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AF RECALL PROGRAM: The Secretary of the Air Force has approved implementation of a Limited Period Recall Program and a Retired Rated Officer Recall Program for Lt Cols and below. These programs are designed to allow Reserve Rated Officers and Retired Reserve Rated Officers under age 60 to return to the Active Duty force to fill flying, UAS and staff billets in the CONUS and overseas. Officers will be recalled for periods between 24 and 48 months depending upon the requirement. Officers recalled under these programs will not be eligible to receive aviator continuation pay. Also, by volunteering for recall, officers will be eligible for deployment.

The following guidelines apply specifically to the Retired Rated Officer Recall Program:
-- Retired regular and reserve officers in the grades of lieutenant colonel and below are eligible to apply
-- Applicants must be under age 60 to apply
-- Officers retired via a Selective Early Retirement Board are eligible
-- Officers permanently retired for a physical disability are ineligible

The following guidelines apply specifically to the Limited Period Recall Program:
-- Applicants must be Air Reserve Component rated officers in the grades of lieutenant colonel and below.
-- ARC officers who separated from active duty from any branch of service because of strength reduction and officers separated from active for nonselection for promotion are eligible to apply.

This is an Active Duty initiative, but in keeping with the Total Force concept ARPC supports this effort. The application period runs through 31 Dec 09. Applicant duty history, availability, and qualifications will be matched against available billets by an Active Duty assignment officer at AFPC. An offer will then be extended and can be accepted or declined within 14 days. Conditions involving length of commitment, deployment eligibility, and other restrictions apply. For more information and application instructions, refer to http://www.afpc.randolph.af.mil/library/voluntaryreturntoactiveduty.asp and to the AFPC "ASK" website at http://ask.afpc.randolph.af.mil (enter 'Limited Period Recall Program' or 'Retired Rated Officer Recall Program' in the search field at top right). You can also call the Air Force Contact Center at 1-800-616-3775, commercial 210-565-5000 and choose the "active duty" menu options provided. After 22 FEB 09, the number changes to 1-800-525-0102. [Source: ARPC/DPAF msg. 28 Jan 09 ++]

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LEGISLATION of INTEREST UPDATE 11: In spite of a busy week working on economic stimulus packages, legislators found time to introduce several additional bills to assist the military community.

- H.R. 775 (Rep. Ortiz, D-TX) would repeal the requirement to deduct VA survivor benefits from military Survivor Benefit Plan annuities.
- H.R. 613 (Rep. Jones, R-NC) would allow a survivor to keep the entire retired pay for the month in which a servicemember dies. Current practice requires the government to recoup the money and pro-rate it based on the date of death.
- H.R. 235 (Rep. Berman, D-CA) would repeal the Government Pension Offset

and Windfall Elimination Provision, which reduce Social Security annuities for many federal civilian retirees and survivors, as well as thousands of teachers and other state employees.

• H.R. 593 (Rep. Smith, D-WA) would better protect against deduction of VA disability compensation from military disability severance pay in instances of combat- or operations-related disabilities. A narrow interpretation of the recent law change on this topic covers only injuries occurring in a combat zone - excluding those incurred in combat training or other operations-related accidents. [Source: MOAA Legislative Update 30 Jan 09 ++]

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MEDICARE PART D UPDATE 33: Leading congressional Democrats have reintroduced the Medicare Prescription Drugs Savings and Choice Act (H.R.684), a bill to provide a prescription drug benefit under Original Medicare which is a program trusted to provide good affordable health insurance for 44 years. If enacted, the legislation would create a government run coverage option that would provide real choice for people with Medicare who now can only receive coverage through a private plan. Creating a benefit under original Medicare is essential to providing reliable, stable standardized coverage that assures access to medically necessary medications. Currently, private plans change what they charge and what drugs they cover year to year, making drug coverage for Part D enrollees unpredictable and inconsistent. The Act addresses the following issues:

• Fluctuating premiums destabilize coverage for individuals with limited income who receive Extra Help, a federal program to help cover the out-of-pocket drug costs for people with Medicare living under or just above the poverty level. Medicare randomly reassigns most individuals with Extra Help annually to a new Part D drug plan if their current plan will no longer qualify for a full-premium subsidy. This year alone over one million people with Medicare were reassigned due to increases in premiums by Part D plans.

• Randomly reassigning people receiving Extra Help to new Part D plans may have serious health implications for individuals. Because Part D plans have wide discretion to decide which drugs they cover and what restrictions they place on coverage, a randomly assigned new plan may not cover an individual’s medications, causing an interruption in treatment.

• A Medicare-run drug benefit will have the ability to negotiate lower drug prices—just like the Veterans Administration does—and be able to offer a low premium that is uniform nationwide. It will create stable coverage for all people with Medicare, including individuals with limited income enrolled in Extra Help. A drug benefit under Original Medicare would provide a consistent formulary. The proposed legislation would prevent drugs from being removed from the formulary mid-year but would allow new medications with clinical benefits to be added.

• A Medicare option will provide consumers a refuge from the greed and ineptitude that has plagued drug benefit administration by many private plans. Most recently, WellPoint, the nation’s largest health insurance provider, was sanctioned by the Centers for Medicare & Medicaid Services (CMS) because of internal system failures relating to the company’s Part D plan. Thousands of people with Medicare who are enrolled in a WellPoint plan have been unable to access their prescriptions at the pharmacy, were charged improper premiums and co-payments, did not receive plan information such as formulary restrictions, and may have been unable to access the appeals and grievance processes, among other violations.

• The new benefit would create a more efficient appeals process, giving people with Medicare greater flexibility to quickly obtain coverage for medically necessary medications that are subject to formulary restrictions.

A new Congress means a new opportunity to revisit important reforms to the Medicare program. A drug benefit under Original Medicare would allow greater savings and access to needed treatments for older Americans and people with disabilities. Readers are encouraged to ask their senators and representative to cosponsor the Medicare Prescription Drugs Savings and Choice Act H.R.684 which already has 13 cosponsors as of 30 JAN. [Source: Weekly Medicare Consumer Advocacy Update 29 Jan 09 ++]

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VA VOCATIONAL REHABILITATION UPDATE 01: A new report from the Government Accountability Office (GAO) concluded the Veterans Affairs Department needs to use more sophisticated workforce planning tools to ensure its Vocational Rehabilitation and Employment (VT&E) Program has staff with the skills to address the increasingly complicated needs of veterans returning from Iraq and Afghanistan, "Many [wounded service members] are surviving with multiple serious injuries and illnesses, including amputations, traumatic brain injury, and post-traumatic stress disorder," the GAO report said. "While some service members will be able to remain on active duty, others will need comprehensive services as they transition into civilian life and work." VA's Veterans Benefits Administration runs the VR&E program. Of the 57 offices nationwide surveyed by GAO they found:

• 54% said they have enough counselors to meet demand, while 40% said they needed more employment coordinators.
• 30% of the offices reported that counselors' skills only moderately met the needs of the veterans they served, while 30% said the same skills gap existed with respect to their employment coordinators.
• 90% reported caseloads have become more complex as veterans' needs become more challenging,
• 80% noted that the agency was only somewhat prepared to meet future demands, while 12% said the agency was not prepared to meet rising needs.

GAO reported that those estimates could actually understate the magnitude of the difficulties facing the program. A 2004 task force recommended that VA study how long it takes counselors to complete their major duties. The report is planned for 2009, and VA will publish its results in 2010. Without those numbers it is difficult for VR&E to establish an appropriate ratio between caseloads and counselors and employment coordinators. The agency based its current target of 125 veterans to one counselor on a study of state vocational rehabilitation programs. But the VR&E workforce rehabilitation system, unlike those administered at the state level is a more complicated five-step process. And VR&E is not even meeting its caseload target. GAO said the regional offices estimated that the average counselor handles cases for 136 veterans. VR&E has increased headquarters staff in recent years, from 33 in fiscal 2004 to 55 in fiscal 2008. The number of regional workers has grown from 917 in fiscal 2004 to 1,101 in fiscal 2008. The program can also refer veterans to counselors who work with VR&E on a contract basis.

GAO's report said it was unclear whether those staff increases were sufficient or whether existing workers were being used appropriately. "Staff time may not be used efficiently, as many regional office staff we interviewed and

surveyed said much of their time was spent on redundant paperwork and data entry requirements that reduced the amount of time they spent with veterans". Former Veterans Affairs Secretary James Peake, who responded to the report in a 29 DEC letter, said the agency would award a contract for a workforce survey by SEP 09. But he disagreed with GAO's assessment that counselors and employment coordinators might not have the requisite skills to assist returning veterans. "The Veterans Benefits Administration has clearly defined critical skills and competencies needed by vocational rehabilitation counselor positions," Peake wrote. "Entry-level counselors are required to possess specific master's level educational credentials in the field of rehabilitation to be eligible for hire." [Source: GovExec.com Alyssa Rosenberg article 29 Jan 09 ++]

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ALASKA TERRITORIAL GUARD: The Secretary of the Army has authorized emergency funds for 26 surviving members of a World War II Alaska militia unit whose retirement pay was being reduced because of a legal technicality, Alaska's congressional delegation said 28 JAN. Army officials last week said a military analysis determined the law recognizing the Alaska Territorial Guard's (ATG) service as federal active duty had initially been misinterpreted. Under the new interpretation, service in the five-year-guard no longer counts in calculating the military's 20-year minimum for retirement pay, although it still applies to military benefits, including medical benefits. The three-member delegation said that at its urging, Army Secretary Pete Geren will dip into an emergency fund to cover the pay for the 26 former members of the largely Native guard. The pay will equal two months worth while Congress works on legislation introduced by the delegation Wednesday to fix the law to allow the service in the unit to counts as active duty for calculating retirement pay.

Army officials could not immediately be reached for comment. But the delegation said the survivors will receive a one-time emergency payment equal to two months pay, with the checks sent out as soon as 29 JAN. Retirement payment claims by 31 other former ATG members remain suspended until the law is clarified, said Jerry Beale of the state Department of Military and Veterans Affairs. He said the military should have gone to Alaska's congressional representatives in the first place. "The Army should have never stopped the pay until the congressional delegation was notified and had an opportunity to clarify the law or at least answer their questions," he said. "But as a result, this certainly brought the service of the members of the ATG to the forefront and people are now aware of how the residents of rural Alaska were willing to defend our nation." An estimated 300 members are still living from the original 6,600-member unit formed in 1942 to protect the vast territory from the threat of Japanese attack years before Alaska became a state. The unit stepped in after the Alaska National Guard was called overseas.

The territorial guards – nicknamed Uncle Sam's Men and Eskimo Scouts – received no pay or benefits for the job. Many replaced their time hunting and fishing for their food with frequent drills and duties that varied from scouting patrols and construction of military airstrips to hundreds of miles of trail breaking. The unit was disbanded with little fanfare in 1947, nearly two years after the war ended. The state has long recognized the contribution of the territorial guard, but federal recognition was slow in coming. Congress finally passed in law in 2000 qualifying time served in the guard as active federal

service. The Army agreed in 2004 to grant official military discharge certificates to members or their survivors. Those who qualified for military retirement benefits began receiving increased pay for service in the militia starting in June, when the former members also received payments retroactive to the law's passage in 2000. Rep. Don Young, (R-AK) called the decision to reduce payments "a huge misstep by the Department of Defense." He said it was the intention of Congress that benefits "would be for life, not until the DoD reinterpreted legislative language to suit their needs." [Source: NavyTimes AP Rachel D'Oro article 29 Jan 09 ++]

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FILIPINO VET INEQUITIES UPDATE 12: Philippine Scouts and other Filipinos who served under direct control of the U.S. military in World War II would get one-time payments of up to $15,000 for their service under a provision of the Senate's economic recovery bill. About 18,000 people might qualify, although numbers are declining every day as World War II veterans die. Buried inside the Senate bill, which includes tax cuts and new spending initiatives intended to create jobs in the U.S., the Filipino payment was inserted at the urging of Sen. Daniel Inouye (D-HI) the new chairman of the Senate Appropriations Committee and a longtime supporter of monthly pensions for World War II Filipino veterans. Providing a one-time payment instead of a pension is a compromise that first surfaced in the House Veterans' Affairs Committee last year as a suggestion from Rep. Bob Filner (D-CA) committee chairman.

Under terms of the Senate bill, S 366, Filipino veterans who served under U.S. military control would file claims for benefits. Payments would be $15,000 for an eligible veteran who is a U.S. citizen and $9,000 for noncitizens. Veterans could not receive more than one payment, even if they served under U.S. control in more than one unit. Claims would have to be filed within one year of the bill being signed into law. The bill includes $198 million to help cover payments. The fate of the provision is not clear. Last year, Inouye and Sen. Daniel Akaka (D-HI) tried but failed to get the Senate to agree to provide long-promised pensions to Filipino veterans. Part of the problem had to do with funding, and part of the opposition came from senators who objected to spending scarce veterans funding on noncitizens – many of whom do not even live in the U.S. – when stateside veterans still have unmet needs. That means there could be a fight on the Senate floor over whether to keep the provision in the American Recovery and Reinvestment Act, the formal name of the economic stimulus bill. If the Senate keeps the provision, the final decision about including Filipino pensions will come in negotiations involving the House of Representatives and the White House. The House did not include Filipino benefits in its version of the recovery bill that was approved 28 JAN. [Source: NavyTimes Rick Maze article 29 Jan 09 ++]

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PROPERTY INSURANCE: Heads up for Florida homeowner vets. After selling property insurance in Florida for more than 60 years, State Farm Insurance plans to leave the business in less than three years. Unless it can charge higher rates, the company says, its Florida unit will be insolvent by the end of 2011. The company claims it's hemorrhaging $20 million a month. ''If we have any further weakening of our financial condition, it would really hamper our ability to pay all of our claims going forward,'' said State Farm Florida President Jim Thompson.

The impact of State Farm Florida's drastic move goes well beyond the mad scramble of customers who own 1.2 million policies -- insuring homes, condo units, rentals, mobile homes, boats, liability and commercial property -- to find new insurers. The company employs about 5,000 people in Florida. As many as another 5,100 work for its 850 agents operating out of Florida. In a 25-page document presented by State Farm Florida to state regulators 27 JAN the firm said it had no immediate plans to cut staff. However, State Farm agents would be unlikely to maintain their staffs if they could not write property insurance, which represents about 50% of their business.

Many regulators, legislators and policyholders were angry and dismayed that State Farm would pull out of the property business over losses and yet continue to write lucrative auto coverage. It also will continue to sell life insurance, annuities and financial services products. Gov. Charlie Crist effectively bid State Farm ''good riddance'' when he heard of the company's proposed action. ''They probably charge the highest rates in the state anyway. Floridians will be much better off without them,'' the governor said. ''You can't just cherry-pick the lines you want to write,'' said State Rep. Julio Robaina, R-Miami. Robaina was referring to a law passed two years ago that aimed to prevent insurers from keeping the money-making businesses and dumping the rest. However, the law has applied to few, if any, companies. State Farm sells much of its auto policies through other units and through its parent company, State Farm Mutual Automobile Insurance.

Losing coverage for State Farm policyholders wouldn't be immediate. The Florida Office of Insurance Regulation (OIR) has 90 days to review and approve or reject State Farm's plan. If it is approved, State Farm then has to give 180 day notice to those policyholders it plans to terminate. In the documents submitted to OIR Tuesday, the company said approximately 470,000 policies would be eliminated in the first year. [Source: Miami Herald Beatrice E. Garcias article 27 Jab 08 + +]

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VETERANS ISSUES UPDATE 01: A roundtable discussion aimed at creating a consensus among military and veterans groups about top priorities for the year ahead, focused on how solving some longstanding problems might be especially important today to veterans and their families who are being hurt by the national economic crisis. The discussion involving 36 organizations representing current and former service members was sponsored by the House Veterans' Affairs Committee, which has responsibility over some, but not all, veterans programs. In comparing the views of the groups, committee staff came up with five shared priorities: advance appropriations for veterans' programs, fixing disability compensation, improving mental health treatment, implementing the new Post-9/11 GI Bill in August and smoothing the transition from military to civilian life.

None of those issues are new, and the problems have proven difficult to fix. Rep. Bob Filner (D-CA) the veterans' committee chairman, said Congress has tried to eliminate a backlog of disability claims that have forced veterans to wait, on average, more than 180 days for a simple claim to be approved and years of delay if the claim is complicated. Congress boosted VA staff so that more people are processing claims, which may be a long-term solution – but while new employees are being found and trained, "the backlog is growing," Filner said. Congress has faced

similar problems in trying to improve job training and rehabilitation programs, creating programs that reduce homelessness and expanding access to veterans' health care. John Rowan, president of Vietnam Veterans of America (VVA), and representatives from the Non Commissioned Officers Association (NCOA) and Veterans of Foreign Wars (VFW) all backed the idea of making quick improvements in veterans programs to help people who have lost jobs or health insurance because of the economic slump. Rowan had the most ambitious idea, proposing to create a new VA division for economic independence that would oversee small business, job training, vocational rehabilitation programs and reintegration efforts for injured and disabled veterans. Rowan said the idea would be to take programs spread throughout the government, where they are the "step-children of some other agency," and make them into veterans' programs.

