

> RAO Bulletin Update

> 1 November 2007

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> -- VA Budget 2008 [08] (Rhetorical Firefight Escalates)

> -- Cell-phone Scare Message (FTC debunks)

> -- Remote Infrared Audible Signs (VA hospital use)

> -- Alzheimer's [04] (Progress Cited in Diagnosis)

> -- VA Fraud [02] (Concealed 2nd Marriage)

> -- VA Cancer Reporting Policy (Hampering Research)

> -- FTC Fraud Survey (30.2 million Adults defrauded)

> -- Veteran Legislation Status 29 Oct 07 ... (Where We Stand)

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> Note: Tricare initiated coverage for the Shingles vaccine effective 19 OCT 07.

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> MEDICARE PART "D" UPDATE 17: Three lawmakers have introduced legislation in the House and Senate to establish a Medicare-administered drug benefit that would compete with private plans currently offered under Part D. The law's introduction was announced by Representatives Marion Berry (D-AR) and Jan Schakowsky (D-IL) at an 23 OCT press call scheduled to publicize both the legislation and a report by the Medicare Rights Center (MRC) and Consumers Union assessing the shortcomings of private Part D plans and the advantages of providing a public option. The Medicare Prescription Drug Savings and Choice Act of 2007, sponsored by Senator Richard Durbin (D-IL) in the Senate and co-sponsored by Representatives Schakowsky and Berry in the House, would offer a public drug plan administered by Medicare with a nationally uniform premium, formulary (list of drugs covered) and cost-sharing requirements. The legislation would require the Secretary of the Department of Health and Human Services to use the breadth of the nationwide formulary to negotiate lower drug prices from pharmaceutical companies.

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> According to the MRC & Consumers Union report, The Best Medicine: A Drug Coverage Option Under Original Medicare, the privatized delivery of Medicare drug coverage has resulted in coverage gaps created by inconsistent formularies and an ineffective appeals process. Changing formularies and premiums has meant instability in coverage for people with Medicare, particularly those with low incomes, according to the report. In a related development, the House of Representatives Committee on Oversight and Government Reform released a report showing the high administrative costs associated with using insurance companies to deliver Part D coverage. Total administrative costs for Part D amounted to 9.8% of the total cost of the program. In comparison, overhead and administrative costs amount to only 1.7% of the cost of original Medicare.

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> In testimony given at an 16 OCT hearing held by the House of Representatives Committee on Ways and Means Subcommittees on Health and Oversight it was revealed that private Medicare plan benefit packages are not adequately regulated by the federal government, resulting in inadequate financial protections for plan enrollees and unpredictable cost-sharing requirements for expensive health services. The subcommittees were convened in response to a JUL 07 report by the GAO, Required Audits of Limited Value, which found that the Centers for Medicare & Medicaid Services had not met the legal requirement to audit at least one-third of private Medicare plans. Instead, the proportion of companies audited decreased from 23.6% in 2001 to 13.9% in 2006. Paul Precht, deputy policy director at the Medicare Rights Center, provided testimony on the lack of federal regulation of plan benefit packages, which allows plans to charge higher prices than Original Medicare for high-cost services and carve-out specific services, such as chemotherapy and other doctor-administered drugs, from yearly out-of-pocket spending limits. [Source: Medicare Watch newsletter 30 Oct 07 ++]

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> VA BUDGET 2008 UPDATE 09: In a risky change of strategy, Democrats are pursuing a plan that would dare President Bush to veto a massive bill that combines spending for veterans care, education and the Pentagon. The

package, which combines three bills into one, would total almost \$675 billion in discretionary spending for the fiscal year that began 1 OCT. Of this, more than 70% is defense-related. The rest is expected to incorporate about \$14 billion more for domestic priorities than Mr. Bush has requested. The plan is a significant tactical change. Democrats had been expected to treat the three bills individually and send them to the White House in a sequence that allowed the party to spell out its priorities. Supporters of the new, more-unified approach say it better serves the party's political message by melding national security and domestic issues. But they also concede it could prove a confrontational, gamble that risks alienating Republican moderates whose support is vital if Congress is to convince the White House to negotiate over domestic spending. Education, veterans' health care and medical-research programs would most benefit from the added \$14 billion. That is about a third of the growth in defense spending over 2007 -- a contrast Democrats will try to draw in the unified bill.

