

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

**Statement of Work**

**A. GENERAL OBJECTIVES AND REQUIREMENTS**

Title: Analysis of the Veterans' Affairs Schedule for Rating Disabilities (VASRD) and Other Issues Identified by the Veterans' Disability Benefits Commission

Background: Public Law 108-136 of the National Defense Authorization Act of 2004 created the Veterans' Disability Benefits Commission (Commission) to carry out a study of the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. The Commission is an independent body that receives funding through the Department of Veterans Affairs (VA). In carrying out its work, the Commission will consult with the Institute of Medicine (IOM) of the National Academy of Sciences with respect to the medical aspects of contemporary disability compensation policies (Sec. 1502(d)).

Disclaimer: The analysis requested in this statement of work is wholly at the discretion of the Veterans' Disability Benefits Commission. Although the VA has responsibility to facilitate the work of the Commission, VA's assistance in administration of this study and associated contract does not mean that VA approves, endorses, or agrees with the proposed research tasks. The scope, research questions and supporting narrative represent work by the Commission and not VA or DoD.

Schedule: The Commission's original schedule called for it to submit a report to the President and Congress by August of 2006; however, the Commission anticipates requesting an extension to this timeframe.

Purposes:

The first purpose of this assessment is to conduct a comprehensive review of the Schedule for Rating Disabilities (VASRD) (used by the Department of Veterans Affairs and Department of Defense) to determine whether the schedule reflects (1) current medical understanding of the relationship between impairment and disability, (2) technological and treatment mitigations of medical conditions as they relate to functioning in the workplace, (3) whether medical or vocational impairments caused by rated disabilities can be improved by ancillary or special purpose benefits such as vocational rehabilitation or environmental adaptations, and (4) sufficiently discrete rating levels to provide veterans with commensurate benefits without resorting to additional disability designations such as Individual Unemployability.

The second purpose of this assessment is to evaluate the utility of the VASRD based on comprehensiveness of listed conditions and their descriptions, ease of training new raters, and degree of correspondence with other schedules such as the American Medical Association Guides to the Evaluation of Permanent Impairment.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

A third purpose is to review and recommend any necessary changes to the criteria and methodology used to recognize "presumptive" service-connected disability.

The Commission also needs IOM input on less complex issues such as the role of healthcare professionals in the claims/appeal process and their training/certification needs.

Scope: The assessment will make an objective, third-party determination of the utility of the VASRD's appropriateness, variability, and validity. Also, the assessment will look at the VASRD's utility in rating the extent to which the service member's service-connected disability(ies) so interferes with his/her earnings capacity and quality of life to inhibit his/her ability to make a successful transition to civilian life and to lead a fulfilling life. It will look at the way in which the rating levels are determined and what skills, knowledge, training, and certification are required of the persons performing the examinations and assigning the ratings. In evaluating the criteria and methodology for establishing presumption of service connection for certain conditions, after reviewing the historical basis of current practice, IOM will propose improvements, possibly to include an epidemiological model, that could be used to support future decisions.

Methodology: The Commission is required to consult with IOM, a private, non-profit organization established under the Congressional charter of the National Academy of Sciences to advise the nation on issues of health and medical policy. IOM will review the medical and functional criteria used to rate impairments and related issues. The Institute of Medicine assembles recognized experts from government, industry, and academe who work independently to reach evidence-based positions and then, through consensus, deliver objective conclusions. A separate panel of experts then conducts a rigorous peer review before IOM releases its report(s) to the Commission.

## **B. TASKS AND ASSOCIATED DELIVERABLES**

### Project Management Requirements:

IOM's technical proposal shall contain a general work plan for accomplishment of the requirements of this task order and include the methodology and deliverables to be accomplished for each aspect of the project. The technical proposal shall also contain proposed staffing information and resumes of key IOM personnel assigned to this project. Immediately after the formation of panel(s) of experts, IOM is to provide resumes of experts contributing to the overall effort.

Period of Performance: Project is to be completed within approximately 15 months after the contract is awarded. IOM is to propose specific milestones.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

In conducting the study, IOM must accomplish the following:

I. Preliminary Research

Review and analyze all key documents regarding disability compensation benefit programs to include DoD's Disability Retirement program and VA's vocational rehabilitation and readjustment counseling services as well as published research on and socioeconomic studies of disabled persons in America.

II. Specific Tasks and Research Questions

*Please refer to Appendix A "Research Questions" for discussion of issues referenced in tasks below. For each task the contractor is expected to provide appropriate options and recommendations for improvement and include general cost estimates (program and administrative) that would result from implementing proposed changes.*

1. How well do the medical criteria in the VA Rating Schedule and VA rating regulations enable assessment and adjudication of the proper levels of disability to compensate both for the impact on quality of life and impairment in earnings capacity? (RQ 6) Provide an analysis of the descriptions associated with each condition's rating level that considers progression of severity of condition as it relates to quality of life impairment and impairment in average earnings capacity.
2. Certain criteria and/or levels of disability are required for entitlement to ancillary and special purpose benefits. To what extent, if any, do the required thresholds need to change? (RQ 20) Determine from a medical perspective at what disability rating level a veteran's medical or vocational impairment caused by disability could be improved by various special benefits such as adapted housing, automobile grants, clothing allowance, and vocational rehabilitation. Consideration should be given to existing and additional benefits.
3. Analyze the current application of the Individual Unemployability (IU) extra-schedular benefit to determine whether the VASRD descriptions need to more accurately reflect a veteran's ability to participate in the economic marketplace. Propose alternative medical approaches, if any, to IU that would more appropriately reflect individual circumstances in the determination of benefits. (RQ 9a and RQ16) For the population of disabled veterans, analyze the cohort of IU recipients. Examine the base rating level to identify patterns. Determine if the VASRD description of conditions provide a barrier to assigning the base disability rating level commensurate with the veteran's vocational impairment.
4. What are the advantages and disadvantages of adopting universal medical diagnostic codes rather than using a unique system? Compare and contrast the advantages/disadvantages of VA Schedule for Rating Disabilities and the American Medical Association Guides to the Evaluation of Permanent Impairment. (RQ 11)

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

5. From a medical perspective, analyze the current VA practice of assigning service connection on "secondary" and "aggravation" bases. In "secondary" claims, determine what medical principles and practices should be applied in determining whether a causal relationship exist between two conditions. In "aggravation" claims, determine what medical principles and practices should be applied in determining whether a preexisting disease was increased due to military service or was increased due to the natural progression of the disease. (RQ 15d and RQ 15e)
6. Describe and evaluate the current model used to recognize diseases that are subject to service connection on a presumptive basis. If appropriate, propose a scientific framework that would justify recognizing or not recognizing conditions as presumptive. (RQ 14)
7. Compare and contrast the role of healthcare professionals in the claims/appeals process in VA and DoD, Social Security, and federal employee disability benefits programs. (RQ 8a) What skills, knowledge, training, and certification are required of the persons performing the examinations and assigning the ratings?

Tasks and Schedule for Deliverables: In broad strokes, the tasks are indicated below and shall be accomplished in accordance with the schedule indicated. If IOM believes that different dates should be established, these proposed dates will be indicated in the technical proposal and the detailed work plan.

Reports and deliverables will be provided to the Executive Director of the Commission and to the TOPM. After receipt, the Executive Director may authorize release of reports to VA and DoD for the purposes of conducting technical and legal review. VA TOPM will need to review deliverables. The TOPM will review and coordinate the response to IOM for all deliverables.

The final product will be a written report including an executive summary, findings, and recommendations. Two electronic copies of the reports (in MS Word in the version compatible with the Commission) will be provided to the Veterans' Disability Benefits Commission and one to the Contracting Officer. The final printed deliverable will include one camera-ready black and white master and one camera-ready color master plus 100 bound copies.

Task 1: Initialize Study. There will be a meeting to kick-off the study. At this meeting key participants (IOM, Commission representative and staff, and the TOPM) will determine how communications will be structured. Participants will discuss data issues and agree upon the methods for obtaining stakeholder input.

Due: Within 1 week of award

Task 2: Detailed Work Plan. IOM and Commission will meet to discuss data collection needs and the approval mechanism for all deliverables. Agreements should be reached

**Department of Veterans Affairs**  
**in support of the**  
**Veterans' Disability Benefits Commission**

at this time as to number, type, and due dates of deliverables as well as the specific analytic techniques to be used. IOM will submit a detailed schedule of tasks and deliverables and present a briefing to Commission officials.

Due: Within 15 workdays of award

Task 3: Payment Schedule. IOM will meet with Commission representatives and TOPM to develop a payment plan. Ten percent of the total payment will be withheld until contract and administrative closure.

Due: Within 20 workdays of award

Task 4: Coordination Meeting. There will be a coordinating meeting for key participants (IOM, CNA, Commission and staff, and the TOPM) to determine how parties will coordinate cross-over issue topics.

Due: Approximately 2 weeks after award

Task 5: Research and Analysis. This task is ongoing from the beginning of the study.

Task 6: Informal Commission Briefings. Informal briefings to coincide with Commission Public Meetings will be presented.

Due: As scheduled, approximately monthly

Task 7: Commission Briefing. A formal briefing for Commission members is to be conducted prior to the issuance of the final report.

Due: Week 63

Task 8: Final Report. IOM is to deliver one unbound, camera-ready black and white copy of the report, one unbound, camera-ready color copy of the report, 100 bound paper copies of the report, and two electronic copies of the report (in MicroSoft Word) to the Commission.