Cutting the processing time for disability checks would be of immediate help to veterans who have lost jobs and also might reduce homelessness among veterans, said Richard Schneider of the NCOA. "This nation is in an unemployment crisis," he said. "We need to fix the claims backlog. It will help the homeless issue. It will help the unemployment issue. It is a tragedy that people have waited years to be paid." Chris Needham of VFW said veterans programs also could help people who lose health insurance when they lose their jobs if VA uses existing waiver authority that would consider current income – and not income over the previous 12 months – when deciding whether they qualify as low-income veterans, which allows them to qualify for health care even if they do not have service-connected medical problems. A smaller group of six veterans' organizations will testify 28 JAN before the Senate Veterans Affairs Committee about their priorities for the 2010 VA budget. [Source: AirForceTimes Rick maze article 27 Jan 09 ++]

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MILITARY HISTORY ANNIVERSARIES:

- 1777 - General George Washington defeats the British led by British General Lord Charles Cornwallis, at Princeton, New Jersey (War of Independence)
- 1780 - American Revolution: Battle of Cape St. Vincent. (War of Independence)
- 1781 - Richmond, Virginia, is burned by British naval forces led by Benedict Arnold. (War of Independence)
- 1815 - War of 1812: Battle of New Orleans - Andrew Jackson leads American forces in victory over the British.
- 1861 - American Civil War: Jefferson Davis resigns from the United States Senate. (American Civil War)
- 1861 - The "Star of the West" incident occurs near Charleston, South Carolina. It is considered by some historians to be the "First Shots of the Civil War". (American Civil War)
- 1863 - The Battle of Fort Hindman occurs in Arkansas. (American Civil War)
- 1863 - Second Battle of Springfield (American Civil War)
- 1863 - President Abraham Lincoln delivers the Gettysburg Address at the dedication of the military cemetery ceremony at Gettysburg, Pennsylvania. (American Civil War)
- 1877 - Crazy Horse and his warriors fight their last battle with the United States Cavalry at Wolf Mountain (Montana Territory).
- 1900 - Boers attack Ladysmith, South Africa - over 1,000 people killed.
- 1909 - United States troops leave Cuba with the exception of Guantanamo

Bay Naval Base after being there since the Spanish-American War.
• 1911 - Naval Lieutenant Eugene Ely became the first man ever to land an airplane on the deck of a ship, the converted cruiser USS Pennsylvania, in San Francisco Bay.
• 1915 - Congress established the United States Coast Guard.
• 1916 - The Battle of Gallipoli concludes with an Ottoman Empire victory when the last Allied forces are evacuated from the peninsula. (World War I)
• 1916 - Paris is first bombed by German zeppelins. (WWI)
• 1917 - The Battle of Rafa occurs near the Egyptian border with Palestine (WWI)
• 1921 - A symbolic Tomb of the Unknown Soldier is installed beneath the Arc de Triomphe in Paris to honor the unknown dead of World War I.
• 1923 - American occupation forces, stationed in Germany since the close of World War I, were recalled.
• 1941 - Battle between HMAS Sydney and HSK Kormoran. The two ships sink each other off the coast of Western Australia, with the loss of 645 Australians and about 77 German seamen. (WWII)
• 1941 - The United Kingdom captures Tobruk, Libya from Nazi forces. (WWII)
• 1944 - The Allies commence Operation Shingle which was an assault on Anzio, Italy. (WWII)
• 1942 - U.S. and Filipino troops complete their withdrawal to a new defensive line along the base of the Bataan peninsula (WWII)
• 1942 - The siege of the Bataan Peninsula begins. (WWII)
• 1942 - Battle of Stalingrad - Soviet Union forces under General Georgy Zhukov launch the Operation Uranus counterattacks at Stalingrad, turning the tide of the battle in the USSR's favor. (WWII)
• 1942 - First use of aircraft ejection seat by a German test pilot in a Heinkel He 280 jet fighter. (WWII)
• 1943 - Nazis liquidate Janowska concentration camp in Lemberg (Lviv), western Ukraine, murdering at least 6,000 Jews after a failed uprising and mass escape attempt. (WWII)
• 1943 - Operation Ke, the successful Japanese operation to evacuate their forces from Guadalcanal during the Guadalcanal campaign, begins. (WWII)
• 1943 - Franklin D. Roosevelt and Winston Churchill begin the Casablanca Conference to discuss strategy and study the next phase of the war. (WWII)
• 1943 - British forces capture Tripoli in Libya from the Nazis. (WWII)
• 1943 - Australian and American forces finally defeat the Japanese army in Papua. This turning point in the Pacific War marks the beginning of the end of Japanese aggression. (WWII)
• 1943 - The Battle of Mount Austen, the Galloping Horse, and the Sea Horse on Guadalcanal during the Guadalcanal campaign ends. (WWII)
• 1943 - The first day of the Battle of Rennell Island, U.S. cruiser Chicago is torpedoed and heavily damaged by Japanese bombers. (WWII)
• 1944 - The siege of the Bataan Peninsula begins. (WWII)
• 1944 - The Allies commence Operation Shingle which was an assault on Anzio, Italy. (WWII)
• 1944 - The Battle of Cisterna takes place in central Italy. (WWII)
• 1945 - The United States invades Luzon in the Philippines (WWII)
• 1945 - The Soviets begin a large offensive against the Nazis in Eastern Europe. (WWII)
• 1945 - The Battle of the Bulge ended (WWII)
• 1945 - Adolf Hitler moves into his underground bunker, the so-called Führerbunker. (WWII)

- 1951 - Chinese communist forces captured Seoul, Korea, from United Nations troops (Korean War)
- 1951 - Operation Thunderbolt began (Korean War)
- 1954 - The first nuclear-powered submarine (USS Nautilus) was launched in Groton CT by Mamie Eisenhower.
- 1959 - Fidel Castro took control of Cuba.
- 1966 - American forces move into the Mekong Delta for the first time (Vietnam War)
- 1967 - Operation Cedar Falls began against the Communist-held Iron Triangle area north of Saigon (Vietnam War)
- 1967 - United States Marine Corps and ARVN troops launch "Operation Deckhouse Five" in the Mekong River delta. (Vietnam War)
- 1968 - Battle of Khe Sanh began (Vietnam War)
- 1968 - Tet Offensive began (Vietnam War)
- 1968 - Battle of Hue began (Vietnam War)
- 1968 - North Korea seizes the USS Pueblo, claiming the ship had violated their territorial waters while spying.
- 1973 - Signing of the Vietnam Peace Accord (Vietnam War)
- 1977 - President Jimmy Carter pardons nearly all American Vietnam War draft evaders inclusive of those who had emigrated to Canada.
- 1979 - Phnom Penh falls to the advancing Vietnamese troops, driving out Pol Pot and the Khmer Rouge. (Third Indochina War - Cambodian-Vietnamese War)
- 1991 - An act of the U.S. Congress authorizes the use of military force to drive Iraq out of Kuwait. (Gulf War)
- 1991 - Allies start Operation Desert Storm with attacks on Iraq (Persian Gulf War)

[Source: Various ++]

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MOBILIZED RESERVE 27 JAN 09: The Department of Defense announced the current number of reservists on active duty as of 27 JAN 09. The net collective result is 357 fewer reservists mobilized than last reported in the Bulletin for 15 JAN 09. At any given time, services may mobilize some units and individuals while demobilizing others, making it possible for these figures to either increase or decrease. The total number currently on active duty in support of the partial mobilization of the Army National Guard and Army Reserve is 94,070; Navy Reserve, 6,148; Air National Guard and Air Force Reserve, 15,289; Marine Corps Reserve, 7,417; and the Coast Guard Reserve, 746. This brings the total National Guard and Reserve personnel who have been activated to 123,670, including both units and individual augmentees. A cumulative roster of all National Guard and Reserve personnel who are currently activated can be found at http://www.defenselink.mil/news/Jan2009/d20090127ngr.pdf . [Source: DoD News Release 064-09 28 Jan 09 ++]

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VA DATA BREACHES UPDATE 42: The Veterans Affairs Department agreed 27 JAN to pay $20 million to veterans for exposing them to possible identity theft in 2006 by losing their sensitive personal information. In court filings, lawyers for the VA and the veterans said they had reached agreement to settle a class-action lawsuit originally filed by five veterans groups alleging invasion of privacy. The money, which will come from the U.S. Treasury, will be used to pay veterans who

can show they suffered actual harm, such as physical symptoms of emotional distress or expenses incurred for credit monitoring. U.S. District Judge James Robertson in Washington must approve the terms of the settlement before it becomes final. “This settlement means the VA is finally accepting full responsibility for a huge problem that continues to worry millions of veterans, retirees, service members and families,” said Joe Davis, spokesman for Veterans of Foreign Wars, which was not involved in the lawsuit. VA spokesman Phil Budahn said: “We want to assure veterans there is no evidence that the information involved in this incident was used to harm a single veteran.”

The lawsuit came after a VA data analyst in 2006 admitted that he had lost a laptop and external drive containing the names, birth dates and Social Security numbers of up to 26.5 million veterans and active-duty troops. The laptop was later recovered intact, but a blistering report by the VA inspector general faulted both the data analyst and his supervisors for putting veterans at unreasonable risk. The data analyst had lost the information when his suburban Maryland home was burglarized on 3 MAY 06, after taking the data home without permission. The VA employee promptly notified his superiors, but due to a series of delays, veterans were not told of the theft until nearly three weeks later, on 22 MAY. Then-VA Secretary James Nicholson later said he was “mad as hell” that he wasn’t immediately told about the burglary.

According to the proposed settlement, veterans who show harm from the data theft will be able to receive payments ranging from $75 to $1,500. If any of the $20 million is left over after making payments, the remainder would be donated to veterans’ charities agreed to by the parties, such as the Fisher House Foundation Inc. and The Intrepid Fallen Heroes Fund. Attorneys for the veterans groups said notices about the proposed settlement will be published in magazines and newspapers around the country, with a toll-free number and other contact information for veterans. Five veterans groups filed a class-action lawsuit in JUN 06 in U.S. District Court in Washington on behalf of all veterans, seeking $1,000 in damages for every veteran whose information was compromised in the computer theft. “This is a very positive result,” said Douglas J. Rosinski, an attorney representing the veterans groups. “A lot of hard work went into finding a resolution that all the parties could be proud to say they were a part of bringing about. [Source: NavyTimes Hope Yen AP article 27 Jan 09 ++]

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RHODE ISLAND VET HOME: The Bristol 339 bed Rhode Island Veterans' Home and Nursing Care Facilities provide 260 beds for long-term convalescent and skilled nursing care for chronically ill veterans and 79 beds for domiciliary self-care veterans. The mission of the home is to provide quality nursing and residential care to those Rhode Island war veterans in need. Social, medical, nursing and rehabilitative services are also provided to veterans and their survivors and/or dependents to improve their physical, emotional and economic well-being. The granddaughter of an ailing Army veteran of World War II occupant told lawmakers 26 JAN that he was repeatedly subjected to medical procedures his family was not told about and endured unsanitary conditions at the home.
The House Committee on Veterans’ Affairs is investigating conditions at the Rhode Island Veterans Home in Bristol, which cares for about 230 patients, after a panel tasked by lawmakers found rancor between management and staff, poor communication with patients’ families and building problems that included a leaking roof.

Barbara Crowley said there was hostility between her family and staff members over the care of her late grandfather, Raymond Parent, who died in 2007. She urged lawmakers to replace nursing home administrators. “I don’t know what happened to my grandfather the last couple of weeks” of his life, she said. Parent was deemed incompetent to make medical and financial decisions for himself when he was admitted to the facility in 2003. But the nursing home sometimes changed his legal status without notifying his family, Crowley said. He underwent three inconclusive colonoscopies before his daughter, who was legally responsible for his care, approved a fourth procedure under pressure from a nursing home doctor, Crowley said. Her grandfather was legally blind and taking blood-thinning medication, meaning he could bleed profusely if cut. As a result, Crowley said she was upset to find uncapped razors in her grandfather’s room. She said she repeatedly found mold in a water pitcher beside his bed.

As her grandfather was dying, a staffer at the nursing home threatened to call State Police to remove Crowley from the facility because she took pictures of unexplained bruises on her grandfather’s arm. The family was pushing to have Parent moved to another nursing home, Crowley said. Rep. Kenneth Carter, the Democratic committee chairman, said his committee intends to eventually issue recommendations for improving care at the nursing home. He has already proposed legislation creating a cabinet-level department responsible for veterans’ affairs. Carter said conditions at the nursing home have improved since retired Brig. Gen. Rick Baccus became facility administrator last year. In an interview, Baccus said he could not confirm the allegations from Parent’s family because he did not work at the Veterans Home at the time. He noted that the report fueling the inquiry by lawmakers is a snapshot of the nursing home’s performance two years ago or earlier. Baccus commanded the prison for suspected terror suspects at Guantanamo Bay for seven months in 2002. After returning to Rhode Island, he was fired from his National Guard job, and later said he was under constant pressure from military intelligence officers to bend his by-the-book rules on how to treat al-Qaida and Taliban suspects. [Source: MarineCorpsTimes AP Ray Henry article 27 Jan 09 ++]

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NURSING HOMES UPDATE 09: All states have a Nursing Facility Medicaid program that provides general health coverage plus coverage for nursing home services. These services include room and board, nursing care, personal care and therapy services. Nursing Facility Medicaid may pay for a stay in a nursing home if you need a “nursing-home level of care” or meet nursing home “functional eligibility criteria; and have income and assets below certain guidelines. Different states have different standards for determining whether you need a “nursing home level-of-care,” but generally look at your ability to function. For example, your state might assess whether you need help with activities of daily living—basic everyday activities such as getting in and out of bed, dressing, bathing, eating and using the bathroom. While Medicare covers some skilled nursing facility care, it will only cover this care for a limited amount of time (up to 100 days in a benefit period) if you meet certain criteria. If you do not meet Medicare’s requirements for the skilled nursing facility benefit or you have reached Medicare’s limit of covered skilled care, Medicaid may pay for this care.

When you have Nursing Facility Medicaid, you still have Medicare coverage for

the medical services you need aside from your nursing care. For example, if you need to go to the hospital or need to go to a doctor or specialist's office, Medicare will pay first for most of these medical services and Medicaid will pay second by covering your remaining costs, such as the Medicare coinsurances, copayments and deductibles. Medicaid may also pay for some medical services that are not covered by Medicare, such as routine dental care. In order to qualify for Nursing Facility Medicaid, you will need to meet financial guidelines in addition to meeting functional eligibility guidelines. You can have income higher than you could have if you did not need nursing home care and still qualify for Medicaid. Your state may have:

- Higher Medicaid income guidelines for people who need nursing home care than for those who do not; and/or
- A "spend-down" or "medically needy" program. Spend-down programs are meant for people who have income higher than would normally qualify them for Medicaid coverage, but who have medical expenses that significantly reduce their usable income.

Some things to be aware of if you are thinking of applying for Nursing Facility Medicaid:

- Nursing Facility Medicaid programs will consider you and your spouse together when looking at your income and assets, but you will be able to set aside a certain amount of your income and assets for your spouse to keep. This amount will not be counted when you apply for Medicaid.
- If you qualify for Nursing Facility Medicaid, you will be able to keep a small amount of your income for a personal allowance. The amount that you can keep for yourself varies by state. Contact your local Medicaid office for the exact amount in your state. You will have to pay the remainder of your income to the nursing home.
- Medicaid has a "look-back period" of up to five years. This means that Medicaid will look at any assets you have transferred in the past few years when determining eligibility and when Medicaid coverage will begin. If Medicaid determines that you have transferred assets in violation of the Medicaid rules, it can penalize you by not paying for part or all of your nursing home stay.
- If you own your home, be sure to talk to an elder law attorney about how it will affect your Medicaid eligibility and coverage. Depending on your circumstances, the equity from your home may count as an asset. When you no longer need long-term care, or when you are deceased, your assets may be used to repay Medicaid for the care that it covered for you.

