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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
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REVIEW OF VETERANS' DISABILITY COMPENSATION: EXPERT WORK ON PTSD AND OTHER ISSUES

WEDNESDAY, FEBRUARY 27, 2008

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:33 a.m., in room 562, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, and Burr.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. The hearing will be in order. Aloha and welcome to all of you to today's hearing.

Disability compensation is at the heart of what our government offers to wounded warriors, yet many veterans and others believe that VA's compensation system is fundamentally broken. To understand what significant changes, if any, are needed, the committee will devote significant time and energy to disability compensation. No one on this committee undertakes this endeavor lightly.

As I said at an earlier hearing on compensation, the Veterans' Disability Benefits Commission report is part of the road map that we are following to improve the system. Today is the third hearing in a series. The first hearing focused on the overall findings and recommendations in the Commission's report. That report relied heavily on the expert work performed by the witnesses before us today.

There were two organizations that provided the bulk of the research used by the Commission, the CNA Corporation and the Institute of Medicine. IOM did a series of studies, including a hard look at VA's system for evaluating military service and PTSD. The recommendations in these studies have tremendous ramifications for servicemembers who are right now in harm's way. IOM also looked at the way VA makes decisions about presumptive disabilities and how disabilities are medically evaluated and rated. IOM's work has broad implications for VA's disability compensation system.

The Veterans' Disability Benefits Commission asked the CNA Corporation for help on one essential question, whether the benefits provided to veterans and their survivors for disability and deaths are appropriate. The recommendations made by IOM and

CNA Corporation could potentially impact millions of veterans and their survivors.

I am pleased that we have representatives of both groups here today to help us better understand those findings.

In particular, there are some who question whether disability compensation serves as a disincentive for wellness. Given IOM's recent report in this area, I would like to know whether this view is supported by the literature IOM reviewed.

In the interest of time, I will stop here and ask the committee members for their statement. Senator Murray?

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Chairman Akaka, for holding today's hearing to review the findings of the Veterans' Disability Benefits Commission. This hearing is a very good opportunity for all of our committee members to better understand the expert work that was done for the Commission by the Institute of Medicine and the CNA Corporation. I want to thank all of today's witnesses who provided the Commission with their medical expertise and their professional analysis. Their collective analysis was critical to the VDBC's final recommendations, recommendations that were evidence-based and data driven.

As most everyone here knows, the VDBC made 113 suggestions designed to bring the VA's disability compensation program into the 21st century. They cover a wide range of issues to ensure that our veterans' benefits compensate all service-disabled veterans and their families fairly and consistently. The men and women who served our country deserve a VA disability benefits system that is worthy of their sacrifice. As a country, we owe it to them to make sure that we do everything to make their transition to civilian life as smooth as possible, and that we compensate them for the physical and mental wounds they incurred as a result of their service.

Unfortunately, that is not happening. The current system is outdated, and it is burdensome. It fails to successfully address the wide range of disabilities that impact the lives of veterans of all ages and rank. It is excessively complex and it all too often is just too slow.

The Veterans' Disability Benefits Commission has made a number of worthy suggestions to address those shortfalls and bring the disability benefits system into the 21st century. Among the most significant recommendations made by the Commission is to update the current ratings schedule and to revise the purpose of the current system, from a model that now only compensates for work disability, to a model that, instead, compensates for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality-of-life.

It is clear that a lot of work went into producing the document that is now before us. After two and one-half years, the VDBC produced a 500-plus-page report with 113 recommendations. This is the most expansive analysis of veterans' disability benefits in more than 50 years. The work done by the IOM and the CNA were key factors in the Commission's decision to make their recommenda-

tions. I thank all of you for being here today and look forward to hearing your discussion about how you came to those conclusions. Thank you very much for your work.

Chairman AKAKA. Thank you very much, Senator Murray.

Now we will hear from our Ranking Member, Senator Burr.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Mr. Chairman, thank you. More importantly, thank you to our witnesses for their willingness to be here to discuss the work you performed for the Veterans' Disability Benefits Commission.

It is clear that you spent countless hours studying the benefits and services provided to our Nation's veterans and thinking of ways to improve them, and for that, I truly want to say thank you on behalf of this entire committee. Your efforts helped the Disability Commission form its recommendations and they will also help guide this committee's efforts to improve the lives of our Nation's veterans.

Before we hear your presentation, I would like to comment on a couple of broad themes that are raised in your report.

First, your report highlights the lack of coordination among the many benefits and services that VA provides to injured veterans. As we all know, VA has a world class health care system, a comprehensive vocational rehabilitation and employment program, and a disability compensation program, among many other benefits. But as the Institute of Medicine found, while VA has the services needed to maximize the potential of veterans with disabilities under one roof, they are not actively coordinated and thus are not as effective as they could be.

As part of a more integrated approach, the Institute of Medicine suggested that we move away from the current process that requires many veterans with Post Traumatic Stress Disorder to obtain a disability rating from VA before they get priority access to VA's mental health services. The Institute of Medicine expressed the belief that, and I quote, "if it were possible to provide a path to treatment that did not involve seeking a disability rating, it would enhance opportunities for recovery and for wellness," unquote. That is what it is all about. I couldn't agree more.

That is why I introduced the Veterans Mental Health Treatment First Act last month. That bill would help veterans suffering from PTSD get treatment before they go through any of the disability rating process. Under my bill, VA would provide veterans with a wellness stipend to help them financially as they seek and complete their treatment program. What a novel approach. All veterans would have to do is agree to comply with the treatment program and hold off on filing disability claims for a short period, hopefully the completion of their rehabilitation period. My goal is to try to change the existing mind set from one that emphasizes disability status to one that emphasizes wellness and restoration. I look forward to hearing from our witnesses today about how we might be able to accomplish that specific goal.

The second important theme that these reports highlighted is the need to update VA's disability compensation system. As the Insti-

tute of Medicine found, the current system has not kept pace with society in understanding disabilities. As we will hear today, the studies point out that some parts of VA's disability rating schedule have not been properly updated for more than six decades. And even the parts that have been updated are not adequate for assessing disabilities like PTSD and Traumatic Brain Injury—conditions that are affecting so many veterans of the War on Terror.

One report also found that the rating schedule does not adequately compensate veterans who become seriously disabled at a young age and have most of their working lives ahead of them. This deficiency is being felt by many young veterans of the War on Terror, like Ted Wade, a veteran from my home State of North Carolina who suffered a devastating injury at the age of 25 while serving in Iraq. As his wife Sarah put it, "due to his injuries, Ted will never again get a pay raise."

In short, the findings in these reports make it very clear that there is an urgent need to update and modernize this system. To do that, the report recommended a wide range of improvements, such as compensating veterans for loss of quality-of-life, completely updating VA's rating schedule, and developing incentives that will promote vocational rehabilitation and help our heroes return to work, which is, I think, our charge.

With these reports and others showing us the serious deficiencies of the current system, we simply cannot ignore the need for modernization. We have young men and women returning home from war with devastating injuries and they need to come back to a system that cuts the red tape and quickly provides them the benefits and, more importantly, the services they need to return to a full and productive life.

To start us on that path, I have been working on a bill that would incorporate many of the recommendations of these reports. In part, my bill would require the entire rating schedule to be replaced with an updated schedule. It would require VA to compensate veterans for any loss of quality-of-life caused by service-related disabilities. It would also require VA to conduct a study on the factors that may prevent injured veterans from achieving their career goals and what steps could be taken to help them overcome those obstacles. Also, this bill would create a new transition payment for injured veterans who were found unfit for duty. These payments would help cover family living expenses so an injured veteran would be better able to focus on rehabilitation, training, and, more importantly, returning to the workforce.

As the Institute of Medicine pointed out, this type of modernization of the disability system will not be easy and may require a large up-front cost. In my view, it is the right thing to do, and I believe we shouldn't stop this process from moving forward.

Mr. Chairman, before I turn back over the mike to you, I want to mention an interesting quote that the Institute of Medicine included in the beginning of its report, and I quote, "Knowing is not enough. We must apply. Willing is not enough. We must do." Unquote. I think it is a great reminder to all of us that we need to do more than just read the reports. We need to take action to fix the problems that have been identified by you and so many others.

Mr. Chairman, I hope we will work together to do just that, so that our wounded warriors will have a modern, fair, and, more importantly, a coordinated system to help them return to full and productive lives. I thank the Chair and I yield the floor.

Chairman AKAKA. Thank you very much, Senator Burr, for your statement.

I want to welcome our panel here and first welcome Dr. Joyce McMahon, Managing Director of the Center for Health Research and Policy with CNA Corporation. She is accompanied by Dr. Eric Christensen.

Representing IOM is Dr. Lonnie Bristow, the Chair of the Committee on Medical Evaluation of Veterans for Disability Compensation. He is also a former President of the American Medical Association. He is accompanied by Michael McGeary.

Also representing IOM is Dr. Dean Kilpatrick, a member of the Committee on Veterans' Compensation and PTSD. He is also the Director of the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. He is accompanied by Dr. David Butler.

Finally, we have Dr. Scott Zeger, who is a member of IOM's Committee on Evaluation of the Presumptive Disability Decision Making Process for Veterans. He is also a professor at Johns Hopkins Bloomberg School of Public Health. He is accompanied by Dr. Rick Erdtmann.

Dr. McMahon, will you please begin with your statement?

STATEMENT OF JOYCE McMAHON, PH.D., MANAGING DIRECTOR, CENTER FOR HEALTH RESEARCH AND POLICY, CNA CORPORATION; ACCOMPANIED BY ERIC CHRISTENSEN, PH.D., SENIOR PROJECT DIRECTOR, CENTER FOR HEALTH RESEARCH AND POLICY, CNA CORPORATION

Ms. MCMAHON. Thank you. Chairman Akaka, Senator Burr, distinguished members, I appreciate the opportunity to testify before the Senate Committee on Veterans Affairs today on the subject of the findings and recommendations of the Veterans' Disability Benefits Commission. This testimony is based on the findings reported in CNA's final report for the Veterans' Disability Benefits Commission.

Our overall focus was to provide analysis regarding the appropriateness of the current benefits program for compensating for loss of average earnings and degradation of quality-of-life resulting from service-connected disabilities for veterans. In addition, the Commission asked us to address additional topics, including disincentives for disabled veterans to work or receive recommended treatment; surveys of raters and veterans' service officers with regard to how they perceive the processes of rating claims and assisting applicants; the economic well-being and quality-of-life of survivors; comparing the VA disability compensation program to other Federal disability programs; evaluating offering a lump-sum option to some service-disabled veterans; individual unemployability, mortality, and Social Security Disability income; and finally, comparing DOD disability determinations to those conducted by the VA.

I am going to briefly summarize our major findings. The other details are in the written testimony.

With regard to earnings comparisons for service-disabled veterans, our primary task was to address how well VA compensation serves to replace the average loss in earnings capacity for service-disabled veterans, in other words, to bring them to parity. We looked at this overall as well as by subgroups based on the body system of the primary disability and on the total combined disability rating, from 10 percent to 100 percent.

We found that for male service-disabled veterans, they are about at parity overall with respect to lost earnings capacity balanced by VA compensation at the average age of entry, which is approximately age 55. However, there are some important differences by subgroup. In general, those with a primary mental disability have lower earnings ratios than those with a primary physical disability, and many of the rating subgroups for those with a primary mental disability had earnings rates below parity. In addition, entry at a young age is associated with below-parity earnings ratios, especially for those who are in the severely disabled subgroups.

The second major tasking from the Commission was to assess veterans' quality-of-life degradation resulting from service-connected disability. Addressing this issue requires surveying service-disabled veterans to estimate their average quality-of-life. We used health-related questions that were taken from a standardized bank of questions that are widely used to examine health status in the overall population. This allowed us to compare the results for the service-disabled veterans to widely published population norms.

We found that as the degree of disability increased, in general, overall health declined. There were differences between those with physical and mental primary disabilities in terms of physical and mental health. For those who had a primary physical disability, there was a marked diminishing in the amount of the physical health scores that they received, but in general that did not lead to lowered mental health except for those who were the most severely disabled. On the other hand, having a primary mental disability led not only to lowered mental health scores, but was also associated with lower physical health, as well. For those with a primary mental disability, physical scores were well below the population norms for all rating groups, and those with PTSD had the lowest physical health scores of all.

In essence, the earnings parity measure that I spoke of allows an estimate of whether the VA compensation benefits provide an implicit quality-of-life payment. There is no explicit quality-of-life payment, of course. If an earnings ratio is above parity, the veteran would be receiving an implicit positive quality-of-life payment. Those with a ratio less than parity effectively receive a negative quality-of-life payment.

Going back to our earnings ratios, we found on average that VA compensation does not provide a positive quality-of-life payment overall, but there are implicit negative quality-of-life payments for severely disabled veterans who enter the system at a young age, and more generally for those with a mental primary disability. This goes along with the context that the loss of quality-of-life appears to be greatest for those with a mental primary disability.

I have other findings, but I am about out of time; so I think I will close at this point. Thank you.

[The prepared statement of Ms. McMahon follows:]

PREPARED STATEMENT OF JOYCE MCMAHON, PH.D., MANAGING DIRECTOR, CENTER FOR HEALTH RESEARCH AND POLICY, CNA CORPORATION

Chairman Akaka, Senator Burr, distinguished members; I appreciate the opportunity to testify before the Senate Committee on Veterans' Affairs today on the subject of the findings and recommendations of the Veterans' Disability Benefits Commission (VDBC). This testimony is based on the findings reported in *Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results, and Selected Topics*, by Eric Christensen, Joyce McMahon, Elizabeth Schaefer, Ted Jaditz, and Dan Harris, of the CNA Corporation (CNA). Details on the specific findings discussed here can be found in the report, which is available at *http://www.cna.org/domestic/health care/*.

The Commission asked CNA to help assess the appropriateness of the benefits that the Department of Veterans Affairs (VA) provides to veterans and their survivors for disabilities and deaths attributable to military service. Our overall focus was to provide analyses regarding the appropriateness of the current benefits program for compensating for loss of average earnings and degradation of quality-of-life resulting from service-connected disabilities for veterans. We also evaluated the impact of VA compensation for the economic well-being of survivors and assessed their quality-of-life.

In addition, the Commission asked us to address additional topics, including:

- Disincentives for disabled veterans to work or to receive recommended treatment.
- Surveys of raters and Veterans Service Officers with regard to how they perceive the processes of rating claims and assisting applicants.
- Comparing the VA disability compensation program to other disability programs
- Evaluating offering a lump sum option to some service-disabled veterans.
- Individual unemployability (IU), mortality, and Social Security Disability Income
- Comparing DOD disability determinations to those conducted by the VA.

EARNINGS COMPARISONS FOR SERVICE-DISABLED VETERANS

Our primary task was to answer the question of how well the VA compensation benefits serve to replace the average loss in earnings capacity for service-disabled veterans. Our approach identified target populations of service-disabled veterans and peer or comparison groups (non-service-disabled veterans) and obtained data to measure earned income for each group. We also investigated how various factors such as disability rating, type of disability, and age impact earned income. Finally, we compared lifetime earned income losses for service-disabled veterans to their lifetime VA compensation, adjusting for expected mortality and discounting to present value terms, to see how well VA compensation replaces lost earning capacity.

Congressional language indicates that the intent of VA compensation is to provide a replacement for the average impairment in earning capacity. VA compensation is not an individual means-tested program, although there are minor exceptions to this. Therefore, we focused on average losses for all service-disabled veterans and for subgroups. We defined the subgroups of disabled veterans, through consultation with the Commission, on the body system of the primary disability (16 in all) and on the total combined disability rating (10 percent, 20–40 percent, 50–90 percent, and 100 percent disabled). In addition, we further split the 50–90 percent disabled group into those with and without individual unemployability status (IU). After meeting certain disability criteria as well as providing evidence that they are unable to engage in substantial gainful employment, IU disabled veterans receive compensation at the 100 percent disabled level.

To make earnings comparisons over a lifetime, it is necessary to have a starting point. In other words, a young service-disabled veteran will have a long period of lost earnings capacity during prime wage-earning years, while a veteran who enters into the VA disability compensation system at an older age will face reduced earnings capacity for a smaller number of years. If a veteran first becomes eligible for VA compensation at age 65 or older, the average expectation of lost earnings is very low, because a large share of individuals are retired or planning to retire soon by this age. The data show that the average age of entry into the VA compensation system is about 55 years, although many enter at a younger or older age. Also, the average age of entry varies somewhat across the body systems of the primary disability and combined degree of disability.

We looked at average VA compensation for all male service-disabled veterans, and found that they are about at parity with respect to lost earnings capacity at the average age of entry (55). We compared the discounted present value of their lifetime expected earnings to the earnings of their peer group (i.e., veterans who were not service-disabled). To calculate expected earnings parity, we took the ratio of service-disabled earned income plus VA compensation divided by the present value of total expected earnings for the peer group. This figure is 0.97, which is near parity. A ratio of exactly 1 would be perfect parity, indicating that the earnings of disabled veterans, plus their VA compensation, give them the same lifetime earnings as their peers. A ratio of less than one would mean that the service-disabled veterans receive less than their peers on average, while a ratio of greater than one would mean that they receive more than their peers.

We also evaluated the parity of earned income and VA compensation for service-disabled veterans compared to the peer group by disability rating group and age at first entry into the VA compensation system. Our findings indicate that it is important to distinguish whether the primary disability is a physical or a mental condition. We found that there is not much difference in the results among physical body systems (e.g., musculoskeletal, cardiovascular), and for mental disabilities, it does not matter much whether the disability is for PTSD or some other mental disability.

Examining veterans with a physical primary disability, our findings indicate that service-disabled veterans are generally at parity at the average age of first entry into VA compensation system (50 to 55 years of age). However, we observed earnings ratios substantially below parity for service-disabled veterans who were IU, and slightly below parity for those who were 100 percent disabled, who entered at a young age. Those who first entered at age 65 or older were generally above parity.

For veterans with a mental primary disability, we found that their earnings ratios were generally below parity at the average age of entry, except for the severely disabled (IU and 100 percent disabled). We found that the severely disabled who enter at a young age are substantially below parity. Those who entered at age 65 or older generally were above parity, except for the 10 percent disabled group, which was still slightly below parity.

To summarize the earnings ratio findings for male veterans, there is general parity overall. However, when we explored various subgroups, we found that some were above parity, while others were below parity. The most important distinguishing characteristic is whether the primary disability is physical or mental. In general, those with a primary mental disability have lower earnings ratios than those with a primary physical disability, and many of the rating subgroups for those with a primary mental disability had earnings rates below parity. In addition, entry at a young age is associated with below parity earnings ratios, especially for severely disabled subgroups.

VETERANS' QUALITY-OF-LIFE SURVEY RESULTS

The second principal tasking from the Commission was to assess whether the current benefits program compensates not just for loss of average earnings, but also for veterans' quality-of-life degradation resulting from service-connected disability. Addressing this issue required collecting data from a representative sample of service-disabled veterans, which would allow us to estimate their average quality-of-life. To do this, we constructed, in consultation with the Commission, a survey to evaluate the self-reported physical and mental health of veterans and other related issues. CNAC's subcontractor, ORC Macro, conducted the survey and collected the data. As with the earned income analysis, we designed the survey to collect data by the major subgroup. We defined subgroups by the body system of the primary disability and combined disability rating, and three SMC categories. We were also able to characterize the survey results by IU status within the 50–90 percent disabled subgroup.

The survey utilized 20 health-related questions taken from a standardized bank of questions that are widely used to examine heath status in the overall population. These questions allowed us to calculate a physical health summary score (physical component summary, or PCS) and a mental health summary score (mental component summary, or MCS). This approach is widely used to measure health status in a variety of national surveys, and it allowed us to compare the results for the service-disabled veterans to widely published population norms. We also calculated five additional health subscales that also have widely published population norms.

For evaluating the survey, we analyzed the results by subgroup similar to the strategy we used for comparing earnings ratios. We looked at those with a primary physical disability and those with a primary mental disability separately. We also examined the PCS and MCS scores for additional subgroups within those categories.

For the population norms, the PCS average is set at 50 points, and the norms decrease slightly with age. For the MSC scores, the population norm is quite flat at an average of 50, and decreases only for the oldest age categories.