Due: Within 64 weeks of award

Task 9: External Briefings. Additional (up to three) briefings for VA and DoD top officials, veterans service organizations, and key Congressional staff may be scheduled after issuance of the final report.

Due: After issuance of final report

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

**C. TASK ORDER REQUIREMENTS**

Reporting Requirements:

In addition to the deliverables specified above, IOM is required to provide the Contracting Officer and the TOPM with written progress reports on the first workday of each calendar month. The progress report will cover all work completed during the preceding month as well as the work scheduled for the subsequent month. The report must identify any problems which arose with a statement explaining how the problem was resolved. This report must also identify any problems which have arisen but were not resolved. The monthly report will provide a basis for a monthly conference call to be held between Commission staff, CNA, IOM, and the TOPM.

The TOPM is required to make written monthly progress reports to the Contracting Officer by the fifth workday of each calendar month. The TOPM will use IOM's monthly report in conjunction with the payment schedule as the basis for recommending authorization of payment of invoices from IOM.

Modifications

The Contracting Officer will issue any changes to this Task Order in writing. No other party is authorized to make changes to the contract.

If for any reason a deliverable cannot be delivered as scheduled, IOM is required to submit a request for a time extension to the Contracting Officer with a copy to the Commission and the TOPM. The request must include the reason(s) for the delay, the impact on the overall project, and the impact on the cost of the project. The Contracting Officer will consider each request on the basis of its merits and will, if approved, issue a modification to the task order. IOM is required to proceed as originally scheduled until such modification is issued.

Section 508 - Compliance For Electronic and Information Technology (EIT)

The Workforce Investment Act of 1998, Public Law 105-220, was enacted on August 7, 1998. Title IV of the Act is the Rehabilitation Act Amendments of 1998. Subsection 508 (b) amended Section 508 of the Rehabilitation Act of 1973. Section 508 requires that when Federal departments or agencies develop, procure, maintain or use Electronic and Information Technology (EIT), they must ensure that the EIT allows Federal employees with disabilities to have access to and use of information and data comparable to the access and use of information and data to that of other Federal employees. Section 508 also requires that individuals with disabilities who are members of the public seeking information or services from a Federal department or agency have access to and use of information and data available to member of the public not having the disabilities.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

Section 508 (a) (2) (A) required the Access Board to publish standards setting forth a definition of EIT and the technical and functional performance criteria necessary for accessibility to such technology by February 7, 2001. The Access Board published the final standards in the Federal Register at 65 FR 80500, December 21, 2000.

Unless an exception applies, all of the EIT supplies and services furnished under this contract must comply with the provisions of Section 508 of the Rehabilitation Act of 1973, as amended. Those supplies and/or services must meet the applicable accessibility standards at 36 CFR Part 1194. The contractor certifies, by execution of this contract or by entering into a contract with the Department of Veteran Affairs , that the supplies and services furnished comply with the accessibility standards to the extent required by law.

Use of DoD Records and Files

Tasks involving DoD records and files will be conducted under Industrial Security Procedures specified in DoD 5220.22-M, "National Industrial Security Program Operating Manual." A need to know is established in connection with such tasks for access to classified documents, and security clearances necessary to complete the task will be obtained through DOD.

**D. GUIDANCE CONSIDERATION FOR DEVELOPING OPTIONS**

IOM will consider the effect of the data and information collected and presented in this effort in terms of the following factors:

1. Responsiveness to the needs and expectations of program users and external groups.
2. Utility in providing Veterans' Disability Benefits Commission members, VA and DoD management officials, and Congressional legislative professionals reliable basis for making decisions.
3. Assurance of cost-effective use of Government resources, practicality of implementation of recommended options, and consistency with sound principles of business management.

**E. CONFIDENTIALITY and NON DISCLOSURE**

All data collection instruments as well as draft and final reports, all data files and associated working papers, and all other materials deemed relevant by the Commission which have been generated by IOM in the performance of this contract are the exclusive property of the U.S. Government and are to be submitted to the TOPM at the completion of the task order.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

All data files are to be submitted in an agreed upon format with full documentation.

The Commission Chairman or his authorized designee will be the sole authorized official to release (verbally, electronically, or in writing) any data prior to the final report or any other written or printed materials pertaining to this contract. Any request for information about this task order presented to the contractor shall be submitted to the Contracting Officer for response.

**F. KEY PERSONNEL**

The technical proposal will include resumes of key personnel who will be working on this project and will also specify their roles and responsibilities. IOM must notify the Contracting Officer immediately of any change in key personnel, providing resumes and detailing roles and responsibilities of new personnel.

**G. OTHER INFORMATION**

Travel: IOM shall be entitled to recover reasonable non-local transportation costs incurred for employees that are pre-approved by the TOPM. Allowable travel cost shall be determined in accordance with Subpart 31.2 of the Federal Acquisition Regulations. Reimbursement of travel costs will be made when the contractor submits an invoice for travel along with supporting documentation (receipts as required by Federal Travel Regulations). Expenses for subsistence and lodging shall be reimbursed to the contractor only to the extent that overnight stay is necessary and authorized for performance of services under this contract at the per diem rates authorized by the Federal Travel Regulations in effect at that time.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

Appendix A

**Veterans' Disability Benefits Commission  
Approved Research Questions  
10-14-05**

**Introduction**

Public Law 108-136 created the Commission and charged it with carrying out a comprehensive study to examine the appropriateness of the benefits provided under laws of the United States to veterans and their survivors to compensate and provide assistance for the effects of disabilities and deaths attributable to military service. The evaluation and assessment must include the appropriateness of the purpose of the benefits, the appropriateness of their level and payment rates under the law and VA schedule for rating disabilities, and the appropriateness of the eligibility standards for compensation. The Commission is also charged with studying any related issues the Commission determines are relevant to the purpose of developing its findings and recommendations. In carrying out the review, the Commission must consult with the Institute of Medicine and include an evaluation and assessment of comparable disability benefits provided to individuals by the Federal government, State governments, and the private sector. The following represents a preliminary consolidated list of some of the key research questions the Commission proposes to address to enable it to assess the appropriateness of the benefits consistent with its statutory mandate. These specific research questions have arisen from historical material, documents, and information provided by witnesses and interested parties. The Commission proposes to study them to arrive at essential findings on the appropriateness of the benefits. However, the Commission's study of these issues should not be taken as foreshadowing any disposition with respect to any item of inquiry.

A logical first step in assessing the appropriateness of benefits is to examine the purposes, or congressional intent, of the current program design and determining whether the benefits are fulfilling congressional intent. To facilitate gathering and reviewing of these key research questions, the Commission temporarily set up three subcommittees: Compensation, Duty-Service Connection and Transition/Coordination/Readjustment. Shown below are the potential key research questions chosen by the three subcommittees for the Commission to consider selecting for further detailed study and approval by the full commission. Once these specific research issues have been chosen to be addressed by the Commission, we will proceed to do a detailed study of these research questions to determine whether the current design is appropriate or whether more appropriate alternatives exist.

**1. How well do benefits provided to disabled veterans meet Congressional intent of replacing average impairment in earnings capacity?**

The schedule for rating disabilities of the Department of Veterans Affairs (VA) had its beginning in PL 65-90, War Risk Insurance Act Amendments. Compensation for service-connected disabilities was to be for "the average impairment in earning capacity" caused by disability. Average impairment was to be based on average loss of earnings for all occupations performing manual labor. If disabled individuals could overcome their handicap, their disability rating would not be reduced.<sup>1</sup>

## Department of Veterans Affairs in support of the Veterans' Disability Benefits Commission

In 1924, legislation was enacted to recognize the effects of disability on the pre-service occupation of the veteran. Since many veterans of World War I had no pre-service occupation, legislation in 1933 abandoned this attempt and reverted back to average impairment of earnings capacity.<sup>2</sup>

In 1939, Congress published a rating and compensation schedule for veterans that became the basis for future increases in the rate of compensation for disabled veterans. The level of benefits was set on the basis of the average entry level earnings of an unskilled adult male working as a common laborer.<sup>3</sup> This level of benefits was not based on data reflecting actual loss of earnings. Peacetime rates were set at 75 percent of those rates for wartime veterans. PL 92-328 equalized peacetime rates with wartime rates effective July 1, 1973.

A striking feature of this schedule was its perfect linearity, beginning at \$7.50 per month for a veteran with a 10 percent disability, increasing by \$7.50 for each additional 10 percent to a maximum of \$75 per month for a 100 percent disability. Certain disabilities received additional compensation. For example, for the loss of use of an eye, foot, or hand, monthly compensation was \$18.75 per month. Addition compensation for the loss of both hands, both feet, or some combination thereof and need of regular aid and attendance resulted in monthly compensation of \$112.50. Maximum monthly compensation for severe disability was \$187.50.<sup>4</sup>

Little research has been done on how well or to what extent the disability benefit meets Congressional intent. Only two efforts have been undertaken to assess the actual loss of earnings by disabled veterans: the President's Commission on Veterans' Pensions,<sup>5</sup> known as the Bradley Commission, in 1956, and the VA's Economic Validation of the Rating Schedule,<sup>6</sup> known as the ECVARS Study, in 1971. The Bradley Commission resulted in increased rates for those rated at 100 percent. The ECVARS Study had no apparent effect on benefits.