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> At the same time, the leadership wants to showcase a commitment to fiscal discipline by cutting special spending projects for lawmakers known as "earmarks" by 40% from 2006 levels, when Republicans controlled Congress. House-Senate negotiators hope to agree on the individual pieces by 31 OCT, after which a final decision must be made on assembling the package. House Appropriations Committee Chairman David Obey (D-WI) appears to be leaning toward the new option in hope of combining enough popular interests to override any veto. White House officials say the inclusion of defense spending in the bill won't alter Mr. Bush's willingness to use his veto power, however. The recent fight over child health insurance suggests that if Democrats are seen as being too political, they won't win over the moderate Republicans they need to prevail. Just last week, for example, House Democrats failed for the third time to get a veto-proof majority for their health bill. Moderates complained Speaker Nancy Pelosi (D-CA) failed to include them adequately in shaping the newest version.

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> The same could happen in the budget fight now. In an interview last week Sen. Thad Cochran (R-MS), senior Republican on the Senate Appropriations Committee, signaled a willingness to intercede with the White House to try to reach some compromise on spending. But when told yesterday of the new proposal to bundle bills together, he was much cooler. "The Democrats are not going to win my support by packaging the bills together," Mr. Cochran said. The fact that Democrats are still debating their legislative strategy this far into the fiscal year reflects the extraordinary confusion surrounding the budget debate this fall. No one predicts a government shutdown, but the Democratic majority faces a lame-duck president who has interpreted the 2006 elections as a call to vigorously exercise his veto power against spending. As a result, none of the 12 annual spending bills has been approved and most of the government has been left to operate under a stopgap spending resolution due to expire 16 NOV.

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> The heart of the dispute lies in about \$22 to \$23 billion that would be added to Mr. Bush's requests for domestic programs such as veterans' care, education, medical research and law enforcement. The \$14 billion in the proposed package constitutes about two-thirds of this money, and Democrats hope to draw a contrast between the increases they want and the much larger increases Mr. Bush will get for his defense priorities. The big exception is funding for the Iraq and Afghanistan military operations, which

Mr. Bush designated "emergency" expenditures outside the budget caps. The president wants almost \$190 billion, of which defense negotiators were prepared to provide a down payment of up \$50 billion added to the core Pentagon budget bill. But if the Pentagon budget is to be combined with education and veterans funds, Democrats won't want any Iraq-related money in the bill since it would make it harder for their liberal members to back the package. [Source: Wall Street Journal David Rogers article 30 Oct 07 ++]

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> VA DIVERTING PATIENTS: James A. Haley VA Medical Center in Tampa and Bay Pines VA Medical Center in St. Petersburg are the nation's busiest and fourth-busiest Veterans Affairs hospitals, respectively. Haley has been on "divert" status for critical patients 27% of the time since 1 JAN 06, or the equivalent of about 170 days, VA figures reviewed by the St. Petersburg Times show. The hospital diverts all patients regardless of condition 16% of the time. Since 2000, Bay Pines has diverted patients far more frequently than any other hospital in Pinellas County. Last year, it diverted veterans during 1,150 hours about 48 days, or 13% of the time, Pinellas paramedic records show. "There's no intent to deny veterans care," said Dr. George Van Buskirk, chief of staff at Bay Pines. "I like to think we're as compassionate as possible. We'd rather send them out to a place that can take care of them than have them languish on a gurney in the hallway." But some question the VA's resources. "The VA has never dealt with its capacity issues seriously," said Bill Geden, district director in west-central Florida for the Blinded Veterans Association. "They're underfunded, undermanned and overloaded." In one instance, Bay Pines said it "made a rare mistake" last June when it turned away a non-veteran who suffered a fatal heart attack 200 feet from its emergency room.

