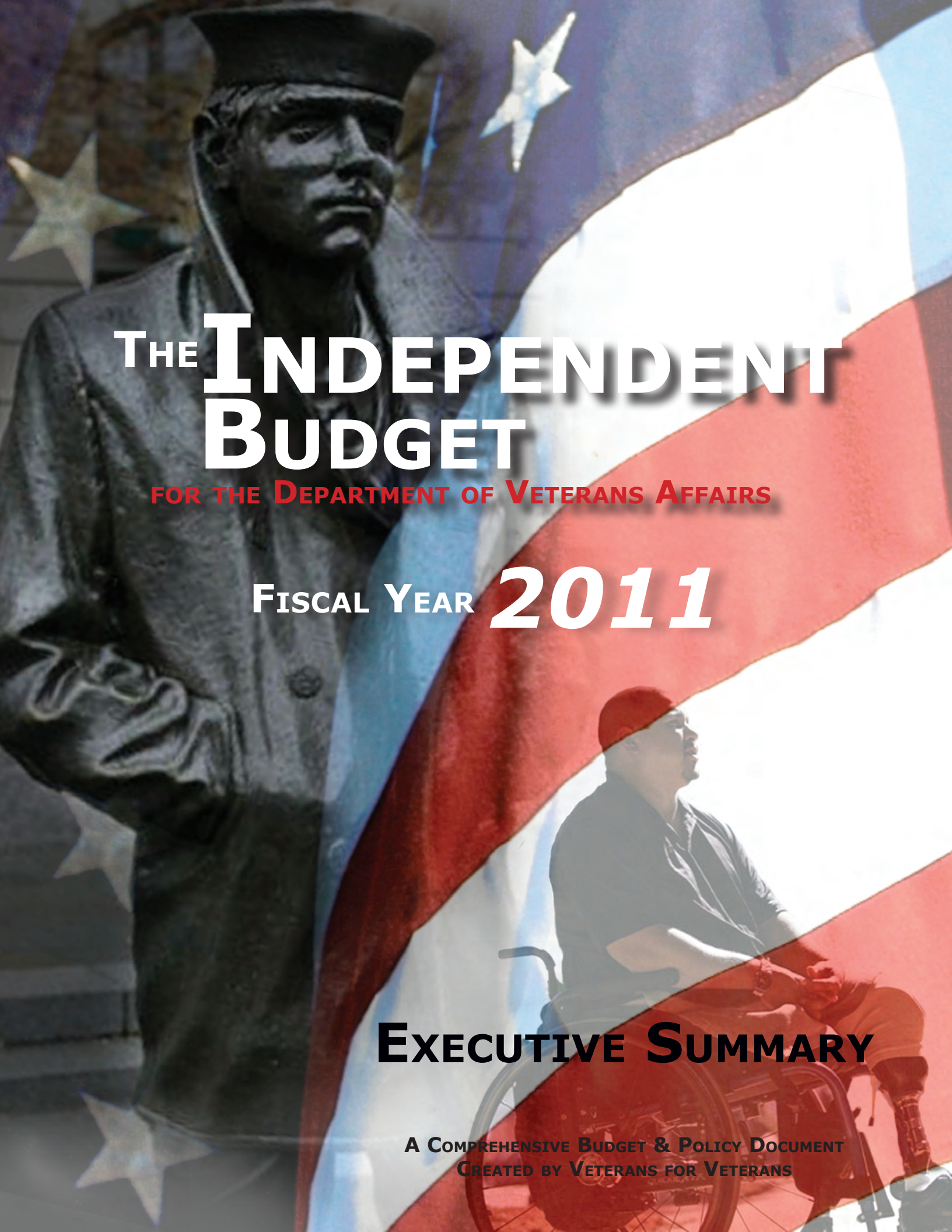


The Independent Budget

for the Department of Veterans Affairs

Fiscal Year 2011

Executive Summary

A Comprehensive Budget & Policy Document
Created by Veterans for Veterans

Prologue

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

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

The Independent Budget for Fiscal Year 2011 will be released in February 2010 concurrent with the release of the President's proposed budget for the Department of Veterans Affairs. This budget by veterans for veterans is designed to alert the Administration, Congress, VA, and the general public to the most important issues concerning VA health care, benefits, and benefits delivery that deserve special scrutiny and attention by policy makers. *The Independent Budget* presents specific funding, policy, and legislative recommendations for FY 2011 and medical care recommendations for FY 2012. Through these efforts we believe VA will be better positioned to successfully meet the challenges of the future. We intend that this document provides direction and guidance to the Administration and Members of Congress.

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

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

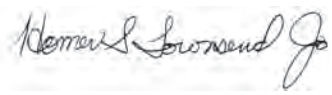
(Continued)

We are proud that this will mark the 24th year of *The Independent Budget*. We are equally proud of the respect and influence that it has gained during that time. The coauthors of this important document—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States— work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

We hope that each reader approaches this document with an open mind and a growing understanding that America's sick and disabled veterans should not be treated as the cannon fodder of war, but rather as the living price of freedom.

James B. King
National Executive Director
AMVETS

David W. Gorman
Executive Director
Disabled American Veterans



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The four coauthoring organizations of *The Independent Budget* (*IB*) have worked in collaboration for 24 years on the *IB* to honor veterans and their service to our country. Throughout the year, each organization works independently to identify and address legislative and policy issues that affect the organizations' memberships and the broader veterans community.

AMVETS

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

Disabled American Veterans

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

Paralyzed Veterans of America

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

Veterans of Foreign Wars of the U.S.

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

(Continued)

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

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

Supporters

Administrators of Internal Medicine
African American Post Traumatic Stress Disorder Association
African American Veterans and Families
African American War Veterans, USA
Air Force Association
Alliance for Academic Internal Medicine
American Association of People with Disabilities
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Military Retirees Association
American Military Society
American Psychological Association
American Veterans Alliance
Armed Forces Top Enlisted Association
Association for Service Disabled Veterans
Association of American Medical Colleges
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Specialty Professors
Association of the United States Navy
Blinded Veterans Association
Brain Injury Association of America
Catholic War Veterans, USA, Inc.
Clerkship Directors in Internal Medicine
Combined Korea and US Veterans Association
Enlisted Association of the National Guard of the United States
Fleet Reserve Association

Forty and Eight
Gold Star Wives of America
Iraq and Afghanistan Veterans of America
Japanese American Veterans Association
Jewish War Veterans of the USA
Kansas Commission on Veterans' Affairs
Lung Cancer Alliance
Mental Health America
Military Officers Association of America
Military Order of the Purple Heart of the USA, Inc.
National Alliance on Mental Illness
National Association for Uniformed Services
National Association of American Veterans, Inc.
National Association of Disability Representatives
National Association of State Head Injury Administrators
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Disability Rights Network
National Society of Military Widows
New Jersey Veterans Memorial Home at Paramus
Non Commissioned Officers Association of the USA
Nurses Organization of Veterans Affairs
Oklahoma Department of Veterans Affairs
Society of Cuban American Veterans
Society of Hispanic Veterans
United Spinal Association
United States Coast Guard CPOA/CGEA
United States Federation of Korea Veterans Associations
US-Korea Allies Council
Veterans Affairs Physician Assistant Association
Vietnam Veterans of America
Washington State, Office of the Governor

Guiding Principles

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

Acknowledgments

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Summary of Recommendations

As America begins the second decade of the 21st century, our country remains engaged in conflicts on two fronts. While the conflict in Iraq is currently waning, the intensity of the war on terrorism in Afghanistan is growing and extremely fierce. On December 1, 2009, President Obama announced he was committing an additional 30,000 troops to the war in Afghanistan.

It is against this dramatic backdrop of dire current military events that the four coauthors of *The Independent Budget (IB)*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—offer their budget and program recommendations based upon their unique expertise and experience concerning the resources that will be necessary to meet the needs of America's veterans in fiscal year (FY) 2011. These recommendations are designed to meet the needs of the thousands of young veterans currently serving in America's armed services who soon will require from the Department of Veterans Affairs (VA) the health care and financial benefits that they have earned and the needs of the millions of veterans from previous conflicts and service who currently depend on VA.

The Independent Budget for Fiscal Year 2011 represents the 24th consecutive year that these veterans service organizations have joined together to produce a comprehensive budget document highlighting the needs of elderly veterans as well as those of younger men and women who are returning from active duty. Currently, according to information from VA, developed by the National Center for Veterans Analysis and Statistics (08/03/09), America's veteran population is estimated to be 23,442,000, which includes 1,802,000 (8%) women. Of America's 23,442,000 million veterans, 7.84 million are enrolled in the VA health-care system, and 5.58 million of them are identified as unique individual patients who received care in VA facilities in 2008. Additionally, 3.03 million veterans receive disability compensation for injuries incurred during service to our country. Also, as of June 30, 2009, 323,189 spouses of deceased veterans rely on VA's dependency and indemnity compensation for the expenses of everyday living.

The Veterans Health Administration—similar to private sector health-care providers and other federal health-care programs, including Medicare, Medicaid, and TRICARE—is facing growing demand for services as America ages and medical treatment and administrative costs spiral upward. In addition to the rising medical operational costs, 39.4 percent of the total veteran population is 65 years of age or older. This group of elderly veterans has an increased demand for VA health care and long-term-care services. Additionally, the influx of new, and often severely disabled, veterans entering the VA system each month brings new demands for sophisticated medical care each year. Therefore, these complicated age-related treatment issues make accurate financial and personnel resource forecasting difficult but more important each year.

Year after year the coauthors of *The Independent Budget* conduct a comparative analysis of VA workload information and carefully review medical and administrative cost data that form the foundation of the *IB's* recommendations. The *IB* coauthors then call upon Congress and the Administration to provide sufficient funding to meet the health-care and financial benefit needs of veterans in a timely and predictable manner. Unfortunately, Congress often has been unable to complete the VA appropriation process prior to the beginning of VA's new fiscal year on October 1. In fact, FY 2010 was no different, as VA once again faced funding provided under a continuing resolution after October 1. As a response to these constant delays in the appropriations process, the *IB* veterans service organizations advocated for a reasonable solution that we believed would lead to sufficient, timely, and predictable funding—advance appropriations. We are pleased that Congress and the Administration recognized the need for funding reform of the VA health-care system by enacting historic advance appropriations legislation in fall 2009. We congratulate Congress and the President on this very important accomplishment and look forward to the day, in the not too distant future, when VA can properly plan to meet the many health-care demands of veterans.

With regard to veterans' benefits, the *IB* recommends that VA fast-track concrete steps that will help ameliorate nagging claims-processing barriers. Continuing studies to find solutions must be replaced by real action plans that produce positive results. 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 2011 provides recommendations for consideration by our nation's elected leadership that are based upon a rigorous and rational methodology designed to support the Congressionally authorized programs that serve our nation's veterans. The *IB* coauthors are proud that more than 60 veterans, military, medical service, and disability organizations have endorsed the FY 2011 edition of this important document. Our primary purpose is to inform and encourage the United States government to provide the necessary resources to care for the men and women who have answered the call of our country and taken up arms to protect and defend our way of life.

Table 1. VA Accounts FY 2011 (Dollars in Thousands)				
	FY 2010 Appropriation	**FY 2011* Administration**	**FY 2011 *IB***	**FY 2012** Advance Approp.**
Veterans Health Administration (VHA)				
Medical Services	34,707,500	37,136,000	40,940,954	39,649,985
Medical Support and Compliance	4,930,000	5,307,000	5,314,595	5,535,000
Medical Facilities	4,859,000	5,740,000	5,706,507	5,426,000
Subtotal Medical Care, Discretionary	**44,496,500**	**48,183,000**	**51,962,056**	**50,610,985**
Medical Care Collections	3,026,000	3,355,000		3,679,000
Total, Medical Care Budget Authority *(including Collections)*	**47,522,500**	**51,538,000**	**51,962,056**	**54,289,985**
Medical and Prosthetic Research	581,000	590,000	700,000	
Total, Veterans Health Administration	**45,077,500**	**48,773,000**	**52,662,056**	
General Operating Expenses (GOE)				
Veterans Benefits Administration	1,689,207	2,148,776	1,914,027	
General Administration	397,500	463,197	425,337	
Total, General Operating Expenses (GOE)	**2,086,707**	**2,611,973**	**2,339,364**	
Departmental Admin. and Misc. Programs				
Information Technology	3,307,000	3,307,000	3,552,884	
National Cemetery Administration	250,000	250,504	274,500	
Office of Inspector General	109,000	109,367	112,020	
Total, Dept. Admin. and Misc. Programs	**3,666,000**	**3,666,871**	**3,939,404**	
Construction Programs				
Construction, Major	1,194,000	1,151,036	1,295,000	
Construction, Minor	703,000	467,700	785,000	
Grants for State Extended Care Facilities	100,000	85,000	275,000	
Grants for Construct of State Vets cemeteries	46,000	46,000	51,000	
Total, Construction Programs	**2,043,000**	**1,749,736**	**2,406,000**	
Other Discretionary	166,000	164,738	170,482	
Total, Discretionary Budget Authority (including Medical Collections)	***56,065,207***	***60,321,318***	***61,517,306***	

*P.L. 111-117, "Consolidated Appropriations Act for FY 2010," included advance appropriations for FY 2011 for VA's Medical Care accounts (Medical Services, Medical Support and Compliance, Medical Facilities). Reevaluated estimates for FY 2011 were not included in the FY 2011 budget request.
**The FY 2011 Budget request includes estimates for the Medical Care accounts for FY 2012. The Government Accountability Office will examine the budget submission to analyze its consistency with the VA's Enrollee Health Care Projection Model for FY 2012.

Key *Independent Budget* Recommendations

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

The Department of Veterans Affairs must receive sufficient funding for veterans' health care in a predictable and timely manner.

The 111th Congress took a historic step toward providing sufficient, timely, and predictable funding in 2009, yet it still failed to complete its appropriations work prior to the start of the new fiscal year on October 1. The actions of Congress in 2009 generally reflected a commitment to maintain a viable VA health-care system. More important, Congress showed real interest in reforming the budget process to ensure that the Department will know exactly how much funding it will receive in advance of the start of the new fiscal year.

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership)—made up of nine veterans service organizations, including the coauthors of *The Independent Budget (IB)*—has advocated for reform in the VA health-care budget formulation process. In 2009 the Partnership made a concerted effort to attain this goal. By working with the leadership of the House and Senate Committees on Veterans' Affairs, the Military Construction and Veterans Affairs Appropriations Subcommittees, and key members of both parties, we were able to move advance appropriations legislation forward. At the beginning of the year, Representative Bob Filner (D-CA), chairman of the House Committee on Veterans' Affairs, and Senator Daniel Akaka (D-HI), chairman of the Senate Committee on Veterans' Affairs, introduced the "Veterans Health Care Budget Reform and Transparency Act" (House Resolution 1016/Senate Bill 423), legislation to guarantee that VA health-care funding be sufficient, timely, and predictable.