The Bradley Commission believed that benefits paid to veterans with similar needs must in most programs be uniform throughout the country. Geographic or industrial variations in wages, and living standards, however, must be given weight in determining the national rates of various benefits. The rates should not be set so high as to undermine incentive for productive activity nor so low that they fail to meet minimum needs. Benefit levels should be consistent with those in other public programs with similar functions.<sup>7</sup>

More recently, some programs have recognized the differences in the cost of living in urban versus rural areas and in different regions of the country. At issue is whether the level of disability compensation benefits would be more appropriate if tied to geographical variances in the cost of living. (See Research Question (RQ) 12)

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<sup>1</sup> VA Disability Compensation Program, Legislative History, Economic Systems Inc., December 2004, page 4.

<sup>2</sup> Ibid, page 4.

<sup>3</sup> Ibid, page 5

<sup>4</sup> Ibid, page 17

<sup>5</sup> A Report By The President's Commission on Veterans' Pensions, Veterans' Benefits In The United States, House Committee on Veterans' Affairs, April 1956.

<sup>6</sup> Committee Print No. 109, Committee on Veterans' Affairs, House of Representatives, July 20, 1971.

<sup>7</sup> The President's Commission on Veterans Pensions, 1956, Highlights of the Commission's Findings and Recommendations, pages 9-13.

**Department of Veterans Affairs**  
**in support of the**  
**Veterans' Disability Benefits Commission**

In the interest of better understanding if the outcomes of the programs are meeting Congressional intent, current research should be conducted to study the effect that disability compensation has on the disabled veteran's total income. This analysis should be done in the context of all benefits or services afforded by Federal government for service-connected disabled veterans. Does the value of all benefits and services adequately provide for the needs of veterans and enable them to maintain a reasonable standard of living? Is there sufficient coordination with other disability programs? How does the income of veterans with service-connected disabilities compare to non-disabled veterans? Can any comparison be made of data before and after receipt of the disability benefit? Also, comparison with available data on the general population should be made. Income data will be obtained by matching with available information from Social Security in order to address this issue.

**2. How well do benefits provided to disabled veterans meet implied Congressional intent to compensate for impairment in quality of life due to service-connected disabilities?**

The Government's obligation is to help veterans overcome special, significant impairments incurred as a consequence of their military service. The objective should be to return veterans as nearly as possible to the status they would have achieved had they not been in military service.<sup>8</sup>

An implied part of Congressional intent was quality of life. Although the legislation does not explicitly state that the intent of the disability program is to compensate for reduction in quality of life due to a service-connected disability, this factor is evident in that Congress has set forth certain presumptions of eligibility for disability compensation and additional compensation for certain disability conditions that reflect a concern for loss of quality life. The law, for example, provides additional compensation for "loss of physical integrity" such as loss of a hand, foot, or eye. Subsections "L" to "S" in 38 U.S.C. §1114 provide additional compensation for veterans with 100 percent service-connected disability whose disabilities present additional disability or burdens (such as blindness or housebound status). Congressional Hearing and Committee reports support this as well.<sup>9</sup> The rating schedule provides compensation for conditions that would not be expected to result in an impairment of earnings capacity, and Congress is aware of and has enhanced the compensation for these conditions, e.g., loss or loss of use of a creative organ and loss of female breast tissue.

Information assessing the impact veterans' disabilities have on their quality of life is not contained in administrative records. A survey of veterans receiving disability compensation should be conducted in order to gain insights into veterans' circumstances and perception of loss of quality life affected by service-connected disability and how well disability compensation and related benefits help to improve their quality of life. Survey questions should gather information on the actual changes in the person's life, such as mobility, pain and suffering, employment stability, activities of daily living, and social interaction.

Consideration should be given to what would constitute a suitable comparison group. One comparison group, for example, might include veterans without disabilities. Another might be non-disabled military retirees. Lastly, comparison with available data on the general population might be made.<sup>10</sup>

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<sup>8</sup> President's Commission. page 4.

<sup>9</sup> VA Disability Compensation Program, Literature Review, Economic Systems Inc., December 2004, pages 17-18.

<sup>10</sup> Ibid. page 10.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

According to the 2001 National Survey of Veterans (NSV), more than 62% of veterans in receipt of compensation said their benefits were extremely or very important to meeting their financial needs.

**3. How well do benefits provided to survivors meet implied Congressional intent to compensate for the loss of the veterans/service members' earning capacity and for the impairment in quality of life due to service-connected death?**

Information assessing the impact of dependency and indemnity compensation (DIC) and related benefits on survivors' economic loss and decreased quality of life is not contained in administrative records. A current survey of survivors receiving DIC should be conducted in order to gain insights into their financial circumstances and perception of loss of quality life and how well DIC and related benefits help to improve their quality of life. The survey would obtain data on survivors' perceptions of the adequacy and equity of the DIC benefit in the context of quality of life. Survey questions should gather information on the actual changes in the survivors' life, such as emotional pain and suffering, employment stability, and social interaction.

**4. How well do benefits provided to disabled veterans and survivors meet implied Congressional intent to provide incentive value for recruitment and retention?**

Legislation does not explicitly state that the intent of the VA disability compensation program and the DIC program and DoD disability retirement and survivors' benefits is to provide incentive value for recruitment and retention. During wartime periods, Congress has provided greater benefits or liberalized rules for eligibility, reflecting the intention of attaining sufficient recruitment and retention. Also, Congress has often legislated benefits for veterans using phrases similar to "in gratitude of service rendered for a grateful Nation," indicating that benefits are provided for a variety of reasons.<sup>11</sup>

**5. Should the benefits package be modified?**

GAO has indicated that all Federal programs need to approach disabilities differently.<sup>12</sup> Is VA providing disabled veterans what they need, which may mean something in addition to or other than monetary benefits? For example, is the appropriate emphasis being placed on vocational rehabilitation and medical rehabilitation, in order to maximize functioning? Should VA offer additional benefits and/or services based on the changing needs of today's military and society, e.g., family counseling, financial counseling, grief counseling, career guidance, etc.? Should the government consider compensating veterans separately for loss of quality of life and loss of earnings capacity? Critics have argued that the government is over compensating veterans for disabilities that seem to cause minimal loss of earnings or quality of life. Other critics have pointed out that certain veterans with more severe disabilities are under compensated when considering the total effect of the disability.

Whether the content and/or structure of VA's benefits package are appropriate will be answered, in part, by the aforementioned veteran survey and income match data. The Commission is pursuing a contract for this purpose. However, the Commission may explore additional avenues such as conducting a needs assessment which would further aid in analyzing the appropriateness of VA's benefits package.

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<sup>11</sup> Ibid. page 17-18.

<sup>12</sup> Federal Disability Assistance: *Wide Array of Programs Needs to be Examined in Light of 21<sup>st</sup> Century Challenges*. GAO-05-626. Washington, DC: June 2, 2005.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

**a. Would the results be more appropriate if reduced quality of life and lost earnings were separately rated and compensated?** Because disability compensation is intended to compensate veterans for average impairment in earnings capacity and impact on quality of life, the feasibility and practicality of a rating schedule that would provide one amount of compensation for earnings impairment and one amount for impact on quality of life should be explored. The impact of disability on earnings capacity and quality of life might be very different for different types of disability and different levels of severity. Beyond the question of whether such a system would be feasible to design, this inquiry should also consider whether increased complexity would outweigh potential benefits.

**b. Are there negative unintended consequences resulting from the current benefit structure? Does the receipt of certain levels of compensation provide a disincentive to work or undergo therapy?** One of the strengths of the compensation program, in general, is that veterans are not penalized by pursuing employment. For example, a veteran who has an 80 percent scheduler evaluation may obtain gainful employment without his or her compensation payments being reduced or terminated. However, it has been argued that the system may, in certain ways, provide a disincentive to overcome one's disability and/or pursue employment. For example, during a recent IG study in which 92 PTSD cases were reviewed, it was indicated that 39 percent of those veterans with PTSD sought less treatment for the condition after achieving a 100 percent evaluation.<sup>13</sup>

The Bradley Commission felt that rates should not be set so high as to undermine incentive for productive activity nor so low that they fail to meet minimum needs.<sup>14</sup> A recent study by Rand found that some military retirees who are not disabled and those who are disabled are either not working or are not working full time. The rates of employment are lower for those that are disabled, however, some of the disabled retirees report that they have no limit on the type or amount of civilian work that they can perform. The study concluded that the reasons for individuals not working are unclear.<sup>15</sup> Further exploration of employment incentives could be accomplished as part of a quality of life survey of disabled and non-disabled veterans and military retirees. The Commission should study this area to better understand the effects of disability compensation on treatment and employment.

**c. To what extent should VA modify its compensation policies if data from certain categories of service-connected veterans demonstrate little or no measurable loss of earning capacity and/or quality of life?** Arguments have been made that the government should not pay individuals lifetime compensation payments for conditions that cause little to no loss of earnings or quality of life. Examples of such conditions include, but are not limited to, hemorrhoids rated at 10 or 20 percent disabling, superficial, painful scars rated at 10 percent disabling, tinnitus (ringing in the ears) rated at 10 percent disabling, acne rated at 10 or 30 percent disabling, etc. Arguments have also been made that certain categories of veterans

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<sup>13</sup> Department of Veterans Affairs Office of Inspector General: Review of State Variances in VA Disability Compensation Payments, Report No. 05-00765-137, Washington, DC, May 19, 2005, pg. ix-x.

<sup>14</sup> The President's Commission on Veterans Pensions, 1956, Highlights of the Commission's Findings and Recommendations, pages 9-13.

<sup>15</sup> An Analysis of Military Disability Compensation, Rand National Defense Research Institute, 2005, page xviii.