For service-disabled veterans with a primary physical disability, we found that their PCS measures were below population norms for all disability levels, and that the scores were in general lower as the disability level increased. In addition, having a primary physical disability was not generally associated with reduced mental health as measured by MCS. Mental health scores for those with a primary physical disability were close to population norms, although those who were severely disabled had slightly lower mental scores.

For service-disabled veterans with a primary mental disability, we found that both the physical and mental component summary scores were well below population norms. This was true for each of the rating groups. This was a distinction from those with a primary physical condition, who (except for the severely disabled) did not have MCS scores below population norms.

To summarize our overall findings, as the degree of disability increased, generally overall health declined. There were differences between those with physical and mental primary disabilities in terms of physical and mental health. Physical disability did not lead to lowered mental health in general. However, mental disability did appear to lead to lowered physical health in general. For those with a primary mental disability, physical scores were well below the population norms for all rating groups, and those with PTSD had the lowest PCS values.

We also used the Veterans Survey to investigate other issues that the Commission raised. First, we investigated whether service-disabled veterans tended to not follow recommended medical treatments because they felt it might impact their disability benefits. We used a series of indirect questions to ascertain this information. We found that this does not appear to be an issue.

In addition, the Commission asked us to investigate whether VA benefits created a disincentive to work for service-disabled veterans. Again, we used a series of indirect questions to ascertain this information. For example, a disincentive to work might be seen through working part-time instead of full-time, or retiring early. We did not find this to be a major issue, as only 12 percent of the service-disabled veterans indicated that they might work, or work more, if it were not for their VA benefits. However, it could be that these individuals felt that they would have no choice but to work more, if they had no VA benefits, and that it might be quite difficult for them to actually work more.

COMBINING EARNINGS AND QUALITY-OF-LIFE FINDINGS FOR SERVICE-DISABLED VETERANS

The quality-of-life measures allow us to examine earnings ratio parity measures in the context of quality-of-life issues. In essence, the earnings parity measures allow an estimate of whether the VA compensation benefits provide an implicit quality-of-life payment. If a subgroup of service-disabled veterans has an earnings ratio above parity, they are receiving an implicit quality-of-life payment. At parity, there is no quality-of-life payment, and those with a ratio less than parity are effectively receiving a negative quality-of-life payment. We turned next to considering the implicit quality-of-life payment in the context of the veterans' self-reported health status.

With regard to self-reported quality-of-life, we had multiple measures to consider, such as the PCS and MCS measures, and a survey question on overall life satisfaction. In addition, there is no intrinsic valuation of a PCS score of 42 compared to a score of 45. We know that a score of 45 reflects a higher degree of health than a score of 42 does, but we have no precise way to categorize the magnitude of the difference. To simplify the analysis, we combined the information from the PCS and MCS into an overall health score, with a population norm of 100 points (each scale had a norm of 50 points separately). Then we calculated the population percentile that would be attributed to the combined score. For example, for a score of 77 points, we know that 94 percent of individuals in the age range 45 to 54 would score above 77. This gave us a way to calibrate our results, in terms of how the overall physical and mental health of the service-disabled veterans compares to population norms. By construction, the 50th percentile is the population norm of this measure.

The results of this analysis confirmed our earlier finding that there are more significant health deficits for those with a primary mental disability than a primary physical disability. We found that overall health for those with a mental primary disability is generally below the 5th percentile in the typical working years for those who are 20 percent or more disabled (this would represent a combined score of 77).

Even for the 10 percent group, the overall health score is generally below the 20th percentile (a combined score of 83).

This approach allows us to consider the implicit quality-of-life payment, based on the parity of the earnings ratio, compared to the overall health percentile and the overall life satisfaction measure (the percentage of respondents who say that they are generally satisfied with their overall life). We investigated this by rating groups and average age at first entry, separately for those with a physical primary disability compared to a mental primary disability. We discuss our findings separately for those with a physical primary disability and for those with a mental primary disability, considering the implicit quality-of-life payment, the overall health percentile and the overall life satisfaction.

For those with a physical primary disability, the average age at first entry varied from 45 to 55, rising with the combined degree of disability. For 10 percent and 20–40 percent disability, there was a negative quality-of-life payment, although their overall health percentile ranged from 28 to 15 percent. For these groups, the overall life satisfaction ranged from 78 to 73 percent. For higher level of disability groups, there was a modest positive quality-of-life payment, ranging as high as $2,921 annually for the 100 percent disabled group. For the 100 percent disabled group, the overall health percentile was 4, meaning that 96 percent of the population would have a higher health score than the average score for this subgroup, and the overall life satisfaction was only 60 percent.

For service-disabled veterans with a mental primary disability, we found that there was an implicit negative quality-of-life payment for veterans of all disability levels except for those designated as IU. Also, for these subgroups, the overall health percentile was at the 13th percentile for 10 percent disabled and at the 6th percentile for 20–40 percent disabled. In fact, for the higher disability groups, the overall health score was at or below 1 percent, meaning that 99 percent of the population would have a higher overall health score. Overall life satisfaction, even for the 10 percent disability level, was only 61 percent. For disability levels 50–90 percent, IU, and 100 percent disabled, the overall life satisfaction measure hovered around 30 percent.

With regard to implicit quality-of-life payments, we found positive quality-of-life payments for those with a physical primary disability at a combined rating of 50 to 90 percent or higher (except for IU). For those with a mental primary disability, we found a positive quality-of-life payment only for the IU subgroup. In comparing overall health percentiles and life satisfaction, however, we found that for all rating groups, those with a mental primary disability had lower overall health percentiles, and substantially lower overall life satisfaction, than those with a physical primary disability. Those with a mental primary disability had lower health and life satisfaction compared to those with a physical primary disability, but received less in implicit quality-of-life payments.

To summarize, we found that VA compensation is about right overall relative to earnings losses based on comparison groups for those at the average age at first entry. But the earnings ratios are below parity for severely disabled veterans who enter the system at a young age and more generally below parity among subgroups for those with a mental primary disability. Earnings ratios tend to be above parity for those who enter the VA system at age 65 or older. On average, VA compensation does not provide a positive implicit quality-of-life payment. Finally, the loss of quality-of-life appears to be greatest for those with a mental primary disability.

EARNINGS AND QUALITY-OF-LIFE FINDINGS FOR SURVIVORS

We computed earnings profiles for survivors using a methodology analogous to that used for service-disabled veterans. We calculated earnings income by age group and compared these earnings levels to the earnings of surviving spouses in the general population. Segmenting by age group is critical as 69 percent of survivors are 65 or more years old.

We also constructed and conducted a survey for survivors to assess how their self-reported health compared to population norms. We focused our comparisons on female survivors and their peers from the Current Population Survey (CPS). We were asked to explore how well Dependency and Indemnity Compensation (DIC) provided a partial replacement for lost earnings attributed to the loss of a servicemember or veteran.

The earnings comparisons show that on average survivors generally have lower earnings than their civilian peer groups, but that the combination of earned income plus VA compensation is as high as, or higher than, the average earned income of their peer groups at every age. In addition, based on our survey results, 90 percent

of the respondents said that they were satisfied with DIC. We concluded that DIC appears to provide an adequate replacement for lost earnings for survivors.

The health differences among survivors and their peers are not as dramatic as the health differences were for service-disabled veterans and their peers, but there are some departures from population norms. The PCS for survivors is below population norms for age 55 and over, and the MCS is below population norms for ages 35 to 64. Those survivors who provided substantive care to a disabled veteran (4 or more hours per day, 5 days a week, for 2 or more years) appeared to suffer some negative effects on physical health and participation in social activities.

RATERS AND VSOS SURVEY RESULTS

The Commission asked us to survey VBA rating officials and accredited veterans service officers (VSOs) of National Veterans Service Organizations (NVSOs) to gather insights from those who work most closely with the benefits determination and claims rating process. Through consultation with the Commission, we constructed separate (but largely parallel) surveys for raters and VSOs. The surveys focused on the challenges in implementing the benefits determination and claims rating process and perspectives on how the process works. Training, proficiency on the job, and resource availability and usage were among the issues examined.

The overall assessment indicated that the benefits determination process is viewed as difficult to use. Many VSOs find it difficult to assist in the benefits determination process. In addition, VSOs report that most veterans and survivors find it difficult to understand the determination process and difficult to navigate through the required steps and provide the required evidence. Most raters and VSOs agreed that veterans have unrealistic expectations of the claims process and benefits.

Raters and VSOs noted that additional clinical input would be useful, especially from physicians and mental health professionals. Raters felt that the complexity of claims was rising over time, and that additional resources and time to process claims would help. Some raters felt that they were not adequately trained or that they lacked enough experience. They viewed mental claims, especially PTSD, as requiring more judgment and subjectivity and as being more difficult and time-consuming compared to physical claims. Many raters indicated that the criteria for IU are too broad and that more specific decision criteria or evidence would help in deciding IU claims.

VA DISABILITY COMPENSATION PROGRAM COMPARED TO OTHER DISABILITY PROGRAMS

The Commission was interested in operational aspects of the veterans' disability compensation program and asked us to compare VA's program with other Federal disability compensation programs to determine whether there are any useful practices that VA could adopt to improve its own operations. Our first task was to identify the major criticisms of operations in the VA disability program. We reviewed a variety of sources that discussed problems with VA performance, including reports from the Government Accountability Office (GAO), reports from the VA Office of the Inspector General (OIG), congressional testimony, and the results of the Commission's site visits.

After identifying the major criticisms of VA, we spoke with the relevant VA staff to get additional information on the areas being criticized. We interviewed individuals who worked in VBA's Compensation and Pension Service, VBA's Office of Employee Development and Training, the Board of Veterans' Appeals, and the Office of the General Counsel. We discussed specific aspects of VA operations that were identified as problematic and the approaches that the other disability programs take in those areas.

Except for the very important issue of timeliness, VA does not appear to be underperforming in comparison with other disability programs. Recent training improvements seem promising for improving VA timeliness in the long term, but effects will not be seen for a while. Some of VA's problems with timeliness could be the result of a complex program design, with multiple disabilities per claim, the need to determine service connection (sometimes many years after separation), and the need to assign a disability rating to each disability.

OPTION FOR A LUMP SUM ALTERNATIVE

The Commission asked us to explore options for replacing the current annuity benefits stream for some service-disabled veterans with a lump sum alternative. We looked at this from the perspective of the potential benefits and costs both to the VA and to service-disabled veterans, and with respect to potential implementation barriers. We also investigated how other countries use a lump sum alternative for their service-disabled veterans. We focused on exploring possible options for those

at the lowest disability levels (10 to 20 percent). In addition, we determined that this would be most feasible for body systems where rating changes were infrequent, as re-rating might generate the need to recalculate lump sum payments or provide an annuity.

For the VA, the anticipated benefits of a lump sum derive primarily from the potential for reduced administrative interactions (which might lead to speedier claims processing) and savings in compensation and administrative costs. If the lump sum were optional, this would increase the choices open to service-disabled veterans. Finally, there are a number of concerns about how the lump sum amounts would be determined, what would happen if a veteran's condition worsened after he/she had taken a lump sum, and whether veterans would use a lump sum "wisely" or not.

We looked at Australia's, Canada's, and the United Kingdom's disability compensation systems for their service-disabled veterans, all of which utilize some version of a lump sum alternative. These countries generally use an annuity system to compensate for "economic" losses, and reserve the lump sum for compensating for "non-economic" or quality-of-life losses. Canada and the UK use lump sums to compensate for lost quality-of-life, while Australia offers the veteran a choice between an annuity and a lump sum.

We made a number of simplifying assumptions and selected a small number of examples to simulate how a lump sum program might be implemented. We found that the VA could obtain net savings, but a lump sum option would be costly up front, taking between 17 and 25 years for the VA to achieve net savings. In addition, we identified a number of institutional issues that would pose execution challenges.

IU AND MORTALITY

The Commission asked us to conduct an analysis of those receiving the individually unemployable (IU) designation. This designation is for those who do not have a 100 percent combined rating but whom VA determines to be unemployable. The designation enables them to receive disability compensation at the 100 percent level.

Overall 8 percent of those receiving VA disability compensation have IU, but 31 percent of those with PTSD as their primary diagnosis have IU status. Ideally, if the rating schedule works well, the need for IU will be minimal because those who need 100 percent disability compensation will get it from the ratings schedule. The fact that 31 percent of those with PTSD as their primary condition have IU may be an indication that the ratings schedule does not work well for PTSD.

Another concern is the rapid growth in the number of veterans designated as IU—from 117,000 in 2000 to 223,000 in 2005. This represents a 90 percent increase, an increase that occurred while the number of disabled veterans increased 15 percent and the total number of veterans declined by 8 percent. The issue is whether disabled veterans were taking advantage of the system, using IU status to increase their disability compensation. The data suggest that this was not the case. While there has been some increase in the prevalence of getting IU status for certain rating-and-age combinations, the vast majority of the increase in the IU population is explained by demographic changes (specifically the aging of the Vietnam cohort) in the veteran population.

We also used mortality rates to determine whether IU recipients were taking advantage of the system. If those with IU had higher mortality rates than those without IU, it would appear to identify clinical differences between those with and without IU. Our findings confirm that those with IU status have higher mortality rates than those rated 50–90 percent without IU, although IU mortality rates are less than for the 100 percent disabled.

COMPARISON OF DOD/VA DISABILITY RATINGS

Due to concern with consistency of DOD and VA disability ratings, the Commission asked CNAC to study the issue. We first looked to see how much overlap there was between the two systems. We found that roughly four-fifths of those who receive a DOD disability rating end up in the VA compensation system in less than 2 years.

Next we explored whether DOD and VA gave approximately the same combined disability rating. On average, we found that service-disabled veterans received substantially higher ratings from VA than from DOD. The question is why? First, VA rates more conditions than DOD does: on average VA rates about three more conditions per person than DOD does. Second, we found that even at the individual diagnosis level, VA gives higher ratings than DOD does on average. For some codes, the average rating from DOD is slightly higher than from VA. But for others, such as

mental diagnostic codes, the average rating from VA is substantially higher than the rating from DOD.

Note that while we found differences in combined and individual ratings given by DOD and VA, we make no judgment as to the correctness of the ratings in either system. We have neither the data nor the clinical expertise to make such judgments. What we have done is point out aspects of the VA and DOD disability systems that differ.

OVERALL OPTIONS AND RECOMMENDATIONS

One issue that emerges from the data concerns service-disabled veterans with a mental primary disability. Their overall health percentiles and overall life satisfaction percentiles are far below those with physical primary disabilities at the same rating level. Their earnings in general are well below those with physical primary disabilities. The data clearly indicate that their life experience is less satisfying than that of their counterparts. It is important to consider how veterans' programs could be made more effective at benefiting this group of veterans. However, there is no current metric to translate the quality-of-life losses documented in the Veterans Survey into dollars.

There are several options for addressing the lack of earnings parity where it exists and for compensation for lost quality-of-life. Earnings parity of those with mental conditions could be improved through higher ratings for mental conditions or special monthly compensation similar to that currently paid for other conditions. However, using higher ratings would require re-rating all of those with a mental disability. Earnings parity for the severely disabled who enter the system at "young" ages could be improved by making disability compensation levels a function of age at first entry into the disability system or through a special monthly compensation.

Another issue is the IU designation that many veterans receive because they are unemployable. If the purpose of this designation truly relates to employment, there could be a maximum eligibility age reflecting typical retirement patterns. If the purpose is to correct for rating schedule deficiencies, an option is to correct the ratings schedule so that fewer need to be artificially rated 100 percent through IU.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO THE CNA CORPORATION

Question 1. Please elaborate on the assertion that VA does not appear to be underperforming in comparison with other disability programs.

Response. The Commission was interested in operational aspects of the veterans' disability compensation program and asked us to compare VA's program with other Federal disability compensation programs. Our focus was limited to comparisons with Federal programs paying monetary benefits to disabled individuals, including Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) under the Social Security Administration (SSA), Workers' Compensation under the Federal Employees' Compensation Act (FECA), disability retirement for Federal employees under the Federal Employee Retirement System (FERS) and the Civil Service Retirement System (CSRS), and DOD's Disability Evaluation System (DES).

Unfortunately, we found that there were no formal evaluations of the effectiveness of specific practices in the other programs we examined, in the areas identified as problematic for VA. This limited our ability to do meaningful comparisons across the programs.

We also found that there are many differences across the various disability programs in terms of purpose, administrative processes, eligibility, benefits, and size. These differences may also limit the potential applicability for VA of lessons from the other programs. For example, each disability program has different administrative processes for filing claims and making appeals. The various disability compensation programs also have different criteria for determining eligibility and benefit levels, and different purposes of the monetary compensation, varying from partial or full replacement of earnings to an income supplement, or even to compensation for a shortened career. The amount and type of information needed for each program are important determinants of how difficult and time-consuming it is to process and resolve a claim.

For any disability compensation program, three important measures of performance in claims processing are timeliness, accuracy, and consistency. In addition, we considered issues involving training, productivity standards, and staff turnover.

Timeliness

Beginning with timeliness, we noted that the time required to decide and resolve a claim depends on how complex the design of the program is. For example, although the VA program does not need to know a claimant's earnings history, it does need to determine service connection and severity for each disability, and each claim can have multiple disabilities.

Compared to the other disability programs, VA performance in terms of timeliness was poor. The average time for VA to complete a claim (without appeals) in FY2006 was 177 days. In comparison, the average for SSDI was 88 days in FY2006, and OPM staff reported that the FERS/CSRS average is currently 38 days. In general, the FECA and DES programs also reported shorter times to adjudication than the VA average. But because of the differences across programs in the work required to process a claim, it is difficult to say whether VA's timeliness problems are due to the complex nature of its disability decisions, or to other factors. VA should evaluate what stages of their claims process are contributing most to the total processing time.

With respect to specific strategies to improve timeliness, VA makes use of "Tiger Teams" to deal with cases that are designated as high priority, such as very longstanding cases or cases where the veteran is very old or terminally ill. But because the success of those teams comes from the fact that they are made up of the most experienced staff, unfortunately the Tiger Team approach is not something that VA can replicate on a larger scale (i.e., there are not enough experienced employees to staff a large number of Tiger Teams). VA might also consider SSA's new Quick Disability Determination (QDD) process, which uses a predictive model to identify cases with a high probability of being granted benefits and then trying to act on those cases within 20 days.

Accuracy

Accuracy is another major dimension of the quality of claims processing. VA's accuracy rate in 2006 was 88 percent. Accuracy is based on whether all issues in the claim were addressed, whether the claim was developed in compliance with the Veterans Claims Assistance Act, and whether the rating decision, effective date, and payment date were correct. VA's accuracy was slightly below the overall accuracy rate for SSDI, which was 96 percent. However, the programs have different claims processing requirements. VA has to rate the severity of a disability, creating more potential for error than the yes-or-no disability decision that is required for SSDI.

We were unable to obtain overall accuracy rates for the other programs. However, in comparing other programs' practices with VA's, the only practice that is substantively different from VA's is SSA's practice of focusing on reviewing the most error-prone type of cases.

Consistency

Measuring consistency is difficult, and none of the programs currently has a measure of consistency of the level that GAO recommends (examining disability decisions with multivariate analysis, controlling for multiple factors, and in-depth independent review of statistically selected case files). It is currently impossible to compare consistency across programs.

Possible ways to improve consistency might include standardizing training for raters, improving standardization of medical examinations, and consolidating the rating process into fewer locations. VA disability compensation claims are currently processed in 57 Regional Offices (ROs), and GAO has recommended that VA consolidate some of its disability compensation operations as one way to improve claim processing quality and reduce variation across regional offices. VA reports that it does in fact have plans to consolidate some of its disability claims processing in the future. However, this might create less in-person access for some veterans.

SSA has a similar regional variation to that observed for the VA. The other programs face fewer consolidation issues or concerns, because they are much smaller programs and have fewer offices and locations for processing claims.

Training issues

VA has also been criticized regarding staff training. However, examination of the other disability programs shows that VA is not lagging behind in its training efforts. None of the other programs seems to have any formal evaluation of their training. VBA has recently focused on increasing the standardization of training. No other disability program has VA's level of standardization.