Once again in 2009, Congress provided historic funding levels for VA that matched, and in some cases exceeded, the recommendations of *The Independent Budget,* in the House and Senate versions of the Military Construction and Veterans Affairs Appropriations Bill. Unfortunately, as has become the norm, the bill was not completed prior to the start of the new fiscal year. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past two years, the larger appropriations process is completely broken.

Congress ultimately approved and the President signed into law Public Law 111-81, "Veterans Health Care Budget Reform and Transparency Act." A review of recent budget cycles made it evident that even when there is strong support for providing sufficient funding for veterans' medical care programs, the systemic flaws in the budget and appropriations process continue to hamper access to and threaten the quality of the VA health-care system. Now, with enactment of advance appropriations, VA can properly plan to meet the health-care needs of the men and women who have served this nation in uniform.

In February 2009, the President released a preliminary budget submission for the Department of Veterans Affairs for FY 2010. This submission only projected funding levels for the overall VA budget. The Administration recommended an overall funding authority of $55.9 billion for VA, approximately $5.8 billion above the FY 2009 appropriated level and nearly $1.3 billion more than *The Independent Budget* had recommended.

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

Funding for FY 2011

The Independent Budget has chosen to present budget recommendations for the Medical Care accounts specifically for FY 2011. Accordingly, for FY 2011, *The Independent Budget* recommends approximately $52.0 billion for total medical care, an increase of $4.5 billion over the FY 2010 operating budget level established by P.L. 111-117, "Military Construction and Veterans Affairs Appropriations Act for FY 2010." Included in P.L 111-117 was advance appropriations for FY 2011. Congress provided approximately $48.2 billion in discretionary funding for VA medical care. When combined with the $3.3 billion Administration projection for medical care collections in 2010, the total available operating budget provided by the appropriations bill is approximately $51.5 billion. We believe that this estimation validates the advance projections that *The Independent Budget* developed at the same time for FY 2011.

The Medical Care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2011, *The Independent Budget* recommends approximately $40.9 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Growth in patient workload is based on a projected increase of approximately 117,000 new unique patients—priority group 1–8 veterans and covered nonveterans. The IBVSOs estimate the cost of these new unique patients to be approximately $926 million. The increase in patient workload also includes a projected increase of 75,000 new Operation Enduring Freedom and Operation Iraqi Freedom veterans, at a cost of approximately $252 million.

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

As the IBVSOs have emphasized in the past, VA must have a clear plan for incrementally increasing this enrollment; otherwise, it risks being overwhelmed by the significant new workload. We are committed to working with VA and Congress to implement a workable solution to allow all eligible priority group 8 veterans who desire to do so to begin enrolling in the system.

Our policy initiatives have been streamlined to include immediately actionable items with direct funding needs. Specifically, we have limited our policy initiatives recommendations to restoring long-term-care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of VA) and centralized funding (based on actual expenditures and projections from the VA's prosthetics service). In order to restore the VA long-term-care average daily census (ADC) to the level mandated by P.L. 106-117, "Veterans Millennium Health Care Act,"*The Independent Budget* recommends $375 million. Finally, to meet the increase in demand for prosthetics, the *IB* recommends an additional $275 million. This increase in prosthetics funding reflects the significant increase in expenditures from FY 2009 to FY 2010 (explained in the section on Centralized Prosthetics Funding) and the expected continued growth in expenditures for FY 2011.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $5.3 billion, and, finally, for Medical Facilities, approximately $5.7 billion. The *IB* recommendation once again includes an additional $250 million for Nonrecurring Maintenance (NRM) provided under the Medical Facilities account. While we appreciate the significant increases in the NRM baseline over the past couple of years, total NRM funding still lags behind the recommended 2 percent to 4 percent of plant replacement value. Based on that logic, VA should actually be receiving at least $1.7 billion annually for NRM (see "Increase Spending on Nonrecurring Maintenance).

Advance Appropriations for FY 2012

Public Law 111-81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2012 and the VA Secretary to provide detailed estimates of the funds necessary for these medical care accounts in his budget documents submitted to Congress. Consistent with advocacy by *The Independent Budget,* the law also requires a thorough analysis and public report of the Administration's advance appropriations projections by the Government Accountability Office (GAO) to determine if that

information is sound and accurately reflects expected demand and costs to be incurred in FY 2012 and subsequent years.

It is important to note that this is the first year the budget documents will include advance appropriations estimates and it is not yet clear exactly what "detailed" information the Administration's budget submission will contain concerning the FY 2012 medical care request. This will also be the first time that the GAO examines the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model, and what recommendations or other information the GAO report will include. The Independent Budget looks forward to examining all of this new information and incorporating it into future budget estimates.

Recommendations:

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

To enable VA to accommodate potentially hundreds of thousands of priority group 8 veterans who may choose to use VA for health care, VA must carefully calculate the total costs to reopen the system to eligible veterans, and Congress must fully fund these costs. Funding supplements must cover full direct and indirect costs of the new workload demands these veterans will bring to the VA health-care system, including the financial impacts of new professional, technical, and administrative staffing required, and expanded or new physical facilities to accommodate their care.

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

The Continuing Challenge of Caring for War Veterans:

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

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

The DOD and VA share a unique obligation to meet the health-care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from postdeployment readjustment problems as a result of combat exposure and from chronic manifestations of older injuries and illnesses incurred in service. Without question, both agencies have done an extraordinary job in treating those who have suffered the most grievous polytraumatic injuries during current conflicts. But these deployments are also causing heavy casualties in what are considered the invisible wounds of war—PTSD, depression, substance-use dis-

orders, family disruptions and distress, and a number of other social and emotional consequences for those who have served. The DOD, VA, and Congress must remain vigilant to ensure that federal programs aimed at meeting the extraordinary needs of the newest generation of combat veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts. Congress must also remain apprised of how VA spends the significant new funds that have been provided and earmarked specifically for the purpose of meeting all enrolled veterans' mental health and physical rehabilitation needs, whether acute or chronic.

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

Traumatic Brain Injuries

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

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

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

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

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, DOD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these powerful detonations. Symptoms can include chronic headaches, irritability, 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 the development of best practices in its treatment; however, we suggest that any studies undertaken include veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. The medical and social histories of previous generations of veterans could be of enormous value to VA researchers interested in the likely long-term progression of brain injuries. Likewise, such knowledge of historic experience could help both the DOD and VA better understand the policies needed to improve screening, diagnosis, and treatment of mild-to-moderate TBI in combat veterans of the future.

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

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

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

Better Case Management and Caregiver Support Are Essential

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

Both the DOD and VA health-care systems are limited in authority as well as capacity to provide mental health and relationship counseling services to family members—an important component of the postdeployment rehabilitation process for veterans and their families. However, the IBVSOs have been informed by a few local VA officials that they are providing a significant amount of training, instruction, counseling, and other services to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the possible absence of legal authority to provide

these services and that scarce resources are being diverted to these needs without recognition of their cost within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency and validity of this need.

The IBVSOs believe Congress should authorize, and VA should provide, a full range of psychological counseling and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and continuous burden of caring for a severely injured and permanently disabled veteran. Also, we believe VA should establish a new national program to make periodic and flexible respite services available to all severely injured veterans. Two bills are currently pending in Congress that would advance caregiver support services, but these bills are currently awaiting further action by both chambers.

Substance-Use Disorder

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

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

Suicide

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

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

Women Veterans

The number of women now serving in our military forces is unprecedented in U.S. history, and women are playing extraordinary roles in the conflicts in Iraq and Afghanistan. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, and military police officers and serve in other military occupational specialties that expose them to combat and the risk of injury and death. To date, more than 100 women have been killed in action, and many have suffered serious mental health problems, including post-combat PTSD and grievous injuries, including multiple amputations, severe TBI, and burns. The current rate of enrollment of women in VA health care constitutes the most dramatic growth of any subset of veterans. According to VA, since 2002, 42.2 percent of women who deployed in OEF/OIF and have since been discharged from military service have enrolled in VA health care.

One issue of particular concern to the IBVSOs relates to the acknowledgement of combat exposure for women service members during OEF/OIF deployments. The PBS documentary film *Lioness* tells the story of the first group of women Army support soldiers who were assigned to all-male Marine units in the Al Anbar province of Iraq during some of the toughest fighting seen in that region. The role of the Lioness was, and is, to defuse tension with Iraqi women and children during searches of their homes and their persons. When these American women first deployed to Iraq, they performed their original military occupational specialty (MOS) duties including truck mechanic, clerk and engineer, but were then called to serve in a different capacity inside these combat arms units.

The Lioness teams are still being deployed today in both Iraq and Afghanistan, and unfortunately, starting from the first teams to the present, this "extraordinary" service is not routinely noted in key official DOD records, including the DD-214 or veterans military discharge certificate. This absence of documentation makes following up their care for PTSD or other post-deployment mental health readjustment issues difficult when their worst hurdle is having to *prove* that they served their country in this capacity and were exposed to combat.

A great deal of guidance is given to VA compensation claims development and rating specialists on various service medals and devices that can be used to support PTSD claims and on how to use DOD resources to corroborate possible combat-related traumatic exposures. However, in the case of many Lioness team members, no Combat Action Award was provided and no other documentation exists in their discharge papers or in their military records to confirm participation in this unique program.

We are aware that former servicewomen, particularly those who volunteered during the early stages of the Lioness program, have encountered difficulties in gaining recognition for their service, both within the military branches and when they leave active duty and seek subsequent assistance from VA. Some former Lioness members report they have had to find their own witnesses and the documentation needed for recognition of their actions under fire and to establish their combat experiences while deployed, in order to establish claims for disability benefits from VBA. We remain concerned that there is no mechanism in place within the military services to properly document service member participation in unique operational missions outside of the requirements of their assigned MOS, such as Lioness duty.

Several of the women featured in the *Lioness* documentary discussed the difficulties they personally experienced in accessing VA health care and benefits related to post-deployment mental health issues. One female veteran reported that her male Vet Center counselor found it difficult to believe she had participated in dozens of missions in which she was armed and engaged in ground combat. She hoped that in the future VA would be better prepared, and she recommended VA hire more female Vet Center counselors, therapists, and OEF/OIF veteran peer counselors.

Another woman reported she had been service connected for PTSD—but at 0 percent disabling, even though she complained of chronic disturbing memories, difficulty sleeping, and anxiety. Clearly, the lack of documentation in these cases makes it more difficult for adjudicators to establish service connection for conditions related to military service. For these reasons we encourage DOD and VA to collaborate to ensure the military services document the additional duties some service members perform and that VHA and VBA staff become more aware of these special duties women are asked to carry out in today's armed forces.

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

Recommendations:

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

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 (PTSD), and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

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

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

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

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on those who have served in Iraq and Afghanistan. Congress should enact legislation to support VA improvements in women's health programs for all women veterans.

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

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[1] *National Journal,* Vol. 41, No. 38, September 19, 2009, 24–31.
[2] Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan: Hearing before the House Committee on Veterans Affairs, 110th Cong., 1 (2007) (testimony of Matthew Goldberg, deputy assistant director for National Security, Congressional Budget Office).
[3] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research, at xx (T. Tanielian & L. Jaycox eds., 2008).
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary, RAND Center for Military Health Policy Research, at xxii (T. Tanielian & L. Jaycox eds., 2008).
[8] Ibid.
[9] Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary, RAND Center for Military Health Policy Research, at xxiii, (T. Tanielian & L. Jaycox eds., 2008).
[10] Follow Up Health Care Inspection: Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation, VA Office of Inspector General Report No. 08-01023-119 at 8, (2008).

Claims Process Improvements Needed:

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

The Department of Veterans Affairs administers a complex set of laws and regulations designed to compensate veterans for the average impairment of earnings capacity due to disabilities (the residuals of disease or injury) incurred coincident with or as a result of military service.

The payment of veterans disability compensation requires a decision that each claimed disability be related to service, a medical examination for each service-connected disability to assess the severity or impairment of the condition, and the assignment of a numerical evaluation for each condition. Finally, the decision-

maker must select an effective date of service connection for each condition and the level of severity for each disability, and, if the disability worsened during the pendency of the claim, determine whether higher evaluations should be assigned at different points of time during that period.

The adjudication of compensation claims is complex and time-consuming. The policy of linear or serial development creates many problems. It extends the process and results in a loss of trust among veteran-claimants. Failure to develop evidence correctly requires serial redevelopment, which delays claims resolution and increases opportunities for mistakes. Further, inadequately trained employees fail to recognize claims that have been adequately prepared for rating purposes. The lack of effective on-the-job training, as well as the failure to involve program expertise (senior veteran service representatives (VSRs) and rating veteran service representatives (RVSRs)) earlier in the process, are critical failures. As a consequence, VA routinely continues to develop many claims rather than making timely decisions. Processing policy should be changed to get claims into the hands of experienced technicians (journey-level VSRs or RVSRs) earlier in the process so that issues with sufficient evidence can be evaluated, while development of other outstanding issues continue (as directed by those technicians).

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

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

On the surface, the disability claims process appears simple: A veteran applies for compensation or pension; VA develops evidence necessary to decide the claim; and VA evaluates the evidence, applies the facts to the law, and grants or denies benefits. However, the complexity of the statutes and regulations requires careful analysis before a proper decision can be made.

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

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

It is difficult to maintain quality control when individual performance reviews are limited to five cases per month and when there is virtually no oversight on the propriety of end-product closures. There is virtually no in-process quality control that could detect errors before they create undue delays and provide real-time feedback to technicians.

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

There is ample room to improve the law in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assistance Act (VCAA) notice letter. Under current notice requirements and in applicable cases, VA's letter to a claimant normally informs the claimant that he or she may submit a private medical opinion. The letter

also states that VA may obtain a medical opinion if it decides to do so. However, these notice letters do not inform the claimant of what elements render private medical opinions adequate for VA rating purposes. To correct this deficiency, the IBVSOs recommend that, when VA issues proposed regulations to implement the recent amendment of title 38, United States Code, section 5103, its proposed regulations contain a provision that will require it to inform a claimant, in a VCAA notice letter, of the basic elements that make medical opinions adequate for rating purposes.

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

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

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

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

Modifying regional office jurisdiction regarding supplemental statements of the case (SSOCs) will improve the timeliness of the appeals process. In the current process, when an appeal is not resolved, the VA regional office (VARO) will issue a statement of the case (SOC) along with a VA Form 9 to the claimant, who concludes, based on the title of the Form 9 (Appeal to the Board of Veterans' Appeals) that the case is now going to the BVA.