To find out more about Nursing Facility Medicaid in your state, contact your State Health Insurance Assistance Program (SHIP) refer to www.shiptalk.org/Public/home.aspx?ReturnUrl=%2fDefault.aspx . For specific eligibility criteria, or to apply, contact your local Medicaid office. To find the Medicaid office nearest you, refer to www.medicareinteractive.org/frames.php?URL=http://64.82.65.67/medicaid/states.html
[Source: Medicaid Interactive Section VIII.c. Medicaid and Medicare 9 Dec 08 ++]

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ARTHRITIS UPDATE 01: There are 27 million Americans who suffer from the most common form of arthritis called osteoarthritis. According to Dr. John Klippel, president and CEO of the Arthritis Foundation, "Many tend to think of this as more of a nuisance. They think of it as only aches and pains and not the serious

problem that it actually is -- the leading cause of disability in this country." Part of the misconception has to do with all the myths surrounding the disease. Following are the 5 most common:

• Myth 1: Arthritis is a disease of the elderly: While older people do develop arthritis, children and teenagers can get certain forms of the condition. The Arthritis Foundation reports two-thirds of people with doctor-diagnosed arthritis are under age 65. Researchers don't know the exact cause of arthritis, but they do know what puts people at risk. These include aging, heredity, joint injury, obesity and lack of fitness.
• Myth 2: Cracking your knuckles causes arthritis: Despite what your grandmother told you, experts say cracking your knuckles is not a risk factor for arthritis.
• Myth 3: Predicting the weather: Researchers have studied the claims, but concluded there is no scientific evidence to suggest arthritis flare-ups occur during bad weather. Klippel also doesn't buy the argument that arthritis patients are better off if they live in a warmer climate. "If you live in a warmer climate, you're simply more active for more months of the year and that's probably why people feel better. It probably has very little to do with the weather itself," Klippel said.
• Myth 4: Exercise aggravates arthritis: Staying active actually is one of the most important ways to prevent and ease the pain of arthritis, Klippel said. It also helps with weight control. For people with arthritis, it hurts to exercise,but over time, the post-exercise pain actually diminishes if you push through it. Joint-friendly exercises are recommended such as walking, biking or swimming. In addition to putting ice on an aching joint, Klippel suggested taking nonsteroidal, anti-inflammatory medication before or after exercising to help relieve the pain.
• Myth 5: Nothing helps: A proper diagnosis can lead to a host of possible treatments, including the latest prescription medicines for pain and rehabilitating aching joints through physical therapy. People should not to wait until the pain is unbearable before seeing a doctor. If aches and pains persist for more than four weeks, that's a time to pay attention.
[Source: CNNHealth.com Judy Fortin article 26 Jan 09 ++]

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VA SmartPay 2 CONTRACT GLITCH: Hundreds of veterans were unexpectedly slapped with fees and penalties last month when Citibank, one of the nation's largest banks and a government contract holder, refused to honor certain checks issued by the Veterans Affairs Department. Multiple sources confirmed that the mistake apparently was caused by a Citibank employee who, without VA's knowledge, changed a contract arrangement between the bank and the department, placing stricter limits on the amount of time veterans had to cash government checks for reimbursement of certain expenses. "Due to a Citibank error, approximately 465 checks which VA had provided to veterans and vendors were not honored when they were presented for payment," VA officials said in a statement. "This resulted in bounced checks and applicable fees and penalties being assessed. As soon as VA became aware of this issue, Citibank was contacted and corrective action was initiated to remedy the situation." Citibank is in the process of reimbursing fees and penalties to the affected parties and has confirmed it will honor any additional checks presented for payment, VA said, adding it will "continue to work closely with Citibank to ensure all veterans and vendors receive full

reimbursement."

The glitch was rooted in the government wide transition last year to the new General Services Administration SmartPay2 contract. Under the program, charge cards and convenience checks are provided to federal agencies through master contracts negotiated with major national banks. Convenience checks are used primarily to pay vendors that do not accept government charge cards. At VA, the checks often are used to reimburse veterans for minor expenses incurred related to their care or support, such as travel and transportation expenses. Veterans are told they have 60 days to deposit these checks, which generally amount to a few hundred dollars. Citibank was the vendor for VA under the original SmartPay contract, which expired on 30 NOV 08. While the bank was chosen as one of three firms to participate in the SmartPay 2 contract, which began 1 DEC 08, VA selected U.S. Bank as the primary vendor under the new contract. In the weeks leading up to the transition to SmartPay2, a Citibank employee, whose identity was not initially disclosed, apparently altered the terms of the original decade long contract with VA. The new terms, which were not approved by VA, allowed veterans only 10 days to deposit convenience checks.

Consequently, in late December and early January, hundreds of veterans began depositing convenience checks into their personal bank accounts only to discover that Citibank would not honor the payments. The veterans were then charged penalties associated with bounced checks or, in some cases, overdraft fees for writing payments with insufficient funds in their accounts. Affected veterans "were caught completely unaware by this," said a former government official familiar with the problem who requested anonymity. "This is a pretty big hit for their income." In a statement, Citibank acknowledged the error and said it was working to make amends. VA has begun the process of reissuing the convenience checks under US Bank to affected veterans and vendors. The department's new contract bank has said it will honor the checks up to 180 days, or longer upon approval from VA that a check is valid. The department issues more than 140,000 convenience checks per year worth approximately $33 million. [Source: GOVExec.com Robert Brodsky article 23 Jan 09 ++]

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AGENT ORANGE LAWSUITS UPDATE 14: On 21 JAN 09, the Supreme Court refused to hear the appeal of Haas vs. Peake. This action makes final a Court of Appeals decision which held that VA could deny service connection for herbicide related presumptive disabilities for certain veterans who received the Vietnam Service Medal but who did not actually set foot in Vietnam. Those most affected by this ruling are veterans who served in Thailand and on board ships off the coast of Vietnam (blue water navy). On 22 JAN 09 VA issued instructions in their Memorandum NO. 01-09-03 allowing the resumption of processing of those cases stayed while the Haas case worked its way through the judicial system. The memo includes a summary of actions taken during the case which led to its release and is included as Addendum (2) to this Bulletin. [Source: VFW National Veterans Service Committee msg 26 Jan 09 ++]

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ESTATE PLANNING: The website www.willsforvets.com is dedicated to assisting U.S. veterans in their estate planning. Each member of their team has agreed to

provide, on a pro-bono basis, “basic” estate planning documents to any U.S. veteran upon request. There is also a Questions & Answers page on the site to answer any questions you may have regarding the below estate planning documents, the information needed to prepare them on your behalf, and the protections they provide your family and you. The legal services are provided in appreciation of each veteran’s service to our country and protection of our democracy. To obtain assistance it is necessary to complete their online form at www.willsforvets.com/Contact_Us.html with your basic contact data and a brief description of the assistance you are looking for. You should receive a response within 7 workdays identifying a pro-bono attorney who will help you. There is no income level prerequisite but the services are designed for vets just getting by in today’s environment or scheduled to be deployed. The documents you should have on hand to ensure proper handling of your estate are:

• Last Will & Testament: Written document that sets forth the manner in which you want your assets to pass to your heirs (spouse, children, grandchildren, nieces, nephews, etc.) upon death. The document appoints the individual(s) whom you desire to administer (pay your creditors, file final tax return, distribute your assets to your beneficiaries) your estate Without the document, your state of residence will statutorily determine to whom your assets will pass and who will serve as the administrator (personal representative, executor) of your estate.

• Power of Attorney: Written instructions in which you designate another individual (the "agent") to make financial decisions on your behalf. The document is typically utilized in the event that you: (i) are rendered incapable of making your own financial decisions; (ii) are unavailable; or (iii) require assistance. The powers granted to the agent may be limited to a particular activity (real estate transaction) or be overly broad (cover everything). The agents powers may: (i) take effect immediately or upon the occurrence of a future event (springing power); and (ii) be temporary or permanent authority to act on your behalf.

• Health Care Directive: Written instructions that set forth what actions should be taken for your health in the event you are unable to make health care decisions on your own behalf (due to illness or incapacity). The document appoints the individual ("health care surrogate") to make all necessary medical decisions in the event you are unable to express your preferences.

• Living Will: Written instructions which allow you to determine how you want to be treated in certain medical conditions (given life-sustaining treatments in the event you are terminally ill or injured or provided food and water via intravenous devices). The document may also appoint an individual to make decisions on your behalf if you are unable to do so. "Life-sustaining treatment" means the use of available medical machinery and techniques, such as heart-lung machines, ventilators, and other medical equipment and techniques that will sustain and possibly extend your life, but which will not by themselves cure your condition. In addition to terminal illness or injury situations, most states permit you to express your preferences as to treatment using life-sustaining equipment and/or tube feeding for medical conditions that leave you permanently unconscious and without detectable brain activity.
[Source: Marc J. Soss www.willsforvets.com Jan 09 ++]

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GI BILL UPDATE 36: Veterans Affairs Department officials said on 22 JAN that President Obama's government-wide freeze on implementing regulations prepared by the Bush administration will not delay work on rules covering the Post-9/11 GI Bill. After months of negotiation with Bush administration regulators at the White House Office of Management and Budget, VA published proposed rules for the benefits program 23 DEC. Comments received through 24 JAN will be used in preparing final regulations. The new GI Bill program, which promises to cover full tuition at a four-year public college or university plus living and book allowances, takes effect 1 AUG. VA spokesman Steve Westerfeld said the freeze on regulations ordered by Obama on Tuesday, his first day in office, prevents the publication of proposed rules and halts issuance of final rules – but it does not delay work on the GI Bill rules, which are "proposed" in their current form and are not yet final.

"VA will continue to review the comments submitted on the proposed rule," Westerfeld said. It will draft final rules that will be reviewed by the new VA secretary, Eric Shinseki, who was sworn in on 21 JAN, and by Obama's team at the Office of Management and Budget, Westerfield said. Shinseki told Congress during his confirmation hearing that implementing the GI Bill on time and without problems is one of his top priorities. In a statement issued after he took the oath of office, Shinseki, a retired general and former Army chief of staff, said he plans to develop a 2010 budget within 90 days that pushes forward on Obama's goal of transforming VA into a "people-centric, results-driven and forward-looking" organization. Launching the GI Bill, streamlining the VA disability claims system, expanding access to VA health care and improving care for returning Iraq and Afghanistan veterans are other top items on his agenda, the statement said. [Source: NavyTimes Rick Maze article 23 Jan 09 ++]

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ECS 2009: The 2009 Economic Stimulus (ECS) package proposed by the 111th Congress will be in income tax cuts vice lump sum payments as provided in ECS 2008. Now that the Senate Finance Committee has offered its version of the stimulus package it is possible to look at how it will impact military retirees and disabled veterans. Bear in mind that proposals to date are far from done and changes are possible as the proposals migrate through the legislative process. Based on what is on the table as of 30 JAN:

• The House- and Senate-proposed payroll tax reductions are the same. Both would reduce income tax withholding and liability by $500 for singles and $1,000 for married couples. These reductions would apply only to people who are currently employed. They wouldn't apply to retirees. Both the House and Senate bills would start phasing out the tax cut for people making more than $75,000 a year ($150,000 for married couples). The House bill would end the tax deduction for those with incomes of more than $100,000 ($200,000 for married couples). The Senate bill would deny any relief to those with incomes above $87,500 ($175,000 married).
• The Senate-proposed package (but not the House plan) has a separate provision that would provide a one-time $300 payment to Social Security annuitants and recipients of VA disability compensation.

The Senate Finance Committee staff was asked whether a disabled vet who is also currently working would qualify for both the income tax reduction and the $300 lump sum payment. Their answer was that the intent is to provide a maximum total

payment of $500 (single) or $1,000 (married). But as a practical matter, a working disabled vet would probably get the $300 payment first, and would also see the full reduction in the income tax withholding from his/her employer. The rub would come at the end of the year, when such people could find themselves "under-withheld" by $300. In other words, if they get the $300 up front and also qualify for the maximum $500/$1,000 tax withholding, they'll end up having to pay the $300 back in taxes at the end of the year. So if you're a working disabled vet, you may want to ask your employer to increase your withholding by enough to make up the $300 difference by the end of the year. [Source: MOAA Leg Up 23 Jan 09 ++]

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MEDICATION LISTS: Just as you wouldn't go commissary shopping with last year's grocery list, the same principle holds true for showing up at a medical appointment with an out-of-date list of prescription drugs, over-the-counter medications, and related health products such as vitamin supplements and herbal teas. "There are many good reasons for bringing a list of all the medications, supplements, etc., you take when you visit your healthcare provider, and each one of these reasons ensures you receive the safest care possible," said Col. Curt Hansen, the Landstuhl Regional Medical Center pharmacy chief and the pharmacy consultant for Europe Regional Medical Command. The benefits include:

- Providing your healthcare providers the most complete and up-to-date record of what you're taking to assist them in prescribing the safest and most effective medication specifically for you.
- Preventing an adverse reaction by ensuring a new drug isn't prescribed that might interact with a medication or supplement you're taking at home, but is not listed on your medical record.
- Improving the quality and time spent talking with your doctor about your care. By providing a list of what you're actually taking, it allows your provider to quickly and accurately compare it with your previous medical history.
- Improving familiarity with your medications. Patients who keep an up-to-date list of their medications with them gain familiarity with their medications and how to take them. This knowledge is reinforced when you immediately update the list due to a change in the medications, vitamins or supplements you're currently taking.
- Saving your life. In addition to the reasons listed above, if you are ever in an emergency where your records aren't available, having a printed copy of your meds in your wallet will inform your providers about what you're taking and prevent the possibility of a severe reaction with new drugs used in your treatment.

It's about helping people help themselves," Colonel Hansen said. "It's critical that patients provide a list at each appointment, especially when you consider all the possible sources where drugs and other products can be obtained - your doctor, the commissary, the base exchange and the economy -- it's easy to see how any of us could forget something we're taking that may adversely affect our medical care." Some medication safety points to consider are:

- Become familiar with your medications and how to take them. Talk to your doctor, nurse or pharmacist about your medications and supplements to reinforce your knowledge and to obtain answers to your questions.
- Keep your medication list updated and accurate.
- Have your list with you, especially each time you travel or go to the clinic, hospital or emergency room.

• If you are too sick to do so yourself, ask a family member or friend to show the medication list to your healthcare providers.
• By participating in your healthcare, you can prevent medication errors. [Source: Landstuhl Germany Regional Medical Ctr Public Affairs Chuck Roberts article 20 Jan 09 ++]

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SENIOR DRINKING: In addition to the cardiovascular benefits that alcohol confers a new study in the American Journal of Epidemiology found that healthy seniors who consume light to moderate amounts of alcohol reduce their odds of developing physical disabilities or dying in the next five years by 23%, compared with either heavy drinkers or those who abstain. By reducing the odds of developing physical problems, seniors can prevent the onset of difficulties with everyday tasks such as getting dressed, standing up without help and grooming. Dr. Michele Bellantoni, a geriatrician from Johns Hopkins University School of Medicine, characterizes these daily tasks as critical to maintaining quality of life among seniors. "It's the difference between living independently and requiring nursing assistance, nursing home care or dependence upon someone else. Any intervention that might reduce this risk is worth looking at," says Bellantoni, who was not involved in the study.

In the study, "seniors" referred to men and women over age 50. Light to moderate drinkers were defined as those who consumed fewer than 15 drinks a week and fewer than five per day (fewer than four daily for women); heavy drinkers were those who consumed 15 or more drinks weekly (or five or more per day); and abstainers were those who drank fewer than 12 alcoholic drinks during the last 12 months. The researchers, led by Dr. Arun Karlamangla, a geriatrician at the University of California, Los Angeles, analyzed data taken from the National Health and Nutrition Examination Survey's Epidemiologic Follow-up Study, which included self-reported data from more than 4,200 men and women. About 92% of study participants were white; the average study participant was 60 years old. A major caveat regarding these findings is that in order to reap the protective benefits of alcohol consumption, the participants had to be healthy to start with. Those who reported themselves as being in poor or fair health did not see any benefits from alcohol consumption.