Staff turnover

For the VA program, high staff turnover is viewed as creating a problem for the quality of claims processing. But it is not clear that the 1-year attrition rate for VA

disability examiners differs from the rate for all new Federal employees. However, minimizing turnover is especially important for VA because of the lengthy training time required for claims processing. GAO has recommended that it might be useful for the VA to take steps to quantify the reasons that raters resign. In any event, VA is not the only disability program facing the problem of high staff turnover, which has been identified as a particularly difficult issue for SSA. The other disability compensation programs reported similar staff turnover concerns.

Summary of comparisons across programs

Except for timeliness, we found no evidence that VA was under-performing in comparison with other disability programs. Some of VA's problems with timeliness could be the result of a complex program design, with multiple disabilities per claim, the need to determine service connection (sometimes many years after separation), and the need to assign a disability rating to each disability. For VA to improve timeliness, it first needs to evaluate the stages of the claims process that are contributing most to the total elapsed time required to complete a claim.

Question 2. IOM made a distinction between overall quality-of-life, and physical limitations that impair a veteran beyond the workplace. Did CNA make a similar distinction in its survey? In other words, did CNA consider overall physical limitations and quality-of-life as independent concepts?

Response. CNA evaluated two scales to describe quality-of-life outcomes for disabled veterans. These scales were the same scales that have been used in a wide variety of research across the years, which enabled us to compare results for disabled veterans to widely-established population norms. First, we calculated a physical health score based on answers to a subset of the questions. We also calculated a mental health score based on answers to a different subset of the questions. Our "overall" quality-of-life assessment was based on adding together these two scores, and weighting them equally—in other words, we counted the physical assessment and the mental assessment as equally important. So to specifically answer the question, the overall quality-of-life measure we calculated was composed of two separate subcomponents—one based on physical limitations, and one based on mental limitations.

We also asked other questions on the survey, such as questions about the respondents' overall satisfaction with life. We did not fold these questions into a quality-of-life measure, because there were no equivalent population norms that the respondents' answers could be compared to.

Question 3. Can you please describe what additional resources raters felt would be helpful as they adjudicated claims for compensation?

Response. The survey findings identified several issues related to the benefits determination process.

- Both raters and VSOs identified additional clinical input on rating teams as potentially useful, especially from physicians of appropriate specialties and from mental health professionals. VSOs identified rehabilitation specialists and medical records specialists as other potentially useful sources of input.
- There is a relatively wide range of perceived training adequacy, perceived proficiency in knowledge, skills and abilities (KSAs), KSAs relevant to the performance of the rater's role, and years of rating experience among rating officials that appears to be related to raters' abilities to implement the process and their ease at rating and deciding claims. Raters who feel less well-trained or less proficient and those who have fewer years of rating experience generally find the process more problematic.
- Raters' perceptions regarding their training adequacy and their KSA proficiency are both somewhat related to their perceptions of the availability of the resources they need to decide a claim such as computer system support, information and evidence, time, and administrative/managerial and clerical support. As perceived training adequacy and KSA proficiency increase, so does perceived resource availability.
- In many respects, rating or deciding mental disorder claims is more problematic than rating or deciding physical condition claims. Raters and VSOs see claims with mental disorder issues, especially PTSD, as requiring more judgment and subjectivity than claims with physical condition issues. Raters and VSOs indicated that it is less likely that mental disorder issue claims rated by different raters at the same VA Regional Office would receive similar ratings, and that deciding the various criteria of a claim is more problematic for mental disorder than for physical condition claims.
- Rating physical conditions in several body systems or subsystems also appears problematic. Raters identified neurological and convulsive disorders, musculoskeletal disorders (especially involving muscles), and disorders of special sense or-

gans (especially eyes), as the most difficult and time consuming physical conditions to rate.

• A significant majority of raters indicate that more specific decision criteria or more specific evidence regarding individual unemployability (IU) would be helpful and that the criteria for IU are too broad.

• Time to rate or decide a disability claim is a scarce resource and a major challenge for raters. Time appears to be most challenging when raters are deciding complex claims, and raters report that claims getting more complex over time.

• A large majority of raters reported that they had insufficient time to rate or otherwise decide a claim, and both raters and VSOs reported that there was too much emphasis on speed relative to accuracy.

• Obtaining needed evidence, especially given the challenge and scarcity of time and the insufficiency of many medical examinations (in particular from private examiners, according to raters) is a challenge in its own right.

• Raters reported that the use of standardized assessment tools and more specific criteria for rating and deciding mental health issues—especially PTSD—would be useful.

• The process is difficult for most veterans and survivors to understand and navigate. Assisting clients to understand the process and the evidence needed for it is a major challenge for VSOs. A majority of VSOs further report that they disagree that the process is satisfactory to most of their clients. Most raters and VSOs believe veterans have unrealistic expectations of the claims process and the benefits they should receive.

• Overall, most raters and VSOs report that they believe that the claims rating process generally arrives at a fair and right decision for veterans. Further, in general, raters and VSOs assessed the performance of their VSOs (and each other) as good; however, most raters reported that they believe VSOs inappropriately coach their clients.

Question 4. The Veterans' Disability Benefits Commission recommended that VA explore developing a tool to assess quality-of-life due to disability. This quality-of-life scale could either be incorporated into the current rating criteria or assessed independently. Which do you believe is preferable? Are there precedents from other disability compensation systems that might be instructive?

Response. We do not aware of precedents to guide this decision. In our opinion, it would be more appropriate to keep the quality-of-life scale as a separate element. If the quality-of-life were to be incorporated into the current rating criteria, this would add another complexity to the rating system of compensation that is already quite difficult for veterans to understand. The current system of compensation is to make up for lost earnings capacity. It would be best not to layer another different purpose on top of that until we understand more about which categories of disabled veterans will be entitled to a quality-of-life adjustment, and how that adjustment will be determined (e.g., based on average quality-of-life, based on combined disability rating, based on combined disability rating and primary type of disability, etc.).

Chairman AKAKA. Thank you. Thank you very much, Dr. McMahon.

Now we will hear from Dr. Bristow.

STATEMENT OF LONNIE R. BRISTOW, M.D., MACP, FORMER PRESIDENT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY MICHAEL McGEARY, SENIOR PROGRAM OFFICER, DIVISION OF HEALTH SCIENCES POLICY, INSTITUTE OF MEDICINE, NATIONAL ACADEMIES

Dr. BRISTOW. Thank you, Mr. Chairman. Chairman Akaka, Ranking Member Burr, and other Members of the Committee, my name is Lonnie Bristow. As you have heard, I am a physician and I have served as the President of the American Medical Association. I am joined on this panel today by Drs. Dean Kilpatrick and Scott Zeger, who will introduce themselves shortly. But on their behalf, let me thank you for the opportunity to testify about the work that our three Institute of Medicine, or IOM, committees have been engaged in.

My task today is to present the recommendations of the IOM committee that I chaired, which was asked to evaluate the VA's schedule for rating disabilities and related matters. Dr. Kilpatrick will follow me to speak about his committee's work, which focused on Post Traumatic Stress Disorder, which is a particular challenge for the VA to evaluate. And Dr. Zeger will conclude our panel's presentation by briefing you on the findings of his committee, which was asked to offer its perspective on the scientific considerations that must underlie the question of whether a health outcome should be presumed to be connected to military service.

We each have submitted our written testimony for the record, which we will summarize in our presentations here. Afterwards, of course, we will be happy to answer the Committee's questions.

In my time remaining, I will quickly list our key findings and recommendations concerning the VA rating schedule and be glad to go into more detail about any of them during the question period.

Our committee found that the statutory purpose of disability compensation, which is to compensate for the average loss of earning capacity, is an unduly restrictive rationale for the program and it is inconsistent with the current or modern concept of disability. The committee recommends that the VA compensate for three consequences of service-connected injuries and diseases: First, for work disability, which is currently does; second, the loss of ability to engage in usual life activities other than work, what disability experts today call functional limitations; and third, for the loss in quality-of-life.

Concerning the ratings schedule, the committee found that the schedule is not as current medically as it could and should be. It found that the actual relationship of the rating levels to the average loss of earning capacity was not known at the time of our assessment. Also, the schedule does not evaluate impact on the veteran's ability to function in everyday life and the schedule does not evaluate the loss in quality-of-life.

Our committee, therefore, recommends that VA immediately update the current ratings schedule medically, beginning with those body systems that have gone the longest without a comprehensive update, and adopt a system for keeping that schedule up to date medically.

Second, VA should establish an external Disability Advisory Committee to provide advice during the updating process.

And third, as part of updating the schedule, it should move to the ICD and DSM diagnostic classification systems.

Fourth, it should investigate the relationship between the ratings and actual earnings to see the extent to which the ratings schedule is compensating for loss of earnings on average and adjust that rating criteria to reduce any disparities that are found.

Fifth, it should compensate for functional limitations on usual life activities to the extent that the rating schedule does not.

And sixth, it should develop a method of measuring the loss of quality-of-life, and where that schedule does not adequately compensate for it, VA should adopt a method for doing so. [Lights went off.]

The committee also reviewed individual unemployability, or IU, and our main finding concerning IU is that it is not something that

can be determined on medical grounds alone. Therefore, our committee recommends that VA conduct vocational assessments as well as medical evaluations in determining eligibility for IU.

This concludes my remarks and I want to thank you again for the opportunity to testify and for testing my vision. [Laughter.]

I would be happy to address any questions you might have about our report subsequently.

[The prepared statement of Dr. Bristow follows:]

PREPARED STATEMENT OF LONNIE BRISTOW, M.D., CHAIR, COMMITTEE ON MEDICAL EVALUATION OF VETERANS FOR DISABILITY BENEFITS, BOARD ON MILITARY AND VETERANS HEALTH, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES

Good morning, Chairman Akaka, Ranking Member Burr, and Members of the Committee. My name is Lonnie Bristow. I am a physician and a Navy veteran, and I have served as the president of the American Medical Association. I'm joined on this panel by Drs. Dean Kilpatrick and Scott Zeger, who will introduce themselves shortly. On their behalf, thank you for the opportunity to testify about the work of our Institute of Medicine (IOM) committees. Established in 1970 under the charter of the National Academy of Sciences, the IOM provides independent, objective advice to the Nation on improving health.

My task today is to present to you the recommendations of the IOM committee I chaired, which was asked to evaluate the VA Schedule for Rating Disabilities and related matters. Dr. Kilpatrick will follow me to speak about his committee's work, which focused on Post Traumatic Stress Disorder, which is a particular challenge for the VA top evaluate. Dr. Zeger will conclude our panel's presentation by briefing you on the findings of his committee, which was asked to offer its perspective on the scientific considerations underlying the question of whether a health outcome should be presumed to be connected to military service.

I had the great pleasure and honor of chairing the IOM Committee on Medical Evaluation of Veterans for Disability Compensation, which was established at the request of the Veterans' Disability Benefits Commission and funded by the Department of Veterans Affairs (VA).

UPDATING THE BASIS FOR DISABILITY COMPENSATION

Our report, A 21st Century System for Evaluating Veterans for Disability Benefits, which was issued last July, makes a number of important recommendations regarding the VA Rating Schedule and related matters. Our first recommendation is to broaden the purpose of the VA disability compensation program, which currently is to compensate for average loss of earning capacity, or work disability. We recommend that VA also compensate for loss of ability to engage in the usual activities of everyday life other than work and, if possible, for diminished quality-of-life. We recognize that legislative action will be required to change the statutory purpose of the disability compensation program, but doing so would bring the compensation program in line with our current understanding that disability has broad effects (see attached figure 4–1 from the report).

ASSESSING THE RATING SCHEDULE

When the Committee reviewed the Rating Schedule, we found that:

- Although it is called the Schedule for Rating Disabilities, it currently evaluates degree of impairment (i.e., loss of a body part or function) rather than degree of disability (i.e., limits on a person's ability to function at work or in life).
- Even in rating degree of impairment, the Schedule is not as current medically as it could and should be.
- The relationship of the rating levels to average loss of earning capacity is not known.
- The Schedule does not evaluate impact on a veteran's ability to function in everyday life.
- The Schedule does not evaluate loss of quality-of-life.

Accordingly, we made a series of recommendations to update and revise the Rating Schedule.

UPDATING THE RATING SCHEDULE

First, the committee recommends that VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update (i.e., the orthopedic part of the musculoskeletal system, the neurological system, and the digestive system). Revisions of the remaining systems could be done on a rolling basis—several a year—after which, VA should adopt a system for keeping the Schedule up to date medically. Also, VA should establish an external disability advisory committee to provide advice during the updating process.

As part of updating the Rating Schedule, VA should move to the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic classification systems that are used in today's health care systems, including VA's.

EVALUATING TRAUMATIC BRAIN INJURY

We were asked by your staff about improving the criteria for Traumatic Brain Injury, or TBI. TBI is an excellent example of where the rating criteria in the Schedule need to be updated in accord with current medical knowledge and practice.

TBI is rated under diagnostic code 8045, "Brain disease due to trauma," which was last updated substantively in 1961. Today, we understand much better how concussions from blast injuries can affect cognition even though there is no evident physical injury. In Iraq, many servicemembers have been subjected to multiple improvised explosive device blasts. The current criteria emphasize physical manifestations, such as paralysis and seizures. The Rating Schedule recognizes that symptoms such as headache, dizziness, and insomnia are common in brain trauma but limits them to a 10 percent rating. It is time to review how to properly evaluate and rate TBI in light of current medical knowledge, along with the rest of the neurological conditions, most of which have not been revised since 1945.

RELATING THE RATING SCHEDULE TO AVERAGE LOSS OF EARNINGS

In addition to updating the Schedule medically, VA should investigate the relationship between the ratings and actual earnings to see the extent to which the Rating Schedule as revised is compensating for loss of earnings on average. This would build on the analyses done by the CNA Corporation at the body system level but use samples large enough to study the most prevalent conditions being rated. Just 38 conditions account for two-thirds of the compensation rating decisions. If VA finds disparities in average earnings, for example, that veterans with a mental disorder rated 70 percent earn substantially less on average than veterans rated 70 percent for other kinds of disabilities, it could adjust the rating criteria to narrow the gap.

COMPENSATING FOR NON-WORK-RELATED FUNCTIONAL LIMITATIONS

The Committee recommends that VA compensate for non-work disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not. To do this, VA should develop a set of functional measures—e.g., ADLs (activities of daily living), IADLs (instrumental activities of daily living)—and specific performance measures, such as time to ambulate a certain distance, or ability to do specific work-related tasks in both physical domains (e.g., climbing stairs or gripping) and cognitive domains (e.g., communicating or coordinating with other people). After the measures are validated in the disability compensation population, VA should conduct a study of functional capacity among applicants to see how well the revised Rating Schedule compensates for loss of functional capacity. There may be a close correlation between the rating levels based on impairment and degree of functional limitations (i.e., the higher the rating, the more functional capacity is limited), in which case the Rating Schedule compensates for both impairment and functional loss. But if the correlation is not high or does not exist, VA should develop a mechanism to compensate for loss of function that exceeds degree of impairment. This could be done by including functional criteria in the Rating Schedule or by rating function separately, with compensation based on the higher of the two ratings.

COMPENSATING FOR LOSS OF QUALITY OF LIFE

The Committee also recommends that VA compensate for loss of quality-of-life. We realize that quality-of-life assessment is relatively new and still at a formative stage, which makes this recommendation conditional on further research and development. VA should develop a tool for measuring quality-of-life validly and reliably

in the veteran population, and then VA should conduct research to determine the extent to which the Rating Schedule might already account for loss in quality-of-life. We might find that veterans with the lowest quality-of-life already have the highest percentage ratings, but if not, VA should develop a procedure for evaluating and rating loss of quality-of-life of veterans with disabilities where it exceeds the degree of disability based on impairment and functional limitations determined according to the Rating Schedule.

EVALUATING INDIVIDUAL UNEMPLOYABILITY

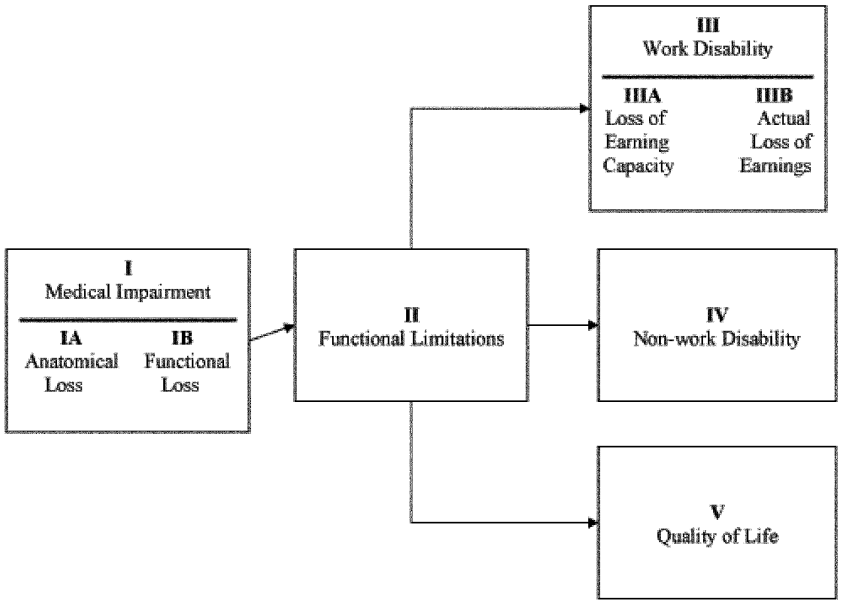
The Committee also reviewed individual unemployability, or IU, which has been a fast-growing part of the compensation program. Our main finding concerning IU is that it is not something that can be determined on medical grounds alone. IU is based on an evaluation of the individual veteran's capacity to engage in a substantially gainful occupation, rather than on the Rating Schedule, which is based on the average impairment of earnings concept. Thus the determination of IU must consider occupational as well as medical factors. To analyze IU claims, raters have medical evaluations from medical professionals and other medical records but usually they do not have comparable functional capacity or vocational evaluations from vocational experts. Therefore, the Committee recommends that, in addition to medical evaluations by medical professionals, VA require vocational assessment in the determination of eligibility for individual unemployability benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of individual unemployability claims.

OTHER RECOMMENDATIONS

The Committee made additional recommendations on issues other than the VA Schedule for Rating Disabilities, which I am not reviewing today. They can be found in our report and our recommendations for improving the medical examination and rating processes were presented to you by our staff director, Michael McGeary, on February 14 (for example, mandating the use of the on-line medical examination templates and having medical consultants to advise the raters on medical evidence).

This concludes my remarks. Thank you for the opportunity to testify. I would be happy to address any questions the Subcommittee might have.

FIGURE 4–1 The consequences of an injury or disease.



From: *A 21st Century System for Evaluating Veterans for Disability Benefits*. National Academies Press, 2007.

Chairman AKAKA. Thank you. Thank you very much, Dr. Bristow. I would tell you that your vision is 20/20. [Laughter.]

Let me say that all of your full statements will be included in the record.

Now we will hear from Dr. Kilpatrick.

STATEMENT OF DEAN G. KILPATRICK, PH.D., PROFESSOR AND DIRECTOR, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA

Mr. KILPATRICK. Thank you, Mr. Chairman and Members of the Committee, for the opportunity to testify on behalf of the Committee on Veterans Compensation for Post Traumatic Stress Disorder. Last June, we completed this report, "PTSD Compensation in Military Service," and I understand that this is available to you. We had several conclusions that I would like to summarize.

First, we had testimony that was presented to committee indicating that clinicians often feel pressured to severely constrain the time they devote to doing the compensation and pension examination that is used and is really the basis for making the disability determinations. These exams may last as little as 20 minutes, even though the protocol suggested in a best practice manual developed by the National Center for PTSD in the VA can take 3 hours or more to complete. The committee believed that the key to proper administration of the VA's PTSD compensation program is a thorough C&P examination conducted by an experienced and well-trained mental health professional. Many of the problems and issues with the current process can be addressed by consistently allocating and applying the time and resources needed for a thorough examination.