Consequently, the veteran may feel compelled to submit additional or repetitive evidence in the mistaken belief that his or her appeal will be reviewed immediately by the BVA. But the VARO issues another SSOC each time new evidence is submitted. This continues until VA finally issues a VAF-8, Certification of Appeal, which actually transfers the case to the BVA.

The IBVSOs propose an amendment to this process that will explain that evidence submitted after the appeal has been certified to the BVA will be forwarded directly to the BVA and not considered by the regional office *unless* the appellant or his or her representative elects to have additional evidence considered by the regional office. This opt-out clause merely reverses the standard process without removing any rights from an appellant. The IBVSOs believe this change should result in reduced appellant lengths, much less appellant confusion, and nearly 100,000 reduced VA work hours by eliminating, in many cases, the requirement to issue supplemental statements of the case. A legislative change, amending 38 U.S.C. § 5103 in a manner that would incorporate an automatic waiver of jurisdiction of regional office jurisdiction authorizing VA to allow the veteran to instead opt out of having his or her case be transferred to the BVA would grant this flexibility. Additional legislative modification could provide greater flexibility to the appeals process as well by substantially reducing the issuance of SSOCs.

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

Recommendations:

Congress should require the Secretary to establish a quality assurance and accountability program that will detect, track, correct, and prevent future errors and to create a work environment that properly aligns incentives with goals and holds both VBA employees and management accountable for their performance.

Congress should modify current "duty to assist" requirements that VA undertake independent development of the case, including gathering new medical evidence, when VA determines the claim already includes sufficient evidence to award all benefits sought by the veteran.

Congress should allow the Board of Veterans' Appeals to directly hear new evidence in cases certified to it, rather than require VA's regional offices to hear the evidence and submit supplemental statements of case.

Congress and VA must develop and deploy a new electronic document management system, capable of converting all claims-related paperwork into secure, official electronic documentation that is easily accessible and searchable by all official personnel involved in the process.

[1] *BVA Dispositions by VA Program, 2008*, Report of Chairman, Board of Veterans' Appeals, 4/23/2009, 5.

Human Resources Needs Continue to Challenge the Department of Veterans Affairs:

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

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

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

In order for VA to continue to build a reputation as an "employer of choice," it must work to (1) refine and modernize human capital policies and procedures, specifically in the areas of recruitment, retention, and succession planning; and (2) provide and create satisfying work environments that encourage scholarship, professional development, and career advancement. VA must also work to reach out to the trained and qualified community of veterans who are potential candidates for VA employment. Ultimately, VA must provide efficient, safe, and productive work environments that attract high-caliber professionals in order to successfully execute the vital VA mission: caring for America's veterans.

Current VA Workforce and Its Future Needs

One of VA's greatest challenges is dealing effectively with succession—especially in the health sciences and technical fields that so characterize contemporary American medicine and health-care delivery.

VHA's Succession Strategic Plan for FY 2009 reports that VHA now faces a succession challenge unprecedented in its history. To meet the needs of America's veterans, it is essential that employee education and development programs, leadership succession planning, and recruitment and retention initiatives be moved forward so that VA can ensure it has talented people with the right skills, experience, and competencies in the right jobs at the right time. For example, the competition for skilled health-care providers and employees with leadership excellence has never been greater. Also, VA has an unprecedented backlog of 1 million disability claims it must process, a supremely labor-intensive requirement.

In the 2009 workforce strategic plan, VA reports that, with respect to health care, "onboard strength in VHA increased by 12.2 percent during the past five years, and an enormous increase in onboard strength of 9.1 percent at the end of FY 2008 was the result of numerous special initiatives including mental health, rural health, and Operations Enduring and Iraqi Freedom (OEF/OIF) initiatives along with federal recovery coordination and consolidation of collection centers throughout VHA."[1] Onboard strength for full- and part-time employees increased by 4.5 percent in FY 2009, and VA also predicts that new employees will increase by 9.3 percent between the end of FY 2009 and FY 2014.[2]

VA reports that by FY 2014, approximately 40.7 percent of the current workforce will be eligible for (or will take) retirement.[3] VHA's Work Force Succession Strategic Plan 2009–2014 estimates that 14 percent of nursing personnel (5,640) are currently eligible for voluntary retirement, and in 2013, 20.1 percent (8,955) of nurses currently working are projected to be eligible to retire. In its assessment of current and future workforce needs, the VHA identified registered nurses (RNs) as its top occupational challenge, with licensed practical/vocational nurses in fourth place, and certified registered nurse anesthetists also among the top 10 occupations with critical recruitment needs.[4]

The VHA is facing the challenge of an increasing percentage of workers becoming eligible for retirement, while moving toward an even more diverse, multigenerational workforce. At the end of FY 2007, 11.5 percent of VHA employees were eligible for regular retirement. Between FY 2008 and FY 2014, 88,700 employees, or approximately 40 percent of the current workforce, will be eligible to retire, and it is estimated that 50,400 of those employees will take regular retirement. Leadership positions will experience an even greater percentage of losses from retirement. For example, by 2014, 83 percent of VA nurse executives will be eligible for, or will have taken, regular retirement.[5] VA reports that approximately 40.7 percent of the current registered nurse workforce and 31.7 percent of current licensed practical/vocational nurse workforce will be eligible or will take retirement by 2014.[6]

In addition, in the workforce strategic plan, VA states that "the average age of VHA employees increased from 45.4 in FY1997 to 48.2 in FY2007, and the average age of permanent new hires has increased from 38.5 in FY1998 to 41.9 in FY 2007."[7] VA also concludes that "personnel are working beyond their eligible retirement age and the recent increases in RN employment may be due to economically-driven boosts in hours and reentry among RNs who might not otherwise participate in the labor market; VHA retention practices together with economic considerations may be keeping the 'baby boomer' generation in the workforce longer, although their employment in VHA cannot be sustained indefinitely."[8]

Veterans Health Administration Needs to Lead

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

VA Registered Nurses

Two national issues are directly contributing to America's national nursing shortage. First, the number of new students entering nursing education programs is insufficient to meet rising demand for nurses; and second, the heightened age and lower numbers of nursing educators has forced nursing schools to restrict or deny applicants into entry-level nursing baccalaureate educational programs.

According to projections from the U.S. Bureau of Labor Statistics in the November 2005 *Monthly Labor Review,* 1,203,000 new RNs will be needed by 2014 to meet job growth and replacement needs. VA must develop a recruitment strategy that attracts and encourages nursing students and new nurse graduates to commit to VA employment by using and increasing educational loan repayment programs and recruiting from local nursing schools. VA must also work to recruit and retain nurses who 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.

The American Federation of Government Employees reported that, in 2007, 77 percent of all RN resignations within VA occurred in the first five years of employment, and the average VA-wide cost of turnover is $47 million per year for nurses. Given the loss of productivity, risks to patient care, and waste represented by such early departures from VA employment, VA simply cannot afford to ignore the concerns of its nurses in the areas of job satisfaction, compensation, and other conditions of employment.

VA must also develop and implement innovative personnel programs that allow for nurse representation and input when facility management makes personnel decisions. The National Commission on VA Nursing report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce,* cited professional development, work environment, respect and recognition, and fair compensation as a few areas that VA must focus on to become an employer of choice for today's nurse population.[9] The commission also recommended that the VHA provide career development opportunities for nurses that enhance their ability to reach professional goals, develop and implement national staffing standards to properly allocate nursing resources and promote patient safety, and expand recognition of nurse achievements and high performance. The IBVSOs continue to support the commission's recommendations and believe that they still serve as a sound template for improvements to VA policies and procedures that govern its health-care workforce.

With regard to nurse compensation, VA must ensure that facility managers are using locality pay and financial incentives, such as retention bonuses, to compete with private sector employers. VA must also work to consistently administer locality pay policies that are based on true local labor market conditions, as well as overtime and premium pay policies for nurses that are in accordance with VA policy.

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

In order to retain a well-trained and qualified nursing staff, it is important that VA work to provide a stimulating work environment that provides educational opportunities and allows nurses, and all medical staff, a healthy work-life balance while ensuring the delivery of efficient care to veterans.

VA Physicians

With respect to VA physicians, a key component of providing quality care and retaining a qualified physician workforce is maintaining an appropriate patient workload. VA must make certain that medical centers are staffed with a sufficient number of physicians in relation to patients to ensure that veterans receive adequate medical attention. About 2,500 (16 percent) of VA physicians are currently eligible for voluntary retirement, and it is projected that by 2012 this number will grow to 2,909 (17 percent).[10] VA must work to offset the loss of experienced personnel and employ recruitment tools that attract and retain high-caliber physicians. Such recruitment strategies include guaranteeing that VA physicians have opportunities for continuing education, research, and fully utilizing existing academic partnerships.

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

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

Certified Registered Nurse Anesthetists

Over the past few years, the demand for certified registered nurse anesthetists (CRNAs) has steadily grown within the private and public nursing sectors. As the need for CRNAs increases, VA becomes more challenged to recruit and retain these professionals. In a December 2007 report, the U.S. Government Accountability Office (GAO) reported that more than half of VA CRNAs are older than 51, and are seven years closer to retirement eligibility than the average CRNA nationally.[11] The GAO further reported that 54 percent of VA medical facility chief anesthesiologists surveyed reported temporarily closing operating rooms, while 72 percent reported delaying some elective surgeries, because no CRNAs were available for the procedures.

The GAO concluded that VA is having difficulty recruiting and retaining CRNAs because it is not providing competitive salaries in comparison to the national labor market. According to the American Association of Nurse Anesthetists, the average turnover and retirement rate for VA CRNAs is approximately 19 percent. VA must vigorously work to retain its current CRNA workforce by providing for professional development opportunities that include developing career paths and internal promotions for CRNAs and individual funding for educational advancements. The GAO reports that many VA facilities are not properly using the VA locality pay system; thus VA CRNAs' salaries have not been adjusted properly and are less competitive with other employers in the health-care industry.[12] It is essential that VA provide adequate oversight to ensure that all facilities are using locality pay correctly and consistently.

Certified registered nurse anesthetists provide the majority of anesthesia services for veterans receiving care in VA medical facilities. Therefore, VA must make certain that this vital service of care for veterans is not compromised by VA's inability to succeed in a competitive market for CRNAs. The IBVSOs believe that VA must utilize recruitment bonuses and educational incentives to help offset the differences in salaries between the private sector and VA to recruit new CRNAs. VA must also work with local nursing schools for CRNA training to recruit nurses receiving a master's degree in anesthesiology and encourage current VA RNs to consider careers as anesthetists.

Mental Health Professionals

According to the American Psychological Association, VA is the largest single employer of psychologists in the nation. The demands placed on VA's mental health service have increased dramatically because of the conflicts in Afghanistan and Iraq. Congress and VA have recognized the need to increase the number of psychologists and have added more than 800 since 2005; however, it should be noted that these increased psychology staffing levels are a recent development.

In all, VA's report of hiring several thousand new mental health professionals includes individuals whom VA has identified as having been offered and accepted positions in mental health, but some of these individuals are not yet providing care for veterans. The length of time for a facility to receive allocated funds for staffing, advertise and recruit for a position, and interview and complete credentialing and security clearances is extremely long. VA officials in the field have reported to the IBVSOs that it is common for nine months or more to pass from the beginning to the end of this process. In some instances it has been reported that candidates who committed to a VA position withdrew their applications because they simply could not wait the number of months needed to complete the hiring process. New graduates are particularly vulnerable to delays in employment offers. When a candidate withdraws after accepting employment, VA must restart the recruitment process. While we have no national statistics on VA's hiring lag time, we believe that it takes four to five months between VA's tentative offer and an applicant's reporting to duty.

The VHA has distributed an unprecedented performance measure to field managers and human resources staffs to improve the hiring process. This measure establishes a 30-day goal to bring new employees on board after they

accept employment with the VHA, which is reportedly one-third of the current length of time it takes the VHA to fully hire a new employee. Even if this goal is achieved, VA's average hiring lag will still be expressed in months. This lengthy hiring process deters new applicants and potentially leads to inefficient use of personnel funds.

In 2006, the GAO issued a report critical of VA's hiring practices in mental health.[13] In the report, the GAO concluded that VA lacked proficiency in spending the funds allocated for hiring and paying mental health professionals. The IBVSOs believe that in most instances, VA is not using all of these funds because of the delays in the hiring process. The longer it takes VA to hire and encumber a new employee, the less likely it is that VA will use the full amount of funding provided for that employee's salary in the remainder of the fiscal year. It is essentially impossible for facilities to spend more than a fraction of funds associated with new positions during a new employee's first year. VA must work to speed up the hiring process for mental health providers, particularly if it intends to refashion its mental health programs with a focus on veteran wellness and recovery. VA must also strive to retain and promote its more experienced mental health practitioners in order to meet new training and supervision requirements for new providers.

Physician Assistants

The IBVSOs are concerned about the growing problem of recruitment and retention of physician assistants (PAs). The VHA Handbook on Physician Assistant Qualification Standards has not changed since 1993, and since 2002, new recommendations dealing with qualifications have not been approved within VHA or the Office of Human Resources, despite a five-year average turnover rate of 14 percent, with an average loss of 125 PAs each year. In the final quarter of FY 2009, VA lost another 98 PAs to retirements and resignations. In the most recent Congressional legislation on recruitment and retention, the VHA never requested any changes, such as incentives or locality pay for PAs, despite this retention problem in this key occupation.

Although the overall VA PA workforce has grown by 19 percent over the past five years, the percentage of VHA midlevel practitioners who are PAs has dropped to 30 percent. We believe that this decline directly relates to recruitment and retention. VA has acknowledged, as indicated previously, that an increasing physician shortage and nursing shortage exists in this country, especially in primary care, at a time when the number of VA patients is expected to increase significantly. Recruitment and retention of nonphysician patient care providers, including PAs, will be critical to meeting VA's patient care needs. To meet this challenge for optimal utilization of PAs, all barriers to effectively address VA recruitment and retention issues must be addressed soon.

According to the American Association of Physician Assistants' (AAPA) 2008 census report, PA employment in the federal government, including VA, continues to decline. AAPA's Annual Census Reports of the PA profession from 1991 to 2008 document an overall decline in the number of PAs who report federal government employment. In 1991, nearly 22 percent of the total profession was employed by the federal government. This percentage dropped to approximately 9 percent in 2008. New graduate census respondents reported they were even less likely to be employed by the government (17 percent in 1991, down to 5 percent in 2008).[14]

Concerns about "Hybrid Title 38-Title 5" Appointments

Congress has authorized so-called "hybrid" appointment authorities in two dozen VHA career fields, such as practical nurse, psychologist, blind rehabilitation specialist, and social worker. While the availability of this hybrid appointment authority has been a boon to VA because of the flexibility it provides in setting grade levels and determining qualification and classification standards for these positions, a number of problems persist that prevent VA from taking full advantage of its usefulness, and impede career advancement for individuals affected by this program. For example, in the case of prosthetic representative and prosthetist/orthotist, the IBVSOs have been advised that the qualification standards for these positions do not take full account of the complexity of the prosthetics service and laboratory, or the varied and complicated facets of the host medical centers where these positions are deployed. Complexity levels, research laboratories, and academic affiliation, for example, ought to influence grade levels for these positions as well as the number of positions necessary.