**Department of Veterans Affairs**  
**in support of the**  
**Veterans' Disability Benefits Commission**

such as the 100 percent disabled are under compensated when considering the total impact of the disability (ies) on their life. How should policies be modified if certain categories of disabled veterans demonstrate excessive loss of earnings capacity and/or quality of life? Should certain compensation payment levels be increased, decreased, or kept the same? Should the composition of conditions in the Rating Schedule change? Should other factors be considered in the adjudication process? As indicated in RQ 1 and 2, income matching and quality of life survey data will be gathered in order to address this crucial issue.

**6. How well do the medical criteria in the VA Rating Schedule and VA rating regulations enable assessment and adjudication of the proper levels of disability to compensate for both the impact on quality of life and impairment in earnings capacity?**

The VA rating schedule and rating regulations are in a constant state of reexamination and change. Changes are made as a result of any of the following: new legislation, precedent decisions of federal courts, and policy changes within VA. Twelve of the 15 body systems have been updated to reflect the most recent knowledge concerning the effects of disabilities since VA began its project to modernize the entire rating schedule in 1991. For example, prior to the revision of the cardiovascular system, ratings were assigned for cardiovascular disease on the basis of shortness of breath, among other symptoms, which was judged by the rating specialist to be mild, moderate, or severe, depending on the veterans' reported subjective symptomatology. As part of the revision, the evaluation criteria were changed to require the more objective metabolic equivalent testing (MET). Although many changes have been made to the rating schedule, some commenters have suggested it may not reflect the current state-of-the-art in medicine, prosthetics, and workforce characteristics. Therefore, current compensation rates may not correlate with lost earnings capacity or diminished quality of life.

Evaluations of 0 percent to 100 percent are assigned in 10 percent increments based on the severity of the disability. Special Monthly Compensation (SMC) is also awarded for things ranging from loss of use of a creative organ to the need for the aid and attendance of another person due to service connected disabilities. Not all of the disabilities known are included in the rating schedule. When a service connected disability does not have its own criteria, the criteria of a closely related disability are used by analogy. In addition, gradations of 0 percent to 100 percent do not exist for every disability contained in the rating schedule. When the evaluations available for a disability are insufficient to account for the level of severity for a condition, claims are referred to the Director, Compensation and Pension Service, for a possible extra-schedular evaluation.

There are some differences in the way mental disorders are evaluated when compared to physically disabled individuals. Mental disorders contain an element of occupational impairment or employability in the rating schedule's evaluation criteria, which is not included in the rating criteria for most physical disorders. Veterans with mental disorders rated 100 percent disabling must be, by terms of the rating schedule, totally impaired, both occupationally and socially, to be so rated. Lesser evaluations are assigned for mental disorders with lesser impact.

Evaluating mental disorders is considered more subjective than evaluating physical disorders. Should more objective techniques such as Global Assessment of Function (GAF)<sup>16</sup> scores, which are required to be used with all Veterans Health Administration mental health patients, or the Minnesota Multiphasic Personality Inventory (MMPI) be used when examining veterans claiming mental disorders? Currently, the rating schedule allows rating the severity of mental disorders in the following increments: 10, 30, 50,

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<sup>16</sup> VHA Directive 97-059, November 25, 1997.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

70, and 100 percent disabling. The rating schedule also contains only one set of criteria for use in deciding the severity of all mental disorders rather than separate criteria for each disorder. Would separate criteria for PTSD versus schizophrenia, for example, improve rating decisions?

Veterans with physical disabilities rated 100 percent disabling have the opportunity, in many cases, to continue work, or to be rehabilitated to another occupation, yet be rated 100 percent disabled. The most severe evaluation for migraine headaches is 50 percent and the evaluation criteria include a severe economic impact. For the vast majority of other physical disabilities, there is no stated economic or occupational impact, although there are quality of life considerations. For example, a veteran with chronic renal failure requiring dialysis on a regular basis is entitled to a total (100 percent) rating. This disability may financially impact a veteran with limited education and non-physical skills to a greater extent than a veteran who can do work which does not require physical activity. There are certainly, however, quality of life considerations for both.

There are also evaluations for disabilities in the rating schedule which apparently reflect neither an economic impact nor decreased quality of life. A splenectomy, for example, is rated as a 20 percent disability while there may not be a discernable economic impact or decreased quality of life resulting from the removal of the spleen. A complete hysterectomy is evaluated as 50 percent plus special monthly compensation for loss of use of a creative organ. While it can be argued that there is a negative effect on quality of life, particularly for women of child-bearing age, there may not be an economic impact resulting from this surgery.

A disability can worsen or improve over time or as a result of treatment or medication. As specified in 38 CFR 3.327, re-examinations can be scheduled for from two to five years after initial rating, if the disability may improve.

VA's measure of impairment, disability criteria, and the structure of the rating schedule could be reviewed by the Institute of Medicine and in conjunction with income loss identified through matching with Social Security and with quality of life information from a survey.

**7. How does the adequacy of disability benefits provided for members of the Armed Forces compare with disability benefits provided to employees of Federal, State, and local governments, and commercial and private-sector benefit plans?**

Public Law 108-136 which established the Veterans' Disability Benefits Commission requires that the Commission compare veterans' disability benefits with benefits provided to individuals by the Federal Government, State governments, and the private sector<sup>17</sup>. Public Law 108-375 requires that the DoD conduct a study that compares disability benefits for members of the Armed Forces with commercial and other private-sector disability plans<sup>18</sup>. Public Law 108-375 also requires that the Government Accountability Office (GAO) conduct a study of the disability benefits for employees of the Federal, State, and local governments.<sup>19</sup> The GAO study is to pay particular attention to jobs in which employees perform tasks with risks analogous to the risks associated the performance of military tasks by members of the Armed Forces.

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<sup>17</sup> Public Law 108-136, § 1502 (c)(3).

<sup>18</sup> Public Law 108-375, § 666 (a) (2) (A).

<sup>19</sup> Ibid. § 666 (d).

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

Comparison with benefits paid from the September 11 Victim Compensation Fund<sup>20</sup> and through tort claims could also provide some indication of the adequacy of veterans and military disability benefits.

**8. How do the operations of disability benefits programs compare?**

VA provides benefits and services for disabled veterans and survivors and DoD provides both longevity retirement and disability benefits for service members and survivors. The Social Security Administration provides benefits for citizens who are disabled, some of whom are veterans. The eligibility qualifications for these programs vary as do the manner in which the benefits are administered. A high-level comparative analysis of key operational aspects of these programs could illuminate areas in which modifications and improvements could be made. Of course, understanding and recognizing the uniqueness of the compensation program is important when addressing this issue. The following areas have been identified for analysis:

- a. The role of clinicians in the claims and appeal processes, and the required number of staff for this function.** <sup>21</sup>
- b. The role of attorneys and legal staff in the claims and appeals processes, and the required number of staff for this function.**
- c. Compensation Claims Process**
  - Steps/cycles in the process
  - Location and number of processing centers
  - Administrative costs, i.e., discretionary spending – staffing, information technology, other.
  - Performance indicators (timeliness, quality, inventory, etc.)
- d. Appeals Process**
  - Steps/cycles in the process
  - Location and number of processing centers
  - Administrative costs, i.e., discretionary spending – staffing, information technology, other.
  - Performance indicators (timeliness, quality, inventory, etc.)
- e. Training and certification of staff and client representatives**
  - Required initial training
  - Required refreshed training
- f. Quality Assurance/Control Program**

**9. Pertinent law and regulations require that disability compensation be based on average impairment of earnings capacity, not on loss of individual earnings capacity.**

- a. Would the results be more appropriate if factors such as the individual's military rank, military specialty, pre-service occupation, education, and skill level were taken into consideration in determining benefits?**

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<sup>20</sup> Created by Public Law 107-42, §401.

<sup>21</sup> Presentation by Colonel Martin Tittle, United States Army Physical Disability Agency, July 22, 2005.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

**b. Would the results be more appropriate if the effect of the veteran's medical condition on his or her occupation were taken into consideration in determining benefits?**

During the period 1924 to 1933, disability ratings attempted to reflect the individual veteran's situation by considering the individual's occupation prior to military service.<sup>22</sup> Legislation reverting back to the "average impairment in earnings capacity" reportedly reflected the fact that most veterans did not have occupations prior to entering military service and that adjusting for pre-service occupations made the rating decisions more complex and time consuming.

Prior to 1993, benefits paid under the survivors program, DIC, were paid at different rates based on the service members' rank. Public Law 102-568 provided for a uniform benefit for survivors. Congress recognized that newest DIC recipients were either survivors of veterans who were non-career enlisted personnel or survivors of junior officers whose rank did not reflect their income potential in civilian life. Congressional testimony indicated an unwillingness to conclude that one family's loss from a service-connected death is somehow greater than another's based on rank.<sup>23</sup>

Analysis of the impact on earnings and quality of life due to disability could form the basis for determining whether factors such as military rank, pre-service occupations, or education should be considered in ratings.

**10. Should lump sum payments be made for certain disabilities or level of severity of disabilities? Should such lump sum payments be elective or mandatory? Consider the merits under different circumstances such as where the impairment is to quality of life and not to earnings capacity.**

The option of making lump sum payments for disabilities has been debated for many years. The Veterans' Claims Adjudication Commission (VCAC) suggested consideration of this option and discussed "pros" and "cons" without proposing policy solutions.<sup>24</sup> The VCAC cited "pros" of lump sum payments as a financial advantage at transition to civilian life, an opportunity to make long-term investments, reduction in the volume of claims, and taxpayer savings. VCAC cited "cons" as reduction in opportunity for increased ratings for worsened conditions, unwise use of the lump sum, high early years program costs, and increases in claims with little merit. DoD separates those found unable to perform their military duties but whose disabilities are 30 percent or less disabling with a lump sum payment based on base pay and years of service.