The VA, for a second point, establishes a rating for the level of disability associated with service-connected disorders through a review that uses the information gathered in the C&P examinations and criteria set forth in the schedule for rating disabilities. Currently, the same set of criteria are used for rating all mental disabilities. They focus on symptoms from schizophrenia, mood, and anxiety disorders.

Our committee found that these criteria are at best a crude and overly general instrument for the assessment of PTSD disability. We recommended that new criteria be developed and applied that specifically address PTSD symptoms and associated disability problems that are firmly grounded in the standards set out in the DSM used by mental health professionals. The committee also recommended that PTSD-specific training for both clinicians and raters be done in order to promote more accurate, consistent, and uniform disability ratings.

The VA asked the committee to address whether it would be advisable to establish a set schedule for reexamining veterans who receive compensation for PTSD. We concluded that it is not appropriate to require across-the-board periodic reexaminations and recommended that reexamination be done only on a case-by-case basis when there are sound reasons to expect that major changes in disability status might occur.

We based this conclusion on two reasons. First, there are finite resources, both personnel and money, to conduct PTSD exams; and we believe these should be focused on the performance of uniformly high-quality and timely initial exams. Second, across-the-board periodic reexaminations are not required for other mental disorders or mental conditions. We felt there was no scientific justification for singling out PTSD disability for special action and we thought that doing so might stigmatize those veterans by implying that their condition requires extra scrutiny.

The Veterans' Disability Benefits Commission subsequently recommended that the VA should conduct PTSD reevaluations every two to 3 years. This, I think, is an honest disagreement from two committees that were looking at the same thing. There are advantages and disadvantages to both of these approaches that our two groups put forward, but the important thing is for the VA to give these both careful consideration when they formulate their policy. I believe that if periodic PTSD reexaminations are implemented, this should not be done until there are sufficient resources to ensure that every veteran gets a first-rate C&P exam done by a well-trained mental health professional conducted in a timely fashion.

With respect to the issue that has been raised about whether compensation for PTSD is a disincentive for veterans receiving or benefiting from treatment or therapy, our committee concluded that there is little direct evidence that receiving compensation or seeking it has negative effects on treatment outcome. This is reviewed substantially in our report.

We also received testimony in the committee which indicated that compensation seeking, or people who were service-connected for PTSD, was shown to be unrelated to clinical outcome or treatment response in a number of randomized clinical trials that had been done to treat PTSD that had been conducted by the VA.

Our committee also reached a whole series of other recommendations regarding the conduct of VA's compensation and pension system for PTSD that are outlined in the body of our report and I appreciate your attention and would be happy to answer questions at the appropriate time.

[The prepared statement of Mr. Kilpatrick follows:]

PREPARED STATEMENT OF DEAN G. KILPATRICK, PH.D., DISTINGUISHED UNIVERSITY PROFESSOR, DIRECTOR, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA AND MEMBER, COMMITTEE ON VETERANS' COMPENSATION FOR POST TRAUMATIC STRESS DISORDER, INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, THE NATIONAL ACADEMIES

Good morning, Mr. Chairman and Members of the Committee. My name is Dean Kilpatrick and I am Distinguished University Professor in the Department of Psychiatry and Behavioral Sciences and Director of the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Thank you for the opportunity to testify on behalf of the members of the Committee on Veterans' Compensation for Post Traumatic Stress Disorder. This committee was convened under the auspices of the National Research Council and the Institute of Medicine. Our committee's work was requested by the Department of Veterans Affairs, which provided funding for the effort. Its work was also presented to and used by the congressionally-constituted Veterans Disability Benefits Commission.

Last June, our committee completed its report—entitled *PTSD Compensation and Military Service*—which addresses potential revisions to the Schedule for Rating Disabilities in the context of a larger review of how VA administers its PTSD compensation program. I am pleased to be here today to share with you the content of that report, the knowledge I've gained as a clinical psychologist and researcher on

traumatic stress, and my experience as someone who previously served as a clinician at the VA.

I will begin with some background information on Post Traumatic Stress Disorder. Briefly described, PTSD is a psychiatric disorder that can develop in a person after a traumatic experience. Someone is diagnosed with PTSD if, in response to that traumatic experience, he or she develops a cluster of symptoms that include:

- *reexperiencing* the traumatic event as reflected by distressing recollections, memories, nightmares, or flashbacks;
- *avoidance* of anything that reminds them of the traumatic event;
- *emotional numbing* or feeling detached from other people;
- *hyperarousal* as reflected by trouble sleeping, trouble concentrating, outbursts of anger, and having to always be vigilant for potential threats in the environment; and
- *impairment* in social or occupational functioning, or clinically significant distress.

PTSD is one of an interrelated and overlapping set of possible mental health responses to combat exposures and other traumas encountered in military service. It has been described as one of the signature wounds of the most recent Iraq conflicts. Although PTSD has only been an official diagnosis since the 1980's, the symptoms associated with it have been reported for centuries. In the U.S., expressions including *shell shock, combat fatigue,* and *gross stress reaction* have been used to label what is now called PTSD.

Our committee's review of the scientific literature regarding PTSD led it to draw some conclusions that are relevant to this hearing. It found abundant evidence indicating that PTSD can develop at any time after exposure to a traumatic stressor, including cases where there is a long time interval between the stressor and the recognition of symptoms. Some of these cases may involve the initial onset of symptoms after many years of symptom-free life, while others may involve the manifestation of explicit symptoms in persons with previously undiagnosed PTSD. The determinants of delayed-onset PTSD are not well understood. The scientific literature does not identify any differences material to the consideration of compensation between these delayed-onset or delayed-identification cases and those chronic PTSD cases where there is a shorter time interval between the stressor and the recognition of symptoms.

Our review also identified several areas where changes to VA's current practices might result in more consistent and accurate ratings for disability associated with PTSD.

There are two primary steps in the disability compensation process for veterans. The first of these is a compensation and pension, or *C&P*, examination. These examinations are conducted by VA mental health professionals or outside professionals who meet certain education and licensing requirements. Testimony presented to our committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD C&P examination—sometimes to as little as 20 minutes—even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take 3 hours or more to properly complete. The committee believes that the key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced mental health professional. Many of the problems and issues with the current process can be addressed by consistently allocating and applying the time and resources needed for a thorough examination. The committee also recommended that a system-wide training program be implemented for the clinicians who conduct these exams in order to promote uniform and consistent evaluations.

The second primary step in the compensation process for veterans is a rating of the level of disability associated with service-connected disorders identified in the clinical examination. This rating is performed by a VA employee using the information gathered in the C&P exam and criteria set forward in the Schedule for Rating Disabilities. Currently, the same set of criteria is used for rating all mental disorders. They focus on symptoms from schizophrenia, mood, and anxiety disorders. The committee found that the criteria are at best a crude and overly general instrument for the assessment of PTSD disability. We recommended that new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the *Diagnostic and Statistical Manual of Mental Disorders* used by mental health professionals.

Our committee also suggested that VA take a broader and more comprehensive view of what constitutes PTSD disability. In the current scheme, occupational impairment drives the determination of the rating level. Under the committee's rec-

ommended framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated, and the claimant would be rated on the dimension on which he or she is more affected. We believe that the special emphasis on occupational impairment in the current criteria unduly penalizes veterans who may be capable of working, but significantly symptomatic or impaired in other dimensions, and thus it may serve as a disincentive to both work and recovery. This recommendation is consistent with the Dole-Shalala Commission's suggestion to add quality-of-life payments to compensation.

Research reviewed by the committee indicates that disability compensation does not in general serve as a disincentive to seeking treatment. While some beneficiaries will undoubtedly understate their improvement in the course of pursuing compensation, the scientific literature suggests that such patients are in the minority, and there is some evidence that disability payments may actually contribute to better treatment outcomes in some programs. The literature on recovery indicates that it is influenced by several factors, and the independent effect of compensation on recovery is difficult to disentangle from these.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the committee recommended that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. Rater certification should foster greater confidence in ratings decisions and in the decisionmaking process.

At VA's request, the committee addressed whether it would be advisable to establish a set schedule for re-examining veterans receiving compensation for PTSD. We concluded that it is not appropriate to require across-the-board periodic reexaminations for veterans with PTSD service-connected disability. The committee instead recommended that reexamination be done only on a case-by-case basis when there are sound reasons to expect that major changes in disability status might occur. These conclusions were based on two considerations. First, there are finite resources—both funds and personnel—to conduct C&P examinations and determine disability ratings. The committee believes that resources should be focused on the performance of uniformly high-quality C&P clinical examinations. It believes that allocating resources to such examinations—in particular, to initial C&P evaluations—is a better use of resources than periodic, across-the-board reexaminations. Second, as the committee understands it, across-the-board periodic reexaminations are not required for other mental disorders or medical conditions. The committee's review of the literature on misreporting or exaggeration of symptoms by PTSD claimants yielded no justification for singling out PTSD disability for special action and thereby potentially stigmatizing veterans with the disability by implying that their condition requires extra scrutiny.

I understand that the Veterans Disability Benefits Commission subsequently recommended that VA should conduct PTSD reevaluations every 2–3 years to gauge treatment effectiveness and encourage wellness. Since the Commission report was released after the end of our work, my committee did not address the disparity in our recommendations. I know that our committee and the Commission both want veterans to receive fair treatment and the finest care, and I consider this to be an honest difference of opinion on how to best achieve those goals. There are advantages and disadvantages to the approaches that our two groups put forward, and the important thing is for VA to give these careful consideration when they formulate their policy. I believe that—if periodic reexaminations are implemented—this should not be done until there are sufficient resources to insure that every veteran gets a first-rate initial C&P exam in a timely fashion.

To summarize, the committee identified three major changes that are needed to improve the compensation evaluation process for veterans with PTSD:

- First, the C&P exam should be done by mental health professionals who are adequately trained in PTSD and who are allotted adequate time to conduct the exams.
- Second, the current VA disability rating system should be substantially changed to focus on a more comprehensive measure of the degree of impairment, disability, and clinically significant distress caused by PTSD. The current focus on occupational impairment serves as a disincentive for both work and recovery.
- Third, the VA should establish a certification program for raters who deal with PTSD clams.

Our committee also reached a series of other recommendations regarding the conduct of VA's compensation and pension system for PTSD that are detailed in the

body of our report. I have provided copies of this report as part of my submitted testimony.

Thank you for your attention. I will be happy to answer your questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO THE DEAN G. KILPATRICK, PH.D., DISTINGUISHED UNIVERSITY PROFESSOR, DIRECTOR, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA AND MEMBER, COMMITTEE ON VETERANS' COMPENSATION FOR POST TRAUMATIC STRESS DISORDER, INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, THE NATIONAL ACADEMIES

Question 1. Dr. Kilpatrick, IOM also stated that PTSD can develop anytime after exposure to a traumatic stressor. IOM found abundant scientific evidence indicating that PTSD can develop at any time after exposure to a traumatic stressor, including cases where there is a long interval between the stressor and the recognition of symptoms. Can you please elaborate further on this topic?

Response. The National Academies' Committee on Veterans' Compensation for Post Traumatic Stress Disorder—of which I was a member—addressed this topic in detail on pages 101–105 of our 2007 report *PTSD Compensation and Military Service*. Quoting the report:

> Determining whether an apparent case of delayed-onset PTSD is actually delayed poses challenges in both clinical and research settings. The difficulty can be attributed to several factors. Foremost, it is rare that a careful longitudinal assessment has been conducted, with data collection beginning soon after exposure to a stressor and continuing long enough to establish (1) the developmental trajectory of PTSD symptoms, (2) the documentation of diagnostic criteria, and (3) the full diagnostic assessment itself. Such information is needed to determine with some degree of confidence how long after exposure symptoms occurred, which and when individual diagnostic criteria manifested, and when and under which version of the *DSM* all diagnostic criteria for the PTSD diagnosis were met. Additionally, there exists a subpopulation of veterans with PTSD who do not seek mental health treatment services or compensation from the Department of Veterans Affairs at the time of the onset of the disease. When such veterans present with PTSD symptoms for treatment or compensation evaluation long after their military service, what appears to be "delayed onset" PTSD may actually be a delayed diagnosis of a disorder that has been present for a substantial period of time.
>
> Some individuals exposed to potentially traumatic events, including war zone stressors, develop subthreshold PTSD—that is, they meet some of the [*DSM IV-TR*] B, C, and D criteria for PTSD * * * but not all, or they fall one or two symptoms short of meeting full diagnostic criteria. Such individuals may not have a history of full PTSD, but with slight increases in symptomatology these cases can cross the diagnostic threshold to become full PTSD. Thus, what appears to be a new, delayed-onset case may actually be someone who for years has experienced symptoms just short of the benchmark criteria required for PTSD diagnosis and who becomes a case due to a small increase in symptomatology. (p. 102)
>
> * * *
>
> Delayed-onset PTSD is consistently observed, albeit in a fraction of the overall PTSD cases, and data indicate that delayed-onset PTSD is perhaps more common among those exposed to war—related trauma than among those exposed to other kinds of trauma Some cases of delayed-onset PTSD are symptomatic individuals who do not meet all the criteria of PTSD. * * * A number of factors have been found to be associated with the delayed onset of PTSD in previously undiagnosed individuals, including the occurrence of negative life events, decline in self esteem, ethnicity, and negative health changes. These factors have been shown to exacerbate symptoms in those with existing PTSD as well * * *. (p. 104)

The report elaborates on this information and provides citations to several peer-reviewed scientific papers that support these observations and conclusions.

Question 2. Dr. Kilpatrick, can you please explain the importance of providing a guaranteed level of benefits that would take explicit account of the nature of chronic PTSD by providing a safety net for those who might be asymptomatic for periods of time?

Response. *PTSD Compensation and Military Service* notes that "some researchers have speculated that veterans may be reluctant to acknowledge therapeutic gains because they believe that this may lead VA to lower their disability rating and thus lower their benefits" (p. 182). VA asked the committee to recommend strategies for reducing disincentives and maximizing incentives for achieving optimal mental functioning for veterans. Among the responses formulated by the committee was a recommendation that the VA consider instituting a set, long-term minimum level of benefits that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the C&P examination. Our report offers this reasoning in support of that recommendation:

> Regulation already specifies an analogous approach for other disorders, including conditions whose symptoms may remit and relapse over time. Multiple sclerosis, for example, has a minimum *rating* of 30 percent without regard to whether the condition is disabling at the moment that the subject is evaluated. However, rather than being limited to a particular minimum rating, the committee suggests that the VA consider what minimum *benefits* level—where "benefits" comprise compensation and other forms of assistance, such as priority access to VA medical treatment—would be most likely to promote wellness. It is beyond the scope of the charge to the committee to specify the particular set of benefits that would be most appropriate or the level[s] of impairment that would trigger provision of these benefits. This would require a careful consideration of the needs of the population, of the new incentives that the policy change would create, of the possible effects on compensation outlays and demand for other VA resources, and of how to maintain fairness with respect to other conditions that have a remitting/relapsing nature.
>
> Providing a guaranteed minimum level of benefits would take explicit account of the nature of chronic PTSD by providing a safety net for those who might be asymptomatic for periods of time. A properly designed set of benefits could eliminate uncertainty over future timely access to treatment and financial support in times of need and would in part remove the incentive to "stay sick" that some suggest is a flaw of the current system. (p. 185–186)

Chairman AKAKA. Thank you very much, Dr. Kilpatrick.

Now we will hear from Dr. Scott Zeger.

STATEMENT OF SCOTT L. ZEGER, PH.D., PROFESSOR, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH; ACCOMPANIED BY RICK ERDTMANN, M.D., MPH, DIRECTOR, MEDICAL FOLLOW-UP AGENCY, INSTITUTE OF MEDICINE, NATIONAL ACADEMIES

Dr. ZEGER. Thank you, Chairman Akaka, Ranking Member Burr, and Senator Murray. I appreciate the chance to be here with you today. I am Scott Zeger, professor of biostatistics at Johns Hopkins University, and was a member of the IOM committee that recently authored this report, "Improving the Presumptive Disability Decision Making Process for Veterans." On behalf of the committee members and our Chair, Dr. Samet, I am pleased to present a summary of our findings to you.

Our committee worked for a year with two goals, first to describe the current process for making presumptive decisions for veterans, and second to propose a more sound scientific framework for making those decisions in the future.

Veterans who have been injured by their service are owed appropriate health care and disability compensation. As one of the most eloquent VSO witnesses to our committee told us, "Americans don't leave their wounded soldiers behind." When scientific information is incomplete, Congress or the Department of Veterans Affairs may

elect to make a presumption of service connection so that a group of veterans may be appropriately compensated.

Our committee studied past presumptions and identified shortcomings in the current process. These include poor tracking of soldiers' exposures—sometimes due to secrecy—and inadequate surveillance of veterans' illnesses. We detected varying approaches to synthesizing evidence on the health consequences of military service and a lack of transparency of the VA decisionmaking process.

Our committee has recommended a more scientific approach that would include the following components: A new process for nominating exposures or health conditions for presumptions that would be open to all stakeholders; a revised process for evaluating scientific information on whether an exposure causes a health condition in veterans; a transparent evidence-based decisionmaking process by the VA; better tracking of the exposures of military personnel and of the illnesses of the veterans; and an organizational structure to support this process.

We specifically proposed the creation of two panels. The first would be called the Advisory Committee to the VA that would assemble and give priority to the exposures and health conditions proposed for possible presumptive evaluation. Nominations would come from veterans and other stakeholders. The second panel would be a Scientific Review Board, an independent body not unlike the IOM, that would evaluate the strength of the evidence that the health condition is caused by the military exposure.

The VA would then use explicit criteria to render a decision to establish a presumption or not, and since better data is the means to achieve better decisions, the Scientific Review Board would also be responsible to monitor DOD and VA information on the health of veterans as it accumulates over time and to nominate new exposures or health conditions for consideration for presumptions.

In proposing causation as the target for inference, the committee recognizes that both causation and association have been used in recent practice. Our focus on cause rather than association is to identify the right target, not to set a higher evidentiary standard. Also, by focusing on the causal target, the committee calls for a broad interpretation of all sources of evidence, not only empirical evidence usually relied on when establishing association. The committee recommends that the VA decide in favor of a presumption when a causal relationship is more likely than not as assessed by the Science Review Board.

The committee recognizes that action by Congress is needed to implement our plan to create the two panels and to assure that we fulfill our commitment to veterans by more accurately tracking their military exposures and their health outcomes after their distinguished service on behalf of us all.

Thanks for the opportunity to speak to you today and I would be happy to address questions that you might have.

[The prepared statement of Mr. Zeger follows:]

PREPARED STATEMENT OF SCOTT L. ZEGER, PH.D., MEMBER, COMMITTEE ON EVALUATION OF THE PRESUMPTIVE DISABILITY DECISION-MAKING PROCESS FOR VETERANS, BOARD ON MILITARY AND VETERANS AFFAIRS, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES AND FRANK HURLEY-CATHARINE DORRIER CHAIR AND PROFESSOR, DEPARTMENT OF BIOSTATISTICS, THE JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Good afternoon Senator Akaka and Members of the Senate Committee on Veterans' Affairs. I am Scott L. Zeger, Professor of Biostatistics from Johns Hopkins University in Baltimore, Maryland, a member of the Institute of Medicine Committee who recently authored the report, *Improving the Presumptive Disability Decision-Making Process for Veterans*. On behalf of Dr. Jonathan Samet, our Committee Chair, and the rest of the 16 members who represent a diversity of scientific and medical disciplines, I am pleased to present a summary of our key findings to you today.

Our Institute of Medicine Committee worked for a year to describe the current process for making presumptive decisions for veterans who have health conditions arising from military service and to propose a more sound scientific framework for making such presumptive decisions in the future.

To address its charge, the Committee met with many stakeholders: past and present staffers from Congress, the Veterans Administration (VA), the Institute of Medicine, veteran's service organizations, and individual veterans. The Department of Defense (DOD) gave the Committee information about how it tracks exposures and health conditions of personnel. The Committee attempted to formally capture how the current approach works and completed a series of case studies to identify "lessons learned". The Committee also considered how information is obtained on the health of veterans and how exposures during military service can be linked to any health consequences via scientific investigation. It gave substantial attention to the process by which information can best be synthesized to determine if a particular exposure causes a risk to health.