An important contributor to the effectiveness of a prosthetics laboratory is employment of technical staff (e.g., prosthetic fitters and technicians). Since the management of these positions is still governed under title 5, United States Code, VA facilities have great difficulty hiring qualified candidates for these relatively low-level positions because they should technically be under title

38, hybrid. Consequently, the higher-skilled prosthetists and orthotists are forced into duties that should be performed by lower-level staff. To provide for proper staff mix to meet the standards of private laboratories, VA should promote the employment of fitters and technicians, and it should eliminate noncertified practitioners except in the case of postresidency placements.

An additional element of concern about the prosthetics career field relates to grade levels. The current qualifications standards lack a career pathway to the GS-15 grade level for the most senior leaders in this field.

Outmoded Human Resource Policies

VA must work aggressively to eliminate outdated, outmoded VA personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment. The IBVSOs have received recurring reports indicating that appointment of a new employee within the VHA can consume up to 90 days. In some professional occupations (especially physicians and nurses), many months can pass from the date of a position vacancy until the date a newly VA-credentialed and privileged professional health-care provider is on board and providing clinical care to veterans.

The inability to make employment offers and confirm them in a timely manner, especially to new graduates it has helped to 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. The VHA (especially including local facility managements) must be held accountable at all levels for improving human resources policies and practices. Congress should require VA to report its efforts to improve recruiting, retention, and environmental/organization practices to 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.

VA Succession Planning, Recruitment, and Retention

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

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

Existing VA loan repayment and scholarship programs were established by Congress to provide individuals interested in VA nursing with the financial support they need to enter and stay in the field. Both a recruitment and retention tool, the centrally funded Employee Incentive Scholarship Program (EISP)[15] pays up to $35,900 for "health care-related academic degree programs."[16] VA testified that since its inception in 1999 through 2007, "approximately 7,000 VA employees have received scholarship awards for educational programs related to title 38 and 'hybrid' title 5-title 38 VA occupations. About 4,000 employees have graduated from academic programs under these auspices. Scholarship recipients include registered nurses (93 percent), pharmacists, physical therapists, and other allied health professionals. A five-year VA analysis of program outcomes demonstrates this program's impact on VA employee retention."[17]

According to further testimony provided by VA in April 2008:

> The VA Education Debt Reduction Program (EDRP) provides tax-free reimbursement of existing education debt of recently hired title 38 and hybrid employees. Centrally funded, the EDRP is the title 38 equivalent to the Student Loan Repayment Program administered by the Office of Personnel Management for title 5 employees. More than 6,000 VA health-care pro-

fessionals have participated in the EDRP. The maximum amount of an EDRP award is limited by statute to $48,000 in exchange for five years of service. As education costs have risen, the average award amount per employee has increased over the years from about $13,500 in FY 2002 to more than $29,000 in FY 2007. While employees from 34 occupations participate in the program, 75 percent are from three mission critical occupations-RN, pharmacist, and physician. The rate of losses from resignation of EDRP recipients is significantly less than that of non-recipients as determined in a 2005 study.[18]

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. Additionally, VA must ensure that the funds associated with both programs are delivered in a timely manner to guarantee availability to employees. These programs have proven themselves to be cost-effective recruitment tools and to provide strong incentives for individuals to remain in VA employment rather than to go elsewhere.

Veterans Benefits Administration

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

With the influx of these new benefits personnel, it is difficult for the IBVSOs as observers to predict that ongoing challenges faced by the VBA are still the result of staffing shortages. In fact, such is the size of the claims backlog that it would be naïve to expect an immediate reduction in the VBA workload. Such an expectation is defeated merely by the time required for new employees to gain necessary experience, and the productivity 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 and providing a work environment for new and existing employees that promotes high productivity and job satisfaction. With such a strenuous and overwhelming workload, VA must use training and performance incentives to attract and retain VBA adjudication staff. When consistently administered throughout VA, incentives such as retention bonuses, awards of recognition for successful completion of training, or performance-based flexible scheduling and telework opportunities have the potential to serve as effective recruitment tools, as well as programs that boost employee morale and job satisfaction.

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

Veterans and VA Employment

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

However, action is necessary in a number of areas to ensure that veterans have greater opportunities to enter and remain part of VA's workforce. First, VA should seek out jobless veterans for positions for which they are qualified. Second, Congress should amend either title 38 or title 5, United States Code, to reverse a federal appeals court decision holding that title 38 employees are not covered by the Veterans Employment Opportunities Act.[19] Third, VA should ensure that veterans preference–eligible individuals are properly acknowledged and rated for their military occupational specialties when seeking VA employment (for example, medics or corpsmen applying for licensed vocational or practical nurse positions should receive significant credit for their prior experience). Finally, to ensure that these protections are enforceable, VA human resources management officials should adopt a tracking system, similar to the system used for tracking employment discrimination data, to ensure qualified veterans are an employment priority for VA.

Recommendations:

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

VA must implement an energized succession plan in VA medical and regional office facilities that utilizes the experience and expertise of current employees, as well as 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 Veterans Benefits Administration.

VA must ensure that VA facility managers are using locality pay and financial incentives authorities (such as retention bonuses) as intended by Congress, to compete effectively for the available labor pool. VA must improve its process to consistently administer locality pay policies that rely on true local labor market conditions, as well as the use of overtime and premium pay policies for clinical staff and others, that are in accordance with VA policy and fully compliant with labor law.

VA must improve exit surveys so that, as employees terminate employment, it can secure reliable data that will aid VA in replacing vacant positions in a timely manner and to determine if conditions of employment, human resources policies, management issues, or other contributing factors need revisions.

Congress must provide further oversight to ensure adequate implementation of Public Law 108-445 and enact legislation that is currently pending that would improve VA human resources management programs and practices.

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, traumatic brain injury, and polytrauma, to ensure VA is adequately staffed to meet these specialized responsibilities.

VA must improve its use of title 38-title 5 "hybrid" appointment authority in the VA health-care system, to take full advantage of the flexibility inherent in this unique appointment authority.

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

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

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

Congress and VA should ensure veterans preference is emphasized in VA human resources management activities and that veterans remain important targets for VA recruitment.

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[1] *Workforce Succession Strategic Plan 2009,* Department of Veterans Affairs, Veterans Health Administration, 7.
[2] Ibid., 9.
[3] Ibid., 30.
[4] Ibid., 28.
[5] Ibid., 2.
[6] Ibid.
[7] Ibid., 9
[8] Ibid.
[9] National Commission on VA Nursing, 2002-2004, final report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce,* March 2004.
[10] Department of Veterans Affairs, Veterans Health Administration Workforce Succession Strategic Plan FY 2008–2012.
[11] GAO-08-56.
[12] Ibid.
[13] GAO-07-66.
[14] American Academy of Physician Assistants, *2008 Census National Report*. http://www.aapa.org/about-pas/data-and-statistics/aapa-census/2008-data.
[15] 38 U.S.C. §§ 7671-7675. Established by Public Law 105-368, Title VIII, the Department of Veterans Affairs Health Care Personnel Incentive Act of 1998, and amended by Public Law 107-135, Department of Veterans Affairs Health Care Programs Act of 2001.
[16] April 9, 2008, testimony of Marisa Palkuti, M. Ed., director, VA Health Care Retention and Recruitment Office.
[17] Ibid.
[18] Ibid.
[19] *Scarnati v. Dept of Veterans Affairs*, 344 F. 3d 1246 (Fed. Cir. 2003).

Seamless Transition from the DOD to VA:

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

As service members return from the conflicts in Afghanistan and Iraq, the Departments of Defense and Veterans Affairs 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. Although improvements have been made in recent years, 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 the DOD to VA were never more apparent than during the controversy surrounding Walter Reed Army Medical Center in 2007. While much of the media coverage concentrated on the difficulties at Walter Reed regarding the care for injured service members, the real problems reflected many of the administrative difficulties associated with transitioning from the DOD to VA.

The IBVSOs continue to stress the points outlined by the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report released in May 2003, and reinforced by the President's Commission on Care for America's Returning Wounded Warriors in September 2007, as well as four other major studies regarding the transition of service members to veteran status. One of the 20 recommendations made by the PTF and those made by the commission was for increased collaboration between the DOD and VA for the transfer of personnel and health information. Great progress has been made in this area by VA; however, this recommendation remains only partially implemented. Testimony in July 2009 to the House Committee on Veterans' Affairs by the Government Accountability Office (GAO) noted that the DOD and VA are still not sharing all electronic health information and that information is still being captured in paper records at many DOD facilities.[1] Whereas progress is being made in the sharing of viewable social history data and physical examination data, and the operation of secure network gateways, demonstration of "initial" document scanning has required substantial additional work past the September 2009 deadline to meet clinicians' needs.

Health Information

The IBVSOs believe the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and bidirectional, allowing for a two-way, real-time electronic exchange of health information and occupational and environmental exposure data. Such an accomplishment could increase health information sharing between providers, laboratories, pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase knowledge and understanding of the clinical, safety, quality, financial, and organizational value and benefits of health information technology. Lessons learned from current conflicts and previous wars also indicate that the DOD must accurately collect medical and environmental exposure data electronically while personnel are still in theater. But it is equally important that this information be provided to VA. Electronic information should also include an easily transferable electronic DOD Form DD-214 (service and discharge record) forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the veteran 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. Although this has occurred at several levels, the current need is for a common standard. In May 2007, the DOD established the Senior Oversight Committee (SOC), chartered and cochaired by the Deputy Secretaries of the DOD and VA with the goal to identify immediate corrective actions and to review, implement, and track recommendations from a number of external reviews. As a result of this recognized need, one of the issues identified for

action was DOD-VA data sharing. The SOC approved initiatives to ensure health and administrative data are made available. These initiatives include the Federal Health Information Exchange (FHIE), the Bidirectional Health Information Exchange (BHIE), and the Clinical Data Repository/Health Data Repository interface between DOD and A health data repositories (CHDR).

To expedite the exchange of electronic health information between the two departments, the National Defense Authorization Act for Fiscal Year 2008 included provisions directing the DOD and VA to jointly develop and implement data sharing by September 30, 2009. In conjunction with interoperability capabilities previously achieved through the FHIE, BHIE, and CHDR, the DOD and VA believed the achievement of six objectives would be sufficient to satisfy the requirement for full interoperability by September 2009: (1) to refine social history data; (2) to share physical exam data; 3) to demonstrate initial network gateway operation; (4) to expand questionnaires and self-assessment tools; (5) to expand Essentris in DOD (also called the Clinical Information System—a commercial health information system customized to support inpatient treatment at military medical facilities); and (6) to demonstrate initial document scanning.

However, the July 2009 GAO testimony indicated that, whereas the DOD and VA had achieved the first three objectives and would meet the fourth by September 2009, the GAO reported that they would not meet the other two by the September 2009 deadline.

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

According to the GAO, the DOD-VA Information Interoperability Plan has achieved three benchmarks. The DOD is sharing viewable social history data that provide VA with clinical information on shared patients. In addition, shared physical examination data allow VA to view DOD's medical data that support the physical examination process for service members who separate from active military service. Finally, five secure network gateways that support health information sharing between the departments have been established. Work to meet the remaining three objectives is still ongoing.

As previously stated, the DOD and had VA indicated that they expected to meet the requirement for expanded questionnaires and self-assessment tools by the September 2009 deadline, however, as confirmed by the GAO, two objectives would still be unmet and would require substantial additional work. The DOD expected to expand its Essentris system to at least one additional site for each military medical service but still would only be sharing 70 percent of data electronically with VA. The DOD acknowledged that further expansion would be needed, and that it might meet only a 92 percent capability by September 2010. Regarding the scanning of medical records, neither the DOD nor VA met the September 2009 requirement. The Departments expected to be able to demonstrate an initial scanning capability by the deadline but also anticipated the need for additional work to expand the capability. As such, both agencies failed to meet the Congressional requirement for full interoperability by September 30, 2009.

Another IBVSO concern regarding health information sharing is outlined in the GAO's November 19, 2009, second report in response to a Senate Armed Services Committee report directing it to review the DOD's administration of the Post-Deployment Health Reassessment (PDHRA). The GAO found that the DOD's central repository was still missing PDHRA questionnaires for about 72,000 service members, or 23 percent of the service members in the GAO's original population of interest.

The PDHRA is a health protection program designed to enhance and extend the postdeployment continuum of care. It is a mandatory process for all active duty and reserve component service members and voluntary for those separated from military service. The PDHRA is administered by active duty health-care providers and/or DOD contract providers through two modes of delivery: a face-to-face interview with a DOD contract health-care provider at active duty locations and via telephone and/or a web-based module and coordinated follow-up referrals with VA. At Reserve and National Guard locations, DOD contract health-care providers are responsible for administering the PDHRA.

The PDHRA offers education, screening, and a global health assessment to identify and facilitate access to care for deployment-related physical health, mental

health, and readjustment concerns for all service members, including Reserve component personnel deployed for more than 30 days in a contingency operation. During the 90–180 days postdeployment period, PDHRA provides outreach, education, and screening for deployment-related health conditions and readjustment issues, outreach, and referrals to military treatment facilities (MTFs), VA health-care facilities, Vet Centers, TRICARE providers, and others for additional evaluation and/or treatment.

Problems identified by the GAO may involve the health, welfare, and safety concerns for Reserves component service members. Although the DOD concurred with the GAO's findings, the IBVSOs urge Congress to continue its oversight on this issue to resolve the weaknesses described in the GAO report. We believe the GAO should be tasked with the three action items to ensure that PDHRA questionnaires are included in the DOD's central repository for all service members, and that the two action items to ensure that documentation of PDHRA problems is consistent with federal internal control standards are implemented and sufficient to achieve its intended goals.

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 Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans suffering from traumatic brain injury, the Under Secretary for health stated, "…case managers will provide long-term case management services and coordination of care for polytrauma patients and will serve as liaisons to their families."

In October 2007, the DOD and VA partnered to create the Federal Recovery Coordination (FRC) program to coordinate clinical and nonclinical care for severely injured and ill service members. By identifying and integrating care and services between the DOD and VA health-care systems, this program subsequently served to satisfy provisions of title XVI of Public Law 110-181 ("Wounded Warrior Act"). With such resources as the 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.