The study did not look at the causes behind the association between alcohol consumption and protection against physical disabilities and death. However, Karlamangla suggests that if alcohol indeed causes a slowing of atherosclerosis (the hardening of arteries) -- as the researchers suspect -- then seniors who drink alcohol might be less likely to experience a decrease in blood flow (and other related mechanisms) that contribute to the body's physical processes slowing down. Another possible explanation Karlamangla offers is that the well-documented cardiovascular benefit of raising good cholesterol levels through alcohol consumption could actually be the same mechanism that's providing the protection against disability that healthy seniors see. Bellantoni points out how rare it is to find something that people can derive pleasure from, that can also be beneficial to their health, and that doesn't come in a pill. "Usually, it's a lot of work and not enjoyable," she explains. She says she enjoys a glass of red wine every night, and she encourages her own patients to drink (in moderation) to their health, too. [Source: CNN Medical Producer Shahreen Abedin article 21 Jan 09 ++]

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TRICARE RESERVE SELECT UPDATE 12: Congressman Bob Latta (R-OH-05) has introduced HR270, identical to HR6185 which he introduced late in the 110th congress. This bill would authorize our Gray Area Retirees to purchase Tricare Standard under the Tricare Reserve Select (TRS) program no later than 1 OCT 09 at a premium equal to the full cost of coverage to Department of Defense (DoD) to be determined by the Secretary of Defense on an actuarial basis. Effective 1 JAN 09, DoD corrected its monthly rates charged for TRS to $47.51 for individuals and $253.00 for family coverage. By statute, the premium DoD charges TRS beneficiaries is supposed to cover 28% of the actual cost of coverage incurred by DoD. Based on the current TRS rates at 28% of actual costs, the full cost to DoD for TRICARE Standard that would be charged to retirees under the Latta bill would be $169.68 for individuals and $901.57 for families. Gray area retirees should compare these rates to comparable coverage under private insurance plans to determine how beneficial this would be to them. the national Guard Association of the United states (NGAUS) supports the Latta bill, which directly addresses one of their prioritized resolutions. At present they are searching for sponsors of a companion bill in the Senate. If you have not done so already, you are urged to support this legislative effort by contacting your Congressional representatives and request they sign-on to the bill. [Source: NGAUS Leg Up 23 Jan 09 ++]

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VA SPECIAL PROGRAMS: VA has special programs for the following groups of veterans and their survivors. For info on each refer to the website indicated:

- Operation Enduring Freedom / Operation Iraqi Freedom Veterans – Information for returning Active Duty, National Guard and Reserve service members of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). www.oefoif.va.gov
- Disabled Veterans – Information for veterans, employers and the general public about benefits administered by VA's Vocational Rehabilitation and Employment Service. www.vba.va.gov/bln/vre/index.htm
- Homeless Veterans – Information on programs and initiatives designed to help homeless veterans live as self-sufficiently and independently as possible. http://www1.va.gov/homeless
- Military Services – Information for separating service members as well as veterans. www.vba.va.gov/bln/21/milsvc
- Minority Veterans – Information on VA programs, benefits and services for minority veterans. http://www1.va.gov/centerforminorityveterans
- Survivor Benefits – Information on VA programs, benefits and services for surviving spouses and dependents of military personnel who died while in active military service and for survivors of veterans who died after active service. http://www1.va.gov/centerforminorityveterans
- Women Veterans – Information on VA benefits, services and health care specifically for women veterans. http://www1.va.gov/womenvet
- Veterans in Business – Information on business ownership and expansion opportunities, programs and resources for veterans, including service-connected disabled veterans. www.vetbiz.gov
- Accessibility – Information on accessibility issues, programs and resources. www.section508.va.gov

[Source: NAUS Weekly Update 23 Jan 09 ++]

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VA FUNDING 2009: Two years after a politically embarrassing $1 billion shortfall that imperiled veterans health care, the Veterans Affairs Department is still lowballing budget estimates to Congress to keep its spending down, government investigators say. The report by the Government Accountability Office, set to be released 23 JAN, highlights the Bush administration's problems in planning for the treatment of veterans that President Barack Obama has pledged to fix. It found the VA's long-term budget plan for the rehabilitation of veterans in nursing homes, hospices and community centers to be flawed, failing to account for tens of thousands of patients and understating costs by millions of dollars. In its strategic plan covering 2007 to 2013, the VA inflated the number of veterans it would treat at hospices and community centers based on a questionably low budget, the investigators concluded. At the same time, they said, the VA didn't account for roughly 25,000 – or nearly three-quarters – of its patients who receive treatment at nursing homes operated by the VA and state governments each year. "VA's use, without explanation, of cost assumptions and a workload projection that appear unrealistic raises questions about both the reliability of VA's spending estimates and the extent to which VA is closing previously identified gaps in noninstitutional long-term care services," according to the 34-page draft report obtained by The Associated Press.

The VA did not immediately respond to a request for comment. In the report, the VA acknowledged problems in its plan for long-term care, which accounts annually for more than $4 billion, or 12% of its total health care spending. In many cases, officials told the GAO they put in lower estimates in order to be conservative in their appropriations requests to Congress and to stay within anticipated budgetary constraints. As to the 25,000 nursing home patients unaccounted for, the VA explained it was usual clinical practice to provide short-term care of 90 days or less following hospitalization in a VA medical center, such as for those who had a stroke, to ensure patients are medically stable. But the VA had chosen not to budget for them because the government is not legally required to provide the care except in serious cases. The GAO noted the VA was in the process of putting together an updated strategic plan. Retired Gen. Eric K. Shinseki, who was sworn in 21 JAN as VA secretary, has promised to submit "credible and adequate" budget requests to Congress. "VA supports GAO's overarching conclusion that the long-term care strategic planning and budgeting justification process should be clarified," wrote outgoing VA Secretary James Peake in a response dated 5 JAN. He said the department would put together an action plan within 60 days of the report's release.

The report comes amid an expected surge in demand from veterans for long-term rehabilitative and other care over the next several years. Roughly 40% of the veteran population is age 65 or older, compared to about 13% of the general population, with the number of elderly veterans expected to increase through 2014. In 2005, the VA stunned Congress by suddenly announcing it faced a $1 billion shortfall after failing to take into account the additional cost of caring for veterans injured in Iraq and Afghanistan. The admission, which came months after the department insisted it was operating within its means and did not need additional money, drew harsh criticism from both parties. The GAO later determined the VA repeatedly miscalculated – if not deliberately misled taxpayers – with questionable methods used to justify Bush administration cuts to health care amid the burgeoning Iraq war. In the report, the GAO said it had found similarly

unrealistic assumptions and projections in the VA's more recent budget estimates submitted in August 2007. According to latest GAO report, the VA is believed to have:

• Undercut its 2009 budget estimate for nursing home care by roughly $112 million. It noted the VA planned for $4 billion in spending, up $108 million from the previous year, based largely on a projected 2.5% increase in costs. But previously, the VA had actually seen an annual cost increase of 5.5%.
• Underestimated costs of care in noninstitutional settings such as hospices by up to $144 million. The VA assumed costs would not increase in 2009, even though in recent years the cost of providing a day of noninstitutional care increased by 19%.
• Overstated the amount of noninstitutional care. The VA projected a 38% increase in patient workload in 2009, partly in response to previous GAO and inspector general reports that found widespread gaps in services and urged greater use of the facilities. But for unknown reasons, veterans served in recent years actually decreased slightly, and the VA offered no explanation as to how it planned to get higher enrollment.
[Source: AP Hope Yen article 23 Jan 09 ++]

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DOD DISABILITY EVALUATION SYSTEM UPDATE 14: Severely wounded troops returning home now have fewer bureaucratic barriers between them and their veterans' benefits. The Defense and Veterans Affairs departments today announced a new, faster means for handling troops with catastrophic injuries who seek the veterans' status that allows them access to VA medical and other entitlements. Michael L. Dominguez, acting undersecretary of defense for personnel and readiness said, "This new policy should allow servicemembers and their families to focus on the essentials of recovery, reintegration, employment and independent living, with the combined assistance from the Defense Department and VA." In the past, injured troops were subject to lengthy reviews under the standard Disability Evaluation System (DES) before being transferred from Defense Department to VA status. Today's announcement waives this requirement for those with catastrophic injuries and reduces their processing time. A catastrophic injury or illness is a permanent, severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that a servicemember or veteran requires personal or mechanical assistance to leave home or bed, or requires constant supervision to avoid physical harm to self or others. The expedited policy will result in receipt of benefits in three to four months, compared to a recovery and standard DES process that would normally take much longer.

Troops who participate in this optional, expedited process will be given a Defense Department disability rating of 100%, and the VA then will identify the applicable range of benefits, compensation and specialty care. "Servicemembers and their families will be empowered to decide, after counseling on the options and potential concerns and benefits, the most appropriate choice for their situation," Dominguez said. The policy allows members who retire under the expedited DES process to re-enter the service with a waiver if they are capable following their rehabilitation, according to a Defense Department news release. The release notes that the expedited policy differs from the DES pilot program, a new process designed to reduce the amount of time required by the current standard disability

processes at the Defense Department and VA, which is administered to troops without catastrophic injury. More than 1,000 troops over the past 14 months have participated in the pilot, which requires one medical examination that yields a single-sourced disability rating. [Source: AFPS John J. Kruzel article 22 Jan 09 + +]

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VETERANS INAUGURAL BALL: The promoter who failed to hold a promised Veterans Inaugural Ball on 20 JAN has left behind a trail of angry corporate sponsors and charities who contributed to the event, disappointed performers who were booked for entertainment, and 17 to 25 beauty queens who were told they would be ambassadors for their states at the ball and help raise up to $10 million for veterans' causes. In e-mails, promoter Dante Hayes promised three or four "action-filled" days highlighted by the black-tie ball that Obama supposedly would visit because veterans were such an important cause. Among the fabrications Hayes used to get donations was a public relations plan he circulated about how the beauty queens, performers and sponsors would be getting attention from the news media with the help of an international communications company, Burson-Marsteller, which he claimed was retained 9 JAN and would stay on the job through 25 JAN. Paul Cordasco, a corporate spokesman for Burson-Marsteller, said Hayes did contact the company asking about a media plan. "We were never engaged by him or signed with him," Cordasco said, adding that the detailed media plan being circulated by Hayes was a fabrication.

The Secret Service and FBI are investigating what happened to the money donated by corporate sponsors and charities and raised through ticket sales to the ball. Also, what happened to Hayes, who heads an organization called the Congressional Education Foundation for Public Policy. He disappeared about the time that the performers and beauty queens were expecting to receive final details on their travel and lodging arrangements, and around the same time that the hotel where the ball was supposed to be held pulled the plug when it had not received payment. Many of those defrauded had spent money buying gowns and tuxedos for the many events and had even made a contribution to the cause because they were such big believers. Up until two days before participants were supposed to travel, Dante Hayes was still talking and promising everything was fine, but when asked about the travel arrangements, he promised to send an e-mail with details which never arrived. Hayes did not respond to telephone calls to three different numbers he had provided to people involved in helping with the inaugural, and he also did not respond to e-mail. Entertainers, the hotel where the ball was going to be held, the people invited to attend and those who bought tickets - which sold for up to $385 for veterans and $500 for nonveterans - said they have not heard from Hayes since they learned there was no ball, no visits with veterans and no money to be turned over to charities.

The person who convinced Nikki Slater and other beauty queens, charities and corporate sponsors to sign on to the event said she also is a victim. Beth Jannery, Ms. Virginia Galaxy 2009, an author, motivational speaker and public relations consultant, said she became involved after contacting Hayes last fall to volunteer to help with the event. "I have a lot of experience with planning events, especially those involved with veterans, and thought this sounded like a good idea," said Jannery, who lives in Great Falls, VA, "I called him because I want to support the troops and I liked the idea of a ball for veterans." Jannery

said that when Hayes learned she was involved in pageants, he enlisted her to recruit pageant winners to take part in the event and also asked for her help in lining up corporate sponsors. Later, she also was promised a six-figure job that never materialized after a sales pitch in which Hayes took her to what ended up being a rented meeting room at an exclusive downtown Washington, D.C., hotel that he claimed was his office space. Jannery said she became suspicious when plans kept changing, conference calls to go over details were postponed or canceled, and Hayes kept finding excuses not to provide a tax identification number that would show his foundation was registered with the IRS as a nonprofit organization, something needed by corporate sponsors when making charitable donations. [Source: NavyTimes Rick Maze article 22 Jan 09 ++]

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TRICARE: CLAIM (Overseas) UPDATE 01: Tricare officials have extended the deadline to 31 MAR for overseas beneficiaries to file claims for reimbursement for bills from previous years. The original deadline was 31 DEC 08 to file claims for services that were received before 31 DEC 07. Since that original deadline was announced, Tricare officials said, they have received nearly 4,500 claims that have been approved for processing and payment. Tricare's overseas claims processor, Wisconsin Physician Services, added staff to process the claims, but manual overseas claims processing requires extra time, officials said. Beneficiaries are urged to "be patient" and wait until February before contacting WPS about the status of their claims. Officials have been educating Tricare providers and beneficiaries about the new emphasis on the deadline. The one-year filing deadline for claims has always been on the books and predates the Tricare program. But the problem was that overseas health care providers, according to the statutes of their countries, often had as much as three years to file a claim, officials said. They have been educating the providers that U.S. statutes apply to Tricare, not the host countries' statutes.

After this new deadline, claims must be submitted within a year of service. Only waiver requests that meet specific guidelines outlined in the Tricare Operations Manuel may be processed. Tricare officials said it is ultimately the beneficiary's responsibility to ensure claims are submitted and processed in a timely manner, according to Tricare policy and federal regulations. In most places in the Pacific and Latin America, beneficiaries have to pay Tricare providers up front and then file the claim themselves. In Europe, that varies. Beneficiaries can file claims by mailing a completed DD Form 2642 with a copy of the itemized bill and receipts to the appropriate Wisconsin Physicians Service address, available on the contact page of the www.tricare4u.com Web site. This 90 day extension also applied to Host Nation (HN) providers. Under the extension policy, claims submitted by HN providers must be received by WPS by 31 MAR and will be initially denied. After denial the HN provider may then request a timely filing waiver by submitting their request to Beneficiary and Provider Services, 16401 E. Centreterch Parkway, Aurora CO 80011. For the Philippines a copy of the TMA memorandum covering the extension can be viewed at http://tinyurl.com/b5sxa2. For additional info or questions contact Ed Chan at Ed.Chan@med.navy.mil. [Source: AirForceTimes Karen Jowers article 29 Jan 09 & Dir, TAO-Pacific message 29 DEC 08 ++]

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PTSD UPDATE 24: More than 44% of Iraq and Afghanistan war veterans who have sought treatment at a VA medical facility have been diagnosed with one or more possible mental disorders, according to the agency's most recent summary of veteran health care. All told, a total of 178,483 veterans who came to VA for help were diagnosed with possible mental disorders from fiscal 2002 through SEP 08, according to the January report of the VHA Office of Public Health and Environmental Hazards. Of that total, 92,998 service members, or 23%, were diagnosed with possible post-traumatic stress disorder, while 63,009, or 16%, were found to have possible depressive disorders. The VA figures overlap to an unknown extent because officials say a veteran may have been diagnosed with more than one disorder. In addition, the total of those who have come to VA for health care is a limited sample of the 1.7 million service members who have served in the two wars – as of 20 SEP 08, 400,304 war veterans had sought such treatment over the past seven years, or about 24% of the totals number of troops who have served in the conflicts.

Because the service members seeking treatment were not randomly selected and are less than one-quarter of the total population of veterans of the wars, VA cautions that they are not a true representative sample. VA also says that up to one-third of its diagnoses might not have been confirmed because they were provisional pending further evaluation, and that revising records is a resource-intensive effort rarely done in the public or private sector. At the same time, the number of VA's possible diagnoses of PTSD has risen "quite steadily" over the past seven years. And, said Antonette Zeiss, VA's deputy director for mental health services, "there's a steeper rate of increase between each of the quarterly reports as time goes on." In addition, the 23% of veterans seen by VA who were initially diagnosed with PTSD, Zeiss agreed, is generally in line with outside estimates.

In an April study by the Rand Corp., nearly 20% of Iraq and Afghanistan veterans surveyed reported symptoms of PTSD or major depression. Many of those who have served in the wars, Rand noted, have been exposed to prolonged periods of combat-related stress or traumatic events. Rand also found that many service members say they don't seek treatment for psychological illnesses because they fear the repercussions will harm their careers. "We know there are guys who desperately need help who aren't coming to us," said Phil Budahn, a VA spokesman. And even among those who do seek help for PTSD or major depression, Rand found, only about half receive treatment that researchers consider "minimally adequate" for their illnesses. Rand concluded that a "major national effort is needed to expand and improve the capacity of the mental health system to provide effective care to service members and veterans." A number of causes could be behind the increase in VA diagnoses, Zeiss said: multiple and prolonged deployments to the wars; better screening by VA; efforts by VA and the military to destigmatize PTSD; and veterans possibly choosing VA care over other options.

Other possible mental health diagnoses of returning vets, according to the VA report, were neurotic disorders (50,569 veterans), affective psychoses (35,937), non-dependent abuse of drugs (27,246) and alcohol dependence syndrome (16,217). VA notes that while the diagnoses are of war veterans, it cannot be certain that all of the conditions are war-related. But, said Zeiss, "most of these conditions would not have been present prior to being in the military. In VA, we assume that these are veterans coming to us who have had significant stresses as a result of their involvement with the military and in war. And we want to treat them and

respect that there's a possibility that these are due to their experience in the military." Despite that and the other caveats, Zeiss said the diagnoses statistics "tell us what level of demand for services there is likely to be." Since the number of VA's PTSD diagnoses is on the rise – and, she noted, represent only about half of all mental health disorder diagnoses – "we also need to sustain an overall mental health system that can treat the whole range of mental problems." The figures, she said, also support a VA decision made three years ago to start training mental health providers to be able to provide the strongest evidence-based treatments for PTSD, such as cognitive processing therapy and prolonged exposure therapy, and application of medications for PTSD symptoms.