Analysis of this option in several different designs is needed to determine the appropriateness or inappropriateness of lump sums in the disability compensation program.

**11. Should universal medical diagnostic codes be adopted by VA for disability and medical conditions rather than using a unique system? Should the VA Schedule for**

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<sup>22</sup> VA Disability Compensation Program, Legislative History, Economic Systems Inc., December 2004, page 4.

<sup>23</sup> Program Evaluation of Benefits for Survivors of Veterans with Service-Connected Disabilities, vol II, pages 12-13

<sup>24</sup> Veterans' Claims Adjudication Commission, December 1996, page 8.

**Department of Veterans Affairs**  
**in support of the**  
**Veterans' Disability Benefits Commission**

**Rating Disabilities be replaced with the American Medical Association Guides to the Evaluation of Permanent Impairment?**

VA uses a unique set of diagnostic codes to classify diseases and disabilities under 15 body systems for evaluation of their severity. DoD also uses VA's Schedule for Rating Disabilities for this purpose. The World Health Organization classifies disease through its International Classification of Disease (ICD) codes and the American Psychiatric Association has its Diagnostic and Statistical Manual, Phase IV (DSM-IV) system for mental disorders. Medical staffs are more used to ICD and DSM codes in the day-to-day practice of medicine. ICD 9 provides codes for diagnoses and procedures. The diagnoses do not have associated degrees of disability, which is an essential factor for VA in evaluating disabilities. In addition, service connection is granted and a disability evaluation is assigned for chronic conditions. The ICD 9 codes include many conditions that are acute and transitory, or are simply procedures performed, which do not usually qualify for a grant of service connection. Procedures performed are included in evaluation of disabilities in some cases. For example, coronary artery disease requiring coronary bypass surgery results in a 100 percent evaluation for three months following surgery, and is then evaluated under the same criteria for coronary artery disease.

The *AMA Guides to the Evaluation of Permanent Impairment* is used in many workmen's compensation programs and in the medical community as well. VA does not use the AMA Guides to determine service connection or degree of disability.

The Commission could ask the Institute of Medicine to provide advice as to the appropriateness of adopting the ICD-9 and DSM code systems and of using the AMA Guide.

**12. Are benefits available to service disabled veterans at an appropriate level if not indexed to cost of living and/or locality? Should the various benefits that are presently fixed be automatically adjusted for inflation?**

As indicated in RQ 1, some programs have recently recognized the differences in the cost of living in urban versus rural areas and in different regions of the country. Would the level of disability compensation benefits would be more appropriate if tied to geographical variances in the cost of living?

By practice, Congress enacts legislation annually to adjust rates for compensation for increases in the cost of living. Covered by these annual cost of living allowances are DIC and Clothing Allowance. Some benefits, such as educational benefits, automatically increase with the annual increase in the cost of living, without necessity for legislation. Several benefits that are available to veterans with service-connected disabilities are not indexed and require specific action by Congress to change. However, Congress has historically not adjusted these benefits each year. Congress has, for example, sporadically and infrequently adjusted the automobile allowance, the maximum allowances for specially adapted housing and home adaptations, and the burial allowance. A recent evaluation of the Loan Guaranty Program assessed the specially adapted housing grant and recommended the maximum amount be increased based on the average annual construction cost increases.<sup>25</sup> The amount of the two types of grant were last increased in 2003 but are not indexed. Lastly, although the Secretary has the authority to increase beneficiary travel for medical care in certain instances, it has not been increased in over 25 years.

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<sup>25</sup> Evaluation of VA's Home Loan Guaranty Program, Economic Systems, ORC Macro, and the Hay Group, 2004, page ES-12.

**Department of Veterans Affairs**  
**in support of the**  
**Veterans' Disability Benefits Commission**

Some of these benefits have not been adjusted for several years. Is the level of these benefits set at an appropriate level? Should they be indexed? In addition, the maximum coverage under the Service Disabled Veterans' Life Insurance Program (SDVI) is \$10,000. When the Government first offered life insurance to members of the Armed Forces in 1917, which they continued as veterans, the maximum coverage was \$10,000. Should this maximum be raised to reflect today's income replacement needs? The SDVI program was created to provide insurance to service-disabled veterans at rates comparable to those commercial insurers charge healthy persons. However, because the premium rates are still based on 1941 mortality tables, the premiums are no longer comparable to standard rates on the commercial life insurance market. Should the premium rates be based on current life expectancy?

**13. Should VA's definition for "line of duty" change? If so, how?**

(38 CFR 3.301). Direct service connection may be granted only when a disability or cause of death was incurred or aggravated in line of duty, and not the result of the veteran's own willful misconduct (38 CFR 3.1) or, for claims filed after October 31, 1990, the result of his or her abuse of alcohol or drugs.

For VA purposes, all disabilities are in the line of duty except when the disability is the result of the veteran's own willful misconduct or substance abuse. Critics have suggested changing this standard so as to limit payment of compensation only for injuries or diseases that occur while performing actual military duty. This argument has been overcome by the theory that military members are on duty 24 hours a day, 7 days a week, therefore any injury occurring on active duty is incurred on duty. The General Accountability Office (GAO), in 1989, suggested that Congress might wish to reconsider eligibility to service connection.<sup>26</sup> Based on case file reviews, GAO questioned whether certain disabilities should be subject to service connection. In March 2003, the Congressional Budget Office, based on GAO's earlier review, provided cost savings estimates based on certain conditions not being subject to service connection.<sup>27</sup>

The "line of duty" issue is closely related to another issue which will be addressed by the full Commission – clarifying the definition and intent of service connected compensation. Another question related to this theme is: Should there be a differentiation between combat and noncombat-related injuries and peacetime and wartime injuries?

**14. To what extent, if any, should VA policies relating to presumptive conditions be changed?**

(Ref: 38 CFR 3.309): Certain diseases shall be granted service connection although not otherwise established as incurred in or aggravated by service if manifested to a compensable degree within the applicable time limits under §3.307 following service in a period of war or following peacetime service on or after January 1, 1947, provided the rebuttable presumption provisions of §3.307 are also satisfied. A presumptive condition is an injury or illness in which VA presumes a relationship exists between service and the conditions being claimed. A

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<sup>26</sup> *VA Benefits: Law Allows Compensation for Disabilities Unrelated to Military Service.* GAO/HRD-89-60. Washington, DC: July 31, 1989.

<sup>27</sup> *VA Benefits: Fundamental Changes to VA's Disability Criteria Need Careful Consideration.* GAO-03-1172T. Washington, DC: September 23, 2003.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

recurring theme within the compensation program has been the expansion of the definition of service connection, mainly under the presumption basis. Is the current process to determine whether a disease should be recognized by VA as a presumptive condition appropriate?

Agent Orange, Radiation and Gulf War Syndrome have resulted in a rapidly growing area of environmental presumptions that have prompted some to raise questions about the disability compensation program. War often affects men and women in profound ways that are not easily explainable or treatable. Many veterans experience problems/diseases that they attribute to chemical or radiation exposure. Leaving aside questions of the possible effect of psychic injuries inflicted by war on these questions, science cannot easily or quickly resolve these issues particularly where (1) chemical/radiation exposure levels are often unknowable or difficult to ascertain and (2) the effect of exposure on diseases experienced is scientifically unsettled.

Notwithstanding this uncertainty, the intense emotions surrounding those genuinely suffering and the perceived unfairness of forcing veterans to "prove" their situation is related to their possible exposure has led Congress and the Executive Branch to create presumptions. If certain studies, for example, (not even necessarily involving veterans) show that those exposed to dioxin have slightly higher rates of diabetes or prostate cancer, there is an inexorable push to compensate all veterans with diabetes/prostate cancer even if it is likely that dioxin exposure is a determinative factor in only a small percentage of cases. Since it is impossible to know what role dioxin played in any particular case, all diabetes and prostate cases are compensated.

Consultation with Institute of Medicine (IOM) about levels of exposure and how they are determined might be able to refine and enhance the process. Currently everyone who served in Vietnam is presumed to have been exposed to dioxin from Agent Orange. This presumption was created because of a lack of information. Has that changed? Do we have a better way of making these determinations?

Should VA consult with IOM to see if a different methodology should be used in determining causal relationships other than the environmental aspect used for the current method? Should the Commission review the Gulf War Illness presumptions? Should the standards for inferential statistical evidence in finding an association between causative factors and disabilities change?

**15. Should certain rating principles related to service connection be modified? (see questions below) (38 CFR 3.303 (a))**

Service connection connotes many factors but basically it means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces. Currently, all types of diseases and injuries are service connectable (Ref. 38 CFR 4.1) except for mere congenital or developmental defects (Ref. 38 CFR 4.9). Also, "age" is not a factor in evaluating service connected disability. (Ref: 38 CFR 4.19)

**a. To what extent, if any, should "age" factor into determining entitlement to service connected compensation?**

Currently, age is not a factor in evaluating service connection. Since some conditions occur as part of the natural aging process, should the age of the veteran when applying for compensation be a factor? For example,

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

should a 45 year old military retiree who gradually developed arthritis in his or her joints over the years be compensated? Should this differ from a 22 year old veteran who claims arthritis due to a traumatic injury? (This issue is closely related to the "line of duty" issue above.) Another age related issue is: Should a veteran be compensated more for a condition that, because of older age, imposes greater overall impairment to the individual?