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

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

Disability Evaluation

The Independent Budget veterans service organizations likewise concurred with the President's Commission recommendation that the DOD and VA implement a single comprehensive medical examination, and we believe this must be done as a prerequisite of promptly completing the military separation process, and, if and when a single separation physical becomes the standard, VA should be responsible for handling this duty because VA has the expertise to conduct a more thorough and comprehensive examination as part of its compensation and pension process.

Moreover, the inconsistencies with the Physical Evaluation Board process from the different branches of the service can be overcome with a single physical examination administered from VA's perspective, and not the DOD's. A Disability Evaluation System (DES) pilot project launched by the DOD and VA in November 2007 for service members from Walter Reed Army Medical Center, the National Naval Medical Center, and Malcolm Grow Medical Center had more than 200 participants and was a step toward developing this single separation physical. In November 2009, the program was expanding to 6 installations and a total of 27 facilities with more than 5,431 service members participating in the pilot program. The completion date for this expansion is scheduled for March 31, 2010, and will be located at Fort Benning, Georgia; Fort Bragg, North Carolina; Fort Hood, Texas; Fort Lewis, Washington; Fort Riley, Kansas; and the Portsmouth Naval Medical Center, Virginia.

This separation physical is targeted primarily at those considered for medical discharge from the military, but should be considered for all separations, whether active duty, National Guard, or Reserve. The DES has improved VA's ability to provide a disability rating shortly after military discharge. Unfortunately, one flaw of the DES is that service members are not encouraged to seek representation from a veterans service organization, instead relying on the services of military counsel. Since most service members undergoing the discharge evaluation process are unaware of the complexities of the system, it would be to their benefit to have an informed and experienced representative. The IBVSOs believe that all veterans transitioning to these situations need the benefit of representation by an advocate.

The problem with separation physicals identified for active duty service members is compounded when mobilized Reserve and Guard forces enter the mix. A mandatory separation physical is not required for demobilizing Reserve and Guard members, and in some cases they are not made aware the option is available to them. Although the physical examinations of demobilizing personnel have greatly improved in recent years, there are still a number of service members who opt out of the examinations, even when encouraged by medical personnel to have them completed. Although the expense and manpower needed to facilitate these physical examinations might be significant, the separation physical is critical to the future care of demobilizing service members. The mistakes of the first Gulf War should not be repeated for future generations of war veterans, particularly among our National Guard and Reserve forces. Mandatory separation physical examinations would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by each to recognize, treat, and compensate for illnesses and injuries resulting from military service.

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) managed by the Veterans Employment and Training Service (VETS) is generally the first service a separating service member will receive. In particular, local commanders, through the insistence of the DOD, began to allow their soldiers, sailors, airmen, marines, and coastguardsmen to attend well enough in advance to take the greatest advantage of the program. The programs were provided early enough to educate these future veterans on the importance of proper discharge physical examinations 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 to seek answers prior to their discharges.

TAP and DTAP continue to improve, but challenges remain at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service members who wish to file a claim for VA compensation benefits and other ancillary benefits 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 disabil-

ities 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 reduce this disparity.

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

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

Although the achievements of the DOD and VA have been good with departing active duty service members, there is a much greater concern with the large numbers of Reserve and National Guard service members moving through the discharge system. Neither the DOD nor VA seems prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life. If service members are uninjured, they may clear the demobilization station in a few days, and little of this time is dedicated to informing them about veterans' benefits and services. Additionally, DOD personnel at these sites are most focused on processing service members through the sites. Lack of space and facilities often restricts contact between demobilizing service personnel and VA representatives.

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

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

Recommendations:

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

The DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health in-

formation and occupational and environmental exposure data. These electronic records should also include an easily transferable DD-214.

The DOD and VA must ensure that the Joint Interagency Program Office finalizes the implementation plan with appropriate milestones and timelines for defining requirements to support interoperable health records.

Congress must continue its oversight of the completion of a fully interoperable health information-sharing system between the DOD and VA.

Congress must continue its oversight of DOD actions to resolve existing weaknesses in administering the postdeployment health reassessment.

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 members' 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 made responsible for handling this duty.

The DOD and VA should encourage active duty service members to seek veterans service organization representation during outprocessing and discharge examination.

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

The DOD, VA, and the Social Security Administration must continue to explore and implement the most effective practices for informing significantly disabled veterans and their families about the supports available to them under Social Security Disability Insurance.

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

Maintain Critical VA Health Infrastructure:

A well-thought-out health infrastructure and strategic plan is urgently needed. Congress and the Administration must work together to secure the Department of Veterans Affairs' future by designing a VA of the 21st century while maintaining the integrity of the its health-care system and all the benefits VA brings to its unique patient population.

We find ourselves at a critical juncture with respect to how VA health care will be delivered and what the Department of Veterans Affairs of the future will be like in terms of its health-care facility infrastructure. One fact is certain—our nation's sick and disabled veterans deserve and have earned a stable, accessible VA health-care system that is dedicated to their unique needs and can provide high-quality, timely care where and when they need it.

Over the past year, VA has begun to discuss its desire to address its health infrastructure needs in a new way. VA has acknowledged its challenges with aging infrastructure; changing health-care delivery needs, including reduced demand for inpatient beds and increasing demand for outpatient care and medical specialty services; limited funding available for construction of new facilities, which are growing prohibitively expensive;

frequent delays in constructing and renovating space needed to increase access; and particularly the timeliness of construction projects. VA has noted, and we concur, that a decade or more is required from the time VA initially proposes a major medical facility construction project, until the doors actually open for veterans to receive care in that facility.

Given these significant challenges, VA has broached the idea of a new model for health-care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF proposal, in lieu of the traditional approach to major medical facility construction, VA would obtain by long-term lease a number of large outpatient clinics built to VA specifications. These large clinics would provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery. Inpatient needs at such sites would probably be managed through contracts with affiliates or local private medical centers, although today we are unclear on how such arrangements would be managed.

VA noted that in addition to leasing new HCCF facilities it would maintain VA medical centers (VAMCs), larger independent outpatient clinics, community-based outpatient clinics (CBOCs), and rural outreach clinics. VA has argued that adopting the HCCF model would allow VA to quickly establish new facilities that would provide 95 percent of the care and services veterans need in their catchment areas, specifically primary care, and a variety of specialty services, mental health, diagnostic testing, and same-day ambulatory surgery.

The Independent Budget veterans service organizations (IBVSOs) agree that the HCCF model seems to offer a number of benefits in addressing VA's capital infrastructure problems, including more modern facilities that meet current safety codes, better geographic placements, increased patient safety, reductions in veterans' travel costs, increased convenience, flexibility to respond to changes in patient loads and technologies, overall savings in operating costs and in facility maintenance, and reduced overhead in maintaining outdated medical centers.

While it offers some obvious advantages, the HCCF model also holds significant challenges. The IBVSOs remain deeply concerned about the overall impact of this new model on the future of VA's system of care, including the potential unintended consequences on continuity of high-quality care; maintenance of its specialized medical programs for spinal cord injury, blindness, amputations, and other health challenges of seriously disabled veterans; delivery of comprehensive services; its recognized biomedical research and development programs; and, in particular, VA's renowned graduate medical education and health professions training programs, in conjunction with longstanding affiliations with nearly every health professions university in the nation. Moreover, the IBVSOs believe the HCCF model could challenge VA's ability to provide alternatives to direct maintenance of its existing 130 nursing home care units (now called Community Living Centers), homelessness programs, domiciliaries, compensated work therapy programs, hospice and respite, adult day health-care units, the Health Services Research and Development Program, and a number of other highly specialized services, including 24 spinal cord injury centers, 10 blind rehabilitation centers, a variety of unique "centers of excellence" (in geriatrics, gerontology, mental illness, Parkinson's, and multiple sclerosis), and critical care programs for veterans with serious and chronic mental illnesses.

In general, the IBVSOs believe the HCCF proposal could be a positive development, with good potential. Leasing has the advantage of avoiding long and costly in-house construction delays and can be adaptable, especially when compared to costs for renovating existing VA major medical facilities. Leasing options have been particularly valuable for VA, as evidenced by the success of the leased space arrangements for many VA community-based outpatient clinics and Vet Centers.

However, the IBVSOs remain concerned with VA's plan for obtaining inpatient services under the HCCF model. VA says it will contract for these essential inpatient services with VA affiliates or community hospitals if needed. First and foremost, we fear this approach could negatively impact safety, quality and continuity of care, and permanently privatize many services we believe VA should continue to provide. We have testified on this topic numerous times, and the IBVSOs have expressed objections in the Contract Care Coordination and Community-based Outpatient Clinics sections of this *Independent Budget*.

In November 2008, VA addressed a number of specific questions related to a Congressional request for more information on VA's plans for the newly proposed HCCF leasing initiative, including whether studies had been carried out to determine the effectiveness of the

current approach; the full extent of the current construction backlog of projects; its projected cost over the next five years to complete; the extent to which national veterans organizations were involved in the development of the HCCF proposal; the engagement of community health-care providers related to capacity and willingness to meet veterans' needs; the ramifications for the delivery of long-term care and specialized services as discussed above; and whether VA would be able to ensure that needed inpatient capacity would remain available indefinitely.

Based on VA's response to that request, it appears VA has a reasonable foundation for assessing capital needs and has been forthright with the estimated total costs for ongoing major medical facility projects. For FY 2011, VA estimated $2.3 billion in funding needs for existing and ongoing projects. The Department estimated that the total funding requirement for major medical facility projects over the next five years would be in excess of $6.5 billion. Additionally, if the new HCCF initiative were fully implemented, VA indicated it would need approximately $385 million more to execute seven of the eight new proposed HCCF leases.

The IBVSOs agree with VA's assertion that it needs a balanced capital assets program, of both owned and leased buildings, to ensure that demands are met under current projections. Likewise, we agree with VA that the HCCF concept could provide modern health-care facilities relatively quickly that might not otherwise be available because of the predictable constraints of VA's major construction program. VA indicated in its Congressional letter that the eight sites proposed for the HCCF initiative were chosen to ensure there would be little impact on VA specialty inpatient services or on delivery of long-term care. However, what is not clear to us is the extent to which VA plans to deploy the HCCF model. In areas where existing CBOCs need to be replaced or expanded with additional services because of the need to increase capacity, the HCCF model would seem appropriate and beneficial. On the other hand, if VA plans to replace the majority or even a large fraction of all VAMCs with HCCFs, such a radical shift would pose a number of concerns for us. But we see this challenge as only a small part of the overall picture related to VA health infrastructure needs in the 21st century. The emerging HCCF plan does not address the fate of VA's 153 medical centers located throughout the nation that are on average 55 years old or older. It does not address long-term-care needs of the aging veteran population, inpatient treatment of the chronically and seriously mentally ill, the unresolved rural health access issues, or the lingering questions on improving VA's research infrastructure.

The major questions that confront us today are, what will VA's 21st century health infrastructure look like and how it will be managed and sustained? Fully addressing these and related questions is extremely important and will impact generations of sick and disabled veterans.

Given the President's pledge to create the VA of the 21st century, the IBVSOs expect VA to establish its plan in a transparent way, vet that plan through our community and other interested parties, and provide its plan to Congress for review, and approval if required.

Congress and the Administration must work together to secure VA's future and the highest quality of care for our nation's veterans. It will take the joint cooperation of Congress, veterans advocates, and the Administration to support this reform, while setting aside resistance to change, even dramatic change, when change is demanded and supported by valid data. Accordingly, we urge the Administration and Congress to live up to the President's words by making a steady, stable investment in VA's capital infrastructure to bring the system up to match the 21st century needs of veterans.

Finally, one of our community's frustrations with respect to VA's infrastructure plans is lack of consistent and periodic updates, specific information about project plans, and even elementary communications. We ask that VA improve the quality and quantity of communication with the IBVSOs, our larger community, enrolled veterans, concerned labor organizations and VA's own employees, affiliates, and other stakeholders, as the VA capital and strategic planning process moves forward. We believe that all of these groups must be made to understand VA's strategic plan and how it may affect them, positively and negatively. Talking openly and discussing potential changes will help resolve the understandable angst about these complex and important questions of VA health-care infrastructure. While we agree that VA is not the sum of its buildings, and that a veteran patient's welfare must remain at the center of VA's concern, VA must be able to maintain an adequate infrastructure around which to build and sustain "the best care anywhere." If VA keeps faith with these principles, we are prepared to aid VA in accomplishing this important goal.

Recommendations:

VA must develop a well-thought-out health care infrastructure and strategic plan that becomes the means for VA to establish a veterans' health-care system for the 21st century.

Congress, the Administration, and internal and external stakeholders must work together to secure VA's future, while maintaining the integrity of the VA health-care system and all the benefits VA brings to its unique patient population.

VA's implementation of the Health Care Center Facility model, including the seven currently proposed projects, must fully address the potential impact of this model on VA's specialized medical care programs; continuity of high-quality care, delivery of comprehensive services, protection of VA biomedical research and development programs, and particularly the sustainment of VA's renowned graduate medical education and health professions training programs.

VA must improve the quality and quantity of communications with internal and external communities of interests, including the coauthors of this *Independent Budget,* concerning its plans for future VA infrastructure improvements.

CRITICAL ISSUE: Education, Employment, and Training:

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

Education

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

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

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

Often veterans decide to attend online universities to achieve their educational goals. This option is not solely used for convenience; it is used as a necessity. Many vet-

erans have families and work obligations that prevent them from attending college in a traditional manner. However, veterans who opt for a degree track through strictly online courses or universities are denied a living stipend. Education benefits cannot be reduced or denied.

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

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

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

Employment and Training

Employment policy is vital to veterans and veterans with disabilities in today's environment in which work is critical to independence and self-sufficiency. People with disabilities, including veterans, often encounter barriers to entry or reentry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties, in turn, contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, entitlement programs cannot keep pace with the current and future demand for benefits.

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

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

The Office of Management and Budget (OMB) estimates the average cost of placing a service-connected veteran in employment at $8,385, calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, the OMB calculations do not include a provision for inflation, increased student tuition costs, and the numbers of veterans who drop out of the VR&E program or enter interrupt status of their rehabilitation plan. Comparisons to other vocational programs are not appropriate since nonfederal dollars are excluded when calculating their cost to place an individual in employment status.

The number of veterans in the various phases of VR&E programs is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Even though the focus of the VR&E program has drastically changed to career development and employment, it is not clear, despite VR&E's addi-

tion of 83 employment coordinators, whether VA is able to meet the current and future demand for employment services. It is just not good enough to say the program's focus is on employment when the data demonstrate that only 9,000 veterans were placed in employment out of 90,000 active cases.

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

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

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

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

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

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

At present, vendors desiring to do business with the federal government must register in the CCR database, and those who indicate they are veterans or service-disabled veterans, self-certify their status without verification. P.L. 109-461 required VA to establish a Vendor Information Page database to accurately iden-

tify businesses that are 51 percent or more owned by veterans or service-disabled veterans. This database was supposed to give all federal agencies a single source in the identification of possible SDVOSBs and VOSBs for consideration during their procurement processes. However, because of a lack of oversight in this area the database has failed to fulfill its purpose.