Overall, possible mental health disorders ranked slightly behind disorders of the joints and back; VA said that about 49% of those veterans of the wars in Iraq and Afghanistan were diagnosed with possible musculoskeletal problems. A category called "symptoms, signs and ill-defined conditions" – a collection of mostly normal symptoms that don't have an immediate, obvious cause during a clinic visit – was third on the list, with 42% of veterans seeking VA health care receiving this possible diagnosis. These were followed by diagnoses of possible diseases of the nervous system and sense organs (36.6%), digestive problems (32.4%), and diseases of the endocrine, nutritional and metabolic systems (23.2%). As with the mental health diagnoses, veterans could have been diagnosed with more than one condition, VA noted. The vast majority of the 400,304 war veterans who came to VA were seen as outpatients. Of the roughly 1.7 million service members who have served in the two wars, 945,423 veterans have become eligible for VA health care – 483,136 active-duty troops, and 462,287 reservists. Some 209,099 and 191,205, respectively, have actually sought care at VA. The latest VA figures represent 42% of the care-eligible population. Most (88%) were male; 50% were ages 20-29; 92% were enlisted; 52% were active-duty; and the vast majority (64%) were Army soldiers. Just 13% of veterans who sought VA treatment were Marines, and just 12% were sailors and airmen, respectively. [Source: AirForceTimes William H. McMichael article 18 Jan 09 ++]

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PTSD UPDATE 25: U.S. Senator Daniel K. Akaka (D-HI), Chairman of the Veterans' Affairs Committee, commented 28 JAN on a new VA Inspector General (IG) report into an email sent by a VA psychologist last year that appeared to discourage health care staff from diagnosing veterans with post-traumatic stress disorder (PTSD). The IG investigation, requested by Akaka found that while the email was poorly written and inappropriate, it did not result in a change in diagnoses at that VA facility. "I appreciate the IG's investigation into this matter. It is fortunate that the actions of a single health professional did not result in an artificial decline in the number of veterans diagnosed with PTSD. I remain concerned that VA's health care system is overburdened and underfunded as the needs of veterans grow greater and more complicated. I will continue to work towards making VA funding more timely, predictable, and robust," Akaka said. Chairman Akaka requested the IG's investigation when the email was brought to light last year. He held a hearing on systemic indifference to invisible wounds on June 4, 2008. The VA IG report dated 29 JAN is available at www.va.gov/oig/54/reports/VAOIG-08-02089-59.pdf. [Source: Sen. Akaka press release 28 Jan 09 ++]

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VA HEALTH CARE LEGISLATION: On 15 JAN Senator Daniel K. Akaka (D-HI), Chairman of the Veterans' Affairs Committee, reintroduced legislation to improve veterans' health care. The Veterans' Health Care Authorization Act of 2009 (S.252) is an updated version of the bill introduced in the previous Congress to improve medical personnel incentives and other aspects of veterans' health care. "VA must have the tools to recruit and retain a qualified health care workforce if the Department is to furnish high quality health care across its system. I urge my colleagues to join my renewed effort to bring these essential improvements to those who have worn the uniform," said Akaka. The Veterans' Health Care Authorization Act includes:

• Recruitment and retention incentives for VA medical professionals, such as pay, benefits, scholarship programs, and work schedules, to attract top quality clinicians;
• Improvements in services and care for women veterans, who compose a significant and growing segment of the military and veteran population; and
• Pilot programs to assist family caregivers, provide outreach and assistance to returning servicemembers in their communities, and help prevent homelessness among veterans.
[Source: Sen Daniel K. Akaka Press Release 15 Jan 09 ++]

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PROSTATE CANCER UPDATE 08: The US Food and Drug Administration recently approved a new drug for the treatment of advanced prostate cancer. Degarelix, an injectable drug manufactured by Ferring Pharmaceuticals and still awaiting a trade name before it can hit the market, belongs to class of drugs known as gonadotropin-releasing hormone (GnRH) receptor antagonists. These drugs block the body’s production of testosterone, which slows prostate cancer growth. The approval is based on encouraging results from a year-long phase III randomized clinical trial. The study showed that degarelix is as effective at suppressing testosterone as leuprolide, a commonly used drug that is also a GnRH agonist, and it appears to take effect much more quickly. At the end of the year, nearly all of the patients on either drug showed testosterone levels comparable with surgical removal of the testes. However, 99% of the patients receiving degarelix reached these low testosterone levels after about 2 weeks of treatment, compared with only 18% of the patients receiving leuprolide. Further, degarelix didn’t appear to cause the temporary surge in testosterone levels at the start of treatment, an effect commonly seen with other hormone therapies for prostate cancer known as GnRH agonists, including leuprolide.

Prostate-specific antigen (PSA) levels were also monitored during the trial. While PSA results are not always clear-cut, a high PSA level is usually a good indicator of the presence of prostate cancer. Patients receiving degarelix saw their PSA levels drop by an average of 64% two weeks after starting treatment, by 85% after one month, and by 95% after three months. PSA levels stayed low during the rest of the trial. Commonly reported side effects included pain, redness, and swelling at the injection site; hot flashes; weight gain; fatigue; and increases in some liver enzyme levels. Once a trade name is green-lighted by the FDA, degarelix will be the only GnRH antagonist available in the United States. (A similar drug, abarelix, was withdrawn from the US market several years ago.) Degarelix is also awaiting approval overseas. For more information refer to

http://www.cancer.org/docroot/CRI/CRI_2_3x.asp?rnav=cridg&dt=36. [Source: American Cancer Society article 13 Jan 09 ++]

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VA SECRETARY UPDATE 12: Retired Army Gen. Eric K. Shinseki took the oath of office today as the Nation's seventh Secretary of Veterans Affairs, assuming the leadership of the Department of Veterans Affairs following confirmation by the Senate on 20 JAN. "The overriding challenge I am addressing from my first day in office is to make the Department of Veterans Affairs a 21st century organization focused on the Nation's Veterans as its clients," Shinseki said. Shinseki plans to develop a 2010 budget within his first 90 days that realizes the vision of President Obama to transform VA into an organization that is people-centric, results-driven and forward-looking. Key issues on his agenda include smooth activation of an enhanced GI Bill education benefit that eligible Veterans can begin using next fall, streamlining the disability claims system, leveraging information technology to accelerate and modernize services, and opening VA's health care system to Veterans previously unable to enroll in it, while facilitating access for returning Iraq and Afghanistan Veterans.

Shinseki, a former Army Chief of Staff, takes the reins of a 284,000-employee organization delivering health care and financial benefits to millions of Veterans and survivors under a $98 billion budget authorized this year through networks of regional benefits offices and health care facilities from coast to coast. Born in 1942 on the island of Kauai, Hawaii, Shinseki graduated from the U.S. Military Academy at West Point in 1965. He served two combat tours and was wounded in action in Vietnam. He served with distinction in Europe, the Pacific and stateside, eventually becoming the Army's senior leader from JUN 99 to JUN 03. Retired from military service in AUG 03, Shinseki's military decorations include three Bronze Stars and two Purple Hearts. Shinseki succeeds Dr. James B. Peake as Secretary of Veterans Affairs. [Source: VA News Release 21 Jan 09 ++]

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VA CLAIM DENIAL UPDATE 01: Nieves-Rodriguez v. Peake could prove to be an excellent tool in forcing VA to back away from the blanket acceptance of VA medical opinions even when private medical opinions submitted by a claimant are more substantive and better reasoned. Service Officers are encouraged to review each rating based on a VA medical opinion with this decision in mind. Service Officers should not hesitate to appeal VA decisions in cases where the veteran has submitted a private medical opinion and the VA has not performed the analysis required by this decision. In Nieves-Rodriguez v. Peake, December 1, 2008, No. 06-0312 United States Court of Appeals for Veterans Claims (CAVC) held that:

- The probative value of a medical opinion primarily comes from the physician's reasoning. A claims file review cannot compensate for lack of a reasoned analysis required in a medical opinion. Factually accurate, fully articulated, and sound reasoning for the medical conclusion, not the mere fact that the claims file was reviewed, contributes probative value to a medical opinion.
- That a private medical opinion may not be discounted solely because the physician did not review the claims file. Likewise, a VA medical opinion may not be preferred over a private medical opinion solely because the VA examiner reviewed the claims file. It is what the examiner learns from the claims file in

forming the expert opinion that matters, not just reading the file.
• That VA does not have a general duty to inform every claimant that seeks or provides a private medical opinion of the availability of the VA claims file. The Court noted that particular medical information contained in a claims file may be significant to the process of formulating a medically valid and well-reasoned opinion and directed that a veteran should take care to personally provide those medical facts of which a physician should be aware in formulating a medical opinion.
[Source: CA VFW National Veterans Service Committee Weekly Update 21 Jan 09 ++]

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VA CLAIM DENIAL UPDATE 02: In Roberson v. Principi, FedCir, 2001, the appeals court held that VA was under an obligation to read correspondence (filings) from veterans, acting without legal representation, sympathetically and liberally in order to fully understand what it was the veteran wanted either in a claim or on appeal. The VA has adjudicated claims using the Roberson ruling at the Regional Office level. In Comer v. Peake, Court of Appeals for the Federal Circuit, 16 JAN 09 the Appeals Court reversed the United States Court of Appeals for Veterans Claims (CAVC) and said that Roberson applies to filings before the Board of Veterans Appeals as well. The court held that:

• Under Roberson, a claim to Total Disability Based On Individual Unemployability (TDIU) benefits is not a free-standing claim that must be pled with specificity; it is implicitly raised whenever a pro se veteran, who presents cogent evidence of unemployability, seeks to obtain a higher disability rating. See Szemraj v. Principi, 357 F.3d 1370, 1373 (Fed. Cir. 2004) (The VA is required, "regardless of the specific labels . . . claims are given in the veteran's pleadings," to read pro se submissions sympathetically and "to determine all potential claims raised by the evidence."
• "The VA disability compensation system is not meant to be a trap for the unwary, or a stratagem to deny compensation to a veteran who has a valid claim, but who may be unaware of the various forms of compensation available to him. To the contrary, the VA "has the affirmative duty to assist claimants by informing veterans of the benefits available to them and assisting them in developing claims they may have.
• To hold that a veteran forfeits his right to have his claims read sympathetically if he seeks assistance from a veterans' service organization would be to discourage veterans from seeking the much-needed assistance that those organizations provide.

Interestingly, the Court opined that the Roberson and Comer decisions would apply even if a claimant was represented by a veteran's service officer (VSO) since they are not trained attorneys and their representation is different from that provided by attorneys. This decision extends the obligation imposed by Roberson to sympathetically read correspondence and filings to both the Regional Office and the Board of Veterans Appeals (BVA). For more info on Comer v. Peak refer to http://www.cafc.uscourts.gov/opinions/08-7013.pdf.
[Source: CA VFW National Veterans Service Committee Weekly Update 21 Jan 09 ++]

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CBO HEALTH CARE BUDGET OPTIONS: Every year there has been budget options made

available by the Congressional Budget Office (CBO) to all federal departments and agencies for consideration in their upcoming fiscal budget requests. Bush Administration CBO Acting Director, Robert A. Sunshine, on 18 DEC 08 provided the Congressional Health Care Staff of CBO's New Health Report Volume 1 which analyzes federal health care financing and delivery programs. More importantly, Volume 1 provides estimates of budget impact of specific health care proposals in the form of 115 OPTIONS (not recommendations) that could be considered in the formulation of Federal Budget Proposals for the 111th Congress. The Budget OPTIONS impact most all federal health care programs. The following CPO Report Options of special interest to NCOA are available to review on the Internet at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf:

- Option 17 - Raise the age of eligibility for Medicare to 67
- Option 27 - Allow people and firms to buy health insurance plans through the Federal Employees Health Benefits Program
- Option 28 - End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8
- Option 29 - Reopen Enrollment for VA Medicare Care among Priority Group 8 Veterans for five years
- Option 87 – Increase the basic premium for Medicare Part B to 35% of the program's cost
- Option 92 - Base Federal Retirees' (employees) Health Benefits on Length of Service
- Option 95 - Increase health care cost sharing for family members of active-duty military personnel. (Provide $500 cash allowance but charge 10% of the cost of care and impose a fee to use military hospitals and clinics)
- Option 96 – Introduce Minimum Out-of-Pocket requirements under Tricare for Life. (In 2011, not cover first $525 of Medicare annual cost share, than cover only half of next $4,725)
- Option 97 - Increase Medical Cost Sharing for Military Retirees who are not yet eligible for Medicare. (TRICARE user fees)
- Option 98 - Require Copayments for Medicare Care provided by the Department of Veterans Affairs to Enrollees without a Service Connected Disability
- Options 99 - 105 - Involve OPTIONS in Long Term Care federal programs

All Federal budget proposals are normally embargoed, not released or discussed, until the Administration formally presents its budget to Congress. Remember the federal departments proposed budgets are individually reviewed, debated, appropriately adjusted, approved by Congress, and recommended to the President for signature. Throughout the Congressional process, military and veteran service organizations communicate with Committees, initiate grass roots efforts to raise citizen concern and comment for consideration by all members of Congress and those Committees that review specific budget proposals. The CBO Report is not new! We have seen a number of such budget "options" proposed in DOD and VA federal budgets which were rejected in the Congressional approval process. Upon receipt of the proposed Administration's Budget, military and veteran service organizations scrutinize the Administration's Recommendations and initiate strategies, including national grass roots involvement, to recommend disapproval of those features which would be a detriment to military and veteran beneficiaries. You'll recall that in past years Administration Budget Recommendations included a number of the "OPTIONS" pointed out above.

The Bush Administration left office with a $1+ Trillion Dollar National Debt.

President Obama stated since becoming President Elect that all budget programs would be on the table for review in his Administration's budget proposals as part of the effort to turn America's economy around. Also, as President Elect he also pursued a major appropriation Stimulus Package seen by many as positive even though it's estimated to increase the Nation's Debt to over $2 Trillion in the short term. Hopefully all military and veteran service organizations, like Congress are now aware of the Federal Health OPTIONS presented by CBO and will be prepared to act in the best interest of their constitutes when such proposals are available in the Administration's Budget Programs. [Source: NCOA Legislative Action Update Jan 09 ++]

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DOD TO VA TRANSITION UPDATE 07: A high-level management committee from the Defense and Veterans Affairs departments said they plan to have interoperable health records by SEP 09 as part of a program between the two departments to streamline information sharing, according to a report released last week. Defense and VA launched a health information sharing project in 2000 and now share exchange a vast amount of medical data, including lab results and medication history through its their Bi-Directional Health Information Exchange. The two departments will continue to share more inpatient electronic data, including clinical notes from physicians, according to the 2009-2011 strategic plan issued by the VA/Defense Joint Executive Council. Gordon Mansfield, deputy secretary at VA who chairs the council, and David S.C. Chu, undersecretary of Defense personnel and readiness, issued the report last week.

The two departments plan to exchange clinical notes, which doctors write to report patients' conditions, in a test environment this JUN and to complete deploying the inpatient clinical note system by 30 SEP. VA and Defense's Military Health System expect to begin operating a secure, redundant network to support health data exchange by 30 JUN. According to the strategic plan VA and Defense also plan to begin sharing chemistry and hematology information in real time at all their medical facilities by 31 OCT. In addition, Defense will start deploying a system to automatically capture and display neuropsychological assessment data essential in identification and treatment of post-traumatic stress disorder by 31 JAN 10. The report recommended that Defense exchange health care information with private sector managed care contractors that provide medical care for active-duty personnel and their families and veterans, as well. Defense is slated to begin in-depth analysis to identify data sharing requirements in March.