Veterans who have been injured by their service, whether their injury appears during service or afterwards, are owed appropriate health care and disability compensation. For some medical conditions that develop after military service, the scientific information needed to determine that the health condition was caused by their service may be incomplete. In such a situation, Congress or the Department of Veterans Affairs (VA) may elect to make a "presumption" of service-connection so that a group of veterans can be appropriately compensated. Presumptions are made in order to reach decisions in the face of unavailable or incomplete information.

Presumptions were first established in 1921. More recently, several presumptions have been made about Agent Orange exposure during service in Vietnam and around the health risks sustained by military personnel in the first Persian Gulf War.

The present approach to presumptive disability decision-making largely flows from the Agent Orange Act of 1991, which started a model for decision-making that is still in place. In that law, Congress asked the VA to contract with an independent organization, the Institute of Medicine, to review the scientific evidence for the health effects of Agent Orange. Subsequently, the Institute of Medicine has produced reports on Agent Orange, evaluating whether there is evidence that Agent Orange is associated with various health outcomes. The Institute of Medicine provides its reports to the VA, which then acts through its own internal decision-making process to determine if a presumption is to be made.

The case studies conducted by the Committee probed this process. The case studies pointed to a number of difficulties that need to be addressed in any future approach:

- Lack of information on exposures received by military personnel and inadequate surveillance of veterans for service-related illnesses.
- Gaps in information because of secrecy.
- Varying approaches to synthesizing evidence on the health consequences of military service.
- In the instance of Agent Orange, classification of evidence for association but not for causation.
- A failure to quantify the effect of the exposure during military service, particularly for diseases with other risk factors and causes.
- A general lack of transparency of the presumptive disability decision-making process.

The Committee discussed in great depth the optimum approach to establishing a scientific foundation for presumptive disability decision-making, including the meth-

ods used to determine if exposure to some factor increases risk for disease. This assessment and the findings of the case studies led to recommendations to improve the process:

• As the case studies demonstrated, Congress could provide a clearer and more consistent charge on how much evidence is needed to make a presumption. There should be clarity as to whether the finding of an association in one or more studies is sufficient or the evidence should support causation.

• Due to lack of clarity and consistency in congressional language and VA's charges to the committees, IOM committees have taken somewhat varying approaches since 1991 in reviewing the scientific evidence, and in forming their opinions on the possibility that exposures during military service contributed to causing a health condition. Future committees could improve their review and classification of scientific evidence if they were given clear and consistent charges and followed uniform evaluation procedures.

• The internal processes by which the VA makes it presumptive decisions following receipt of an IOM report have been unclear. VA should adopt transparent and consistent approaches for making these decisions.

• Adequate exposure data and health condition information for military personnel (both individuals and groups) usually have not been available from DOD in the past. Such information is one of the most critical pieces of evidence for improving the determination of links between exposures and health conditions. Approaches are needed to assure that such information is systematically collected in an ongoing fashion.

All of these improvements are feasible over the longer term and are needed to ensure that the presumptive disability decision-making process for veterans is based on the best possible scientific evidence. Decisions about disability compensation and related benefits (e.g., medical care) for veterans should be based on the best possible documentation and evidence of their military exposures as well as on the best possible information. A fresh approach could do much to improve the current process. The Committee's recommended approach (see Figure GS–1 attached) has several parts:

• an open process for nominating exposures and health conditions for review; involving all stakeholders in this process is critical;

• a revised process for evaluating scientific information on whether a given exposure causes a health condition in veterans; this includes a new set of categories to assess the strength of the evidence for causation, and an estimate of the numbers of exposed veterans whose health condition can be attributed to their military exposure;

• a consistent and transparent decision-making process by VA;

• a system for tracking the exposures of military personnel (including chemical, biological, infectious, physical and psychological stressors), and for monitoring the health conditions of all military personnel while in service and after separation; and

• an organizational structure to support this process.

To support the Committee's recommendations, we suggest the creation of two panels. One is an Advisory Committee (advisory to VA), that would assemble, consider and give priority to the exposures and health conditions proposed for possible presumptive evaluation. Nominations for presumptions could come from veterans and other stakeholders as well as from health tracking, surveillance and research. The second panel would be a Science Review Board, an independent body, which would evaluate the strength of the evidence (based on causation) which links a health condition to a military exposure and then estimates the fraction of exposed veterans whose health condition could be attributed to their military exposure. The Science Review Board's report and recommendations would go to the VA for its consideration. The VA would use explicit criteria to render a decision by the VA Secretary with regard to whether a presumption would be established. In addition, the Science Review Board would monitor information on the health of veterans as it accumulates over time in the DOD and VA tracking systems, and nominate new exposures or health conditions for evaluation as appropriate.

This Committee recommends that the following principles be adopted in establishing this new approach:

1. Stakeholder inclusiveness
2. Evidence-based decisions
3. Transparent process
4. Flexibility
5. Consistency
6. Causation, not just association, as the target for decision making.

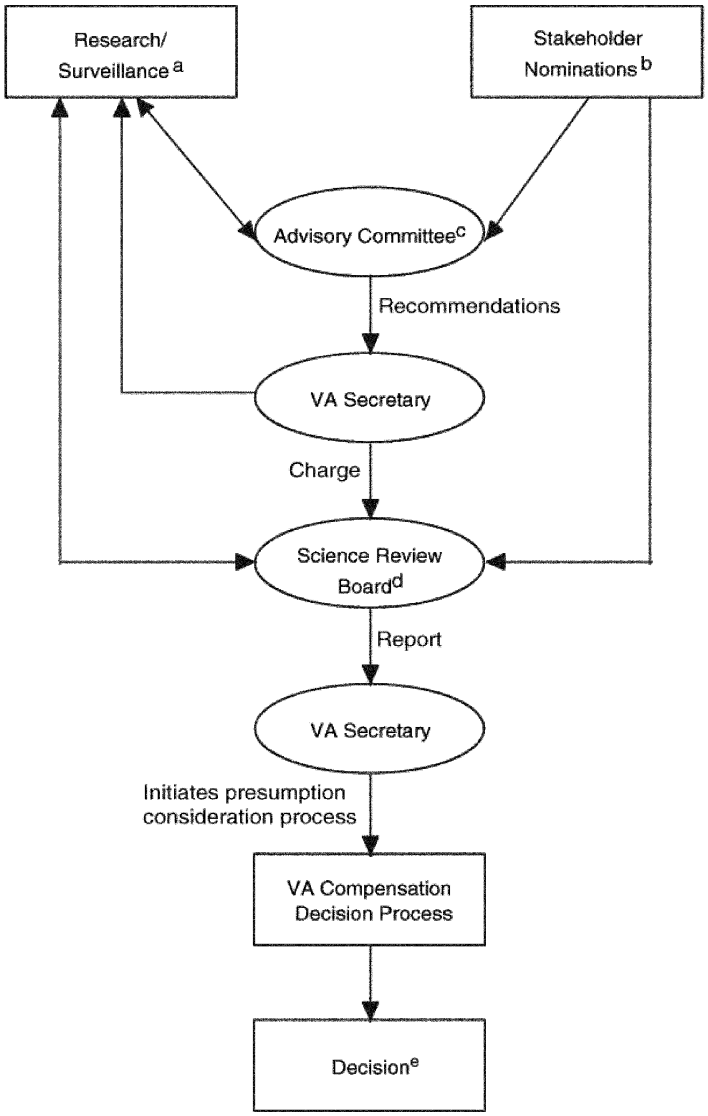
The last principle needs further discussion, as it departs from the current approach. In proposing causation as the target, the Committee had concern that the approach of relying on association, particularly if based on findings of one study, could lead to "false-positive" presumptions. The Committee calls for a broad interpretation of evidence to judge whether a factor causes a disease in order to assure that relevant findings from laboratory studies are adequately considered. The Committee also recommends that benefits be considered when there is at least a 50 percent likelihood of a causal relationship, and does not call for full certainty on the part of the Science Review Board.

The Committee suggests that its framework be considered as the model to guide the evolution of the current approach. While some aspects of the approach may appear challenging or infeasible at present, feasibility would be improved by the provision of appropriate resources to all of the participants in the presumptive disability decision-making process for veterans and future methodological developments. Veterans deserve to have these improvements accomplished as soon as possible.

The Committee recognized that action by Congress will be needed to implement its proposed approach. Legislation to create the two panels is needed and Congress should also act to assure that needed resources are available to create and sustain exposure and health tracking for service personnel and veterans. Many of the changes proposed by the Committee could be implemented now, even as steps are taken to move the DOD and VA toward implementing the model recommended. Veterans deserve to have an improved system as soon as possible.

Thank you for the opportunity to testify. I would be happy to address any questions the Subcommittee might have.

FIGURE GS–1 (IOM 2007) Proposed Framework for Future Presumptive Disability Decision-Making Process for Veterans.



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[b] Includes veterans, Veterans Service Organizations, federal agencies, scientists, general public, etc.

[c] This committee screens stakeholders' proposals and research in support of evaluating evidence for presumptions and makes recommendations to the VA Secretary when full evidence review or additional research is appropriate.

[d] The board conducts a two-step evidence review process (see report text for further detail).

[e] Final presumptive disability compensation decisions are made by the Secretary, Department of Veterans Affairs, unless legislated by Congress.

ENCLOSURE: IMPROVING THE PRESUMPTIVE DISABILITY DECISION-MAKING PROCESS FOR VETERANS

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Improving the Presumptive Disability Decision-Making Process for Veterans

Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans, Jonathan M. Samet and Catherine C. Bodurow, Editors

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Summary

INTRODUCTION

The United States has long recognized and honored military veterans' service and sacrifices. Veterans injured by their service, becoming ill while in service, or having an illness after discharge as a long-term consequence of their service have been given healthcare coverage and disability compensation. As the complexity of exposures during combat has increased, the list of service-connected illnesses has grown. The Department of Veterans Affairs (VA) now provides disability compensation to approximately 2.6 million veterans for 7.7 million disabilities annually, expending approximately $24 billion for this purpose (VBA, 2006, pp. 19, 24, 27).

Disability compensation for military veterans requires that there be a service connection. A medical illness or injury that occurred while a member was in military service is considered service connected whether caused by or aggravated by an exposure or event during service *or simply occurring coincidentally* with military service. However, if a medical condition appears after the period of military service and it is presumed to be *caused by* or aggravated by an exposure or an event that occurred during military service, then veterans may receive compensation based on that presumption (Pamperin, 2006).

In making a decision to provide compensation, VA needs to determine whether the illness of concern can generally be caused by exposures received during service and whether the illness in a specific claimant was caused by the exposure. The answer to the general question of causality comes from a careful review of all available scientific information, while the answer to the question of causation in a specific person hinges on knowledge of the exposure received by that individual and of other factors that may be relevant. If the scientific evidence is incomplete, there may be uncertainty on the question of causation generally; if there is limited or no information on exposure of individual claimants or if other factors also contribute to disease causation, there may be uncertainty on the question of individual causation.

To provide benefits to veterans in the face of these two broad types of uncertainty, Congress and VA make presumptive decisions that bridge gaps in the evidence related to causation and to exposure. Presumptions may relieve the veteran of persuading VA that the exposure produced the adverse health outcome and of proving that an exposure occurred during military service (Pamperin, 2006). Once a medical condition is service connected through presumptions, and the veteran can document military service consistent with having received the given exposure, the

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veteran only has to show the basic fact that he or she suffers from the condition in order to receive a disability payment and eligibility for medical care (Zeglin, 2006).

In 2004, Congress established the Veterans' Disability Benefits Commission (the Commission), which was charged with "studying the benefits provided to compensate and assist veterans for disabilities attributable to military service" (VDBC, 2006, p. 1; as found in Appendix A). The Commission identified the presumptive disability decision-making process as a topic needing assessment and asked the Institute of Medicine (IOM) to establish a committee for this purpose that would be funded by VA. The resulting committee, the Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans (the Committee), was given the following charge by VA:

- 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.

The Commission further elaborated the charge, asking the Committee to "help ensure that future veterans are granted service connection under a presumptive basis based on the best scientific evidence available" (VDBC, 2006, p. 4; as found in Appendix A). The Commission asked the Committee to "evaluate the current model used to determine diseases that qualify for service connection on a presumptive basis, and if appropriate, propose improvements in the model" (VDBC, 2006, p. 1; as found in Appendix A). The Commission emphasized that "having a method of granting service connection quickly and fairly based on a presumption is of critical importance to our disabled veterans and their surviving spouses" and that "ensuring that future presumption processes reflect the then current medical knowledge about the causal relationship would benefit the entire veteran community" (VDBC, 2006, p. 4; as found in Appendix A). The Commission's summary statement further commented that "(t)o the extent possible, suggestions that will avoid the necessity for many future presumptions by ensuring that exposure of service members is documented and scientific evidence is made available would be important."

IOM appointed a 14-member committee that covered the broad scientific and medical areas of general, occupational, and psychiatric medicine; biostatistics; epidemiology; toxicology; industrial hygiene; and exposure and risk assessment. The Committee's members also brought expertise in law, philosophy, causal decision making, and policy as well as knowledge of the Department of Defense (DoD) and VA's approach to disability compensation.

THE COMMITTEE'S APPROACH TO ITS CHARGE

In fulfilling its charge, the Committee first investigated and attempted to characterize Congress' and VA's recent approach to presumptive disability decision-making, and then developed a conceptual framework for a new, more evidence-based process. It then constructed a way to move forward that builds on the framework and addresses deficiencies of the current process.

The Committee held three open meetings to gather information on the current presumptive disability decision-making process. The Committee heard from past and present congressional staff members, representatives of VA, DoD, IOM, various stakeholder groups (e.g., veteran service organizations [VSOs]) and the general public. Committee members also participated in conference calls with DoD experts on medical surveillance and exposure data collection and exposure assessment systems.

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The Committee reviewed extensive background information including: documents provided by the Commission, public laws and supporting House and Senate reports, *Federal Register* notices, VA documents [e.g., cost estimates, a white paper on VA's decision-making processes (found in Appendix G), and responses by VA to written questions from the Committee], DoD documents, and past IOM reports commissioned by DoD and VA. The Committee conducted 10 case study reviews—mental disorders, multiple sclerosis, Prisoners of War, amputees and cardiovascular disease, radiation, Mustard Gas and Lewisite, Gulf War, Agent Orange and prostate cancer, Agent Orange and type 2 diabetes, and spina bifida (not a presumption but a VA program area)—that cover a wide variety of circumstances for which presumptions have been established by Congress and VA since 1921. The case studies were a foundation for the Committee's efforts in understanding past practices of all participants in the presumptive disability decision-making process (see Appendix I).

The Committee also researched and considered capabilities and limitations of the exposure data and health outcome information available to DoD and VA for exposure assessment, surveillance, and research purposes. The Committee examined whether DoD and VA have a strategic research plan and vision for the necessary interface between the agencies, as well as with other, relevant research organizations.

The Committee considered the use of scientific evidence in guiding the process for making presumptive decisions that affect the compensation of veterans. Drawing upon the Committee members' expertise in epidemiology, medicine, toxicology, biostatistics, and causal decision making, the Committee covered the evaluation of evidence for inferring association and causation as well as methods for quantifying the contribution of an agent to disease causation in populations and extending this quantification to individuals. Using this framework, the Committee developed an evidence-based approach for making future decisions with regard to presumptions.

THE PRESUMPTIVE DISABILITY DECISION-MAKING PROCESS FOR VETERANS

In 1921 Congress empowered the VA Administrator (now Secretary) to establish presumptions of service connection for veterans. Only Congress and the VA Secretary have the authority to establish presumptions. Over time, presumptions have been made to relieve veterans of the burden to prove that disability or illness was caused by a specific exposure which occurred during military service (e.g., Prisoners of War). Since 1921, nearly 150 health outcomes have been service connected on a presumptive basis (see Appendix F). In February 2006, Congress codified all regulatory presumptions that VA had put in place to that time.

The current presumptive disability decision-making process for veterans involves several steps and several organizations. The process involves input from many parties—Congress, VA, the National Academies, and stakeholders (e.g., VSOs, advisory committees, and individual veterans) (Figure S-1). Congress has made presumptions itself. In the current model, Congress or stakeholders acting through Congress may call on VA to assess whether a presumption is needed. The VA turns to IOM for completion of a review of the scientific evidence. The findings of that evaluation are considered by VA in its presumptive disability decision-making process. Decisions made in the courts have also influenced the current presumptive process.

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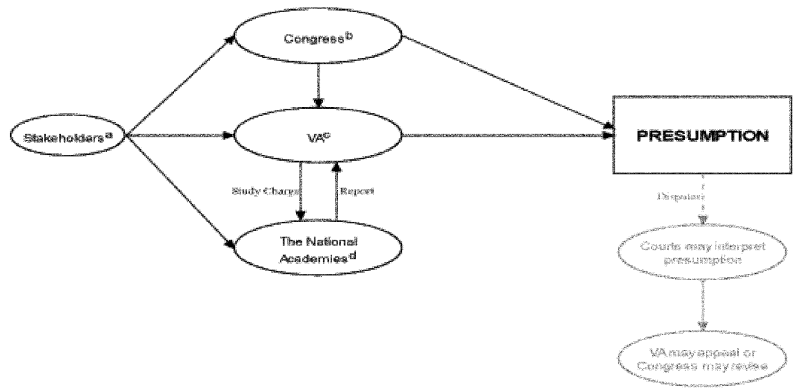

FIGURE S-1 Roles of the Participants Involved in the Presumption Disability Decision-Making Process for Veterans.

[a] Stakeholders include (but are not limited to) veterans service organizations (VSOs), veterans, advisory groups, federal agencies, and the general public; these stakeholders provide input into the presumptive process by communicating with Congress, VA, and independent organizations (e.g., the National Academies).

[b] Congress has created many presumptions itself; in 1921, Congress also empowered the VA Secretary to create regulatory presumptions; on several occasions in the past, Congress has directed VA to contract with an independent organization (e.g., the National Academies) to conduct studies and then use the organization's report in its deliberations of granting or not granting regulatory presumptions.

[c] VA can establish regulatory presumptions; VA sometimes contracts with the National Academies to conduct studies and uses the organization's report in its deliberations of granting or not granting regulatory presumptions.

[d] The National Academies (Institute of Medicine and National Research Council) submit reports to VA based on requests and study charges from VA.

Three major legislative actions by Congress have influenced the recent presumptive decisions—the Radiation Exposed Veterans Compensation Act of 1988 (Public Law 100-321. 100th Cong., 2d Sess.), the Agent Orange Act of 1991 (Public Law 102-4. 102d Cong., 1st Sess.), and the Persian Gulf War Acts of 1995 (Veterans' Benefits Improvement Act of 1994. Public Law 103-446. 103rd Cong., 2d Sess.) and 1998 (Making Omnibus Consolidated and Emergency Appropriations for the Fiscal Year Ending September 30, 1999, and for Other Purposes. Public Law 105-277. 105th Cong., 2d Sess.). The concept of "at least as likely as not" with regard to exposure potential was introduced for radiation exposures and its use has since been continued. The Agent Orange Act (Public Law 102-4. 102d Cong., 1st Sess.) grew out of events following the Vietnam War, and its language expresses substantial and significant elements of the presumptive story. The presumptions put in place by Congress for Gulf War illnesses represent the first time that Congress produced a list of health outcomes which it defined as "undiagnosed illnesses" (Veterans Education and Benefits Expansion Act of 2001. Public Law 107-103. 107th Cong., 1st Sess.).

When Congress enacted the Agent Orange Act of 1991 (Public Law 102-4. 102d Cong., 1st Sess.), it started a model for a decision-making process that is still in place. Congress asked VA to contract with an independent organization—VA contracted with IOM—to review the scientific evidence for Agent Orange. Since 1994, IOM has produced biennial reports on Agent Orange for VA to use as it considers making presumptive decisions (IOM, 1994, 1996, 1999, 2001, 2003b, 2005b). IOM has also delivered five volumes on the Gulf War (IOM, 2000, 2003a, 2005a, 2006, 2007). Congress requires VA to respond after receiving an IOM report with a determination as to whether VA will make a service connection for particular health outcomes on a presumptive basis. VA has described its internal decision-making processes to the Committee in a general fashion, and the Committee has reviewed VA's *Federal Register* notices and documents (see Chapter 3). However, it remains unclear to the Committee how VA makes particular determinations with regard to weighing strength of evidence for causation and exposure potential in making its presumptive decisions.