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

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

The VA Office of Policy, Planning and Preparedness examined VA's pension program in 2002 and, though small in number, 7 percent of unemployed veterans on pension and 9 percent of veteran spouses on pension cited the dollar-for-dollar reduction in VA pension benefits as a disincentive to work. Now that veterans with catastrophic nonservice-connected disabilities retain access to VA health care, work incentives for VA's pension program should be reexamined and policies toward earnings should be changed to parallel those in the SSI program.

Recommendations:

VA must fully cover tuition and fees at all public undergraduate schools, while setting a national standard for private and graduate schools.

VA must provide a living stipend that is equal to the stipend for traditional students based on the zip code in which the veteran lives.

VA must include title 32 service as acceptable service under the Post-9/11 GI Bill.

VA must grant Post-9/11 GI Bill benefits to veterans who enroll in apprenticeships, on-the-job training, and vocational programs.

Congress must provide the funding level to meet the increasing veteran demand for VA Vocational Rehabilitation & Employment (VR&E) program services.

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

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

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

The VR&E Service should initiate a nationwide study to reveal the reasons why veterans discontinue participation in the VR&E program and use the information to design interventions to reduce the probability of veterans dropping out of the program.

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

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

Until changes are made in the law to broaden access to VR&E, Congress must ensure that all vocational systems to which veterans with significant disabilities must turn have adequate resources to serve those veterans.

Congress should authorize identical subsistence allowance rates under VA Vocational Rehabilitation (Chapter 31) benefits and the Post-9/11 GI Bill.

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

Congress should establish stronger oversight and outreach to all federal agencies by the Office of Small Business Programs, Small Business Administration, and all other federal agencies tasked with protecting and promoting service-disabled veteran-owned small businesses, to assist in the development and implementation stronger strategies/plans to reach the 3 percent goal. The annual reports filed by all federal agencies reporting the prior fiscal years' actual percentage of goal achieved should serve as guidance on which agencies need the most assistance in developing stronger plans.

Congress must provide the Department of Veterans Affairs with additional funding for the Center for Veterans Enterprise so they can adequately meet the increasing veteran demand for entrepreneurial services. These additional funds should also be appropriated for the employment of more staff at CVE to meet the growing veteran entrepreneur population.

VA must help eliminate the barriers that veterans face in regard to the formation and development of their business ventures.

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

Congress should take appropriate steps to require all agencies to use the VIP to certify veteran status and ownership before awarding contracts to companies claiming to be veteran owned or service-disabled veteran owned.

Work incentives in the VA pension program should be reexamined and consideration given to changes that would reduce benefits as earned income rises, as occurs with recipients of Supplemental Security Income.

Recommendations to Congress

Benefit Programs

Compensation and Pensions

Compensation

To offset rises in the cost of living, Congress should enact legislation that automatically adjusts compensation and dependency and indemnity compensation by a percentage equal to the increase Social Security recipients receive.

Congress should reject any recommendation 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.

Congress should enact a one-time adjustment to ensure that once again veterans and survivors of those who gave the ultimate sacrifice in service to our nation will 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 enact legislation that extends title 38, United States Code, section 1154 to anyone who served in a combat zone. This action would ease the evidentiary burden on veterans and time-consuming development by VA, while leaving in place the need for the veteran to prove the existence of a disability and medical evidence connecting that 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 legislation to increase the special monthly compensation under title 38, United States Code, sections 1114(k)–(s) by an immediate 20 percent above the current base amount, and increase by 50 percent the current base amount of special monthly compensation under title 38 U.S.C. § 1114(k).

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

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

Pensions

Congress should amend eligibility requirements in title 38, United States Code, Part II, 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 or similar medal or badge for participation in military operations not falling within an officially designated or declared period of war.

Dependency and Indemnity Compensation

Congress should pass an amended bill Senate Bill 1118 that provides for a rate of 55 percent of the rates from title 38, United States Code, sections 1114(k)–(s), provided the veteran was so entitled (or would have been, except for still being on active duty) at the time of death.

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

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

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. The grant should be at the same level as the initial housing grant.

Congress should increase the allowance from $14,000 to $28,000 for veterans who have service-connected disabilities for certain combinations of loss, or loss of use, of extremities, and increase the allowance from $2,000 to $6,000 for veterans who have a permanent and total service-connected disability rating due to blindness in both eyes and the anatomical loss or loss of use of both hands. Then Congress should provide for automatic annual adjustments in the future to keep pace with inflation.

Congress should make the Temporary Residence Adaptation a stand-alone program so that the grant amount would not count against the overall grant for permanent housing.

Congress should eliminate the expiration date of grant eligibility upon implementation of the previous recommendations.

Automobile Grants and Adaptive Equipment

Congress should increase the automobile allowance to 80 percent of the average cost of a new automobile in 2009 and then provide for automatic annual adjustments based on the rise in the cost of living.

Congress should consider increasing the automobile allowance to cover 100 percent of the average cost of a new vehicle and provide for automatic annual adjustments based on the actual cost of a new vehicle, not the CPI.

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 VA 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 with a review every five years to determine if the amount remains adequate.

Veterans' Mortgage Life Insurance

Congress should increase the maximum coverage under Veterans' Mortgage Life Insurance from $90,000 to $150,000 with a subsequent increase to $200,000 after January 1, 2012.

General Operating Expenses

Veterans Benefits Administration

Compensation and Pension Service

Congress should require the Secretary to establish a quality assurance and accountability program that will detect, track, correct, and prevent future errors and to create a work environment that properly aligns incentives with goals and holds both VBA employees and management accountable for their performance.

Congress should modify current "duty to assist" requirements that VA undertake independent development of the case, including gathering new medical evidence, when VA determines the claim already includes sufficient evidence to award all benefits sought by the veteran.

Congress should allow the Board of Veterans' Appeals to directly hear new evidence in cases certified to it, rather than require VA's regional offices to hear the evidence and submit supplemental statements of case.

Congress and VA must develop and deploy a new electronic document management system, capable of converting all claims-related paperwork into secure, official electronic documentation that is easily accessible and searchable by all official personnel involved in the process.

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 Veterans Benefits Administration but only after ensuring that quality problems are fully and adequately addressed.

Congress should ensure thorough 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.

Judicial Review

Court of Appeals for Veterans Claims

Scope of Review: Enforce Fairness in the Appeals Process

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

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

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

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

Court Facilities

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

Medical Care

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.

To enable VA to accommodate potentially hundreds of thousands of priority group 8 veterans who may choose to use VA for health care, VA must carefully calculate the total costs to reopen the system to eligible veterans, and Congress must fully fund these costs. Funding supplements must cover full direct and indirect costs of the new workload demands these veterans will bring to the VA health-care system, including the financial impacts of new professional, technical, and administrative staffing required, and expanded or new physical facilities to accommodate their care.

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

Congress must continue its oversight of the completion of a fully interoperable health information-sharing system between the DOD and VA.

Congress must continue its oversight of DOD actions to resolve existing weaknesses in administering the postdeployment health reassessment.

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

Congress should provide funds necessary in the Veterans Health Administration's FY 2011 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 VA maintains a full continuum of mental health-care services across the system and should enhance its efforts for the oversight of VA's mental health transformation and implementation of its Mental Health Strategic Plan and Uniform Mental Health Services (UMHS) initiatives.

Consistent with strong Congressional oversight, the Under Secretary for Health should appoint a mental health management work group to study the funding of VA mental health programs and make appropriate recommendations to the Under Secretary to ensure that VHA's allocation system sustains adequate funding for the full continuum of services mandated by the Mental Health Enhancement Initiative and UMHS hand-

book and remains in full commitment to recovery as the driving force of VA mental health programs.

Given the urgency of ensuring the implementation of the UMHS package, Congress should consider oversight hearings on the implementation strategy of the VA Office of Mental Health Services 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.

Congress should require VA to survey veterans, family members, and VA mental health staff about their satisfaction with services and increase its oversight to ensure that veterans' needs for high-quality, comprehensive mental health care are met and that recovery principles govern all of VA's efforts in mental health.

Congress should ensure that the new mandatory, face-to-face mental health screening process for postdeployed combat service members (including National Guard and Reserves) required by the National Defense Authorization Act of 2010 is conducted by personnel who are effectively trained to identify these hidden service-incurred wounds, and to treat them when found. This responsibility should be jointly embraced by both DOD and VA mental health-care programs in a shared effort under the authority of P.L. 97-174, "VA-DOD Health Resources Sharing and Emergency Operations Act."

OEF/OIF Issues

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.

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on those who have served in Iraq and Afghanistan. Congress should enact legislation to support VA improvements in women's health programs for all women veterans.

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

Access Issues

Although *The Independent Budget* veterans service organizations applaud both Congress and VA for increasing the beneficiary travel reimbursement rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by private conveyance. Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary motor travel.

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

Congress should provide oversight on 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.

The Administration must allocate an adequate portion of its appropriations for services and repairs of advanced technological prosthetics.

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

Congress must continue to support and advance bills, such as the Veterans Hearing and Assessment Act, and others like it, which would mandate auditory research, including tinnitus, for all veterans.

Special Needs Veterans

Congress must conduct joint Armed Services and Veterans' Affairs Committee hearings to oversee the implementation of the Vision Center of Excellence. Moreover, the Joint Executive Council, Health Executive Council, and Senior Oversight Committee (SOC) must provide greater oversight.

Congress should appropriate approximately $8.55 million in fiscal year 2011 for further implementation of the Vision Center of Excellence that will be located at the new Walter Reed National Military Medical Center.

Congress must continue to appropriate funding under the Congressionally Directed Medical Review Program for eye and vision research. For FY 2011 vision research should be maintained as a separate line item and it should be funded at $10 million.

Congress should approve beneficiary travel for those catastrophically disabled veterans who need to attend an inpatient blind rehabilitative center.

Congress should, once again, require the annual reporting requirement to measure capacity for VA spinal cord care and other specialized services as originally required by Public Law 104-262.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses. Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.

Congress should appropriate sufficient funding for VA's Medical and Prosthetic Research program to permit it to resume robust research into the health consequences of Gulf War veterans' service, and to conduct research on effective treatments for veterans suffering from Gulf War illness (GWI). The unique issues faced by Gulf War veterans should not be lost in the urgency to address other issues related to armed forces personnel who are currently deployed, and to veterans more recently discharged.

Congress should provide VA sufficient research funding to enable it to consider conducting additional research on effective treatments for veterans suffering from GWI.

Congress should renew and make permanent VA's previous "special treatment authority" for veterans who served in the Southwest Asia theater of operations during the Persian Gulf War.

Congress should make permanent the presumptive period for undiagnosed illnesses from the Persian Gulf War, due to expire September 30, 2011.

Congress should ensure that sufficient funding is appropriated to VA's Medical and Prosthetic Research program, or to its Medical Services appropriation, to permit VA to consider establishing a lung cancer pilot computerized tomography (CT scan) screening program for veterans at high risk of developing lung cancer based on published best practices and in collaboration with the clinicians who developed those practices.

Given the higher incidence of tobacco use in both the current active duty and veteran populations, and the extraordinary cancer rates in the veteran population compared to the U.S. general population, Congress should reconsider its prior decision to omit tobacco-related diseases in veterans from compensation benefits to them as service-connected illnesses.

Congress should ensure sufficient and sustained resources to strengthen the capacity of VA health-care services for homeless veterans' programs to enable VA to meet the physical, mental health and substance-use disorder needs of this population (including vision and dental care services).

Congress should increase appropriations for the Homeless Veterans Reintegration Program, managed by the U.S. Department of Labor Veterans Employment and Training Service, to the authorized level of $50 million.

Congress should increase appropriations for the Veterans Workforce Investment Program (VWIP). Also managed

by the Department of Labor, 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 additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers when such services cannot be made available within VA facilities.

Congress should require applicants for Department of Housing and Urban Development McKinney-Vento homeless assistance funds to develop specific plans for housing and services for 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 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 the GEC's 2009 Long-Term-Care Strategic Plan.

Congress must enforce and VA must abide by Public Law 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 $275 million in construction grant funds for FY 2011.

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.

To keep VA research funding at current-services levels, the program needs at least $20 million (a 3.3 percent increase over FY 2010) to account for inflation. However, *The Independent Budget* veterans service organizations (IBVSOs) believe an additional $100 million in FY 2011, beyond inflationary coverage, is necessary for sustained support of the new VA research initiatives discussed above. Thus, the *IB* recommends an increase of $120 million for the VA Medical and Prosthetic Research account in FY 2011, for a total of $700 million in the research appropriation.

The IBVSOs anticipate VA's ongoing research facilities assessment will identify a need for research infrastructure funding significantly greater than the 2003 Draft National CARES 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 Appropriations and Veterans' Affairs by June 1, 2010. Surfacing this key report will en-

sure that the Administration and Congress are well informed of the deteriorating condition of VA's research infrastructure and of its funding needs so these may be fully considered for the FY 2011 budget formulation process.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs recommend the Administration and Congress establish a new appropriations account in FY 2011 and thereafter to independently define and separate VA research infrastructure funding needs from capital and maintenance funding for direct VA medical care. The account should be subdivided for major and minor construction, and for maintenance and repair needs. This revision in appropriations accounts will empower VA to address research facility needs without interfering with direct health-care infrastructure.

The IBVSOs believe correction of the known infrastructure deficiencies should not be further delayed. Therefore, we recommend a Major and Minor Construction appropriation for FY 2011 of $300 million dedicated exclusively to renovating existing research facilities to address the current and well-documented shortfalls in research infrastructure. In sum, we recommend Congress fund VA's Medical and Prosthetic Research program as follows:

- To cover anticipated inflation and provide appropriate program growth, $700 million;
- For capital infrastructure, renovations, and maintenance, $300 million.

Administrative Issues

Congress must provide further oversight to ensure adequate implementation of Public Law 108-445 and enact legislation that is currently pending that would improve VA human resources management programs and practices.

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, traumatic brain injury, and polytrauma, to ensure VA is adequately staffed to meet these specialized responsibilities.

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

Congress and VA should ensure veterans preference is emphasized in VA human resources management activities and that veterans remain important targets for VA recruitment.

Congress must provide sufficient funding to include resources to support programs to recruit and retain critical nursing staff in VA health care; in particular, to support eventual enlargement of the Nursing Academy for all VA facilities.

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

Congress should support changes in per diem and travel requirements to decrease costs for the Travel Nurse Corps program.

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

Congress should provide support to enable nurses to obtain a step increase for achieving a nursing certification.