Eric Shinseki, confirmed as the VA secretary in the Obama administration, told the Senate Veterans Affairs Committee on 14 JAN that he would work with the Joint Executive Council and Defense Secretary Robert Gates to ensure exchange of health information between the two departments, and he viewed any obstacles to data sharing as a managerial rather than a technical problem. The strategic plan also revealed that the Veterans Tracking Application, originally developed by Defense to follow wounded personnel evacuated from Afghanistan and Iraq, will be enhanced to maintain a common database of severely injured service members for a new version of the Defense Disability Evaluation System, which is used to evaluate wounded service members. The plan also called for development of a My eBenefits Web site, which will serve as a single information source for service members and veterans as directed in an AUG 07 report issued by the President's Commission on Care for America's Returning Wounded Warriors. The commission said a portal should

have been be in operation by AUG 08. [Source: NextGov.com Bob Brewin article 20 Jan 09 ++]

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NEW YORK VET BENEFITS UPDATE 01: The state of New York offers property tax exemptions to veterans as follow:

Eligible funds: The law provides a partial exemption from real property taxation for property purchased with the proceeds of a veteran's pension, bonus or insurance monies, or dividends or refunds on such insurance, compensation paid to prisoners of war, mustering-out pay, etc. These types of payments are called "eligible funds". The exemption reduces the property's assessed value to the extent that eligible funds were used in the purchase, generally up to a maximum of $5,000. It is applicable to general municipal taxes (county, city, town or village), but not to school taxes or special district levies. The application form for the eligible funds exemption is RP-458 available at http://www.orps.state.ny.us/ref/forms/pdf/rp458.pdf which must be filed with the local assessor by the taxable status date". I most towns this date is 1 MAR, but recommend you check the date with your assessor to be sure. An exemption provided to veterans who qualify for grants to purchase or modify specially adapted homes to accommodate their serious disabilities, or the homes of their widowed spouses, is covered by section 458(3) and by item 10 on the RP-458 form.

Alternative Exemption: This exemption provides a property tax exemption of 15% of assessed value to veterans who served during wartime and an additional 10% to those who served in a combat zone. The law also provides an additional exemption to disabled veterans equal to one-half of their service-connected disability ratings. The application form for the alternative exemption is RP-458-a available at http://www.orps.state.ny.us/ref/forms/pdf/rp458a.pdf which must be filed with your local assessor. The alternative exemption is applicable only to general municipal taxes and not to school taxes or special district levies. Unlike the eligible funds veterans' exemption, however, the alternative exemption is limited to the primary residence (including, at local option, cooperative apartment) of a veteran, and is not based on eligible funds.

Cold war Veterans: Veterans who served during the Cold War period are entitled to a New York property tax exemption of either 10 or 15% of assessed value (as adopted by their local municipality). The law also provides an additional exemption to disabled veterans, equal to one-half of their service-connected disability ratings. The basic exemption is limited to 10 years, but there is no time limit for the disabled portion of this exemption. In both instances, the exemption is limited to the primary residence of the veteran, and is applicable only to general municipal taxes, not to school taxes or special district levies. Where the exemption is offered by local option of the municipality, the veteran must file an application RP-458-b with the Department of assessment by taxable status date. In Nassau County this date is 2 JAN. Applications are available on the state's website www.orps.state.ny.us/ref/forms/pdf/rp458b.pdf or on the Department of Assessment Website at www.mynassauproperty.com. For eligibility the following is germane:

- The property must be used exclusively for residential purposes.
- The property must be the primary residence of a Cold War veteran or the

unremarried spouse of a Cold War veteran unless that person is absent from the property due to medical reasons or institutionalization.
• The veteran must show a discharge or release from the U.S. Armed Forces under honorable conditions and that the service was during the Cold War period.
• If the veteran seeks the additional exemption available under the law, proof must be provided to show a service-connected disability.
• If a portion of the property is used for non-residential purposes, the exemption will apply only to that portion of the property that is used exclusively for residential purposes.
• The legal title to the property must be in the name of the veteran or the spouse of the veteran or both, or the unremarried surviving spouse of the veteran.
• If the property is owned by more than one qualified owner, the exemption to which each is entitled may be combined. Also, if a veteran is also the unremarried surviving spouse of a veteran, that person may also receive any exemption to which the deceased spouse was entitled.
• This exemption is not available to those veterans currently receiving either the eligible funds or alternative veterans' exemption.
[Source: http://www.orps.state.ny.us/pamphlet/exempt/vets.htm#eligible Jan 09 ++]

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U.S. EMBASSY MANILA HOLIDAYS: Following are the U.S. and Philippines holidays observed by the U.S. Embassy, SSA, VARO, and the DEERS/RAPIDS Workstation Manila. On these dates services will not be available:

• Martin Luther King Jr Day (U.S.): Monday, January 19
• President’s Day (U.S.) Monday, February 16
• Bataan & Corregidor/Heroism Day (PHIL): Monday, April 6
• Maundy Thursday (PHIL): Thursday, April 9
• Good Friday (PHIL): Friday, April 10
• Labor Day (PHIL): Friday, May 1
• Memorial Day (U.S.): Monday, May 25
• Independence Day (PHIL): Friday, June 12
• Independence Day (U.S.): Friday, July 4
• Ninoy Aquino Day (PHIL): Friday, August 21
• National Heroes Day (PHIL): Monday, August 31
• Labor Day (U.S.): Monday, September 7
• Eid-ul-Fitr (subject to proclamation-PHIL): TBD
• Columbus Day (U.S.): Monday, October 12
• Veterans Day (U.S.): Wednesday, November 11
• Thanksgiving Day (U.S.): Thursday, November 26
• Bonifacio Day (PHIL): Monday, November 30
• Christmas Day (U.S./PHIL): Friday, December 25
• Rizal Day (PHIL): Wednesday, December 30
• Last Day of the Year (PHIL): Thursday, December 31
[Source: U.S. Embassy ACS Newsletter Jan 09 ++]

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VARO MANILA UPDATE 01: Effective 2 JAN 09 the Department of Veterans Affairs Regional Office located at 1131 Roxas Blvd, Manila, Philippines implemented an appointment system for all visitors to their public contact section in the U.S. Embassy. VA will no longer entertain walk-in visitors; all visitors will be

required to have an appointment before they are admitted to the Embassy. For an appointment if calling from Manila or outside the country dial [02] 528-2500. If in country calling from outside Metro Manila area use the VA no charge number 1-800-1888-5252 using a PLDT line. Keep in mind that the VARO is closed on all American and Philippines holidays. [Source: U.S. Embassy ACS Newsletter Jan 09 ++]

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PASSPORT ISSUANCE IN RP UPDATE 01: Effective 2 FEB 09, the U.S. Embassy-contracted courier, Air21/FedEx, will no longer accept payments for passport applications. Air 21/Fedex will continue to deliver U.S. passport application forms, submit personal U.S. passport applications to the Embassy, and return completed U.S. passports to customers. U.S. passport fee payments may be made by the applicant, or his/her representative, at the U.S. Embassy in Manila, Window D, American Citizen Services, between 7:30 a.m. and 11:00 a.m., Monday through Friday, except on U.S. and Philippine holidays. Payments may also be made at the American Consular Agency in Cebu between 9:00 a.m. and 11:00 a.m., Monday through Friday, except on U.S. and Philippine holidays. Payments mailed directly to the Citizenship and Passport Unit, American Citizen Services, Consular Section, U.S. Embassy, 1201 Roxas Blvd., Manila will be accepted. Unfortunately, the U.S. Embassy cannot assume any responsibility for payments sent to them. Payments may be made in cash or via credit card only. For questions, contact the Citizenship and Passport Unit, American Citizen Services of the U.S. Embassy at (02) 301-2000, local 2555 or 2532, between 2:00 p.m. and 4:00 p.m., Monday through Friday, except on U.S. and Philippine holidays. They can also be reached via e-mail: acsinfomanila@state.gov. [Source: ACS InfoManila Warden msg 16 Jan 09 ++]

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COLA 2010 UPDATE 02: The good news is that the cost of living went down another full percentage point in December. The bad news is that inflation will have to rise more than 5% during the last 9 months of the year for military retirees to see any COLA at all for 2010. That seems unlikely at this point, since the CPI rose more than 5% for the full year only once in the last 19 years. On the other hand, that time was -- last year! With the price of oil gyrating between $35 and $160 a barrel in the last 12 months, anything can still happen. But with the whole economy in a deep funk, a whole lot would have to change in the next 9 months for there to be any COLA at all next year. And if that radical change does come, chances are we might not like it. One last reminder: the law doesn't allow a negative COLA. If inflation is negative for the year, there just won't be a COLA. [Source: MOAA Leg Up 16 Jan 09 ++]

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TRICARE UNIFORM FORMULARY UPDATE 27: On 8 JAN a Defense Department advisory panel recommended moving some nasal allergy and asthma medications to the third tier, or $22 copay level. Drugs proposed for the higher copay include Beconase AQ, Rhinocort Aqua, Omnaris, Veramyst, Patanase, and Nasacort AQ. Five medications would remain available at lower copay levels, including Flonase, Nasarel, Nasonex, Astelin, and Atrovent. The Asthma inhaler Maxair and the inhalation solution Alupent also will be moved to the higher $22 copay. Ventolin, Proventil, Proair and Xopenex inhalers will continue to be available at the normal copays, along with the inhalation solutions Accuneb and Xopenex. The new third-tier

recommendations will be submitted to the Assistant Secretary of Defense (Health Affairs) for a final decision. DoD will provide notifications to all beneficiaries currently taking the medications being moved to the third tier so they and their doctors can consider alternative medications available at the lower copay. Information on alternative medications can be found via TRICARE's Formulary Search Tool http://www.tricareformularysearch.org/dod/medicationcenter/default.aspx. A doctor who believes it is important for a patient to take the third-tier medication can provide "medical necessity" justification to TRICARE. If approved, the patient will continue receiving the medication at the lower copay. [Source: MOAA Leg Up 16 Jan 09 ++]

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GI BILL UPDATE 35: MOAA has learned that some people nearing retirement from active service who are eligible for the new Post-9/11 GI Bill will be able to transfer their benefits to a spouse or dependent children. Congress gave the Defense Department broad authority to set the rules for transferring the benefits as a tool to induce retention or reenlistment in the Armed Forces including the National Guard and Reserves. The Post-9/11 GI Bill program begins on 1 AUG 09. The transfer program will work as follows, assuming an individual has qualifying Post-9/11 service in the Armed Forces -- active duty or service in the Selected Reserve. To be eligible to transfer to a spouse or child, a member must:

- Have served at least 6 years in the Armed Forces on the date of election and agree to serve four additional years from that date; or
- Have at least 10 years of service in the Armed Forces on the date of election and be precluded from committing to four additional years by law or Service/DoD policy. For example, servicemembers subject to high-year tenure rules and who have 10 years' service at the time of election would be eligible
- Members who are currently retirement eligible or who will become retirement eligible during the period Aug. 1, 2009 through Aug. 1, 2012 can also qualify. "Retirement eligible" means completion of 20 years of active federal service or completion of 20 years' reserve service

Here's how the program will work for various cohorts of retirement eligibles:

- For those eligible to retire on or before 1 AUG 09, no additional service is required
- For those eligible for retirement after 1 AUG 09 and before 1 AUG 09, one year additional service is required
- For those eligible for retirement after 1 AUG 10 and before 1 AUG 11, two years' additional service is required
- For those eligible for retirement after 1 AUG 11 and before 1 AUG 12, three years' additional service is required

[Source: MOAA Leg Up 16 Jan 09 ++]

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TRICARE PRIME UPDATE 03: If you are a Tricare Prime beneficiary living in a Tricare Prime Service Area (PSA), it is important to remember that your local military treatment facility (MTF) is your first option for many health care services. In a PSA, when a primary care manager gives you a referral for specialty care, an inpatient admission or other care requiring written prior authorization, you must first seek that care at the MTF. This is known as the MTF “right of first refusal.” The MTF staff reviews referrals to determine if the

requested service is available at the MTF within Tricare access standards. If an appointment is available, the MTF will provide the service. If an MTF appointment is not available within Tricare appointment access standards, you will be referred to a Tricare network civilian provider within Tricare appointment and drive time access standards. Tricare Prime appointment access standards entitle you to receive:
• An urgent care appointment within 24 hours
• A routine care appointment within one week (7 days)
• A specialty care appointment within four weeks (28 days)
• A wellness visit within four weeks (28 days)
Note: For additional info on the Tricare Prime program refer to http://www.humana-military.com/south/bene/TRICAREPrograms/prime.asp.
[Source: NAUS weekly Update 16 Jan 09 ++]

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HEALTH CARE AVAILABILITY: Federally-funded health centers will care for you, even if you have no health insurance. You pay what you can afford, based on your income. Health centers provide:
• Checkups When You're Well
• Treatment When You're Sick
• Complete Care When You're Pregnant
• Immunizations And Checkups For Your Children
• Dental Care And Prescription Drugs For Your Family
• Mental Health And Substance Abuse Care If You Need It

These centers are managed by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). Health centers Cn be found in most cities and many rural areas. To locate the one nearest to you go to http://findahealthcenter.hrsa.gov/SearchByCounty.aspx, type in your state and county, and click the 'Find Health Centers' tab for a list of health centers near you. You will be provided with the address, phone number, a map, and driving directions. [Source: DisabilityInfo.gov notice 16 Jan 08 ++]

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VA SECRETARY UPDATE 11: Jim Nicholson, the former secretary of veterans' affairs who once headed the Republican National Committee, said 16 JAN that he expects President-elect Obama will come to have deep respect for the U.S. military, just as President Bush's respect for the military grew during his two terms in office. Nicholson, a U.S. Military Academy graduate and Vietnam veteran who is a close friend and staunch supporter of the outgoing president, spoke in an interview about how he thinks history will judge Bush's eight years as a time of building a stronger military and improving veterans programs. "Bush learned a great deal while president, and his admiration and respect for the military grew immensely," Nicholson said. "That happens to most presidents, and I think the same thing will happen with Obama." While Bush's decision to send U.S. troops into Iraq remains controversial, Nicholson said he thinks history will judge the 43rd president in a less harsh light "as people reflect on the significance of keeping us safe for seven years after we were attacked." "You can debate the decision but you cannot debate the results," he said. Nicholson served Bush as U.S. ambassador to the Vatican, a job he started just days after the Sept. 11, 2001, terrorist attacks, and went on to serve as the second of three VA secretaries under Bush.

Nicholson had a rough road in the job, as he headed the department when it faced a budget crisis, a growing backlog of disability claims, long waits for medical appointments and the threat of identity loss for hundreds of thousands of veterans because of lost, stolen and misplaced personnel files. Nicholson said for all the problems, veterans – especially combat veterans from Iraq and Afghanistan – ended up seeing improved services during the Bush administration because VA budgets more than doubled and dramatic improvements were made in medical programs, such as the screening of every combat veteran who entered VA's doors for post-traumatic stress disorder and traumatic brain injuries. [Source: Navy Times Rick Maze article 16 Jan 08 ++]

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DOD PDBR UPDATE 05: This board mandated by Congress to review disability ratings of wounded veterans is finally accepting applications after months of delays. The application form is now available at http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd0294.pdf. It must be signed and mailed to SAF/MRBR, 550-C Street West, Suite 41 Randolph AFB TX 78150-4743. Congress created the Physical Disability Board of Review PDBR) after investigations found inconsistencies in how the military assigns ratings. The board has been delayed since its creation in 2007. It wasn't until JUN 08 - months after the panel was to begin operating - that the Defense Department formally announced its creation. "Even at this late date, it is still good news to hear that the board is finally taking applications," Vanessa Williamson, the policy director at New York-based Iraq and Afghanistan Veterans of America, said. "But unless they are doing active outreach to troops and veterans, those with wrongly decided claims will not even know that recourse is available." The board posted its application on a Defense Department Web site last week after it was approved by the federal Office of Management and Budget.

A wounded soldier's disability rating is based on the severity and long-term impact of a veteran's injury. A rating above 30% means a service member gets a monthly retirement check and care at military hospitals. Those rated below 30% get severance payments that are taxed. While they continue to get health care, it is provided by the Department of Veterans Affairs instead of the military. Their families, once covered by military health insurance, no longer receive government-provided health care. Retired Army Lt. Col. Mike Parker, an advocate for wounded soldiers, said the delay is a minor issue compared with other problems. Parker said the military often doesn't rate a veteran's most disabling condition and isn't using the Department of Veterans Affairs rating system. "The Defense Department has stated the PDBR can continue to rate service members with Defense Department and service created criteria that result in lower disability ratings," he said. "The problems that caused artificially low and illegal Defense Department disability ratings in the past will continue under the PDBR."

By law, the PDBR will reassess whether an applicant's rating should be raised, possibly to 30% or higher, which would make the person eligible for lifetime military retired pay and TRICARE coverage for themselves and their dependent family members. In the process, the PDBR will:

- Examine the applicant's disqualifying condition for their medical separation.
- Ensure the action was fair and accurate.
- Compare the DoD and Veterans' Affairs ratings.

• Make a recommendation as to whether the rating should be changed. The Board cannot lower a veteran's current disability rating, and any positive change to the rating will result in the military records being corrected.