**b. To what extent should the benefit of the doubt rule be reconsidered or redefined?**

(38 CFR 4.3) When the evidence does not satisfactorily prove or disprove that a condition is related to service, thus raising a reasonable doubt, the doubt is resolved in favor of the claimant. Is this standard appropriate? Are there other standards that should apply?

**c. To what extent should service connection on a "secondary" basis be redefined?**

(38 CFR 3.310) A disability which is proximately due to or the result of a service connected disease or injury shall be service connected. Because this represents one avenue of entitlement to service connection, the Commission should address it. Questions that should be explored include, but are not limited to, the following: Are "secondary" claims handled in an equitable manner in regards to scheduling VA examinations, rendering medical opinions, and adjudicating the claim? Is the current methodology appropriate in determining whether a claimed condition is secondary to an existing service connected condition? The Commission will consult with the Institute of Medicine to determine if, and how, the current process can be refined and enhanced. Is there a different methodology that should be used in determining causal relationships?

**d. To what extent should service connection on an "aggravation" basis be redefined?**

(38 CFR 3.306) A preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease. Does the current methodology to determine whether a condition was aggravated by service or increased due to natural progress of the disease need to be enhanced? An analysis of the laws, regulations, and procedures pertaining to service connection on an "aggravation" basis should be undertaken.

**16. Do changes need to be recommended for the Individual Unemployability (IU) benefit?**

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

(38 CFR 4.16) Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities, provided that certain schedular requirements are met. GAO is currently conducting a study on IU and is expected to produce a final report in February 2006. The Commission will consider the GAO report in its deliberations. The following list represents some of the issues that may warrant exploration by the Commission:

- Currently, age is not a factor in determining entitlement to or continuation of IU. Some have argued that IU should not be awarded to those veterans who are, in some cases, well into their retirement years. As of March 2005, 79,519 out of the 213,303 veterans receiving IU were over 65 years old (37%). Over 29,000 veterans receiving IU are over 80 years old (14%).<sup>28</sup>
- From FY 1999 to FY 2004, the number of veterans receiving increased benefits for IU increased 107 percent from 95,052 to 196,916.<sup>29</sup>
- Under VA's Income Verification Match Program, in FY 2004, 4.3 percent of all veterans receiving IU benefits reported income to IRS in excess of \$6,000.<sup>30</sup>
- Inconsistent rating practices for IU claims.

**17. Because Vocational Rehabilitation and Employment (VR&E) benefits are an integral part of the compensation package for many service connected veterans, what changes, if any, are needed in this program?**

The VA Vocational Rehabilitation and Employment Task Force recommended various redesign changes that should be made for the 21<sup>st</sup> Century.<sup>31</sup> Positive changes have already occurred due to these recommendations. However, questions still exist about fundamental and operational aspects of the program and its relationship to the compensation program to include, but not limited to, the following:

- Should age be a factor in determining eligibility? For example, should a 22 year old veteran and an 80 year old veteran be afforded the same consideration for entitlement for vocational rehabilitation benefits? Should normal retirement age be used as a cutoff?
- Should VR&E counselors be involved in determining whether a service connected veteran is unemployable?
- Veterans are generally required to be 20 percent disabled before entitlement can be established. Is this threshold appropriate? (see RQ 20)

**18. Should there be a time limit for filing an original claim for service connection? (does not include claims for service connection on a presumptive basis)**

Currently, there is no time limit for filing a claim for compensation. For example, VA will accept original claims for compensation from veterans who have been discharged from

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<sup>28</sup> Veterans Benefits Administration, Data and Information Services, Data Request 05-140 from Compensation and Pension Service, April 8, 2005.

<sup>29</sup> Department of Veterans Affairs Office of Inspector General: Review of State Variances in VA Disability Compensation Payments, Report No. 05-00765-137, Washington, DC, May 19, 2005, pg. vii

<sup>30</sup> Ibid, pg.72

<sup>31</sup> Report to the Secretary of Veterans Affairs: *The Vocational Rehabilitation and Employment Program for the 21<sup>st</sup> Century Veteran*, VA Vocational Rehabilitation and Employment Task Force, March 2004.

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

the military for over 50 years and never previously filed a claim. Some commenters have suggested the imposition of time limits for filing compensation claims is reasonable and other commenters have objected on the grounds that such time limits are unwarranted and inconsistent with the intent of disability compensation.

**19. Currently, a pending claim terminates at the time of the veteran's death even when dependents remain. To what extent, if any, should this law be changed?**

The U.S. Court of Appeals for Veterans Claims and the U.S. Court of Appeals for Federal Circuit, interpreting existing statute, have consistently held that a pending claim dies with the death of the veteran. Many have argued that this legislation should be liberalized. The Commission should study and address the appropriateness of the current laws surrounding this issue.

**20. Certain criteria and/or levels of disability are required for entitlement to ancillary and special purpose benefits. To what extent, if any, do the required thresholds need to change?**

Are the established thresholds that determine ancillary or special purpose benefits appropriate? Because eligibility to these types of benefits is contingent on the disability and/or death of the veteran, the Commission should determine the appropriateness of the established thresholds that determine a wide range of ancillary and special purpose benefits. Some examples include, but are not limited to, the following: A veteran is generally required to be 20 percent disabled before entitlement to vocational rehabilitation can be established. A certificate of eligibility for financial assistance in the purchase of automobile and necessary adaptive equipment will be paid when a veteran has a service connected loss or permanent loss of use of one or both feet or one or both hands, or has permanent impairment of vision of both eyes. In order for a child, spouse, or surviving spouse to be eligible Chapter 35, Dependents' Educational Assistance, the veteran must have a total service-connected disability that is permanent in nature. Do the criteria thresholds need to change for the myriad of benefits that are contingent on the service connected disability or death of the veteran?

**21. What recommendations, if any, should the Commission make in regards to Concurrent Receipt policies?**

Should veterans that are paid at the 100 percent level because of entitlement to individual unemployability be eligible for full concurrent receipt (like scheduler 100 percenters)? Should all veterans who have retired from the military based on longevity be eligible for concurrent receipt (instead of only the 50 percenters and higher)? Should all veterans who have retired from the military based on disability be eligible for concurrent receipt? Should phase-in rates and time periods change? Should surviving spouses who are receiving Dependency and Indemnity Compensation payments be eligible to also receive full payments under the DoD's Survivor Benefit Plan?

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

**22. Should the Commission explore and recommend changes to the "duty to assist" law? If so, how?**

Congress, in legislation, has reaffirmed the longstanding principle that the Federal government has an obligation to assist veterans in filing and prosecuting their claims. The duty to assist, as provided in statute, includes a duty to inform the veteran what is necessary for substantiation of the claim and a duty to assist the veteran in obtaining the necessary evidence. Should veterans and/or their legal representatives be responsible for developing their own claims? How does VA's duty to assist impact department resources, claims backlog, remand rate, etc.? Should VA clarify what is "sufficient evidence?"

**23. Should the Commission explore the Character of Discharge Standard?**

(38 CFR 3.12) Pension, compensation, or dependency and indemnity compensation is not payable unless the period of service on which the claim is based was terminated by discharge or release under conditions other than dishonorable. A discharge under honorable conditions is binding on the Department of Veterans Affairs as to character of discharge. Some veterans have multiple periods of service, one of which could have been dishonorable. A dishonorable discharge for one period of service does not negate rights or entitlement earned by virtue of a separate period of honorable service. Is this standard appropriate?

**24. Should compensation payments be protected from apportionments and garnishments?**

(38 CFR 3.451) Currently, compensation payments may be specially apportioned between the veteran and his or her dependents or the surviving spouse and children on the basis of the facts in the individual case as long as it does not cause undue hardship to the other persons in interest, except as to those cases covered by §3.458(b) and (c). Many have argued that VA should not be in the apportionment business. Some have also argued that the courts should adjudicate such decisions, which would be binding on the VA.

Currently, VA compensation can only be garnished when a former member of the Armed Forces has waived all or a portion of military retired or retainer pay in order to receive the compensation, and then only the amount of VA compensation that represents the military retired pay or retainer pay that has been waived is subject to garnishment.

**25. In regards to Post Traumatic Stress Disorder (PTSD), what policy changes, if any, need to be recommended?**

Many questions and concerns have been raised regarding PTSD. Given its complexity and the significant increase of PTSD cases in recent years, there are many aspects of it that warrant possible study. Recently, questions have been raised about the adjudication of PTSD claims, to include inconsistencies in the assignment of disability

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

evaluations and insufficient documentation of stressful events during the military.<sup>32</sup> In addition, concern has been raised over the frequency of occurrence of stress-related symptoms among veterans of Operation Enduring Freedom and Operation Iraqi Freedom. These issues represent a few of many that have surfaced throughout the relatively short period of time that PTSD, as a diagnosed condition, has existed.