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

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

The Independent Budget veterans service organizations (IBVSOs) and professional PA associations appreciate that Congress is intending to legislate a resolution to this problem. We expect that the PA director would be appointed to major health-care VA strategic planning committees, in the planning of seamless transition and polytrauma centers, and traumatic brain injury case management staffing. The PA director should especially be involved in the work

of the Office of Rural Health Care and continue working with the VHA Primary Care Office on utilization of PAs in the planned expansion of new initiatives on improving primary care access for veterans. PAs can also provide critical services for our growing population of female veterans of Operations Enduring and Iraqi Freedom (OEF/OIF), since 54 percent of all PAs are female, and would be sensitive to the health-care needs of female veterans.

Congress should enact legislation establishing a full-time director of Physician Assistant (PA) Services within the Office of the Under Secretary for Health and provide oversight on VA's efforts to implement this new position, requiring periodic reports from the Department.

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.

Congress should require VA to provide a status report on implementation of section 214, title 2 of Public Law 109-461.

Construction Programs

Construction Issues

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

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

Congress should consider the advantages of allowing VA to carry over some maintenance funding from one fiscal year to the next to reduce the temptation of hospital managers to inefficiently spend NRM money at the end of a fiscal year rather than lose it.

Congress, the Administration, and internal and external stakeholders must work together to secure VA's future, while maintaining the integrity of the VA health-care system and all the benefits VA brings to its unique patient population.

Congress must appropriate $15 million to provide funding for each medical facility to develop a master plan. The master plan shall include all services offered at the facility and also should include long-term care, severe mental illness, domiciliary care, and polytrauma programs as they relate to the particular facility.

Education, Employment, and Training

Education

Congress should enact legislation that will establish a living stipend that is equal to the stipend for traditional students based on the zip code in which the veteran lives.

Congress should enact legislation that includes Guard and Reserve duty that is in direct support of the federal government but housed under title 32 as acceptable service under the Post-9/11 GI Bill.

Congress should enact legislation that will allow for the provision of Post-9/11 GI Bill benefits to veterans who enroll in apprenticeships, on-the-job training, and vocational programs.

Congress should enact legislation to authorize subsistence allowances for veterans participating in chapter 31 at the same rates as those eligible for chapter 33 benefits.

Vocational Rehabilitation And Employment

Congress must provide sufficient funding and staffing to ensure that VA's Vocational Rehabilitation and Employment program can meet the increasing demand being placed on it, particularly with the many seriously injured service members returning from Iraq and Afghanistan who will need this assistance.

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 for the entirety of their employable lives.

Congress should eliminate the 30-month maximum program participation for Independent Living Services (IL) and the statutory cap of 2,600 new, per annum, Vocational Rehabilitation and Employment (VR&E) Independent Living program participants. The effect of the cap, with the increasing veteran demand for services, will delay needed IL programs to severely disabled veterans.

Congress must provide sufficient funding for NVTI to ensure necessary training is continued, while developing new programs and strategies for the training of state and federal personnel. Increased funding will allow for an increase in state-of-the-art web-based training.

With the removal of the IL cap and a greater focus on serving veterans with severe disabilities, the *IB* also recommends that VR&E be given additional professional, full-time employment slots for IL specialist counselors who are fully devoted to delivering services to those individuals determined to have serious employment handicaps.

Congress must ensure adequate resources are available to effectively monitor and identify agencies that are not meeting the 3 percent mandate and hold them accountable for failure to meet their mandated requirements. The annual reports filed by all federal agencies, reporting the prior fiscal year's actual percentage of the mandate achieved, should serve as guidance on which agencies need the most assistance in the development and implementation of stronger contracting plans.

Congress must provide the Department of Veterans Affairs with dedicated funding to ensure the success of the Center for Veterans Enterprise so that it may fully staff its organization to adequately meet the increasing demand for timely certification of veterans' status, as legitimate entrepreneurial entities.

Congress should take the necessary actions to require all federal agencies to use a single-source database in all verifications of veteran ownership statuses, before unknowingly awarding contracts to companies on the basis of claiming service-disabled veteran–owned small business or veteran-owned small business preference. Furthermore, internal promotion and education on proper usage of the database should coincide with its implementation.

National Cemetery Administration

NCA Accounts

Congress should provide the National Cemetery Administration with $274.5 million for fiscal year 2011 to offset the costs related to increased workload, additional staff needs, general inflation, and wage increases.

Congress should fund the State Cemeteries Grants Program at a level of $51 million.

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

Congress should increase the plot allowance from $300 to $1,150 for all eligible veterans and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected burial 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

VA 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.

VA should amend its *Schedule for Rating Disabilities* by dropping the requirement for a medical opinion as to the etiology of the condition when loss of the sense of taste or sense of smell is manifest, was appropriately diagnosed in service, and is not a preexisting condition.

General Operating Expenses

Veterans Benefits Administration

VBA Management

To improve the responsiveness of the Veterans Benefits Administration, the VA Under Secretary for Benefits should give VBA program directors more responsibility for the performance of VA regional office directors.

Compensation and Pension Service

Congress and VA must develop and deploy a new electronic document management system, capable of converting all claims-related paperwork into secure, official electronic documentation that is easily accessible and searchable by all official personnel involved in the process.

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

VA should hold managers accountable to ensure that the necessary training and time is provided to ensure all personnel are adequately trained. Feedback on the effectiveness of the training should be collected from regional offices, and the Office of Employee Development and Training, Technical Training and Evaluation, Veterans Benefits Academy, and the five business lines should incorporate any emerging trends into revised training plans.

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 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.

The performance management system for claims processors should be adjusted to allow managers greater flexibility and enhanced tools to acknowledge and reward staff for higher levels of performance.

Investments in VBA Initiatives

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

VA should ensure that recent funding specifically designated by Congress to support the IT needs of the VBA, and of new VBA staff authorized in FY 2009, are provided to VBA as intended, and on an expedited basis.

The chief information officer (CIO) 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 CIO on key VBA programs and, if warranted, shift appropriate responsibility for management, planning, and budgeting from the CIO to the Under Secretary for Benefits.

Medical Care

Finance Issues

To enable VA to accommodate potentially hundreds of thousands of priority group 8 veterans who may choose to use VA for health care, VA must carefully calculate the total costs to reopen the system to eligible veterans, and Congress must fully fund these costs. Funding supplements must cover full direct and indirect costs of the new workload demands these veterans will bring to the VA health-care system, including the financial impacts of new professional, technical, and administrative staffing required, and expanded or new physical facilities to accommodate their care.

VA 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 used to fulfill VA's mission to veterans.

VA should ensure that objectives and performance measures are directly correlated to each other and reflect the strategic goal they aim to 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 include outcome measures with output measures and Congress should charge the Government Accountability Office with the review of key VA managers' performance to ensure that they are accountable for the performance of functions over which they have direct control.

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 records should also include an easily transferable DD-214.

The DOD and VA must ensure that the Joint Interagency Program Office finalizes the implementation plan with appropriate milestones and timelines for defining requirements to support interoperable health records.

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

The DOD and VA should encourage active duty service members to seek veterans service organization representation during outprocessing and discharge examination.

The DOD, VA, and the Social Security Administration must continue to explore and implement the most effective practices for informing significantly disabled veterans and their families about the supports available to them under Social Security Disability Insurance.

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

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

The Veterans Benefits Administration-Veterans Health Administration eligibility data interface must be improved, simplified, and made more accurate and accessible to clerical staffs responsible for VHA billing programs.

The VA Office of Inspector General should conduct an expanded, renewed, and updated evaluation of its December 2004 report on Medical Care Collection Fund first-party billings and collections for all veterans receiving compensation and pension benefits.

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

Mental Health Issues

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

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

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

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

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

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

VA should invest in research on effective stigma reduction, readjustment, prevention, and treatment of acute post-traumatic stress disorder (PTSD) 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 the site of care, and allocate the resources necessary to provide universal access to evidence-based care.

VA should conduct a rigorous study of the intensity of mental health care to determine if it has been reduced for older generations of veterans in order to generate the capacity to absorb newer arrivals (primarily veterans of Operations Enduring and Iraqi Freedom) with more acute needs. If the study finds results in the affirmative, VA should begin to address that trend.

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 recovery from mental health disabilities that may be created or influenced by VA's disability compensation system.

VA should immediately correct case management program deficiencies and begin to treat psychological injury and mental illness in veterans with the same intensity that it treats serious physical injuries.

VA and the DOD should move rapidly to develop health policy and research inquiries that are responsive to the recommendations published in the 2007 IOM report, *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress*.

VA needs to improve its succession planning in mental health to address the professional field shortages, recruitment, and retention challenges noted in this *Independent Budget*.

VA should ensure that qualified women mental health counselors with expertise in military sexual trauma are available in all Vet Centers and that all professional staff are provided training on the current roles of women returning from combat theaters and their unique postdeployment mental health challenges.

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

Congress should ensure that the new mandatory, face-to-face mental health screening process for postdeployed combat service members (including National Guard and Reserves) required by the National Defense Authorization Act of 2010 is conducted by personnel who are effectively trained to identify these hidden service-incurred wounds, and to treat them when found. This responsibility should be jointly embraced by both DOD and VA mental health-care programs in a shared effort under the authority of P.L. 97-174, "VA-DOD Health Resources Sharing and Emergency Operations Act."

OEF/OIF Issues

The DOD and VA 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 TBI and develop best practices for the screening, diagnosis, and treatment of it.

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 (PTSD), and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

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

The DOD and VA must increase the number of providers who are trained and certified to deliver

evidenced-based care for postcombat PTSD and major depression.

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

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on those who have served in Iraq and Afghanistan. Congress should enact legislation to support VA improvements in women's health programs for all women veterans.

Access Issues

The Veterans Health Administration should make external comparisons to measure 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.

VA should consider implementing complementary recommendations contained in the Booz Allen Hamilton report *Patient Scheduling and Waiting Times Measurement Improvement Study.*

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

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

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

The Veterans Health Administration 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 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 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 responsible offices in the Veterans Health Administration and at the VA departmental level, collaborating with the Office of Rural Health (ORH), should seek and coordinate the implementation of novel methods and means of communication, including use of the 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.

Although *The Independent Budget* veterans service organizations applaud both Congress and VA for in-

creasing the beneficiary travel reimbursement rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by private conveyance. Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary motor travel.

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 staff position in each Veterans Integrated Service Network, and more if appropriate, with the exception of VISN 3 (urban New York City).

VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with the ORH. VA should be required to report to Congress its degree of success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans, also in consultation with the ORH.

VA should establish additional mobile Vet Centers where needed to provide outreach and readjustment 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 professions 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 or initiatives, aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations and to supply addition health manpower to rural America.

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

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

At highly rural VA CBOCs, 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 when VA is unavailable and other providers are capable of meeting those needs. VA should evaluate the effectiveness of rural mobile Vet Centers and report the findings to its Rural Advisory Committee and to Congress.

Veterans designated by VA as being catastrophically disabled veterans 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 protect all funding for prosthetics and sensory aids from being obligated elsewhere.

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

The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as a 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 issued to veterans in an appropriate and timely manner.

The VHA must keep prosthetics standardization separate from other standardization efforts within VHA as the program deals with items prescribed for individual patients.

VA must make certain that the Prosthetic and Sensory Aids Service (PSAS) remains separate from other acquisition functions in VA in order to ensure timely delivery of prosthetic services.

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 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 (VISN) prosthetics representatives have a direct line of authority over all prosthetics' employees throughout the VISN, including all prosthetics and orthotics personnel.

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

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

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

VA must fully fund and support its National Prosthetics Representative Training Program and expand the program to meet current shortages and future projections, with responsibility and accountability assigned to the chief consultant for Prosthetics and Sensory Aids (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 Veterans Health Administration must work to increase the number of training slots in the National Prosthetics Representative Training Program to keep pace with the number of vacancies within the VHA for prosthetics representatives.

The VHA and its Veterans Integrated Service Network (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's Office of Research and Development and the Prosthetics and Sensory Aids Service work collaboratively and expeditiously to apply new technology transfer to maximally restore a veteran's quality of life.

The IBVSOs strongly support full implementation of the VA new amputation system of care and encourage Congress to provide adequate resources for the staffing and training of this important program.

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 Veterans Health Administration must rededicate itself to a program of excellence in hearing loss and tinnitus as well as other auditory processing disorders.

VA must restore clinical staff resources in both inpatient and outpatient audiology programs, and develop tinnitus components to existing audiology facilities.

The National Institutes of Health, DOD, and VA must continue their collaborative relationships with regard to both basic and clinical research on tinnitus.

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 DOD and VA must continue to build the electronic eye trauma registry to ensure seamless transition of veterans needing eye care services. Moreover, long-term outcome studies of vision research and the Eye Trauma Registry must be functional to improve the care of eye-injured veterans.

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. VA should also include blind rehabilitation outpatient specialists in all new recruitment, scholarship, and retention employee programs.

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

VA should develop a comprehensive continuum of care model for spinal cord disease patients to include 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 commission the National Academy of Sciences' Institute of Medicine to update the *2001 Gulf War Veterans: Treating Symptoms and Syndromes* report to determine whether treatments are effective in veterans suffering from GWI and whether these veterans are receiving appropriate care.

VA should change the current direction of its GWI 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.

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

The Veterans Health Administration should establish postdeployment health clinics, enhanced exposure assessment programs, and improve the quality of disability evaluations for the Veterans Benefits Administration's Compensation & Pension Service. To deliver high-quality occupational health services, VA should consider es-

tablishing a holistic, multidisciplinary postdeployment health service led by occupational health specialists at every VA medical center.

The Office of Management and Budget should release and 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 ensure that women veterans gain and keep access to comprehensive primary care services (including gender-specific services) at every VA medical facility and large community-based outpatient clinic.

VA should redesign its women veterans care-delivery model to establish an integrated system of health-care delivery that covers a comprehensive continuum of care.

VA needs to ensure every woman veteran has access to a qualified primary care physician(s) who is trained to provide gender-specific care for all physical and mental health conditions.

VA should establish collaborative care models incorporating mental health providers into women veterans' primary care teams. 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 the Readjustment Counseling Service's Vet Centers.

VA should report the findings of the Women's Comprehensive Health Implementation Planning to Congress, along with an action plan to improve quality and reduce disparities in health-care services for women enrolled in VA care. The Government Accountability Office should review and report to Congress on its evaluation of the results of VA's plans.

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

VA should fund a prospective, longitudinal 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 to compare the health status of deployed and nondeployed female veterans.

VA should complete and report to Congress its comprehensive study of the barriers to VA health care experienced by recently discharged female veterans.

VA should make every effort to reduce women's unnecessary exposure to radiation and pharmaceutical teratogens and identify compounds associated with an increased risk of birth defects—and immediately revise its Veterans Health Information Systems and Technology Architecture (VistA) pharmacy software to provide alerts for potential teratogens to women veterans under age 50.