The scope of the PDBR is very limited. The result of this is there may not be very many disability rating upgrades. For one thing, the PDBR can only look at the condition(s) originally deemed by the service as the reason for the member's unfitness to continue serving. It can't consider any medical conditions other than those that the parent service might have disregarded in developing the original disability rating. That is, if the member had several different conditions, but the service cited only one as the reason for discharge, the other conditions can't be considered in the PDBR deliberations. Further, a member who applies to the PDBR cannot subsequently ask their service Board of Correction of Military/Naval Records (BCMR/BCNR) to review the same issue of whether they should have received a higher rating for the same medical condition(s) that resulted in their separation. In contrast, an application to the service BCMR/BCNR permits consideration of all evidence submitted, including evidence that the service failed to give adequate consideration to other unfitting conditions in making the original rating. Eligible veterans should review the Frequently Ask Questions posted at www.health.mil/Content//docs/PDBR%20faq.pdf to determine which board best suits their specific needs. [Source: NavyTimes AP Kevin Maurer and MOAA articles 16 & 23 Jan 09 ++]

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MORTALITY RATES ACTIVE/RESERVE: Department of Defense actuaries have discovered significantly higher mortality rates among active duty retirees compared to reserve retirees, and the disparity stretches back decades. In any given year, looking at populations of non-disabled military retirees age 60 and older, the death rate for active duty enlisted retirees is 20 to 25% higher than for reserve enlisted retirees. Active duty officer retirees who are 60 and older die in numbers roughly 10% higher than retired reserve peers. All retired officers, and retired reserve enlisted members, still live a few years longer, on average, than the general population. But for retired active duty enlisted, it’s about even with other Americans. Defense officials haven’t done a study to explain death rate differences among military retirees. Speculation centers on stresses of full time service including past wars, frequent moves, constant physical activity to stay in shape, and stress-induced habits such as smoking and alcohol consumption. Another possible factor, one official acknowledged, is that active duty retirees rely for decades on military health care. That’s not a knock on the care but on the fact that patients and doctors are reassigned frequently and continuity of care can suffer compared to what reservists experience.

The mortality rate differences were revealed during a DoD Board of Actuaries meeting last August. They were presented to support a recommendation that retirement cost projections should begin to use dual mortality rates, one for active duty retirees and a lower rate for reserves. The board accepted the change. But one board member was unnerved by the finding of different mortality rates in the military retiree population. “Are you startled by this? I was,” John Hartnedy told fellow board members and policy advisers at the meeting, according to a transcript. Later that day, after more board business, Hartnedy reopened the issue. “I just can’t get this mortality difference out of my head,” he said, calling higher death rates for active duty retirees “very troublesome.” “Is there

something out there that we can do, or that we can look at, to maybe explain this a little bit?" Hartnedy asked. It "just troubles me to no end that our active life military retirees are dying off at a rate like that."

Peter Rossi, one of the DoD actuaries who compiled and analyzed the numbers, was there last August to share results with the board. In several recent phone interviews, Rossi has explained what he and colleagues found. They looked back to the mid-1970s in calculating mortality rates for non-disabled reserve retirees, who retire at age 60, and active duty retirees. Though active duty members can retire after 20 years, only deaths of retirees 60 and older were used to make rate comparisons with reserves. Controlling for gender differences and also for whether retirees are rated as disabled by the Department of Veterans Affairs, the actuaries still found sharp differences in death rates, particularly between enlisted retirees. In fiscal years 2004 and 2005, for example, the proportion of deaths reported among active duty officer retirees, 60 and older, was 10% higher than for reserve officer retirees. The rate difference was 22% for active duty enlisted retirees versus enlisted reserve retirees. "The 22% gets you into a range where you really start to raise eyebrows," said Jack Luff, experience studies actuary at Society of Actuaries' headquarters in Schaumburg, Ill. "That's worth looking into further because it's more than you would expect."

Rossi also produced average life expectancy comparisons. In 2004, for instance, 60-year-old active duty enlisted retirees had an average life expectancy of 19.6 years. That was nearly two years short of life expectancy (21.5 years) for reserve enlisted retirees. How significant is two years? "Very," Rossi conceded. He noted that the life expectancy difference between male and females in the general population at age 60 is three to four years. So a two-year spread between reserve and active duty enlisted retirees at 60 is "a big difference," he said. "We all know that if you're a man [and have] a spouse of the same age, she is going to outlive you. But active and reserve, same age, and we have a significant probability the reservist is going to outlive the active duty member? That is startling," Rossi said. Luff concurred, pointing out that two years is also the life expectancy gap at 60 between a woman who smokes cigarettes and one who doesn't. The life expectancy gap at 60 for officers also favors reservists over active duty retirees, by nearly a year, 24 versus 23.1. But both groups live longer from age 60 than Americans in general. That average life expectancy at 60 is just under 20 years if gender weighted to match military retirees.

Tom Bush, a senior policy official for reserve affairs, suggested to the board last August that more active duty retirees might have used tobacco or alcohol more often than did reservists. Hartnedy suggested post-traumatic stress might be a factor, even controlling for VA-rated disabilities. "I would think that kind of mental strain" from years on active duty "would have an impact…very long term, after retiring," he said. The board's discussion shifted to whether frequent reactivation of Reserve and Guard personnel to fight in Iraq and Afghanistan will result, years from now, in a rising death rates for reserve retirees. "Maybe that mortality [rate] would converge to the same number" with wartime deployments by reservist, Rossi suggested at the meeting. "Unfortunately," Luff told me this week, "that's a probable conclusion." If mortality rates do climb for reserve retirees, said Hartnedy, "it may tell us something about how we treat them when they come back." Bush assured the board that the department and the services were reaching out to returning veterans to find and treat stress-related conditions. [Source: Special to Stars and Stripes Tom Philpott article 17 Jan 09 ++]

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VA HOSPITALS UPDATE 01: The Veterans Health Equity Act of 2009 [S.239A] introduced 14 JAN in the Senate proposes to provide equal access in every state to a full-service veterans' hospital. Three states – Alaska, Hawaii and New Hampshire – do not have full-service veterans hospitals, but the bill orders only access to either a VA hospital or comparable contract services in the continental U.S. Freshman Sen. Jeanne Shaheen (D-NH) the chief sponsor of the bill, made no secret of the fact that she is looking out for her state. "New Hampshire is currently the only state that does not have a full-service veterans hospital or a military hospital that provides comparable care to veterans," she said. "This imposes a great burden on too many New Hampshire veterans who are forced to travel out of state for routine medical services." New Hampshire's other U.S. senator, Judd Gregg (R-NH) said the 130,000 veterans living in the state who need VA care travel to Maine, Massachusetts or Vermont. "Often, especially in the winter months, interstate travel can be extremely dangerous in New England, and our veterans should not be forced to travel long distances in order to receive the medical care they have earned and deserve," he said.

Shaheen, whose father, husband and son-in-law are veterans, called the situation for New Hampshire veterans "unconscionable." If it is "not feasible" to build a new full-service hospital in New Hampshire or to make the VA hospital in Manchester a full-service facility, the bill requires contracting out for services, she said. "Our veterans deserve first-rate medical care, regardless of where they live," she said. A similar bill is being sponsored in the House of Representatives by Rep. Carol Shea-Porter (D-01-NH). The legislation faces an uphill battle because New Hampshire politicians have been unable to persuade the House and Senate committees overseeing veterans' issues, or the Department of Veterans Affairs, that the state needs a full-service hospital. VA Secretary James Peake visited the Manchester hospital last year when the issue heated up during the congressional elections, and he left without making any promises to support a bigger hospital with expanded services. [Source: NavyTimes rRck Maze article 15 Jan 09 ++]

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TRAUMATIC BRAIN INJURY UPDATE 06: The Department of Defense today announced the opening of a 24-hour outreach center to provide information and referrals to military service members, veterans, their families and others with questions about psychological health and traumatic brain injury. The new center, which is operated by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), can be contacted around the clock, 365 days a year, by phone at (866) 966-1020 or by e-mail at resources@dcoeoutreach.org . "We're providing 24/7 support to assist callers with questions regarding psychological health and traumatic brain injury," said Brig. Gen. Loree K. Sutton, M.D., director of DCoE. "Getting the best possible information and tools, hassle-free, will empower and strengthen warriors and their families to successfully manage what can be confusing and disturbing circumstances." The center can address everything from routine requests for information about psychological health and traumatic brain injury, to questions about symptoms a caller is having, to helping callers find appropriate health care resources. DCoE promotes resilience, recovery and reintegration of service members facing psychological health and traumatic brain

injury issues, and works to advance research, education, diagnosis and treatment of these conditions. "If we need to research a question, we'll do the legwork and quickly reconnect with callers," Sutton said. "We welcome feedback on how we can better meet the needs of those we are so privileged to serve." The DCoE outreach center is staffed by behavioral health consultants and nurses, most with master's degrees. In addition to answering questions, staffers refer callers to contact centers in other parts of the Department of Defense, other federal agencies, and outside organizations when appropriate. Other contact centers also refer callers to the DCoE outreach center. The center serves members, leaders and healthcare providers of the Army, Navy, Air Force, Marines, Coast Guard, National Guard, Reserve and all uniformed services, along with veterans of all the services. The families of service members and of veterans are also served by the new center. For additional info refer to http://www.dcoe.health.mil . [Source: DoD News No. 035-09 dtd 15 Jan 09 ++]

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NEVADA VET BENEFITS: With an estimated 339,235 vets in Nevada, one in nine residents is a veteran which places Nevada among the top five states in the percentage of veterans in its population. However, it is 48th in the percentage of its veterans receiving compensation or pension benefits, and 48th for the per capita cash value of those benefits, according to the Nevada Office of Veterans Services. The national average for monthly compensation and pension of $1,453 is 60% higher than the Clark County's average of $910. And, with the Las Vegas economy in what some characterize as a depression and legislators pressed to balance the state budget, many expect things will get worse. As a result, even fewer veterans may access their benefits at a time when: soldiers, looking for an education, are returning home from Iraq and Afghanistan; Vietnam-era veterans are retiring here along with other baby boomers; and veterans of World War II and Korea need care in their twilight years.

One reason for the dismal ranking is that the Nevada Office of Veterans Services has few service officers compared to the number of veterans. This handful of state-paid advocates identify veterans and shepherd them through the bureaucratic labyrinth that is the federal VA, as they apply for benefits or appeal the VA's routine rejections. The state office has one Veterans Services officer for every 20,000 vets. That is half the national average and far below the average of one for every 2,000 or 3,000 vets as is the case in some California counties, said Tim Tetz, director of the state Office of Veterans Services. "In many cases, we promised to take care of them (veterans) for life, and then we abandon them," Tetz said. "The VA makes the vets jump through so many hoops that many people give up, and that is why we need the veteran service officers. Everything is tied to the veteran service officer, whether it is PTSD, the education benefits, the health care benefits or changes to your home or your car if you've been injured." States with more service officers go beyond helping veterans get financial benefits from the VA. They are better equipped to assist with job-related problems and veteran access to medical and mental health services.

The Office of Veterans Services is a small state department. It operates two cemeteries and a nursing home for veterans, and employs nine Veterans Services officers. It has limited influence in Carson City at a time when Gov. Jim Gibbons, also a veteran, has ordered all departments to slash budgets more than 20%. Tetz

has cut costs at the vets' nursing home and trimmed his budget elsewhere to avoid reducing the number of service officers in the state. Their services to Nevada veterans are too vital, he said. Furthermore, every $1 spent by Nevada to employ a service officer generates about $735 in additional federal payments for Nevada veterans to spend in their communities, he said. Jeanette Rae, program manager for the Office of Veterans Services, said the agency has four service officers in Las Vegas and another at the state-run, veterans nursing home in Boulder City. Adding those to veteran advocates from the VA and from nonprofit groups such as U.S. Vets, the Veterans of Foreign Wars and others, the ratio shrinks from 20,000 to 14,000 veterans for every vets' advocate, she said. "With the huge number of veterans down south, we have a ratio that is rather astronomical," Rae said from her Northern Nevada office.

Unlike other state agencies, Veterans Services spends taxpayer money to access federal money that can make some veteran, who might have been a financial liability to his community, an asset instead. Rather than have veterans frequenting emergency rooms, county jail cells or homeless shelters, they might own homes, pay taxes and send their children to college if they are identified as veterans and qualify for compensation, health coverage, a pension or other service from the VA, Rae said. In August, a Vietnam-era veteran won a lengthy battle with the VA in which the agency forced him to appeal claim after claim before he received the benefits he had earned, Rae said. He came to the state agency for help eight years ago, and might have given up hope but for the experience and knowledge of the service officers on his case, she said. The benefits that veteran earned included years of retroactive compensation and a monthly stipend. Given his medical condition, it is likely his death will be "service related" and his widow will be eligible for his monthly compensation, Rae said. "We have changed a family forever," she said.

If the number of Nevada veterans receiving their VA benefits -- and the value of the benefits -- were equal to national averages, Nevada's veterans would receive $173 million more than they do now, said Jay Hansen, a professional lobbyist and guest speaker at the Nevada 2008 Veterans Summit held in DEC 08. That would be new money, which would continue coming to the state year after year until a veteran died and no longer received his benefits, he said. "That is a huge amount of money, and it is something that you can have a direct impact on," Hansen told veterans advocates at the Summit. "And, that is if we just got to the national average." Lou Helwig, deputy secretary of the New Mexico Department of Veterans Services, said “An investment in veterans services officers paid dividends in New Mexico. Like Nevada today, New Mexico 10 years ago was ranked near the bottom of the 50 states in per capita compensation and pension its veterans collected. Now, it ranks first. We felt the state should be in charge of the grass-roots effort. The importance of representing a veteran with power of attorney is significant in terms of the claims being more likely to be successful than if the veteran fills out the claim himself. In addition to hiring more veterans services officers, New Mexico demanded the service officers be more proactive and it established a collaborative approach by enlisting the federal VA, nonprofit groups and other veterans services organizations.”

"The Legislature (in Nevada) needs to think of veterans as an economic force," Helwig said. "The average income of a veteran in New Mexico is more than $2,000 a month." Other states, including Maryland, have taken legislative steps to increase their role in veterans affairs. Maryland passed a bill this year

requiring the state to help veterans who aren't getting timely mental health treatment from the VA. Assemblywoman Kathy McClain, D-Las Vegas, and state Sen. Terry Care, D-Las Vegas, are the two state lawmakers on the state's Veterans Services Commission, which oversees state veterans' services. Both are serving their last terms in the Legislature due to term limits, which means the commission will have new representatives in 2011. During a committee meeting earlier this month, neither was optimistic about avoiding additional cuts to the veterans services agency during the upcoming legislative session. "We have a big problem with the state budget and we are going to have to look at ways of enhancing our revenue," said McClain, chairwoman of the Veterans Services Commission. "This depression is not going to be over for some time and we can't keep cutting essential services." [Source: Las Vegas Review-Journal Frank Geary article 11 Jan 09 ++]

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SENIOR'S VEHICULAR FATALITIES: Motor vehicle crashes account for less than 1% of fatalities among people 70 and older; heart disease and cancer are the leading causes of death.1 People ages 70 and older are less likely to be licensed to drive compared with younger people, and drivers 70 and older also drive fewer miles. However, older drivers are keeping their licenses longer and driving more miles than in the past. Per mile traveled, fatal crash rates increase starting at age 75 and increase markedly after age 80. This is largely due to increased susceptibility to injury, particularly chest injuries, and medical complications among older drivers rather than an increased tendency to get into crashes. Fragility begins to increase at ages 60-64. At age 75, older drivers begin to be markedly over involved in crashes, but fragility is the predominant factor explaining the elevated deaths per mile traveled among older drivers. The following facts are based on analysis of data from the U.S. Department of Transportation's Fatality Analysis Reporting System (FARS). For a more specific breakdown by age, year, and cause between 1975 and 2007 refer to http://www.iihs.org/research/fatality_facts_2007/olderpeople.html#cite2

- A total of 4,598 people ages 70 and older died in motor vehicle crashes in 2007. This is 22% fewer than in 1997 when deaths peaked, but a 22% increase since 1975. The rate of fatalities per capita among older people has decreased 35% since 1975 and is now at its lowest level.
- Seventy-nine percent of motor vehicle crash deaths in 2007 involving people 70 and older were passenger vehicle occupants, and 16% were pedestrians. Since 1975, deaths of older passenger vehicle occupants have increased 57%, while deaths of older pedestrians have declined 47%. Although few older adults are killed while riding motorcycles, this number has risen. Almost fifteen times as many people 70 years and older were killed on motorcycles in 2007 than in 1975.
- In 2007 motor vehicle crash deaths per capita among males and females began to increase markedly starting at ages 70-74. Across all age groups males had substantially higher death rates than females.
- Six percent of fatally injured passenger vehicle drivers 70 years and older in 2007 had blood alcohol concentrations (BACs) at or above 0.08%, compared with 16% for drivers ages 60-69 and 41% for drivers ages 16 to 59.
- Based on travel data collected between April 2001 and March 2002, the rate of passenger vehicle fatal crash involvements per 100 million miles traveled was higher for drivers 80 and older than for drivers of any other age group except teenagers. Drivers 85 and older had the highest rate of fatal crash involvement.3

• Among passenger vehicle drivers involved in fatal crashes in 2007, the proportion in multiple-vehicle crashes at intersections increased as driver age increased starting at ages 55-59. Multiple-vehicle crashes at intersections accounted for 44 percent of fatal crash involvements among drivers 80 and older.
• The rate of pedestrian deaths per 100,000 people in 2007 was almost twice as high for people 70 and older combined (2.7 per 100,000) than for those younger than 70 combined (1.4 per 100,000). For all age groups the rate of pedestrian deaths per capita was higher for males than females.
[Source: Insurance Institute for Highway Safety Jan 09 ++]

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VA COPAY UPDATE 06: When the co-payment amount for prescription drugs goes up, veterans tend to stop taking needed medications, a new study has found. Reporting in the 27 JAN. issue of the journal Circulation, University of Pennsylvania researchers found that adherence to medication dropped more than 19% among veterans who had to make co-payments when that amount was increased in 2002. By comparison, medication adherence dropped by only 12% among veterans who were exempt from co-pays. In addition, the odds of being without medication for more than three months was three times higher during this time among veterans who had to make co-pays than among those exempt from the payments, the study found. "This decline in adherence was not just a result of short gaps in use interspersed between prescription refills," said Jalpa A. Doshi, a research assistant professor of medicine at the University of Pennsylvania and lead author of the study. "In fact, the co-payment increase was accompanied by a significant increase in the likelihood of having continuous gaps of 90 days or more in lipid-lowering medication use."