**26. To what extent is the coordination between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) adequate to meet the needs of service members/veterans, particularly the needs of service-connected disabled veterans?**

Initial efforts to overcome statutory limitations, minimize the duplication of services, share medical resources and reduce the cost of operations between VA and DoD were first directed in 1982 with enactment of the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, hereafter referred to as the "Sharing Act."<sup>33</sup> VA and DoD were required by this law to establish a federal interagency Medical Resource Committee. Twenty-one years later, in May 2003, the final report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) cited the need for leadership, collaboration and oversight, noting that "the Departments' efforts to implement both the overall law [the Sharing Act] and the specific requirement for a joint committee have been sporadic and uneven;" most sharing occurred for specific resources at the local level, with "little attention ... to collaboration and sharing at the headquarters level of either Department."<sup>34</sup>

***Improved coordination of VA and DoD programs and systems*** was one of five management weaknesses identified in 2001 under the President's Management Agenda and included in VA's Fiscal Year 2004 Annual Performance and Accountability Report.<sup>35</sup>

Today at the executive level in both Departments, there are three joint councils that have been established to facilitate collaborative initiatives:

1. VA/DoD Joint Executive Council (JEC) chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness (established in February 2002).
2. VA/DoD Health Executive Council (HEC) chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs (established in 1997).
3. VA/DoD Benefits Executive Council (BEC), chaired by the VA Under Secretary for Benefits and the Assistant Secretary of Defense for Force Management Policy (established in January 2002).

These three councils and the work groups and task forces that have emerged from them share a common mission: "To improve the quality, efficiency and effectiveness of the delivery of

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<sup>32</sup> Department of Veterans Affairs Office of Inspector General: Review of State Variances in VA Disability Compensation Payments, Report No. 05-00765-137, Washington, DC, May 19, 2005.

<sup>33</sup> Public Law 97-174, the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, signed into law on May 4, 1982.

<sup>34</sup> President's Task Force to Improve Health Care Delivery for Our Nation's Veterans: Final Report 2003, page 13

<sup>35</sup> Department of Veterans Affairs FY 2004 Annual Performance & Accountability Report, November 2004, pages 50, 54-55

**Department of Veterans Affairs**  
**in support of the**  
**Veterans' Disability Benefits Commission**

benefits and services to veterans, service members, military retirees and their families through an enhanced VA and DoD partnership.<sup>36</sup> Additionally, "the HEC and the BEC work to identify challenges and remove barriers which impede collaborative efforts, assert and support mutually beneficial opportunities to improve business practices, ensure high quality cost effective health-related services for both VA and DoD beneficiaries, and improve transitional services and benefit delivery processes for separating service members."<sup>37</sup>

On April 15, 2003, the Deputy Secretary of Veterans Affairs, Dr. Leo S. Mackay, Jr., and the Under Secretary for Defense Personnel and Readiness, Dr. David S.C. Chu, signed the VA/DoD Joint Strategic Plan. This plan identified six strategic goals: leadership, commitment and accountability; high quality health care; seamless coordination of benefits; integrated information sharing; efficiency of operations; and joint contingency/readiness capabilities.<sup>38</sup> The accompanying document, the VA/DoD Joint Strategic Planning Initiative, detailed the objectives, tasks and target dates related to the accomplishment of each of the strategic goals. A follow-up report on the joint strategic planning initiatives, along with the accomplishments of the VA/DoD executive councils, was to be published in the First Annual Report of the VA/DoD Joint Executive Council at the end of calendar year 2004.<sup>39</sup>

In December 2004, one of the task forces of the HEC and the BEC, the VA's Seamless Transition Task Force, issued its year end report,<sup>40</sup> highlighting accomplishments to date, lessons learned and future plans. One outcome of this Task Force led to the establishment of a permanent Office of Seamless Transition to focus on services and benefits to service members returning from combat theaters with service-related conditions.

Despite the noteworthy efforts of VA and DoD, at a May 19, 2005, hearing of the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs, the Government Accountability Office (GAO) testified that while VA has given high priority to providing services to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) service members, there has been a lack of systematic data from DoD about who is seriously injured, the nature of their injuries, and where the service members received treatment.<sup>41</sup> At the time of the hearing, GAO reported: a data-sharing agreement between VA and DoD had been pending for two years; DoD raised HIPAA<sup>42</sup> privacy concerns; and the proposed memorandum of understanding being considered between the two Departments still posed challenges. "GAO found that the draft memorandum restates many of the legal authorities contained in the Privacy Rule for the use and disclosure of individually identified health data. As a result, DOD and VA will still have to agree on what types of individually identifiable health data can be exchanged and when the data can be shared."<sup>43</sup>

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<sup>36</sup> VA/DoD Joint Strategic Plan, April 15, 2003, Introduction

<sup>37</sup> Source document: VA Office of Policy, Planning & Preparedness weblink on VA-DoD Joint Initiatives: [http://www.va.gov/opp/VA\\_DoD/VA\\_DoD.htm](http://www.va.gov/opp/VA_DoD/VA_DoD.htm).

<sup>38</sup> VA/DoD Joint Strategic Planning Initiative, April 15, 2003, page 1.

<sup>39</sup> Department of Veterans Affairs FY 2004 Annual Performance & Accountability Report, November 2004, page 55.

<sup>40</sup> Department of Veterans Affairs Seamless Transition Task Force Year End Report, December 2004.

<sup>41</sup> GAO-05-722T: *Systematic Data Sharing Would Help Expedite Servicemembers' Transition to VA Services*, May 19, 2005, Highlights.

<sup>42</sup> Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule, which govern the sharing of individually identifiable health data.

<sup>43</sup> *Ibid*, Highlights

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

Between May 19, 2005, and June 27, 2005, a Memorandum of Understanding (MOU) between DoD and VA was signed by officials of both Departments, defining data sharing between DoD and VA.<sup>44</sup> It is unclear at this time whether changes were made to the draft MOU that GAO reviewed, to address the concerns GAO reported in its testimony on May 19, 2005.

On July 26, 2005, in testimony before the Subcommittee on Military Personnel of the House Armed Service Committee, the VA Deputy Under Secretary for Health, Michael J. Kussman, M.D., reported that in an effort to seamlessly transition the most severely injured from the Global War on Terrorism, ". . . both health care systems [DoD and VA] adapted quickly to use traditional manual processes to collect and share data to ensure continuity."<sup>45</sup> Traditional manual processes, in an era of advanced information technologies and multi-m/billion dollar budgets to support these technologies in both Departments, pose questions that further amplify Issue 1: to what extent is the coordination between the Departments of Veterans Affairs (VA) and the Department of Defense (DoD) adequate to meet the needs of veterans, particularly the needs of service connected disabled veterans?

- What improvements are needed to assess and ensure that the immediate and future needs (benefits and services) of service members who are medically separating from active duty are met?
- What improvements or enhancements could be made to expedite claims processing for seriously disabled and injured prior to separation?
- What improvements or enhancements could be made to the disability rating process to standardize, coordinate findings and minimize duplication between VA and DoD?
- What are the impediments and challenges and how might these barriers be overcome?

"The lines limiting organizational jurisdiction and authority should be invisible to the servicemember or veteran crossing them."<sup>46</sup> This statement from the Executive Summary to the 1999 Congressional Commission on Servicemembers and Veterans Transition Assistance provides a guiding principle by which this Commission will address the questions outlined above.

**27. To what extent is the coordination for seriously injured and disabled service members/veterans adequate within VA between the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) and internally within each of the Administrations? What are the internal and external impediments, challenges and gaps, and how might these barriers be overcome?**

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<sup>44</sup> Memorandum of Understanding between the Department of Defense and the Department of Veterans Affairs for Purposes of Defining Data-Sharing between the Departments, June 27, 2005.

<sup>45</sup> Hearing of the Subcommittee on Military Personnel, House Armed Services Committee, July 26, 2006; <http://armedservices.house.gov/schedules/Kussman72605.pdf>.

<sup>46</sup> The Congressional Commission on Servicemembers and Veterans Transition Assistance, Executive Summary, January 14, 1999, page 2.

## Department of Veterans Affairs in support of the Veterans' Disability Benefits Commission

On August 28, 2003, the Under Secretary for Health and the Under Secretary for Benefits established a task force for the seamless transition of returning service members. The group was charged with coordinating and streamlining VBA and VHA activities as well as to work with DoD on long-range initiatives.

In fiscal year 2004, VA reported that 4.7 percent of its resources were obligated to address its **Strategic Goal 2: Ensure a smooth transition for veterans from active military service to civilian life.**<sup>47</sup> The Commission will focus on the efforts inside VA to address the needs of those separating service members with service-connected disabilities.

At the end of calendar year 2004, VA's Seamless Transition Task Force reported on its accomplishments, lessons learned and future plans.<sup>48</sup> Among the lessons learned, the Task Force acknowledged:

- The need to be pro-active and coordinate all Department efforts;
- VHA and VBA employees need consistent and accurate information and guidance about the other administration's policies and procedures;
- Some service members and their health care providers could not easily identify VA employees at each Military Treatment Facility (MTF);
- Some service members couldn't distinguish between VBA and VHA employees and their roles and responsibilities in the seamless transition process.
- Using spreadsheets to manually count and monitor service members at each MTF was time-consuming and cumbersome, especially as the number of OIF and OEF casualties increased into the thousands.<sup>49</sup>

On July 21, 2005, the director and staff from the VA Office of Seamless Transition provided an overview of its strategic goal to provide timely access to VA services and benefits and the long-term objective to institutionalize the seamless transition process.