VA should enhance its military sexual trauma programs by requiring consistent training and certification of health-care personnel across all medical and mental health disciplines, in techniques for screening men and women at risk for military sexual trauma, providing effective care and treatment options. VA should publish evidence-based clinical practice guidelines for sexual trauma patients.

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

In conjunction with its academic affiliates, VA should expand its continuing and graduate medical education programs in 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's Women Veterans Advisory and Minority Veterans Advisory Committees should include veterans who served in Afghanistan or Iraq.

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

Long-Term-Care Issues

For the Office of Geriatrics and Extended Care (GEC) 2008 Strategic Plan to be successful, VA must implement of many of its recommendations with exception to the recommendation to revise the Congressionally mandated nursing home capacity level.

VA should explore the impact inconsistent eligibility policies may have on its long-term-care programs and veterans access to extended care services.

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

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 enforce and VA must abide by Public Law 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 $275 million in construction grant funds for FY 2011.

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.

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

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

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

VA should ensure that 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/spinal cord disease (SCI/D). As VA develops its 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 imple-

menting the Capital Asset Realignment for Enhanced Services spinal cord injury/dysfunction 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 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 available to veterans (outside the two pilot programs discussed herein), Congress should consider providing an assisted living benefit 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.

Administrative Issues

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

VA must implement an energized succession plan in VA medical and regional office facilities that utilizes the experience and expertise of current employees, as well as 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 Veterans Benefits Administration.

VA must ensure that VA facility managers are using locality pay and financial incentives authorities (such as retention bonuses) as intended by Congress, to compete effectively for the available labor pool. VA must improve its process to consistently administer locality pay policies that rely on true local labor market conditions, as well as the use of overtime and premium pay policies for clinical staff and others, that are in accordance with VA policy and fully compliant with labor law.

VA must improve exit surveys so that, as employees terminate employment, it can secure reliable data that will aid VA in replacing vacant positions in a timely manner and to determine if conditions of employment, human resources policies, management issues, or other contributing factors need revisions.

VA must improve its use of title 38-title 5 "hybrid" appointment authority in the VA health-care system, to take full advantage of the flexibility inherent in this unique appointment authority.

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

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

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

Congress and VA should ensure veterans preference is emphasized in VA human resources management activities and that veterans remain important targets for VA recruitment.

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

Each Veterans Health Administration medical center should designate sufficient staff with volunteer man-

agement 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.

This care coordination program should be designed to augment and enhance the VA health-care system, specifically including: proactive outreach and screening programs designed to identify veterans who may be at risk for certain medical conditions and refer them for evaluation by a local VA medical center; nonclinical coaching that facilitates patient education and self-management skills, including goal setting; and enhanced access to care.

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 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 for Project HERO that include administrative and unit cost comparisons to existing contract costs by facility and by the Veterans Integrated Service Network.

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 quarterly results by facility and by VISN of operations under Project HERO, including patient access and satisfaction, clinical safety and quality, clinical information sharing, workload volume by facility and its affiliate, and administrative and unit cost data.

Data and trend analysis should be included in quarterly reports on Project HERO and be presented in a consistent format.

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 fee care payment methodology, to include outpatient fees 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 Veterans Health Administration should establish performance criteria and metrics that will allow a fair and consistent evaluation of the three pilots and that VA have an evaluation conducted in FY 2010 by a qualified, nonprofit, independent organization. Once there is evidence

of the most effective, sustainable approach and software tools that achieve desired results, VA should move swiftly to implement that solution throughout the VHA.

Rather than relinquishing ownership of fee claims management and process, the VHA should retain Veterans Integrated Service Network responsibility for fee basis claims using the automated tools that should soon be available from the pilot projects to increase timeliness and accuracy.

The Assistant Secretary for Information and Technology should perform a critical top-to-bottom assessment of the OI&T leadership and organization. Needed changes should be made to address effective OI&T-Administration coordination and collaboration, including close involvement of OI&T's "customers" in establishment of that office's plans and priorities and, in the case of health care, participation by Veterans Health Administration clinical and administrative frontline staff throughout the development cycle, and effective interagency coordination with the Department of Defense on joint information technology developments.

The Assistant Secretary should invite VA medical center directors to provide input into performance plans and make significant contributions to the annual performance evaluations of the chief information officer staff assigned to their facilities.

VA should modernize and update the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record (HER) system to provide an EHR that meets National Health IT standards, relying on public domain, open source programming code.

VA and the DOD should expedite joint development of interoperable electronic health records with real-time access to comprehensive, computable electronic health records and medical images. Congress, the DOD, and VA should carefully monitor and oversee the development of the North Chicago-Great Lakes facility merger to ensure that IT solutions meet the needs of the population being served there—and may serve as a more general model of IT interoperability between the DOD and VA.

The Independent Budget veterans service organizations strongly support the development of a virtual lifetime electronic record. VA and the DOD, with the assistance of the Administration and with strong Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have been barriers to past efforts in formulating the VLER.

VA must implement recruitment and retention tools to include PAs and provide succession plans to Congress on this occupation. The Office of Human Resources should update and issue new employment policies for PAs.

The Veterans Health Administration should strengthen academic affiliations and expand new agreements to provide clinical rotation sites for PA students. Currently the 147 accredited PA training programs are searching for qualified facilities for clinical sites, and VA could use this opportunity to recruit new student graduates rotating through VA clinics.

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

VA should provide continuing psychological support services to family caregivers. 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 (OEF/OIF).

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

The VA 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 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.

VA should establish a method to compensate 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.

In addition to the hoped-for Congressional statutory mandates in caregiver support, VA should develop support materials for family caregivers, including the following:

- a "Caregiver Toolkit," in hard copy and from the Internet—to supplement the recently published "National Resource Directory," which may not be fully responsive to their needs—and to include a concise "recovery road map" to assist families in understanding, and maneuvering through, the complex systems of care and resources available to them
- social support and advocacy support for 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 VHA and the Veterans Benefits Administration
- a monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled OEF/OIF veterans, through My HealtheVet or another appropriate web-based platform.

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

VA should conduct caregiver assessments to identify the particular problems, needs, resources, and strengths of family caregivers of severely injured service members and veterans, and determine appropriate support services to establish a basis for helping caregivers maintain their health and well-being.

Construction Programs

Construction Issues

VA 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 the Department to begin addressing the substantial maintenance backlog of Facilities Condition Assessment-identified projects.

VA must develop a well-thought-out health care infrastructure and strategic plan that becomes the means for VA to establish a veterans' health-care system for the 21st century.

VA's implementation of the Health Care Center Facility model, including the seven currently proposed projects, must fully address the potential impact of this model on VA's specialized medical care programs; continuity of high-quality care, delivery of comprehensive services, protection of VA biomedical research and development programs, and particularly the sustainment of VA's renowned graduate medical education and health professions training programs.

VA must improve the quality and quantity of communications with internal and external communities of interests, including the coauthors of this *Independent Budget,* concerning its plans for future VA infrastructure improvements.

VA should develop a plan for addressing its excess space in nonhistoric properties that are not suitable for medical or support functions as a result of their permanent characteristics or locations.

VA must evaluate the use of architect-led design-build as an alternate method of project delivery in place of the contractor-led design-build project delivery method currently employed by the Department.

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

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

VA must allocate funding for adaptive reuse of historic structures.

Education, Employment, and Training

Education

VA should implement regulations that will fully cover tuition and fees at all public undergraduate schools. Additionally, the Department should establish a national standard for private and graduate schools to ensure predictability and continuity in tuition and fee rates.

Resources need to be allocated to assist veterans with dependents while they receive training, rehabilitation, and education. Specifically, increased living stipends to assist these veterans with their cost-of-living and/or provision of childcare vouchers or stipends would be particularly helpful to these heavily burdened families. Childcare is a substantial expense for many of these veterans. Without additional aid to offset these financial burdens, many disabled veterans will continue to be unable to afford the costs associated with more favorable long-term educational rehabilitation.

Vocational Rehabilitation and Employment

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

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

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

The Vocational Rehabilitation & Employment Service should initiate a nationwide study to reveal the reasons 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 in order for Congress to determine the sufficiency level of funding to be allocated to the program.

With the removal of the IL cap and a greater focus on serving veterans with severe disabilities, *The Independent Budget* also recommends that VR&E be given additional professional, full-time employment slots for IL specialist counselors who are fully devoted to delivering services to those individuals determined to have serious employment handicaps.

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.

State vocational rehabilitation and VA VR&E programs should offer joint training to their staffs on traumatic brain injury, post-traumatic stress disorder, and other veteran-specific disability issues to improve cross-agency coordination.

VA should work with the Rehabilitation Services Administration to establish national criteria for state agencies' acceptance of veterans with service-connected disability ratings to avoid inconsistent admission policies that may unnecessarily deny services to these 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.

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 must develop an effective outreach strategy to not only identify veteran-owned businesses, but also help to eliminate the barriers that veterans face in regard to the formation and development of their business ventures.

All federal agencies should be required to certify veteran status and ownership through the VA's Vendor Information Page program before awarding contracts to companies claiming veteran status.

VA must develop and implement a uniform training program for all staff involved with the federal procurement process. VA must also provide systems to identify the strengths and weaknesses in its procurement processes, as well as continued training and evaluations of contracting staff in an effort to successfully identify weaknesses within the program as a whole.

The Department of Veterans Affairs, Department of Labor, Small Business Administration, and Office of Federal Contract Compliance Programs must exercise better oversight and stronger enforcement of consequences for any government agency or nongovernment business claiming to be awarding set-asides to veteran-owned businesses when, in fact, they are not. These agencies must place an immediate focus on proactive measures to eliminate untruths, such as "rent a vet," and cease to exercise "reactive" strategies. VA, the DOL, the SBA, and the OFCCP should pool their resources and successful strategies to ensure swift action and nonduplication of measures.

Work disincentives in the Veterans Pension Program should be reexamined and consideration given to changes that would parallel Social Security work incentives such as a trial work period and reduction in benefits as earned income rises.

Recommendations to the Administration

Judicial Review

Court of Appeals for Veterans Claims

Scope of Review: Enforce Fairness in the Appeals Process

The Administration should appoint new judges to the Court of Appeals for Veterans Claims from the knowledgeable pool of current veterans law practitioners.

Medical Care

Finance Issues

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

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

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.

OEF/OIF 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, as well as continue to address the needs of previous generations of veterans with PTSD and other combat-related 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 for services and repairs of advanced technological prosthetics.

The National Institutes of Health, DOD and VA must continue their collaborative relationships with regard to both basic and clinical research on tinnitus.

Special Needs Veterans

The Office of Management and Budget should release and 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 report the findings of the Women's Comprehensive Health Implementation Planning to Congress, along with an action plan to improve quality and reduce disparities in health-care services for women enrolled in VA care. The Government Accountability Office should review and report to Congress on its evaluation of the results of VA's plans.

Administrative Issues

The Independent Budget veterans service organizations strongly support the development of a virtual lifetime electronic record. VA and the DOD, with the assistance of the Administration and with strong Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have been barriers to past efforts in formulating the VLER.

Construction Programs

Construction Issues

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

Congress, the Administration, and internal and external stakeholders must work together to secure VA's future, while maintaining the integrity of the VA health-care system and all the benefits VA brings to its unique patient population.

Education, Employment, and Training

Vocational Rehabilitation And Employment

All federal agencies should be required to certify veteran status and ownership through the VA's Vendor Information Page program before awarding contracts to companies claiming veteran status.

Recommendations to the Department of Defense

Medical Care

Finance Issues

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 records should also include an easily transferable DD-214.

The DOD and VA must ensure that the Joint Interagency Program Office finalizes the implementation plan with appropriate milestones and timelines for defining requirements to support interoperable health records.

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

The DOD and VA should encourage active duty service members to seek veterans service organization representation during outprocessing and discharge examination.

The DOD, VA, and the Social Security Administration must continue to explore and implement the most effective practices for informing significantly disabled veterans and their families about the supports available to them under Social Security Disability Insurance.

Mental Health Issues

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

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

VA and the DOD should move rapidly to develop health policy and research inquiries that are responsive to the recommendations published in the 2007 IOM report, *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress.*

Congress should ensure that the new mandatory, face-to-face mental health screening process for postdeployed combat service members (including National Guard and Reserves) required by the National Defense Authorization Act of 2010 is conducted by personnel who are effectively trained to identify these hidden service-incurred wounds, and to treat them when found. This responsibility should be jointly embraced by both DOD and VA mental health-care programs in a shared effort under the authority of P.L. 97-174, "VA-DOD Health Resources Sharing and Emergency Operations Act."

OEF/OIF Issues

The DOD and VA 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 TBI and develop best practices for the screening, diagnosis, and treatment of it.

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

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

Specialized Services

Prosthetics and Sensory Aids

The National Institutes of Health, DOD, and VA must continue their collaborative relationships with regard to both basic and clinical research on tinnitus.

Special Needs Veterans

The DOD and VA must continue to build the electronic eye trauma registry to ensure seamless transition of veterans needing eye care services. Moreover, long-term outcome studies of vision research and the Eye Trauma Registry must be functional to improve the care of eye-injured veterans.

Administrative Issues

VA and the DOD should expedite joint development of interoperable electronic health records with real-time access to comprehensive, computable electronic health records and medical images. Congress, the DOD, and VA should carefully monitor and oversee the development of the North Chicago-Great Lakes facility merger to ensure that IT solutions meet the needs of the population being served there—and may serve as a more general model of IT interoperability between the DOD and VA.

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Recommendations to the Department of Labor

Education, Employment, and Training

Vocational Rehabilitation And Employment

There must be stronger oversight and outreach to all federal agencies by the U.S. Department of Labor, Office of Small Business Programs, Small Business Administration, and all other federal agencies tasked with protecting and promoting service-disabled veteran–owned small businesses, to assist in the development and implementation of stronger strategies and plans to reach the 3 percent mandate.

The Department of Labor's Small Business Administration, Office of Federal Contract Compliance Programs, and Employment & Training Administration must collaborate in designing and implementing a single-source database and employer outreach program for the promotion of veterans' entrepreneurship at the local and national level. This system must allow all employers to locate veterans for employment. Additionally, all veterans must have equal access to federal subcontracts held by larger prime contractors.

The Department of Veterans Affairs, Department of Labor, Small Business Administration, and Office of Federal Contract Compliance Programs must exercise better oversight and stronger enforcement of consequences for any government agency or nongovernment business claiming to be awarding set-asides to veteran-owned businesses when, in fact, they are not. These agencies must place an immediate focus on proactive measures to eliminate untruths, such as "rent a vet," and cease to exercise "reactive" strategies. VA, the DOL, the SBA, and the OFCCP should pool their resources and successful strategies to ensure swift action and nonduplication of measures.

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