Analysis of the Agent Orange and Gulf War examples (see Appendix I) shows important similarities and differences relevant to the overall presumptive process. One difference is that Agent Orange is a single product (actually a mixture of compounds which contains the contaminant dioxin), extensively researched for associated health outcomes, whereas the health consequences of the Gulf War are unlikely to be the result of any single agent. Military service men and women may have received a number of health-relevant exposures during service in the Persian Gulf, complicating the development of evidence reviews. For Agent Orange, there is one exposure of concern and a more constrained set of health indicators. There have been some differences in approaches of Agent Orange and Gulf War committees. The IOM Agent Orange reports (IOM, 1994, 1996, 1999, 2001, 2003b, 2005b) did not explicitly include a causal category in their evaluations whereas recent Gulf War reports (IOM, 2000a, 2003a, 2005a, 2006, 2007) did include a category for evidence sufficient to infer causation when characterizing the strength of evidence for agents evaluated. For neither set of reports does VA describe in its *Federal Register* notices how it accounted for exposure potential or magnitude in making its presumptive decisions.

FINDINGS OF CASE STUDIES

The case studies offered a diverse set of lessons learned and indicated elements of the current process that need to be addressed. In carrying out the case studies, this Committee had the oppor-

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tunity to retrospectively examine the work of IOM committees as they grappled with the challenge of using uncertain evidence and of VA staff as they used the findings of IOM committees to make decisions about presumptions. The case studies demonstrate that the process has acted to serve the interests of veterans in many instances. Congress and VA have repeatedly acted to maximize the sensitivity of presumptive decisions so as to assure that no veteran who might have been affected is denied compensation. On the other hand, in maximizing sensitivity of presumptive disability decision-making, substantial numbers of veterans whose illnesses may or may not have been actually service related are nonetheless compensated. There are both financial and nonfinancial costs to such decisions.

The case studies illustrate the use of presumptions to cover gaps in evidence, gaps that exist in part because of lack of information on exposures received by military personnel and inadequate surveillance of veterans for service-related illnesses. Secrecy is a particularly troubling source of incomplete information, as illustrated by the veterans who participated in studies of mustard gas and lewisite. Research carried out directly on the health of veterans has proved useful in some instances, leading to a decision, for example, on granting disability compensation for cardiovascular disease in amputees. But the research has not been systematic, and in the example of cardiovascular disease in amputees no further evidence relevant to a presumption made in 1979 has been collected. Research on radiation risks in veterans has been severely constrained by a lack of dose information, and the studies on radiation-exposed veterans have not been highly informative.

Across the case studies, the Committee found variable approaches to synthesizing evidence on the health consequences of military service. The inferential target of scientific evidence reviews has not been consistent and varied between causation (e.g., Mustard Gas and Lewisite, Gulf War) and association alone (e.g., Agent Orange). The more recent IOM Agent Orange reports have emphasized findings of observational studies on association and interpretation might have been enhanced by placing the findings within a biological framework strengthened by greater attention to other lines of evidence. In the Agent Orange case studies, the category "limited/suggestive" for classifying evidence for association has been used for a broad range of evidence from indicating the mere possibility of an association to showing that an association is possibly causal. The "limited/suggestive" evidence of association—on which the VA's presumptive decisions to compensate type 2 diabetes and prostate cancer were made—may be below the level of certainty needed to support causation absent strong mechanistic understanding or to meet the Congressional language of "if the credible evidence for the association is equal to or outweighs the credible evidence against the association" which the Committee refers to "at least as likely as not."

Both prostate cancer and diabetes illustrate situations in which the contribution of military exposures should be assessed against a background of disease risk that has other strong determinants: age in the case of prostate cancer and family history and obesity in the case of type 2 diabetes, as indicated by the IOM committee in its report (IOM, 2000b). For both diabetes and prostate cancer, the magnitude of the relative risks observed for pesticide exposure implies that the contribution of military exposures is likely to be small in comparison to those of the other contributing factors. In such circumstances, an estimation of the proportion of cases attributable to military exposures could be helpful to the VA in considering whether or not to presumptively service-connect disabilities. The Committee recognizes that development of such estimations is a complicated process dependent on acquiring better exposure data which may not be available for some period of time.

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In the case studies, the Committee's analyses were based on the very general information provided by VA about its internal decision-making processes. The case studies and VA's decision to withhold documents related to specific decisions from the Committee did make clear, however, that these processes are not fully transparent. VA believes that access to predecisional documents by outside sources could stifle candid staff discussions on issues. Once IOM carries out its reviews and provides VA with reports documenting the extent of evidence available on associations, the internal processes of VA that follow are not fully open to scrutiny. This closed process could reduce trust of veterans in the presumptive disability decision-making process and may hinder efforts to optimize the use of scientific evidence. The Committee also found inconsistency in the decision-making process.

SCIENTIFIC FOUNDATION FOR PRESUMPTIVE DISABILITY DECISION MAKING

In developing a future approach for presumptive disability decision making, the Committee first gave extensive consideration to causal inference and the processes used to make causal judgments. In other words, the Committee considered how scientific evidence is used to determine *if* exposure causes some disease. These determinations are generally made by expert committees which examine all relevant evidence for strengths and weaknesses and then synthesize the evidence to make a summary judgment. The Committee defines "exposure" in a broad manner to include chemical, biological, infectious, physical and psychological stressors. The Committee recognizes that psychological stressors may be particularly difficult to describe, let alone measure and quantify.

The Committee then considered the quantification of the contribution of a particular exposure to disease causation. This second issue addresses the question of *how much* of the observed disease in a group, both in absolute and relative terms, is caused by the exposure.

Provision of compensation to veterans on a presumptive basis, or to any other group that has been injured, requires a *general* decision as to whether the agent or exposure of concern has the potential to cause the condition or disease for which compensation is to be provided in at least some individuals, and a *specific* decision as to whether the agent or exposure has caused the condition or disease in a particular individual. The determination of causation in general is based in a review and evaluation of all relevant evidence including: (1) data on exposures of military personnel during service, (2) evidence on risks for disease coming from observational (epidemiologic) studies of military personnel, and (3) other relevant epidemiologic evidence, including findings from studies of nonmilitary populations exposed to the agent of interest or similar agents, and (4) findings relevant to plausibility from experimental and laboratory research. The determination of causation in a particular case is based first on the general determination as to whether the exposure can cause disease, then on information about the exposures of the individual being evaluated for compensation, and on any other relevant information about the individual.

The Committee considered the properties of a decision-making process, recognizing the possibility of two types of systematic errors: making a decision to compensate when the exposure has not caused the illness (false positive) and to not compensate when the exposure has actually caused the illness (false negative). The Committee recommends that any decision process consider the trade-off between these two errors and attempt to optimize both the sensitivity (i.e., minimize the false negatives) and the specificity (i.e., minimize the false positives). Generally, higher sensitivity cannot be achieved without lower specificity. These errors have costs. False

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positive errors result in the expenditure of funds for cases of disease not caused by military service while false negative errors leave deserving veterans uncompensated. The appropriate balancing of these costs also needs consideration.

The Committee considered ways to classify evidence, reaching the conclusion that a broader and more inclusive evidence review process is needed. It found that IOM reviews could be enhanced if a broader array of epidemiologic and other evidence (e.g., animal, and mechanistic data) was considered. The Committee also found that the target of inference had varied from causation (e.g., Mustard Gas / Lewisite, Gulf War) to association (e.g., Agent Orange). Consequently, the Committee recommends that categories of evidence for reviews be established to make clear those relationships that are at least as likely as not to be causal. The Committee has concluded that a categorization of evidence is needed that gives a scientifically coherent rendering of the language employed by Congress in calling for review of available scientific evidence. The Committee proposes a four-level hierarchy that classifies the strength of evidence for *causation, not just association,* and that incorporates the concept of equipoise: that is, whether the weight of scientific evidence makes causation at least as likely as not in the judgment of the reviewing group.

The Committee also gave consideration to the quantification of the burden of disease attributable to an exposure. This quantification would be made to provide an evaluation of the numbers of veterans to be compensated, but it would not be a component of the evidence evaluation for causation. For the purpose of quantification, the attributable risk, termed the *service-attributable fraction,* can be calculated if the needed information is available on the relative risk of disease among exposed individuals. For those exposures meeting the necessary level of evidence for compensation, the Committee recommends that the service-attributable fraction should be estimated overall and for subgroups of veterans, perhaps grouped by level of exposure, if the requisite data are available. Until more complete exposure information becomes available in the future, such calculations may not be possible for all conditions for which presumptions are made.

COMMITTEE'S RECOMMENDED APPROACH FOR THE FUTURE

Overview

The Committee's recommended approach for the future (Figure S-2) has multiple new elements: a process for proposing exposures and illnesses for review; a systematic evidence review process incorporating a new evidence classification scheme, and quantification of the extent of disease attributable to an exposure; a transparent decision-making process by VA; and an organizational structure to support the process. The Committee also calls for comprehensive tracking of exposures of military personnel and monitoring of their health while in service and subsequently.

Organizational Structure

The Committee recommends the creation by Congress of two new permanent boards: the Advisory Committee, serving in an advisory capacity to VA, and the Science Review Board (independent from VA). The Advisory Committee would consider the exposures and illnesses that might be a basis for presumptions and recommend to the VA Secretary exposures and illnesses needing further consideration. It would also consider research needs and assist VA with strategic research planning. The Science Review Board would evaluate the evidence for causation and, if

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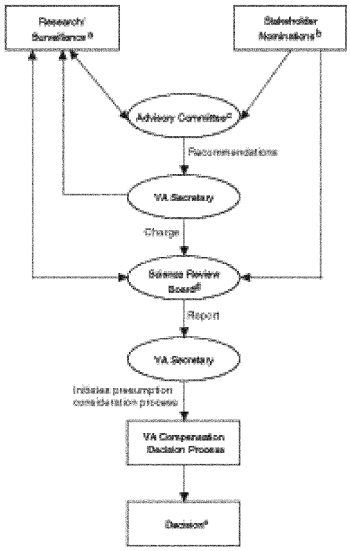

FIGURE S-2 Proposed Framework for Future Presumptive Disability Decision-Making Process for Veterans.

[a] Includes research for classified or secret activities, exposures, etc.

[b] Includes veterans, Veterans Service Organizations, federal agencies, scientists, general public, etc.

[c] This committee screens stakeholders' proposals and research in support of evaluating evidence for presumptions and makes recommendations to the VA Secretary when full evidence review or additional research is appropriate.

[d] The board conducts a two-step evidence review process (see report text for further detail).

[e] Final presumptive disability compensation decisions are made by the Secretary, Department of Veterans Affairs, unless legislated by Congress.

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warranted, estimate the service attributable fraction of disease in veterans. One critical element in the deliberations of the Science Review Board would be evidence from monitoring the exposures and health of the veterans. The Science Review Board would provide VA with input for its presumptive decisions, including a summary report of the available scientific evidence in a standardized classification scheme.

Congress and VA may find alternative processes to achieve the overall objective of the Committee's recommendations: an evidence-based approach to making presumptive disability decisions. The Committee recognizes that specific elements of its proposal (e.g., the call for carrying out exposure assessments and making exposure estimates) are not yet fully practicable and would take time to develop and implement. However, future methodologic developments should enhance the feasibility of some of the challenging elements of this proposal. The Committee believes that this proposal can significantly improve the presumptive disability decision-making process for veterans and therefore, the process for implementing it should begin without delay.

Underlying Principles

VA's decision to make a presumption may involve weighing difficult and incomplete scientific evidence, in the context of veterans' concerns and society's obligations to the affected veterans, and potential costs. Although the potential complexity of the decision-making process may make a complete codification difficult, the underlying principles can be clearly expressed. The Committee suggests the following six principles as a foundation for its proposed framework: (1) stakeholder inclusiveness, (2) evidence-based decisions, (3) transparent process, (4) flexibility, (5) consistency, and (6) using causation, not just association, as the basis for decision making. Flexibility and consistency are not contradictory constructs here. Flexibility refers to the ability to be adaptable through time in evaluating scientific evidence, and consistency refers to being consistent in the process of evaluating evidence and making consistent decisions based on a comparable level of certainty based on the scientific evidence.

Proposals to Review for Potential Presumption

In this process, conditions and causative agents or circumstances would be proposed for review based on evidence of a connection between the condition and military service and evidence that a sizable or well-defined group of veterans is likely to be affected. The possibility of a need for a presumption might arise from surveillance of veterans or active military personnel, laboratory research discoveries, or findings from studies of exposed workers. The process would be open, with proposals accepted from any source (e.g., veterans, veterans' families, VSOs, VA, DoD, other governmental bodies, researchers, or the general public). Proposals accepted by the VA Secretary would be sent to the Science Review Board for full, comprehensive scientific evaluation.

Science Review Board

The Committee recommends a two-step process for scientific evaluation by the Science Review Board. The first step would involve a systematic review of all relevant data to decide the strength of evidence for causation, using one of four categories:

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1. *Sufficient*: the evidence is sufficient to conclude that a causal relationship exists.
2. *Equipoise and Above*: the evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists.
3. *Below Equipoise*: the evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
4. *Against*: the evidence suggests the lack of a causal relationship.

If the evidence for causation were categorized as *Sufficient* or at *Equipoise and Above*, then we anticipate that VA would consider a presumptive service-connection based upon causal evidence categorization and its consideration of the service attributable fraction if available (to be estimated in the second step of the process, described below). As is current VA policy, if the evidence is at Equipoise, the benefit of the doubt would be given to the veteran. If the evidence were categorized as *Against*, then we anticipate that VA would not consider a presumptive service-connection. If, however, the evidence were categorized as *Below Equipoise*, then we anticipate that VA would, after carefully considering the prospects and recommendations for future research, decide on an appropriate time frame for the subsequent scientific review of the evidence, with the expectation that the evidence would then be sufficient to resolve matters either for or against the causal claim at that time. Such information would be considered by the Advisory Committee serving in its capacity as overseer of the overall process and advisor to the VA Secretary.

If the VA Secretary were to decide that a presumption would not be established for evidence categorized as *Below Equipoise* or (for other reasons for evidence categorized as) *Equipoise and Above*, then during the period of further evidence development and gathering and prior to the subsequent scientific review of the evidence, VA should consider providing some support to potentially affected veterans, such as providing provisional access to medical care.

As evidence accumulates, the balance might move to strengthen or to weaken the case for causality. Importantly, the Science Review Board should be free to upgrade the level of evidence, to downgrade the level of evidence, or to leave it as the same categorization. For evidence that has reached the classification of *Sufficient*, we would not anticipate a potential lowering of the classification, if the original determination was correctly made and based on sound scientific evidence.

If the strength of the evidence reaches *Sufficient* or *Equipoise and Above*, then the evaluation would move to step two, the calculation of the service-attributable fraction of disease when required data and information are available. This calculation is independent of the classification of the strength of evidence for causation, and the magnitude of the service-attributable fraction is not considered in the application of the four-level schema for categorizing evidence. Rather, the service-attributable fraction would be of value for decision making, giving an understanding of the scope of the population to be covered by a presumption.

In step two, the Science Review Board would consider the extent of exposure among veterans and subgroups of veterans, as well as dose-response relationships. When such information is available, the board would estimate the service-attributable fraction and its related uncertainty. The purpose of step two is to convey the impact of the exposure on veterans as a whole for the purpose of decision making and planning, but not to serve inappropriately as an estimate of

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probability of causation for individuals. Some exposures may contribute greatly to the disease burden of veterans, while other exposure (even with a known causal effect) may have a small impact overall. This additional information would be useful to VA in its decision making as to whether a presumption should be made for the veteran population in general, for subgroups, or not at all. In the absence of service-attributable fraction data, as will likely occur for many exposures over the short-term, we assume the VA would consider presumptions on the information contained in step one.

Expanding the Evidence Base

In the Committee's view, the best scientific decisions about presumptions can be made only with comprehensive exposure and health surveillance of military personnel. Data collection should begin on entry into the military and continue through discharge, and when harmful exposures are suspected surveillance should be extended indefinitely. Surveillance refers to the ongoing collection, analysis, and use of data relevant to the health of a population. Elements of a surveillance system are already in place, but fall short of what is required. A fully functioning surveillance system would track military exposures and health outcomes, during military service and after discharge, and maintain a repository of data and biological specimens so that emerging and unanticipated questions could be retrospectively addressed. The system needs to be seamless in following military personnel, including National Guard and reservists, from active duty as they transition and become civilians.

This surveillance system should also track job and deployment history for each soldier through the period of service, with exposure assessment and monitoring for a range of job categories. Information on disease risk factors more generally could also be tracked. Use of personal biological samples for individual monitoring also holds promise.

Assessing exposures relevant to the neuropsychiatric disorders that are frequent among veterans of recent and current combats is particularly problematic. Documentation of stress is requisite to the diagnosis of posttraumatic stress disorder (PTSD), but approaches for capturing exposures to such stressors and to the circumstances of combat have not yet been developed and put into place. Research is needed for this purpose that builds on existing approaches so that data become available over the long-term.

In addition to surveillance, the Committee recommends an effort to coordinate and focus research on the health effects of military exposures. Associations identified in the surveillance data might need follow-up through more focused epidemiologic studies or exposure assessments. Toxicological research might be indicated to explore the mechanistic basis for an association between an exposure and a health condition.

VA Procedures

Ultimately, the decision regarding which proposed topics for potential presumptions deserve full evaluation resides with VA. In the Committee's proposed process, VA also receives scientific input from the Science Review Board. We recommend that VA establish a uniform and transparent process for making decisions regarding presumptions following receipt of evidence reviews. VA should establish procedures with input from the many stakeholders, and a clear, evidence-based rationale should be offered for all decisions. The Committee's recommendations that follow are aimed at providing a sound scientific framework for the presumptive disability decision-making process. The Committee clearly recognizes that there are social, economic, political, and legal factors beyond the scope of scientific evidence that may influence the presump-

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tive disability decision-making process for veterans and the presumptive decisions which are established by Congress and VA.

Scientific evidence is not static, and it often is less than certain. Given that the scientific basis for presumptive decisions will change over time, the Committee recommends that VA should be able to adjust future decisions when such change is scientifically justified. This does not mean that the Committee recommends that benefits previously granted should be terminated. The Committee is aware that disabled veterans and their families are often dependent on such payments and that it could create a hardship to remove them, a matter which VA disability policy recognizes in other situations.

SPECIFIC RECOMMENDATIONS

Based on its evaluation of the current process for establishing presumptive disability decisions and its consideration of alternatives, the Committee has specific recommendations for an approach that would build stronger scientific evidence into the decision-making process and, at the same time, be even more responsive and open to veterans. We propose a transformation of the current presumptive disability decision-making process. We recognize that considerable time would be needed to implement some of these recommendations as would additional investment to create systems needed to track exposures and health status of currently serving military service personnel and veterans. Progress depends on greater research capacity and improvements in the evaluation and utilization of scientific evidence in making compensation decisions. We find that there are elements of the current process that could be changed quickly and we recommend that VA consider prompt action as it moves toward implementation of a new approach. The recommendations that follow are based around the Committee's proposed framework for making presumptive decisions. We list the recommendations in relation to the appropriate body.

Congress

Recommendation 1. Congress should create a formal advisory committee (Advisory Committee) to VA to consider and advise the VA Secretary on disability-related questions requiring scientific research and review to assist in the consideration of possible presumptions.

Recommendation 2. Congress should authorize a permanent independent review body (Science Review Board) operating with a well-defined process which will use evaluation criteria as outlined in this Committee's recommendations to evaluate scientific evidence for VA's use in considering future service-connected presumptions.