The Commission was encouraged to learn that the VA Seamless Transition Office staff has been organized to include expertise from VHA, VBA, DoD, the Guard and Reserve. The Commission will study this collaborative effort to glean further insights, while also considering GAO findings, such as testimony delivered before the Senate Committee on Veterans' Affairs in March 2005. GAO acknowledged the steps VA had taken to give high priority to seriously injured service members returning from Iraq and Afghanistan, yet found challenges in coordination and certain program areas.<sup>50</sup>

**28. To what extent is the coordination adequate within DoD between the Office of the Secretary of Defense for Personnel and Readiness, Health Affairs and Force Management Policy, and the branches of Service? What are the internal and external impediments, challenges and gaps and how might these barriers be overcome?**

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<sup>47</sup> Department of Veterans Affairs FY 2004 Annual Performance & Accountability Report, November 2004, pages 69-70

<sup>48</sup> Department of Veterans Affairs Seamless Transition Task Force Year End Report, December 2004, pages 3-6

<sup>49</sup> Ibid, pages 5-6

<sup>50</sup> GAO-05-444T, VA Disability Benefits and Health Care: Providing Certain Services to the Seriously Injured Poses Challenges, March 17, 2005

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

The Department of Defense also has separate business lines within its organizational structure involved with the transition of disabled service members. Health Affairs and Force Management Policy are similar business lines to VHA and VBA in functional responsibilities. The different branches of the Service, the Guard and Reserve add another dimension to the coordination landscape that the Commission will explore.

On July 21, 2005, DoD's Transition Assistance Program presented an overview of programs and resources available to service members transitioning from active duty status, and ongoing collaborations with VA, the Department of Labor, Homeland Security, Public Health Service and organizations within the Office of the Secretary of Defense.

**29. To what extent do DoD and VA provide disabled members/veterans the means and the opportunity to succeed in their transition to civilian life? What are the adequacy, quality, and timeliness of the benefits provided by each agency?**

The transition from active duty to civilian life is more complex and challenging for individuals affected by life changing events, such as limb loss and other service connected disabilities. Access to medical treatment, recovery and rehabilitation are needs that must be evaluated and met in a dynamic, ongoing, triaged continuum that often includes the need for medical and vocational rehabilitation, with individual and family counseling also included.

GAO published a report in January 2005, citing the need for more VA and DoD collaboration to expedite vocational rehabilitation services for seriously injured service members.<sup>51</sup>

- To what extent is there coordination between all of the resource links/needs of the disability compensation and benefits programs?
- Is there sufficient flexibility in the compensation and benefits programs design to identify and respond to changing or special needs?

"There is no universal response to trauma or disability. Recovery does not follow an orderly sequence of phases. Individuals may experience phases (stages, steps) on a continuum, may regress to an earlier phase, skip one or more phases, or phases may overlap with other phases. Each stage of adjustment requires different coping patterns."<sup>52</sup>

What are the pivotal/decision points in the transition time line and separately, but concurrently, in the rehabilitation time line of a service-connected, disabled veteran that serve as benchmarks or assessment points to identify needs, adaptive solutions and the appropriate benefits package? The following markers in the recovery process may serve as potential benchmarks or assessment points for the Subcommittee to consider:

1. At the time of the injury or event
2. Cognitive realization
3. Self-exploration: what are my choices? (What resources are available? What resources and information are needed to make good decisions for the individual?)
4. Support: peer support, family and community (local), State and other
5. Sensitivity and adaptive training for family members

<sup>51</sup> GAO-05-167, Vocational Rehabilitation: More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers, January 14, 2005

<sup>52</sup> Amputee Coalition of America, National Peer Network Guidelines, revised © 2003, page 8

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

6. Peer support training.

GAO found that the Vocational Rehabilitation and Employment (VR&E) program services were being offered to seriously injured service members expeditiously. DoD, however, expressed concerns that expedited outreach about VA benefits could work at cross purposes to military retention. With advances in medicine and prosthetic devices, some of the injured are returning to active duty. For others, they may need time to recover and adjust to the prospect that they may be unable to remain in the military and will need to prepare instead for civilian employment. "...individual differences and uncertainties in the recovery process make it inherently difficult to determine when a seriously injured servicemember will be most receptive to assistance. The nature of the recovery process is highly individualized and depends to a large extent on the individual's medical condition and personal readiness."<sup>53</sup>

The Subcommittee will look further into the approaches taken by VA and DoD and at a private sector model.

**30. What policy and cultural shifts must be made to produce a common, shared, bi-directional data exchange of information and access to medical and personnel records between VA and DoD and within VA between VBA and VHA?**

Goal 4 of the Joint [VA/DoD] Strategic Plan developed in April 2003 targeted integrated information sharing through the efficient sharing of beneficiary data, medical records, and other information through secure and interoperable information management systems.<sup>54</sup>

In testimony to the SVAC in March 2005, GAO reported that "VA does not have systematic access to DoD data about the population who may need its services. Specifically, VA cannot reliably identify all seriously injured servicemembers or know with certainty when they are medically stabilized, when they are undergoing evaluation for a medical discharge, or when they are actually medically discharged."<sup>55</sup> Similar assertions were reiterated at a hearing of the Oversight and Investigations Subcommittee of the House Committee on Veterans' Affairs in May 2005.<sup>56</sup>

In December 2004, DoD reported nearly one million service members deployed to either Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF). The VA Seamless Transition Task Force found in its year end report that there were many different definitions for the deployed OIF/OEF population, which resulted in incomplete and inaccurate data collection by DoD. The entire OIF/OEF population, including sub-populations such as activated Reserve Forces, service members with multiple deployments, service members retained under "stop loss," and those killed are data needed for VA to identify, monitor, plan and project the VA benefit use among OIF and OEF veterans. The data could also be used to identify certain

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<sup>53</sup> GAO-05-444T, VA Disability Benefits and Health Care: Providing Certain Services to the Seriously Injured Poses Challenges, March 17, 2005, page 5

<sup>54</sup> VA/DoD Joint Strategic Plan, April 15, 2003, page 1

<sup>55</sup> Ibid, page 5

<sup>56</sup> GAO-05-722T, Systematic Data Sharing Would Help Expedite Servicemembers Transition to VA Services, May 19, 2005, Highlights

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

medical conditions (such as amputations, traumatic brain injuries, and post-traumatic stress disorder) and implement new medical treatment methods.<sup>57</sup>

Access to timely, accurate personnel information and medical records from DoD is critical to VA's mission and seamless transition.

- What technologies and strategies could be employed to produce original or certified documentation to streamline and support the delivery of benefits and services across the continuum from entry in service to burial and extended to survivors, when appropriate?
- How would the adaptation of the ICD9 format affect the disability rating and transition processes? This question could be addressed by the Institute of Medicine (IOM) in its work with the Commission.

**31. To what extent are the training, education and outreach programs (of DoD, VA, and DOL) adequate to ensure that the greatest number of active duty, Guard and Reserve personnel are informed of the full range of Federal government veteran benefits and services and provided tools such as a statement of education and military occupational specialties experiences adaptable to civilian job searches?**

In a briefing of the Subcommittee on July 21, 2005, the director of the VA Seamless Transition Office presented an overview of VA's outreach efforts to OIF/OEF service members. There are OIF/OEF points of contact, case managers and benefits counselors at both VA facilities and MTFs to care for the severely disabled. Eight MTFs have VA social workers and claims representatives that counsel, enroll, initiate claims and transfer care to VA; 157 V[H]A facilities have a designated Point of Contact to expedite transfers, enroll, transfer records and coordinate with VBA; 157 V[H]A facilities also have case managers that coordinate care and communicate with the MTFs.<sup>58</sup>

The VA Seamless Transition Office presented a slide with the number of outreach and military services briefings given to active duty in fiscal year 2004: 7,210 briefings with 261,391 in attendance; in fiscal year 2005: 4,637 briefings with 192,599 in attendance. The number of outreach and military services briefings given to National Guard/Reserve in fiscal year 2004 were reported as: 1,399 briefings with 88,366 in attendance; in fiscal year 2005: 974 briefings with 68,351 in attendance.<sup>59</sup>

In addition, 140 military installations actively participate in the Benefits Delivery at Discharge (BDD)<sup>60</sup> program and VA coordinates services with the following DoD organizations: Marines – Marine4Life; Army – DS3; Air Force – Palace HART; Navy- Safe Harbor; All Services: Military One Source and Military Severely Injured Center (MSIC). DOL participates with a program called REALifelines, and volunteer organizations include VET IT, the National Military Family Association Program and Family Readiness Centers.<sup>61</sup>

<sup>57</sup> Department of Veterans Affairs Seamless Transition Task Force Year End Report, December 2004, pages 5-6

<sup>58</sup> Department of Veterans Affairs Office of Seamless Transition, Veterans' Disability Benefits Commission, July 21, 2005, Slide 8

<sup>59</sup> Ibid, Slide 12

<sup>60</sup> Ibid, Slide 25

<sup>61</sup> Ibid, Slide 14

**Department of Veterans Affairs  
in support of the  
Veterans' Disability Benefits Commission**

VA also provides a dedicated website for "one-stop" information links to detailed information about the benefits and services available to transitioning OIF and OEF veterans at <http://www.seamlesstransition.va.gov/seamlesstransition/>. The links provide portals to additional websites addressing benefits, medical, dependents, transition assistance, active duty, and Reservists/National Guard.

Two challenges featured on the list of Challenges that the VA Seamless Transition Office identified were delivering outreach benefits/services and early disability services/benefits and rehabilitation prior to separation from active duty.<sup>62</sup>

- What are the pivotal points in the transition time line that demonstrate the greatest outreach impact and should portions of the time line be expanded?
- Which education and training methods and mediums should be used to cultivate a shared philosophy and cultural integration from the top down?

The Commission will consider additional strategies to effect outreach and education to service-connected disabled veterans.

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<sup>62</sup> Ibid, Slide 16