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> The VA says it cannot assess how the Florida hospitals' diversion rates compare to others nationally. But officials at both Haley and Bay Pines say they are making it a priority to achieve better performance. In 2003, for example, Bay Pines diverted paramedics 2,464 hours or 28% of the time. Similar statistics were posted in 2004. This year, Bay Pines is diverting about 7% of the time, roughly 500 hours so far. Haley's diversion numbers have not improved in recent years, though it also has expanded its emergency care and hired three "bed czars." Meanwhile, the number of patients treated at both hospitals is on the rise.

> "It's like putting your finger in a dike, actually," said Dr. Edward Cutolo, Haley's chief of staff. Bay Pines treated 49,800 patients in 2000 and tallied 516,000 outpatient visits. In 2006, the numbers increased to 95,000 and 1.1 million. The problem is not specific to VA hospitals. About 36% of all hospitals reported going on diversion, a survey by the American Hospital Association shows. "It's a crisis across America, not just the VA," said Michael O'Rourke, assistant director of veterans health policy at the Veterans of Foreign Wars. "There's a shortage of emergency room physicians, and there's a shortage of beds, and there's a shortage of nursing staff." [Source: Associated Press article 29 Oct 07 ++]

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> VA GUARDIAN: Payment of benefits to a duly recognized fiduciary may be made on behalf of a person who is mentally incompetent or who is a minor; or, payment may be made directly to the beneficiary or to a relative or other person for the use of the beneficiary, regardless of legal disability, when it is determined to be in the best interest of the beneficiary by the

VA's Veterans Service Center Manager. Unless otherwise contraindicated by evidence of record, payment will be made direct to the following classes of minors without any referral to the Veterans Service Center Manager:

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> . Those who are serving in or have been discharged from the military forces of the United States; and

> . Those who qualify for survivors benefits as a surviving spouse.

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> Unless otherwise contraindicated by evidence of record, immediate payment of benefits may be made to the spouse of an incompetent veteran having no guardian for the use of the veteran and his or her dependents prior to referral to the Veterans Service Center Manager under the following circumstances:

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> . When payments have been discontinued or withheld from a fiduciary, benefits may be temporarily paid to the person having custody of the minor or incompetent.

> . Where a child is in the custody of a natural, adoptive or stepparent, benefits payable on behalf of such child may be paid to the parent as custodian of the child.

> . Benefits due a minor or incompetent adult Indian who is a recognized ward of the Government, for whom no fiduciary has been appointed, may be paid to the proper officer of the Indian Service designated by the Secretary of the Interior to receive funds for said person.

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> Guardians are allowed to keep a percentage of the VA payments if the state in which they reside allows it. In Florida this is 5%. [Source:

www.warms.vba.va.gov/regs/38CFR/BOOKB/PART3/S3_850 Oct 07 ++]

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> VA TIDBITS:

> . The law provides a grant not to exceed \$5,500 for certain disabled veterans toward the purchase of an automobile. If a veteran received this grant when the amount was lower, he cannot use the difference toward the purchase of another automobile. A veteran with a qualifying service-connected disability or disabilities may receive only one VA automobile grant.

> . There is no limit to the number of times VA can furnish specially adapted equipment for a veteran's automobile. For qualifying veterans, VA will pay for the purchase, repair, replacement, or reinstallation of adaptive equipment needed for the safe operation of a vehicle.

> . A veteran does not have to be rated 100% in order to be eligible for an automobile grant. If he or she has lost the use of a limb and that injury is service-connected, he or she meets the eligibility requirements.

> . Divorce terminates all eligible for a spouse to receive any part of a veterans disability compensation when it becomes final.

> . Under the improved pension plan all other VA compensation and/or pensions are counted as income. The VA will not accept an election of improved pension unless it is to your advantage.