Department of Veterans Affairs

Recommendation 3. VA should develop and publish a formal process for consideration of disability presumptions that is uniform and transparent and which clearly sets forth all evidence considered and the reasons for the decisions reached.

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Science Review Board

The recommendations that follow are directed towards the proposed, future Science Review Board, the entity to be established in the Committee's proposed approach.

Recommendation 4. The Committee recommends that the goal of the presumptive disability decision-making process be to ensure compensation for veterans whose diseases are *caused by* military service and that this goal must serve as the foundation for the work of the Science Review Board. The Committee recommends that the Science Review Board implement its proposed 2-step process.

Recommendation 5. The Committee recommends that the Science Review Board use the proposed four-level classification scheme, as follows, in the first step of its evaluation. The Committee recommends that a standard be adopted for "causal effect" such that if there is at least as much evidence in favor of the exposure having a causal effect on the frequency or severity of disease as there is evidence against, then a service-connected presumption will be considered.

1. *Sufficient*: the evidence is sufficient to conclude that a causal relationship exists.
2. *Equipoise and Above*: the evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists.
3. *Below Equipoise*: the evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
4. *Against*: the evidence suggests the lack of a causal relationship.

Recommendation 6: The Committee recommends that a broad spectrum of evidence, including epidemiologic, animal, and mechanistic data, be considered when evaluating causation.

Recommendation 7. When the causal evidence is at Equipoise and Above, the Committee recommends that an estimate also be made of the size of the causal effect among those exposed.

Recommendation 8. The Committee recommends that, as the second part of the 2-step evaluation, the relative risk and exposure prevalence be used to estimate an attributable fraction for the disease in the military setting (i.e., service-attributable fraction).

Department of Defense and Department of Veterans Affairs

The following recommendations are intended to improve the evidence on exposures and health status of veterans:

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Recommendation 9. Inventory research related to the health of veterans, including research funded by DoD and VA, and research funded by the National Institutes of Health and other organizations.

Recommendation 10. Develop a strategic plan for research on the health of veterans, particularly those returning from conflicts in the Gulf and Afghanistan.

Recommendation 11. Develop a plan for augmenting research capability within DoD and VA to more systematically generate evidence on the health of veterans.

Recommendation 12. Assess the potential for enhancing research through record linkage using DoD and VA administrative and health record databases.

Recommendation 13. Conduct a critical evaluation of Gulf War troop tracking and environmental exposure monitoring data so that improvements can be made in this key DoD strategy for characterizing exposures during deployment.

Recommendation 14. Establish registries of soldiers and veterans based on exposure, deployment, and disease histories.

Recommendation 15. Develop a plan for an overall integrated surveillance strategy for the health of soldiers and veterans.

Recommendation 16. Improve the data linkage between the electronic health record data systems used by DoD and VA—including capabilities for handling individual soldier exposure information that is included as part of the individual's health record.

Recommendation 17 Ensure implementation of the DoD strategy for improved exposure assessment and exposure data collection.

Recommendation 18. Develop a data interface that allows VA to access the electronic exposure data systems used by DoD.

Recommendation 19. DoD and VA should establish and implement mechanisms to identify, monitor, track, and medically treat individuals involved in research and other activities that have been classified and are secret.

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RESPONSES TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO SCOTT L. ZEGER, PH.D., MEMBER, COMMITTEE ON EVALUATION OF THE PRESUMPTIVE DISABILITY DECISION-MAKING PROCESS FOR VETERANS, BOARD ON MILITARY AND VETERANS AFFAIRS, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES AND FRANK HURLEY-CATHARINE DORRIER CHAIR AND PROFESSOR, DEPARTMENT OF BIOSTATISTICS, THE JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Thank you for the opportunity to speak to your Committee on February 27, 2008 on the important question of how to use the best available science in the VA's presumption process as detailed in our Institute of Medicine report of the Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans. I am writing in response to your letter of March 3, 2008, that provided two questions in follow-up of my testimony. Attached, please find my responses.

I appreciated the opportunity to speak to the Committee. Please do not hesitate to contact our Committee's Chair, Dr. Jonathan M. Samet, or me if we can be of further assistance as you consider and use the report.

Question 1. Dr. Zeger, I am interested in hearing about your Committee's recommended new process for VA to follow in establishing presumptions. To aid the Committee in its understanding of this proposed approach, please take an existing issue—establishment of a presumption in the case of possible Agent Orange exposure for veterans who served off the coast of Vietnam—and describe how the Committee's recommended approach would be applied.

Response. The Committee calls for a prospectively implemented evidence-based approach that could have provided needed data and information on Agent Orange exposure in the Vietnam War, had it been in place at the time. The Committee's report calls for improved exposure surveillance during wartime deployment. Had such a system been in place during the Vietnam War, we might have the relevant data about the level and duration of exposures on board ship, as well as other loca-

tions in Vietnam, rather than having to speculate about them half a century later and make an exposure presumption. Having established a legal presumption regarding exposure to Agent Orange, the issue of shipboard exposure is less of a scientific question and more one of legal construction of the law and implementing regulations

The first step in the process would be for a specific issue or concern (i.e., potential exposure and potential resulting health condition) to be presented to the Advisory Committee. This could come from two general sources. (1) surveillance data and/or research results produced by VA, DOD, public health agencies or academicians and (2) nominations from an individual (e.g., veteran, veteran's family), a group (e.g., VSOs), Federal agencies, academicians or general public. VA staff serving the Advisory Committee would quickly compile as much information as they could to present to the Advisory Committee. The Advisory Committee is envisioned as a screening group and would review the available information to make a determination whether there was enough evidence to request a full scientific review by the Science Review Board. If the Advisory Committee determined there was not enough evidence, it could recommend additional research be conducted to establish the strength of a causal relationship between the potential exposure and potential resulting health condition. If the Advisory Committee determined there was enough evidence, it would recommend to the VA Secretary that a full scientific review of the evidence be conducted by the Science Review Board.

The next step in the process would be for the VA Secretary to issue a specific charge to the standing Science Review Board. In addition, the VA Secretary may decide that additional research and/or surveillance data should be generated for the specific potential exposure and potential resulting health condition.

The Science Review Board (SRB), with the assistance of its associated staff, would conduct a comprehensive evidence review of the strength of the causal relationship between the potential exposure and potential resulting health condition. The SRB would make a determination and classify the strength of causal evidence into one of four categories: Sufficient, Equipoise and Above, Below Equipoise or Against. The category of Equipoise and Above signifies that the health condition was at least as likely as not to be caused by the potential exposure. If the SRB classified the strength of causal evidence as Sufficient or as Equipoise and Above, the SRB would then move to the calculation of the service-attributable fraction. The calculation of the service-attributable fraction is independent of the classification of the strength of evidence for causation, would be of value in decision-making by the VA, and can only be accomplished when required data and information are available. In an instance in which data and information were not available to calculate service-attributable fraction, the SRB would only report its classification of the strength of causal evidence between the potential exposure and potential resulting health condition. The SRB would report its findings to the VA Secretary.

The VA Secretary would initiate the VA's presumption consideration process following receipt of the SRB report. VA would make a compensation decision, and the final decision would be made by the VA Secretary (unless legislated by Congress).

The Committee believes that this process would be more efficient and consistent than the current one. The Advisory Committee, VA staff to the Advisory Committee, Science Review Board and its associated staff would all be established entities. The current process requires that new scientific review committees are assembled each time a new concern or study charge is given by VA. As evidenced by presumptions established to date, there have been different approaches in evidence evaluation and classification as well as how and which scientific evidence has been used in establishing presumptions.

Question 2. Dr. Zeger, with respect to presumptive disability decision-making, IOM recommended a standard of "causal effect." In some cases, servicemembers may have been subjected to multiple potential exposures of uncertain dosage. If causation is unclear, does your Committee believe that a showing of increased incidence of certain disabilities in the subject group should be a basis for a presumption of service-connection?

Response. Our committee recommends that the presumptive process focus on the question: does the exposure *cause* the disease or condition in question. Empirical association such as an increased incidence of disease in an exposed group is one source of evidence in favor of causation, but so is relevant biological knowledge about the mechanisms by which an exposure might cause the disease is also relevant. Our recommendation to focus on cause rather than association is not raising the evidentiary bar for a presumption. Rather, it broadens the scope of relevant evidence to be considered. The committee further recommended that presumptions be found when all of the relevant evidence, carefully considered by a panel of experts, leads them to conclude that the causal connection is *at least as likely as not*. This relatively low

threshold of evidence accommodates many of the uncertainties that exist in presumption cases. By refocusing on the question of cause, by considering all of the relevant evidence and by establishing a threshold of at least as likely as not together with available service-attributable fraction data, the Committee believes that the VA can achieve the appropriate if delicate balance between society's commitment to its veterans and the use of public's resources.

The charge to our Committee did not specifically ask the Committee to address "multiple potential exposures of uncertain dosage" in establishing causation and, as such, this is not specifically addressed in the Committee's report. The current presumptive disability decision-making process establishes presumptions for individual health conditions related to exposure from one specific agent (with the exception of Congress' Gulf War presumptions of undiagnosed illnesses). However, our Committee recognized that each Servicemember will be exposed to different agents during their service in garrison and in the field. The Committee's approach could be used to evaluate multiple potential exposures. If the Science Review Board (SRB) determined that the evidence demonstrated that it was at least as likely as not that multiple potential exposures caused a specific health condition, then the SRB would classify that specific, defined situation as Equipoise and Above. The SRB would submit its report to the VA Secretary, and the VA would make compensation and final decisions to establish or not establish a presumption in such an instance.

Chairman AKAKA. Thank you very much, Dr. Zeger.

Now we will have rounds of questions by the Committee.

My first question is directed to Dr. Kilpatrick. Dr. Kilpatrick, IOM found that disability payments may actually contribute to better treatment outcomes. Can you please explain that further?

Mr. KILPATRICK. Well, there is sort of a lore out there that basically says, veterans who get compensation for PTSD have no incentive to seek treatment and they have no incentive to get better because they are, in essence, being compensated for being sick. The committee received testimony from several individuals and reviewed research that indicated that basically there was not any strong evidence to suggest that.

There were anecdotes to that, but actually some of the research that we reviewed indicated that, first of all, there was no difference between people who got compensation versus not in terms of responding well to treatment, and something that people don't look at sometimes is that it appeared that maybe some veterans might seek compensation to be able to access treatment. In other words, the VA, as we understood it, has to prioritize eligibility based on some criteria. One of those criteria is: that if you were service-connected for PTSD or other things above 50 percent, I believe it is, that puts you at a higher priority to receive treatment.

So, on one level, people might have to seek out disability just to be able to get treatment. On the other hand, there was some testimony that we got that was done of veterans who said that they felt validated when they were having a problem and they went to the VA and the VA said, we agree that you have a service-connected problem, and so in that case, they might feel better about themselves in addition to being able to access the treatment.

Chairman AKAKA. Thank you. Dr. McMahon, you heard the IOM's response to my previous question. I now turn to you. You surveyed veterans about how disability payments impact their willingness to follow medical treatment. Can you describe for the committee the results of this survey? What do the results suggest about the relationship between disability compensation and medical treatment, especially treatment for PTSD?

Ms. MCMAHON. I will certainly try to shed some light based on the survey questions that we used. We approached this through a

series of indirect questions. We didn't just directly ask veterans if they did not seek treatment or if they had terminated treatment because they were perhaps fearful of losing their benefits. So we set up a series of indirect questions to ask them about their treatment plans and ask them about the therapy they might receive and then approach this in an indirect manner.

The substance of our finding was we found virtually no evidence of any systematic desire on the veterans' parts to avoid treatment or to curtail treatment because of the fear of losing their benefits. And in fact, if you want to address this, the exact number——

Mr. CHRISTENSEN. Yes. The actual number was less than half of one percent of all veterans essentially had behavior that reflected not following treatment or not getting treatment or not seeing it through to the end because they were concerned about their benefits.

Chairman AKAKA. Thank you for that response, Dr. Christensen.

Dr. Bristow, one significant recommendation made by the Commission is to expand the concept of disability to include limitations in daily living and loss of quality-of-life. Please describe IOM's evaluation of these concepts.

Dr. BRISTOW. The rating schedule as it was originally developed was framed in a society that was largely agrarian and so the emphasis was upon whether or not an individual's physical limitations impeded their ability to work, often in farm work. Society has changed considerably over the almost 100 years since the schedule began to evolve and it is clear that when an individual suffers a disability, there is more impact on their life than just their ability to earn a living. Such things as their ability to interact with their family, with their loved ones, with their neighbors, and to enjoy the everyday living activities that most of us sort of take for granted can be severely hampered.

When we talk about quality-of-life, we are talking about the individual's perception of their well-being in several domains—the physical, the psychological, social and economic. What do we mean by that? We are talking about how an individual sees themselves in terms of, "Am I fitting in with what I would normally expect to be able to do."

Now, there has been social scientific research in this area for almost 20 years, in evaluating a person's quality-of-life. If I may take a moment, a study was done in Ontario, Canada, involving some 12,000 disabled workers in a workers' compensation program. They made a series of approximately 84 videos of individuals who had various disabilities going through the ordinary activities of daily life. These videos depicted the impact of being blind, for example, on being able to prepare your own breakfast, being able to get about in your home.

They made a series of 84 such videos, and then they showed four or five of those videos to each of these 12,000 individuals, never showing a video that contained the same disability that the disabled person had, but other disabilities. Then, they asked those individuals to rate what sort of impact on their perception of life it would be if you had that type of disability—from zero, which they considered to be perfectly normal, up to 100, which was death. They also took at the same time some 300 normal individuals in

Ontario who had no disability and put them through the same process of viewing four or five of these videos each and saying, "What would it mean to you if you were blind and had to try to shave," as depicted on the videos. From that, they were able to construct a measure of the loss of quality-of-life for various disabilities in those particular workers' compensation programs.

Now, what we need in the VA is a similar approach—not for workers' compensation, but—for the impact on a veteran's life, and we need to have comparable studies that would assess how veterans who are disabled perceive themselves and how veterans who are not disabled perceive themselves if they were to have this disability and to be able to construct from that measures of the impact on the quality-of-life for veterans who are disabled.

What my committee is recommending is that once that has been done, then go back to the rating schedule to see how well the rating schedule is, in fact, reflecting that impact on quality-of-life for the various disabilities that veterans have. And, if it turns out that the rating schedule is already—as Dr. McMahon said, factoring that in in some way—fine; all well and good. But, if it is not, then we believe our Nation needs to take steps to include that factor; because quality-of-life is recognized now to be much more important to a person than we were able to perceive 80 years ago.

Chairman AKAKA. Thank you very much, Dr. Bristow.

Senator Burr?

Senator BURR. Thank you, Mr. Chairman.

Dr. Kilpatrick, I want to make sure I understood you correctly in something that you said, because I thought it was a little bit different, maybe, from the testimony. You stated that somebody needed to have a disability established before you felt they would get the proper treatment within the VA system. Did I accurately reflect what you said?

Mr. KILPATRICK. Well, let me tell you what I meant. What I meant to say is that it was our understanding that the VA does prioritize treatment if there are not enough resources in the health care system for the VA to treat all veterans, if they all came forward at the same time for treatment. There would not be sufficient resources to do that. Therefore, there is a priority system, which differs for veterans of different wars; but, it also filters in the level of service connection that you have, which is one thing that moves you up or down the priority list in terms of getting you in for treatment.

So therefore, it is possible that some of the recent veterans may have—I mean, they are first priority to get in; but, for example, some Vietnam veterans might not be first priority to get in, yet they would have a higher priority depending on the level of disability for PTSD that they had.

Senator BURR. Clearly past veterans have gone through disability ratings. They filed their disability claims. They have probably been re-rated numerous times, and I think we are certainly focused on this new starting point for today's warrior and how the system needs to reflect not only technology in the delivery of care, but their expectations.

The challenging thing, especially as it relates to PTSD and other mental disabilities, is that I think most clinicians know that the

first 6 months is the most crucial time of intense rehabilitation, of intense treatment, yet it is proven within the system you don't even get a disability determination in 6 months, at the earliest, and likely it extends much past that.

The focus of our attention is how do we take these young warriors and put them in intense rehabilitation in hopes that when they come out the other end, the disability is better or it is gone. As a matter of fact, I am troubled because the Inspector General's report in 2005 found that, generally, once a PTSD rating was assigned, it was increased over time until the veteran was paid 100 percent. Now, I have got to be clear. My objective is to make sure that the initial rating after treatment goes down, hopefully; and if it doesn't, we have a system that, in the future, will account for quality-of-life and for loss of work.

I have difficulty with the VA model today, because it seems like you come in one side and you go out another side sicker than when you came in. That is not health care. Health care is designed to make one better. So, I would only caution you on that statement. I think I am less concerned with what their rating is for disability when that disability determination is made. I am more concerned that when they are seen, if they believe that there is a need for mental health services, that we get them in that program; that we do everything to keep them in that program; that we make sure any financial challenges that a family has, we overcome, so that the service personnel's focus is on treatment. The most important thing for me right now is treatment; and on the back end, we can make a more accurate evaluation of the disability, the degree of the disability, and consequently, what the compensation should be.

Clearly, I am alarmed at what the Inspector General found, and that is, if we enter them into the system, if we don't get them the type of services that they need up front, the outcome today is that eventually they become 100 percent disabled. I think our objective ought to be to make sure that nobody reaches 100 percent, because we have got the services in place to change their course, yet 100 percent is there in case everything that we collectively try fails.

Let me move to you, Dr. Bristow, for a second because I am curious as to where Chairman Akaka went, and I am having a difficult time distinguishing. I see the two areas, quality-of-life and the work disability, and I am having a hard time separating quality-of-life from the non-work disability, because I guess I put myself in a category that I am not disabled. When my wife says, "Change that light bulb," 3 weeks later when I haven't changed that light bulb—if I were disabled, it is a quality-of-life issue: that I see that I can't physically do it. There are some things that I am limited in doing, non-work-related, that had I not had the disability, I could do. I could respond.

Help me distinguish these two, because I think my concern is that the more you split the categories, the more difficult it is for us to come to a system and to design something that is reflective of the balance that we need.

Dr. BRISTOW. Yes, sir, Senator. Let me try to do that. I would say that the non-work-related disabilities that we are referring to are measurable disabilities—how much time does it take you to climb a flight of stairs? How well can you carry out certain func-

tions that are common to everyday life? Those are measurable, as I said, speed, dexterity, that sort of thing.

When we speak of quality-of-life, we are speaking instead of the individual's perception of themselves, and as I said, how they fit into this world. That is not the same thing as whether or not you can lift a 50–pound load from the floor repetitively over the course of 5 minutes.

So, one is non-work-related. It is not something that you are engaged in in your occupation, but it impacts how quickly can you get to work if you have difficulty with ambulation, how much difficulty is there in getting dressed in the morning. Those are the non-work-related disabilities. I would consider them measurable or at least estimable.

The quality-of-life issues, on the other hand, are such things as, "I can't put my arms around my kid who is growing up because I don't have an arm." That is not measurable; it is a self-perception. What we are saying is that in the modern world's concept of disability, it is recognized that that is something that should be taken into consideration. Workers' compensation systems in a number of areas are attempting to take into consideration quality-of-life changes as a result of a disability. I believe it can be safely said that the Veterans Administrations in Canada and in Australia are attempting to take into account the quality-of-life impact from a disability and to develop some form of compensation for that.

Senator BURR. I appreciate your comments, as I do from all of you, and I hope you understand why we are going into such depth. We have got a system that hasn't changed in 50 years. The historical precedent that is set is that we may not change this for another 50 years. So, hopefully we design it in a way that it accommodates those things that we can't anticipate we are going to run into, but also that it reflects where we are technologically, where we are from a standpoint of our commitment, our promise, our obligation. My hope is that we get it right or that we come as close as humanly possible, and that is why I commend the Chairman and his willingness to take on as much input into this, because it is an extremely important course that we take.

I apologize. My time has run out and I think the Chair is going to have another round, I feel certain.

Chairman AKAKA. Thank you very much, Senator Burr.

Dr. Zeger, let me just move back to more of the structure. Can you please explain the relationship between the Advisory Committee, the Science Review Board, and VA? Should VA be required to follow the recommendations of these new panels?