The finding is of particular importance today, Doshi indicated, because of efforts being made to save federal dollars. "In this era of large federal budget deficits, it is clear that there will be ongoing pressure to reduce or at least constrain growth of the VA budget, and one of the approaches that the Congress may take to cut costs is through increases in VA prescription co-payments," Doshi said. The study looked at what happened when co-pay amounts were increased earlier this decade. In 2002, it found, many veterans went without needed medication after the VA (Department of Veterans Affairs) raised co-payments from $2 to $7 for a month's supply of a prescription drug. The co-pay amount was increased again in 2006, to $8, Doshi said. And several presidential budget proposals, including the 2008 plan, included a co-payment increase to $15 for a 30-day supply, she said. "While these proposals were not incorporated into legislation, it is likely they might be in the future," Doshi said. "Policymakers must consider the findings and implication of studies such as ours in future policy reform initiatives." Co-pay amounts are the same whether a drug is a generic or a brand-name medication, she said. "This is particularly relevant in the case of cholesterol-lowering medications such as statins, wherein two brand-name statins have become available as generics since 2006 and are available at significantly lower prices to the Department of Veterans Affairs," Doshi said "Presumably, the VA could charge veterans lower co-payments for such medications and thereby facilitate higher adherence with drugs from such essential medication classes."

For the study, Doshi and her fellow researchers collected data on 5,604 veterans taking cholesterol-lowering drugs prescribed by the Philadelphia VA Medical Center from NOV 99 to APR 04. They compared veterans who had to make co-

payments with similar veterans who were exempt from prescription drug co-payments, and they looked at adherence to cholesterol-lowering drugs in the two years before and the two years after the co-pay increase. Besides the overall drop in adherence rates, the researchers detected a decline among a particular group of veterans. "Of even greater concern was our finding that a similar adverse effect of the co-payment increase was observed in groups at higher risk for coronary heart disease who were using these medications for either primary or secondary prevention," Doshi said. Because of this, she said, "policymakers need to pay particular attention to the fact that a 'one-size-fits-all' approach to designing cost-sharing policies may adversely affect certain higher-risk patients."

As an alternative to an across-the-board increase, Doshi suggested linking co-payments to individual needs: "specifically, lower patient co-payments for higher expected therapeutic benefit and higher co-payments for lower therapeutic benefit." She called that idea "a more promising approach." Dr. Steffie Woolhandler, an associate professor of medicine at Harvard Medical School, said she thinks the study highlights the need for reform that would make medical treatment and medication available to all. "This paper provides striking evidence that co-payments for medications are potentially lethal," Woolhandler said. "Even a seemingly modest increase in the cost of vital medications discourages many patients from taking medications that we know prevent heart attacks and strokes." The finding "adds further evidence that Americans need full coverage, without co-payments or deductibles, if we are to realize the full promise of today's medical advances," she stressed. [Source: HealthDay Steven Reinberg article 15 Jan 09 ++]

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VA INSURANCE DIVIDENDS IN 2009: One million veterans are in line to share $319.8 million in annual insurance dividends during 2009, according to the Department of Veterans Affairs (VA). VA operates one of the nation's largest life insurance programs, providing more than $1 trillion in coverage to seven million service members, veterans and family members. The dividend payments are being sent to an estimated one million holders of VA insurance policies on the anniversary date of their policies. Sent automatically through different payment plans, the amounts vary based on the age of the veteran, the type of insurance, and the length of time the policy has been in force. The dividends come from the earnings of trust funds into which veterans have paid insurance premiums over the years, and are linked to returns on investments in U.S. government securities. VA officials caution veterans about a long-running scam in which various groups charge fees to "locate" veterans who are eligible for the dividends. Veterans eligible for the dividends have had VA life insurance policies in effect since they left the military and have received annual notifications from VA about the policies.

Dividends are paid each year to veterans who served between 1917 and 1956 and who hold certain government life insurance policies. The policies are known by letters that appear at the beginning of each policy's identification number. Following are payments by policy type in 2009:

- World War II veterans holding National Service Life Insurance ("V") policies comprise the largest group receiving 2009 insurance dividend payments. They are expected to receive total payments of $243.8 million.
- An additional group of World War II-era veterans, those who have Veterans Reopened Insurance ("J", "JR" and "JS") policies, will in total receive dividends

of $8.1 million.
• Korean War era veterans who have maintained Veterans Special Life Insurance ("RS" and "W") policies can expect to receive dividends totaling $67.2 million.
• Dividends totaling $725,000 will be paid to veterans who served after World War I until 1940 who hold U.S. Government Life Insurance ("K") policies.

Veterans who have questions about their policies may contact the VA insurance toll-free number at 1-800-669-8477 or send an email to VAinsurance@va.gov. They may also refer to www.insurance.va.gov. [Source: VA News Release 14 Jan 09 ++]

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VA VistA UPDATE 02: Patients at Veterans Affairs health centers around the country were given incorrect doses of drugs, had needed treatments delayed and may have been exposed to other medical errors due to software glitches that showed faulty displays of their electronic health records. The glitches, which began in AUG 08 and lingered until last month, were not disclosed to patients by the Veterans Affairs Department even though they sometimes involved prolonged infusions for drugs such as blood-thinning heparin, which can be life-threatening in excessive doses, according to internal documents obtained by The Associated Press under the Freedom of Information Act. In one case, a patient having chest pains at the VA medical center in Durham, N.C., was given heparin for 11 hours longer than necessary as doctors sought to rule out a heart attack. There is no evidence that any patient was harmed, even as the VA says it continues to review the situation. But the issue is more pressing as the federal government begins promoting universal use of electronic medical records. President George W. Bush has supported the effort and incoming President-elect Barack Obama has made it a top priority, part of an additional $50 billion a year in spending for health information technology programs that he has proposed.

The goal of electronic medical records nationwide is to help avert millions of medical mistakes attributed in part to paper systems, such as poorly written prescriptions. But health care experts say the VA's problems illustrate the need for close monitoring. Veterans groups were also harshly critical, saying the VA's secrecy created a false sense of security. "It's very serious potentially," said Dr. Jeffrey A. Linder, an assistant professor of medicine at Harvard Medical School who has studied electronic health systems. "There's a lot of hype out there about electronic health records, that there is some unfettered good. It's a big piece of the puzzle, but they're not magic. There is also a potential for unintended consequences." The VA's recent glitches involved medical data – vital signs, lab results, active meds – that sometimes popped up under another patient's name on the computer screen. Records also failed to clearly display a doctor's stop order for a treatment, leading to reported cases of unnecessary doses of intravenous drugs such as blood-thinning heparin. The VA said there were nine reported cases in which patients at VA medical centers in Milwaukee, Durham NC, and Marion IN were given incorrect doses, six of them involving heparin drips for patients with chest pain. The other cases involved infusions of either sodium chloride or dextrose mixtures that were prolonged for up to 15 hours past the doctor's prescribed deadline.

The VA noted that veterans with questions or concerns can request a copy of their medical record at any time, such as via the "My HealtheVet" online system at

http://www.myhealth.va.gov. In all, nearly one-third of the VA's 153 medical centers reported seeing some kind of glitch, although the VA said that number could be higher since some facilities may not have filed reports. Stephen Warren, the VA's acting assistant secretary for information technology, said VA hospitals were able to minimize the consequences because they had several alternative systems in place for nurses to check on a patient's treatment. Alert doctors also reported glitches after noticing that a patient's record looked similar to a previous patient's. Warren said the VA was confident that its doctors took proper precautions to avoid harm to their patients. But he added, "VA believes that veterans are active partners in their health care, and encourages patients to always follow up with their health care teams to ensure that their treatment options meet their understanding and their health care needs." Veterans groups questioned the VA's decision to keep the problems quiet. "This is disturbing on a number of levels because of what could have happened," said Veterans of Foreign Wars National Commander Glen Gardner. "Being told that no patients were harmed still does not absolve the VA from its responsibility to forewarn patients that something is amiss. Trust is paramount in doctor-patient relationships, and nothing should ever be allowed to undermine that confidence."

According to interviews and the VA's internal memos, the glitches began after the VA distributed its annual software upgrade last August. By early October, hospitals began reporting the troubling problems: When doctors pulled up electronic records of different patients within 10 minutes of each other to offer treatment advice, the medical information of the first patient sometimes displayed under the second person's name. In some records, a doctor's stop order for intravenous injections also failed to clearly display. The VA issued several safety alerts to medical centers beginning 10 OCT. It also imposed new safety measures until the glitches were fully corrected in December. "Patients can ... be at risk for delay in treatment changes or possible medication errors," according to one internal memo dated 31 OCT. "These changes have resulted in reported delays for stopping continuous infusion orders (e.g., stopping IV heparin drips)." Dr. Bart Harmon, a former Pentagon chief medical information officer who helped coordinate the government's electronic records system from 1997 to 2007, cautioned that the VA's problems could become more common as more hospitals and doctors' offices move toward electronic records. "This is a classic problem in health care – it's hard to get people to invest in prevention," said Harmon, who now works for Harris Healthcare Solutions, an information technology firm based in Melbourne, Fla. "The money tends to drift to obvious risks that are wrong. But safety checks are a new investment that needs to be maintained. [Source: Yahoo Health AP Hope Yen article 14 Jan 09 ++]

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VA VistA UPDATE 03: The chairman of the House committee overseeing the Veterans Affairs Department sharply criticized the agency on Thursday for not publicly disclosing it found a software bug in a computer system in AUG 08 that resulted in not discontinuing drug administration to nine patients. Rep. Bob Filner, (D-CA) chairman of the House Veterans Affairs Committee, wrote that he was "disappointed to learn of troubling new revelations from the Department of Veterans Affairs regarding operating problems with the most recent upgrade to the electronic medical records system." A glitch in a drug administration system for infusion pumps, which deliver intravenous drugs to patients, resulted in placing a doctor's order to discontinue a patient's intravenous drugs at the bottom of a list instead

of at the top, where nurses typically look for it, said Gail Graham, deputy chief information management officer at VA. The software bug affected intravenous medications given to nine patients, Graham said, and none were injured. VA's electronic health record system, managed 1.6 billion transactions in 2008 in the 153 medical facilities the department operates and treated 5.6 million patients, Graham said. Until VA fixed the bug, nurses were instructed to manually check the drug administration system to make sure they had not overlooked an order to discontinue treatment.

The Veterans Health Information Systems and Technology Architecture (VistA) is an enterprise-wide information system built around an electronic health record (EHR), used throughout the United States Department of Veterans Affairs. It is one of the most widely used EHRs in the world servicing over four million veterans. VistA supports both ambulatory and inpatient care, and includes several significant enhancements to the VA's original DHCP (Decentralized Hospital Computer Program) system. The most significant is a graphical user interface known as the Computerized Patient Record System (CPRS) for clinicians released in 1997. In addition, VistA now includes computerized order entry, bar code medication administration, electronic prescribing and clinical guidelines. The adoption of VistA has allowed the VA to achieve a pharmacy prescription accuracy rate of 99.997%, and the VA outperforms most public sector hospitals on a variety of criteria, enabled by its implementation.

The glitch in the computer system was first reported last week by VA Watchdog blog. Filner noted, "VA continues to discover problems and attempts to fix them quietly and internally, and then downplays them as inconsequential and nonthreatening. After numerous offers, VA bureaucrats still refuse to alert Congress to the issues and problems that affect our constituents -- our veterans -- in a timely and proactive way." Filner said he would continue to look into this incident. Rep. Steve Buyer (R-IN) ranking member of the committee said he was "deeply concerned about the consequences on patient care that could have resulted from this 'software glitch,' and that mistakes were not disclosed to patients who were directly affected." Buyer said VA should conduct determine if any veterans were harmed by the glitch. Paul Sullivan, executive director of the Veterans for Common Sense, said, "We remain alarmed at VA's cavalier approach to handling this latest computer malfunction. VA should be more transparent, and VA should have notified and apologized to our veteran patients."

VA advocates should consider the bug in the context of the overall success of its electronic drug administration system, which has reduced medication errors by 86%, said Stephen Warren, the department's acting chief information officer. Electronic medical systems are powerful tools, but software systems are prone to errors, which means heath care organizations need systems that can automatically identify errors, said Ken Farbstein, a consultant who also runs the Patient Safety blog. VA said in a statement that its internal processes and controls catch errors. The glitch with the drug software was "recognized at several VA sites across the country. The patient safety concerns were conveyed through established channels. National alerts were issued to make sure everyone knew about the problems, and the software was repaired. No patients were harmed. The episodes illustrate VA's capability to effectively learn from, and respond to, close calls, recognizing that any problems in its electronic health records system can imperil our patients." [Source: GOVexec.com Bob Brewin article 16 Jan 09 ++]

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HAVE YOU HEARD: An old Navy Chief and an old Marine Gunny were sitting at the VFW arguing about who'd had the tougher career:

'I did 30 years in the Corps,' the Marine declared proudly, and fought in three of my country's wars. Fresh out of boot camp I hit the beach at Okinawa , clawed my way up the blood-soaked sand, and eventually took out an entire enemy machine gun nest with a single grenade. As a sergeant, I fought in Korea alongside General Macarthur. We pushed the enemy inch by bloody inch all the way up to the Chinese border, always under a barrage of artillery and small arms fire. Finally, as a gunny sergeant, I did three consecutive combat tours in Vietnam. We humped through the mud and razor grass for 14 hours a day, plagued by rain and mosquitoes, ducking under sniper fire by day and mortar fire all night. In a firefight, we'd fire until our arms ached and our guns were empty, then we charge the enemy with bayonets'.

'Ah', said the Sailor with a dismissive wave of his hand. 'Lucky bastard, all shore duty, huh?

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VETERAN LEGISLATION STATUS 30 JAN 09: Refer to the Bulletin's Veteran Legislation attachment for or a listing of Congressional bills of interest to the veteran community that have been introduced in the 111th Congress. Support of these bills through cosponsorship by other legislators is critical if they are ever going to move through the legislative process for a floor vote to become law. A good indication on that likelihood is the number of cosponsors who have signed onto the bill. Any number of members may cosponsor a bill in the House or Senate. At http://thomas.loc.gov you can review a copy of each bill's content, determine its current status, the committee it has been assigned to, and if your legislator is a sponsor or cosponsor of it. To determine what bills, amendments your representative has sponsored, cosponsored, or dropped sponsorship on refer to http://thomas.loc.gov/bss/d111/sponlst.html. The key to increasing cosponsorship on veteran related bills and subsequent passage into law is letting our representatives know of veteran's feelings on issues. You can reach their Washington office via the Capital Operator direct at (866) 272-6622, (800) 828-0498, or (866) 340-9281 to express your views. Otherwise, you can locate on http://thomas.loc.gov your representative and his/her phone number, mailing address, or email/website to communicate with a message or letter of your own making. Refer to http://www.thecapitol.net/FAQ/cong_schedule.html for dates that you can access your representatives on their home turf. [Source: RAO Bulletin Attachment 13 Jan 09 ++]

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