> . The VA audits the periodic guardianship accountings that are required by the Probate Court. If discrepancies are discovered, the Probate Court is notified and asked to take corrective action. The welfare and needs of disabled veterans under guardianship are monitored by VA Field Examiners who make periodic visits with these veterans. Unattended needs or adverse conditions are reported to the guardian or, if necessary to the Probate

Court for required action.

> . If a veteran dies in a VA hospital, for confidentiality reasons the VA does not put a death notice or obituary in the local newspaper or newspaper from where the veteran lived. Such notices are at the discretion of the veteran's family or guardian and are handled either by the funeral home with the family's guidance, or by the family itself.

> [Source: www.va.gov Oct 07 ++]

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> BIOTAPE REFUNDS: Smart Inventions, Inc. and Jon Nokes have entered into a settlement agreement that will provide up to \$2.5 million in consumer refunds to purchasers of the Biotape, an adhesive product that was falsely claimed to relieve pain when applied to the skin. In addition, a federal district court has ruled that Darrell Stoddard, the tape's inventor who appeared in a nationally televised infomercial, must give up the \$86,000 he received from infomercial sales. The FTC had charged that all three defendants deceptively claimed that Biotape provided significant, permanent relief from severe pain and was superior to other pain-relief products. The infomercial claimed that Biotape was "a space age conductive mylar that connects the broken circuits that cause . . . pain." The agency will contact consumers regarding refunds. For more information refer to <http://www.ftc.gov/opa/2007/09/biotape.shtm>. [Source: FTC news release 18 Sep 07 ++]

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> VA FLAG-FOLDING RECITATION BAN: Complaints about religious content have led to a ban on flag-folding recitations by Veterans Administration employees and volunteers at all 125 national cemeteries. It all started because of one complaint about the ceremony at Riverside National Cemetery in California. During thousands of military burials, the volunteers have folded the American flag 13 times and recited the significance of every fold to survivors. For example, the 12th fold glorifies "God the Father, the Son and Holy Ghost." The complaint revolved around the narration in the 11th fold, which celebrates Jewish war veterans and "glorifies the God of Abraham, the God of Isaac and the God of Jacob." The National Cemetery Administration decided to ban the entire recital at all national cemeteries. Details of the complaint weren't disclosed. VA spokesman Mike Nacincik said the new policy outlined in a 27 SEP memorandum is aimed at creating uniform services throughout the military graveyard system. He said the 13-fold recital is not part of the U.S. Flag Code and is not government-approved.

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> Veterans and honor detail volunteers, including Bobby Castillo, 85, and Rees Lloyd, 59, are furious. "That the actions of one disgruntled, whining, narcissistic and intolerant individual is preventing veterans from getting the honors they deserve is truly an outrage. These are decisions that should be made by the families of our deceased veteran comrades and not by Washington bureaucrats" Lloyd said. "This is another attempt by secularist fanatics to cleanse any reference to God." Lloyd, who is a California civil rights attorney, says he and his allies at the Alliance Defense Fund are considering their legal options. World War II Navy veteran Castillo said it's "a slap in the face to every veteran. When we got back from the war, we didn't ask for a whole lot," Castillo said. "We just want to give our veterans the respect they deserve. No one has ever complained to us about it. I just don't understand." Lloyd and Castillo are part of a 16-member detail that has performed military honors at more than 1,400

services. They were preparing to read the flag-folding remarks at the Riverside cemetery when graveyard staff members stopped them.