Dr. ZEGER. Thank you, Mr. Chairman. The committee was not so bold as to recommend that the VA must do something, because it recognizes that the VA and Congress have the responsibility for establishing the exact process and the decision about a particular presumption. What we did ask, however, is that a more scientific basis be put in place so that the best evidence is brought to the decision that the VA and Congress make. There are two parts of the process we see opportunity for revision.

The first is a way to prioritize the many potential presumptions that arise. The committee believes that we should encourage affected veterans to come forward with their health or exposure con-

cerns; we need a place where VSOs may bring concerns of the community. So, the first Advisory Committee would be a place that would receive a range of potential nominations for presumptions, would prioritize them, and put some into a scientific process.

The Science Review Board would be the place where the best available evidence would be gathered and assessed and then recommendations would be made to the VA. The VA would have the responsibility for the ultimate decision about the presumption, or Congress in the cases where it is involved.

Chairman AKAKA. Thank you very much.

Dr. McMahon, CNA's quality-of-life study found that mental disability does appear to lead to lower physical health, but physical disability does not lead to lower mental health. To some, this might seem counterintuitive. We generally understand that physical disability is often associated with lower mental health. Is this true for veterans and non-veterans alike?

Ms. MCMAHON. We looked at the issue of the health scores separately for physical and mental health scores from the results of the survey, and what we found for those who had a primary physical disability—and let me just back up and clarify. Veterans may have a number of different disabilities. We categorize them by the primary disability being physical or mental. So, for those who had a primary physical disability, what we found is that for those with a reasonably low rating of disability, up to, say, 50 percent, they did not appear to have a mental score that was different from the norm of the population in general. So, they did not have a mental score that reflected a difference from the general civilian population.

On the other hand, for those who were severely disabled with a primary physical disability—say an 80 percent or 100 percent disability—they did show that they had below average mental health scores, as well. So, it is their disability on the physical side was associated with a loss of the mental score, as well.

On the other hand, for those who had a primary mental disability, we were surprised to see that at every rating category, there was a loss in both the physical and the mental health scores compared to the overall population norms. That was not something we anticipated.

Chairman AKAKA. Dr. McMahon, CNA's analysis found that a higher number of those designated as individually unemployable suffer from disabilities such as PTSD. CNA's report states that this suggests a failure of the VA rating schedule. In your opinion, what changes should be made to the rating schedule to correct the overreliance on IU? What changes should be made to the criteria for IU?

Ms. MCMAHON. Well, we did look at IU and one of the findings we had is that, overall, 8 percent of those receiving VA disability compensation have IU, but 31 percent of those with PTSD as their primary diagnosis had an IU designation. We concluded from this that there was an indication that the rating schedule was not working well for PTSD and that many of the people who had PTSD were having to come back and say, we have an inability to work and we need a higher rating. So, that suggested to us that the rat-

ing was not working well enough for that group of people and possibly for others, as well.

What you would do to address that, I think, could occur in a number of ways. One suggestion is that if people are unable to work, even though they don't have a 100 percent rating in this area, that possibly they are not being rated correctly. I am not a clinician. I can't say exactly how I would rate someone with PTSD to do this, but I can say that we did review this issue. With the survey of our raters and VSOs, we asked these people how they felt about the rating process, and they particularly indicated that they found the claims becoming more complex. They found that it was much more difficult to rate a mental disability than a physical disability, other things being equal, and in particular, PTSD was the hardest to be objective about. There was a subjectivity to the evaluation that troubled them, that led to some inconsistencies, perhaps. And so they spoke up for the need for more time and especially more clinical input from physicians and mental health practitioners to assist them in making that determination for PTSD.

And I think when you weave these stories together, it is an indication that the process needs to be addressed, that the raters are not comfortable with what they are being asked to do. They need more assistance. They need more time to consider this kind of claim in particular and that might lead to a better outcome.

Chairman AKAKA. Senator Burr?

Senator BURR. Dr. McMahon, thank you very much. I was fascinated with your statement that physical disabilities didn't lead to mental deficiencies, but mental disabilities did lead to physical deficiencies. I think that is sort of at the heart of what I have tried to drive, and that is: with that known, the focus—especially on mental disabilities—should be treatment as quickly and as effectively as we possibly can. Because I think the data proves and your study proves that that leads to a physical deficiency if, in fact, we don't thoroughly address the mental disability that exists. And as we look at one, a primary objective of making a veteran better when they leave than when they came in; and two, how do we eliminate the slide in the future of one who continually gets worse. Well, clearly to inject the physical side into it, you now have a veteran that is affected in multiple ways.

You mentioned that veterans who become severely disabled at a young age may have a long period of lost earnings. I mentioned Sarah Wade earlier, and as she put it, "Ted will never again get a pay raise." For these young severely disabled veterans, you found that they are substantially below parity in terms of compensating for their lost earnings. Would you walk us through your suggestions for how you would make sure that young severely wounded warriors, like Ted, are being adequately compensated in the future?

Ms. MCMAHON. I would be happy to do that. I believe that when we looked at the parity of the disabled veterans, we found that the average age of entry into the VA system is about at age 55, and to put it as simply as possible, someone coming in at that point has had a fairly long job history so far in their lives and now the disabling condition has become something that they can no longer cope with quite so well. And so they come into the VA system and

then we look at what that says for the compensation over their expected lifetime. This is a lifetime look that we took in terms of the compensation.

So, for the young veteran who has become severely disabled at a young age, they are facing an entire lifetime of having an inability to completely participate in the workforce as compared to their peers that are able to do this in a normal fashion. So, they are looking at a long period of years when they are disadvantaged in terms of their work capabilities, and that is what leads to some of the disparity that we see. It is not a system that expects you perhaps to come in at age 25 and be there for the rest of your life.

As for the question of how you would deal with that, it is possible that you could deal with it partly by having a compensation that would depend on the age of entry. Another possibility would be to have a special compensation element for those people who came in at a very young age to reflect that condition.

I think another thing that I would want to say is that I also view that the better solution is treatment and getting the person to be well-adjusted to life and able to contribute as much as they can. It does seem to me that you don't want to simply say, well, we will give you more money if, in fact, what you can do is give more treatment to help people. And I think in particular with PTSD, that treatment is crucial and getting treatment that is thorough and adequate as well as you can to give people the best chance as possible to return to a normal life is a very important aspect of it.

Senator BURR. Let me ask you, about 30 percent of our veterans with service-related disabilities are also military retirees who by definition would be eligible for DOD retirement benefits, including an annuity, health insurance for their entire family, access to tax-free shopping at commissaries and exchanges. Now, specifically for those retirees with less disabling conditions: did your study address whether they, on average, work less than veterans who do receive these benefits? I hope you understand what I am trying to analyze.

Ms. MCMAHON. I do understand, and we did not look at that issue. I can't give you an answer on that.

Senator BURR. Is that something important for us to look at as we try to construct something that truly reflects what fair compensation is, and by the way, to eliminate disincentives that may exist in the system? I am not suggesting to take things away from people, but to identify disincentives that need to be balanced.

Ms. MCMAHON. Partly, I would say that this becomes a policy issue, and my comments on this are not based so much on an analysis of findings but just in terms of other kinds of policy assessments that have been made over time. If you view your retirement benefit as being something that you have earned, then it is something that is yours, that you own—it is sort of like you have paid into a system and received it. It is somewhat like having a retirement system in the civilian market where you may have paid into a fund and then that money is yours at the end. And so in that sense, it is not really a compensation, it is a retirement fund that you have built up.

In that sense, what we looked at in the study was strictly based on income-earning ability and compensation. We did not address, and I can't think how we could have addressed the issue of various

retirement funds that individuals acquire in various ways other than the obvious one with the military. So, that is just not something that we were able to bring into the picture.

Senator BURR. Dr. Bristow, do you want to add something to that?

Dr. BRISTOW. Yes, sir. Thank you, Senator. Our committee was quite interested in this issue but from the other end of the spectrum, in that, particularly in the IU program, the Veterans Administration is prohibited from taking into account the age of the individual who applies and does not make any allowance for how long this person would be expected to be able to be employed in the future. Our committee, in fact, has recommended that research studies should be done to see whether or not that is an appropriate policy, and I think what I have heard today suggests to me even more so that it really should be done. There should be some reasonable accounting taken for the age of the individual and what is projected to be their likelihood of employability over a period of time.

Ms. MCMAHON. And I would follow up with that. We also looked at unemployability that way and one of the things we noted is that this payment, once achieved, can be received indefinitely, whereas most people have retired by a certain age. And so this concept of considering the age of the individual with regard to the benefit received is something that we addressed, as well.

Senator BURR. Well, I genuinely want to say how grateful I am to all of you for your willingness to be here. The Chairman has been very gracious with me on the clock. I want to ask all of you, I will have additional questions——

Chairman AKAKA. We will do another round.

Senator BURR. The Chairman says he is going to do another round. I will probably have additional questions beyond that, as well, and they may not all be tomorrow. They may be as we work through the construction of where it is we need to go. And I hope all of you will make yourselves available to help us as we try to construct what we believe is the most appropriate path forward.

Chairman AKAKA. Thank you very much, Senator Burr. We will have another round here.

Dr. Kilpatrick, IOM recently published a report on the effectiveness of the best approaches for treating PTSD. Did IOM reach any conclusions on whether or not cognitive therapy is readily available to veterans?

Mr. KILPATRICK. That was not our committee, but I am generally familiar with that report and my recollection is that in terms of cognitive behavioral therapy, they identified one treatment, which was prolonged exposure, that said that it really met the gold standard test of having then multiple studies that were replicated for effectiveness for PTSD. I think there are some other treatments that some of us think are probably very close to that level of gold standard, as well, and I believe that the committee determined that many VA mental health professionals have not been trained in those particular treatments.

And so to that extent, I believe they would say that there is a shortage of trained clinicians to provide those treatments in the VA, which the VA, in fairness, is working on and I know has training programs and is also trying to hire new mental health profes-

sionals. But I think where we stand right now is that the most effective treatment that was identified is not readily available to every veteran at every VA.

Chairman AKAKA. Dr. McMahon, CNA found that service-disabled veterans with serious mental disabilities earn less in every age group and rating group than veterans with physical disabilities. What do you believe accounts for this difference? Should veterans with mental disabilities receive higher ratings to compensate for their lower earnings?

Ms. MCMAHON. I am not completely certain, of course, what makes the difference, but I can speculate a little bit about what I think is a reasonable interpretation of that finding. I think with physical disability, it is often something that can be compensated for, not in money terms in this context, but compensated for in other ways. It may be that there is an artificial limb that is provided. It may be that there is an accommodation of a workspace that is changed or stairs are replaced by an elevator or something like that which allows a person to be able to work more effectively. In addition, people can recognize what the physical limitation is and perhaps find ways to work around it in a fairly straight-forward fashion. I didn't say that well.

When you are dealing with a condition that is a mental disability, I don't think it is as easy to understand how to accommodate the person in that circumstance. I don't think it is a visible thing, such as I have lost a limb or I need to have someone help me come up the stairs or something of that nature. And so I think it is harder for the accommodation to be made for that person. It is just not easily recognized what is needed to make them fit well into the work environment so readily.

In terms of compensation, should there be extra compensation, I would say that I view it as one of two things. Either you find a way to treat the person so that they are able to be accommodated into the workforce in a better fashion or you have to recognize that we are not able to make that accommodation, and then in that sense, yes, they would need an additional compensation.

Chairman AKAKA. Dr. Bristow——

Dr. BRISTOW. Yes, sir?

Chairman AKAKA [continuing]. Can you please explain the importance of VA beginning to use the ICD and DSM classification systems that are used in today's health care systems?

Dr. BRISTOW. Yes, sir, I would be happy to. In fact, this will apply to the last question that you raised with Dr. McMahon.

The ICD coding system and the DSM coding system allow for the most precise definition of a state of disease in a given individual. What VA is currently using is extraordinarily imprecise and, in fact, even when they acknowledge what the diagnosis correctly is, in the area of mental illness, which is a glaring example, administratively, VA has decided we will decide all mental illness in terms of its disability using the same set of criteria, and those criteria that have been selected do not fit well with many mental illnesses. They may fit very well with a person who has got schizophrenia, but they have very minimal application to a person who has PTSD.

If they were using DSM as a coding system, DSM provides and identifies where the problems are being manifested in that given

individual. It would then be a lot easier to say, well, if the person is having these manifestations, that indicates a severer level of disability than using a broad-brush which has very little application to where the problems are for this specific illness.

So, it is imperative, in my opinion and in the opinion of our Committee, that VA move to using the same coding classification that is being used all over the world—that is being used within the VA's health care system itself. It is just that when they leave VA's health service and transfer the information over, it is recoded into something terribly archaic, and that negatively impacts the ability of the disability system, which wants to do the right thing; but it makes it very hard for them to do the right thing when they are using the wrong tool.

Chairman AKAKA. Thank you very much, Dr. Bristow.

I will call on Senator Burr, though I have one more question to ask all of our witnesses. I will do that after he is done.

Senator BURR. Dr. Bristow, I want to call on your Presidency of the AMA to ask you, is it healthy for the Chairman to drink such a large cup of Starbuck's coffee? [Laughter.]

I am not sure I can figure out how you could make it through this hearing having drunk that whole thing.

You know, I am reminded as I sat here that we have done a tremendous job with homelessness in this country, and that is both sides, the veterans' side but also the general public side. There is one thing that we learned extremely early in it and we are still having a difficulty implementing. We can do a great job at providing a roof and walls to an individual, but without the wrap-around services, you can't put somebody permanently in housing. It takes the wrap-around services to treat the other conditions that they run into that make them permanent from a standpoint of being in a home.

So, I hope all of you understand why I have been so insistent about making sure that we provide the services. It is not just, how do we get the disability right. It is how do we provide the level of health care so that, hopefully, the disability goes down over time, if that is possible.

Dr. McMahon, I want to ask you one last question. The VDBC noted, and I quote them, "it is commonly acknowledged that the disability compensation program compensates for injuries and diseases that do not impair earnings capacity but have negative consequences for veterans," and I would only ask you, were you able to draw any conclusions along those lines?

Ms. MCMAHON. I am going to be very candid and say I am not exactly certain what context that is taken from. Our mandate was to look for those things that had an impact on the ability to earn and to look at what compensation consequences there were, and that was really the thing that drove our considerations. I suspect that this is something that I would understand better if I could read more of the context surrounding the statement.

Senator BURR. We will ask it in a written follow-up question and try to point to you——

Ms. MCMAHON. That would be better. Thank you.

Senator BURR [continuing]. Exactly the context that it was in, and again, I want to—yes, sir, Dr. Bristow?

Dr. BRISTOW. Very quickly, I think that a good example of the VA's efforts, good faith efforts in that direction would be compensation for loss of procreative organs, which have obviously nothing to do with a person's earnings capacity, but it is a recognition once again of an attempt to go into the area of quality-of-life, which is important.

If I can sneak in one last little quick statement? Our committee felt it is going to be important as we go forward to give each applying veteran a more complete evaluation than they currently have been receiving; not only a compensation and pension evaluation, and a medical evaluation, but they really should have a vocational evaluation when they first apply, so as to be able to inform that veteran and help that veteran decide how can they emphasize the "ability" part of disability rather than the "dis" part. Find out what they can do to help them return to normal, to as much normalcy as possible, and that can only be done if we provide that type of service when they first apply. Yes, you have these impairments, but you also have these potentials, and maybe we can help you go to school to work on some of your strengths. If we can do this, it will help that veteran get the most out of life.

Mr. KILPATRICK. Senator Burr, I just wanted to clarify, as well, that our committee, whereas it was focusing on the disability process, noted that there was a separation between the disability determination and encouragement and involvement in just what Dr. Bristow was talking about. And as a mental health professional who treats PTSD, I would say that we all think that veterans should get access to the best mental health services possible. There might be a difference of opinion about whether being involved in a disability for PTSD would affect that or not. I don't think our committee felt that it would.

But clearly, we are in agreement that services in the VA should change its procedures and what not, and laws if necessary, to make sure that everybody does have access to the best mental health services because it benefits society, obviously, not just the veterans, to be in a situation where they improve as much as they can, where they get over the terrible things that have happened to them and that they can live as productive a life and as happy a life as possible.

Senator BURR. I appreciate that, and I hope you understand where I am getting that. I am not sure that it is good enough for us to say, it is available. I think our policy has to facilitate people to take advantage of it. It is not just about access. It is about accepting that pathway of treatment and rehabilitation.

I am somewhat passionate about it because I look at the data and the data suggests the model we currently have, which provides access for many if not a majority of the veterans, does not work. I am not suggesting that that is something that is reflective of something we have done wrong or the system has done wrong. It is the fact that veterans for possibly a host of reasons have not entered into the system with the intent that the system will make them better. I truly believe if they believed that, they would be in it.

So, shouldn't we try something different? Shouldn't we create the incentive to get them in, because you—the medical professionals—

tell us that if we are in there, you know what? The outcome is different. So, I think this is a process of how do you get the disability side correct, but also how do you take the delivery side and make it work for veterans.

Again, I thank each and every one of you.

Chairman AKAKA. Thank you, Senator Burr.

Here is my last question. I am continuing to try to get from the source—which you are—to VA, to find out whether everything was done that needed to be done in this area. So, my question to the four of you is, is there anything—anything at all, either in your report or from your overall work for the Commission—which is not included in the report or is not reflected in the way you intended it to be? Dr. McMahon?

Ms. MCMAHON. I believe that the Commission was extremely receptive to the work that we did and I do not believe that there is anything that they did not consider that we put forward to them. It was a remarkable experience—dealing with 13 Commissioners who had their own points of view—but I think, in the end, we were able to give them what they asked for and they reflected that very well in their report.

Chairman AKAKA. Thank you. Dr. Bristow?

Dr. BRISTOW. Thank you, Mr. Chairman. I believe the Commission did an outstanding job. I would say that I am not certain that the Commission quite grasped one aspect that my committee was trying to put forward, and that is the Veterans Administration has available to it an enormous mine of information upon which we can, when properly mined, base evidence-based decisions, evidence-based programs that best serve our veterans. It currently would be enhanced if we had the right sort of coding system, and once that is in place, begin to utilize the information that is right there. We have a treasure trove of potential information which needs to be mined that will allow us to best use our resources. We can find out what is the best way to provide services by utilizing the research opportunities that are just begging to be used.

Chairman AKAKA. Thank you. Mr. Kilpatrick?

Mr. KILPATRICK. I would say that our committee did a very thorough job of identifying areas of difficulty and then coming up with, I think, some common sense ways to reform the process of compensation and, as I mentioned previously, to further integrate the disability part of the VA with the health care and treatment delivery and rehabilitation part of the VA.

I think that although our committee sort of tangentially discussed this, I mean, what I see as one of the big challenges is that for PTSD, we do have some effective treatments now. We always need more research. I mean, I couldn't be a researcher and not say that we need more research, but we need more—we do need more research, but we do have some things that work now. I think we need more studies to look at—to evaluate efficacy and effectiveness. I think we also—the VA is going to need to do even more than it is doing now to make sure that we have well-trained mental health professionals who are up to date in evidence-based treatments and assessment procedures.

Chairman AKAKA. Thank you. Dr. Zeger?

Dr. ZEGER. Yes. Thank you. I would like to report that our committee was very impressed by the degree to which General Scott and the Commissioners were interested in our committee process. We had the good fortune of meeting with some of them in San Antonio when we had open hearings for VSOs and veterans. It would have been much better had it been in Hawaii, of course, but it was very nice to be with them in San Antonio. I am particularly pleased—I know the committee is—that the Commission has accepted all of the recommendations that we have put forward to them and we are now looking forward to seeing a transition toward a more scientific basis for presumptions.

Chairman AKAKA. Well, thank you so much for your responses. This has been a great hearing, and as I mentioned, I look upon all of you here as a source that will help VA do its job better. We are looking forward to trying to support what needs to be done to improve the programs that we have to help our veterans.

So, in closing, let me say thank you very much, all of you, for appearing before us today.

The hearing is adjourned.

[Whereupon, at 11:03 a.m., the committee was adjourned.]

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