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> Charlie Waters, parliamentarian for the American Legion of California, said he's advising memorial honor details to ignore the edict. "This is nuts," Waters told the Riverside Press-Enterprise by telephone from Fresno. "There are 26 million veterans in this country, and they're not going to take us all to prison." An American Legion commander in California says he and other veterans will defy the new ban. VA spokesman Nacincik said that though the flag-folding narrative includes references to God that the government does not endorse, the main reason for the new rules is uniformity. "We are looking at consistency," Nacincik said. "We think that's important." Rabbi Yitzhak Miller of Temple Beth El said he understands the ban. "It is a perfect example of government choosing to ignore religion in order to avoid offending some religions," Miller said. "To me, ignoring religion in general is just as problematic as endorsing any one religion." [Source: AP OneNewsNow.com article 26 Oct 07 ++]

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> VA FLAG-FOLDING RECITATION BAN UPDATE 01: To ensure burial services at the 125 national cemeteries operated by the Department of Veterans Affairs (VA) reflect the wishes of veterans and their families, VA officials have clarified the Department's policy about recitations made while the U.S. flag is folded at the gravesite of a veteran. "Honoring the burial wishes of veterans is one of the highest commitments for the men and women of VA," said William F. Tuerk, VA's Under Secretary for Memorial Affairs. "A family may request the recitation of words to accompany the meaningful presentation of the American flag as we honor the dedication and sacrifice of their loved ones." Traditional gravesite military funeral honors include the silent folding and presentation of an American flag, a 21-gun rifle salute, and the playing of "Taps." The clarification includes the following:

> . Volunteer honor guards are authorized to read the so-called "13-fold" flag recitation or any comparable script;

> . Survivors of the deceased need to provide material and request it be read by the volunteer honor guards; and

> . Volunteer honor guards will accept requests for recitations that reflect any or no religious traditions, on an equal basis.

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> Veterans with a discharge other than dishonorable, their spouses and eligible dependent children can be buried in a national cemetery. Other burial benefits available for all eligible veterans, regardless of whether they are buried in a national cemetery or a private cemetery, include a burial flag, a Presidential Memorial Certificate and a government headstone or marker. [Source: VA News Release 30 Oct 07 ++]

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> AGENT ORANGE LAWSUITS UPDATE 10: The Haas vs. Department of Veterans Affairs case is going to be argued on 7 NOV at the US Court of Appeals for the Federal Circuit. This case has implications far beyond the payment or continuing non-payment of Agent Orange related benefits to Blue Water Navy sailors who never set foot on the ground. If the lower court (the US Court of Appeals for Veterans Claims) is upheld in tissue 06 decision, the DVA will be forced to begin processing claims for, and paying benefits to US Navy, Coast Guard, and Marine Corps, [and possibly Merchant Marine] veterans who served off the coast of Vietnam during the war, but never set foot on

the ground. In essence, the decision reverts to the policy of granting presumptive eligibility to anyone who was rewarded the Vietnam Service Medal, or the Armed Forces Expeditionary Medal for service in Vietnam, a policy which was in effect from the enactment of the Agent Orange Act of 1991 until the DVA erroneously and unilaterally stop paying benefits to Blue Water Navy Veterans in 2002. But, the case, once it is upheld, will also, by dint of the presumptive service connection, create a new class of potential litigants in lawsuits against the chemical companies that manufactured the dioxin based defoliants, but also the United States Government, which specifically demanded the chemical composition to be delivered by the chemical manufacturers.

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> It is the reason cited in the paragraph above on which the decision in Haas rests. The government escaped the Agent Orange Class Action Lawsuit of the 1990s as part of a structured deal going into litigation -- otherwise it would never have been settled. That may now be a moot point, however. The folks at BlueWaterNavy.org, the former Blue Water Navy Forum at Yahoo Groups, and the VNVets Blog have organized the Blue Water Navy Vietnam Veterans Association, and in doing so, have achieved class action size and status. Regardless of how the court rules in Haas, the option now exists to litigate a new class action settlement from both the Agent Orange chemical companies and the government. The new association is a unified focal point for blue water navy veterans and all of their issues, including the addition to the list of diseases, and subsidiary diseases and conditions currently authorized for payment under the Agent Orange Act. Keep in mind, a law suit is not a guaranteed outcome, nor is inclusion in it guaranteed. Often, those variables are negotiated prior to litigation, and sometimes during the suit.

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> One of the things being looked at is the cross reference of spray maps and the locations of ships off shore vs. AO conditions in veterans who were on those ships at that time. The association has already begun collecting data. Instructions for enrollment in the association are available via the BlueWaterNavy Forum at <http://bluewaternavy.org/phpBB2/index.php>. Interested veterans and their wives, widows, and/or children are invited to register and log in to the forum. Membership in the forum is not the same as membership in the Association, nor is membership in either one automatic. Membership is open to Blue Water Navy Veterans, USMC Veterans and USCG and USMM Veterans who served off the coast of Vietnam during the war and did not set foot on the ground. Veterans Advocates can also enroll regardless of their service background. [Source: Blue Water Navy Vietnam Veterans Association notice 26 Oct 07 ++]

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> VA FLU SHOTS UPDATE 01: To safeguard the health of America's veterans, the Department of Veterans Affairs (VA) is urging all veterans, especially those enrolled in VA's health care system, to receive flu vaccinations this season. Walk-in clinics, even drive-in clinics for the vaccinations- which are free for veterans enrolled in VA's health care system-are being offered at many of VA's 153 hospitals and more than 900 outpatient clinics. Veterans should check with their nearest VA health care facility to learn about local vaccination programs. "Vaccination is a simple way of preventing serious health care problems, especially among the elderly, those with compromised immune systems and veterans with spinal cord injuries," said

Acting Secretary of Veterans Affairs Gordon H. Mansfield. "Part of VA's health care service is ensuring veterans get their flu shots." Veterans should discuss flu vaccinations with their primary health care provider. Physicians recommend flu vaccinations for pregnant women, people with chronic medical conditions, those at least 50 years of age, patients in long-term care facilities, and people who live with those at high risk for complications from flu. A recent study by Dr. Kristin Nichol, a nationally recognized expert on the flu and chief of medicine at the Minneapolis VA Medical Center, found dramatic reductions in deaths and sickness after getting a flu shot. Vaccination reduced hospitalizations for pneumonia or influenza by 27%, and there was a 48% reduction in deaths. In addition to information about flu vaccines available in VA's medical centers and clinics, VA maintains information for consumers on its Web site at: <http://www.publichealth.va.gov/flu/>. [Source: VA Media Relations 25 Oct 07 ++]

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> TRICARE FLU IMMUNIZATION: Fall is the best time to get the flu vaccination in the United States, according to health officials. This gives the body a chance to build up immunity before the winter flu season. "Tricare beneficiaries should check with their local military treatment facility or primary care manager to find out when and where they are offering the flu vaccine," said Army Major General Elder Granger, Deputy Director, Tricare Management Activity (TMA). "All beneficiaries are encouraged to protect themselves against this potentially deadly virus." Influenza kills about 36,000 Americans each year, and leads to about 200,000 hospitalizations, according to the Centers for Disease Control and Prevention. It is strongly recommended that the following people get vaccinated each year: all children aged six months to their fifth birthday; adults aged 50 years and older; persons with underlying chronic medical conditions; pregnant women; health care workers involved in direct patient care; child care and elderly care workers; and persons at high risk for severe complications from influenza. Tricare will cover the Flu shots administered in a civilian pharmacy or drugstore are not covered by Tricare. For Tricare for Life beneficiaries, Medicare covers flu vaccinations and Tricare would pay as second payer, if needed. Tricare covers two types of vaccinations; the inactivated vaccine containing a killed virus and given with a needle, and the nasal-spray flu vaccine made with live, weakened flu viruses that do not cause the flu. For more information about influenza refer to www.cdc.gov/flu/. For more information about your Tricare benefits refer to www.Tricare.mil. [Source: TMA Press Release 07-76 dtd 25 Oct 07 ++]

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> VA SECRETARY UPDATE 03: The Secretary of Veterans Affairs presides over the U.S. government's second largest Cabinet department, after Defense. It is a politically sensitive job, especially of late, with new studies showing that the Bush administration has vastly underestimated the cost of providing health care to the more than 750,000 soldiers who have returned home from the wars in Iraq and Afghanistan. But three months ago, former secretary James Nicholson resigned abruptly after a difficult tenure and tension among vets is rising because the White House still hasn't nominated a replacement. Some veterans advocates say the VA is in such disarray that the White House has been unable to find a top-notch candidate willing to take the job, much less go through a confirmation hearing. "Who wants to come in for 15 months

and take over a department that has been left in shambles?" asks Paul Sullivan, a former VA official who now heads Veterans for Common Sense. White House spokeswoman Emily Lawrimore declined to comment on particular candidates, but says, "We are working hard to nominate a highly qualified individual." She adds that the White House hopes to announce a nominee "soon."

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> In response to criticism over the issue, President Bush has unveiled new proposals to revamp the health-care and disability system for vets, partly by streamlining the bureaucracy. Days later, USA Today reported the results of a new internal VA study showing that the number of Iraq and Afghanistan vets diagnosed with post-traumatic-stress disorder is rising rapidly, from 29,041 a year ago to 48,559 this year. Few of these soldiers are even counted in the Pentagon's official tally of 27,753 wounded in Iraq. Yet a Pentagon task force recently concluded that the number of mental-health professionals available to vets is woefully inadequate, and the average wait time for disability claims is six months. Linda Bilmes, a policy analyst at Harvard who will testify before Congress this week, calculates that over the next decade, the disability costs for vets will be at least \$60 billion-more than six times the administration's official projections. The numbers coming out of government budget offices, she says, are significantly underestimating the reality. All this has angered some vets and their families. "I would love to have the president live my life for one week to see how difficult it is," says Annette McLeod, wife of Army specialist Wendell McLeod, who is suffering from PTSD after serving in Iraq. "How do you fund a war but not fund the casualties?" [Source: Newsweek magazine Michael Isikoff and Jamie Reno article 29 Oct Issue ++]

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> VA SECRETARY UPDATE 04: President Bush on 30 OCT nominated retired Army Lt. Gen. James Peake to direct the embattled Department of Veterans Affairs, which is strained by the influx of wounded troops returning from Iraq and Afghanistan. "He will work tirelessly to eliminate backlogs and ensure that our veterans receive the benefits they need to lead lives of dignity and purpose," Bush said. Peake, 63, is a physician who spent 40 years in military medicine and was decorated for his service in Vietnam. He retired from the Army in 2004 after being lead commander in several medical posts, including four years as the U.S. Army surgeon general. The nomination comes as the administration and Congress struggle to find clear answers to some of the worst problems afflicting wounded warriors, such as adequate mental health treatment and timely payment of disability benefits.

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> Peake currently is chief medical director and chief operating officer of QTC Management Inc., which provides government-outsourced occupational health, injury and disability examination services. If confirmed by the Senate, Peake would lead the government's second-largest agency with 235,000 employees in the waning months of the Bush administration. In his new post, Peake, the son of a medical services officer and Army nurse, would manage the VA, criticized for poor coordination in providing medical treatment and disability benefits to millions of veterans. Earlier this year, a presidential commission chaired by former Sen. Bob Dole, R-Kan., and Donna Shalala, former Health and Human Services Secretary during the Clinton administration, proposed sweeping change that could add to the VA's backlogged system by shifting most of the responsibility in awarding disability benefits from the Pentagon to the VA. The VA's backlog is between

400,000 and 600,000 claims, with delays of 177 days. Former Secretary Nicholson in May pledged to cut that time to 145 days, but little headway has been made with thousands of veterans from Iraq and Afghanistan returning home. "There is a lot of work to be done as we move forward on implementing the Dole-Shalala commission recommendations," Peake said. "The disability system is largely a 1945 product, 1945 processes around a 1945 family unit. About everybody that has studied it recently said it is time to do some revisions." Sen. Patty Murray, D-Wash., a member of the Senate Veterans Affairs Committee, said Peake will have to prove he is up to the task of improving the beleaguered veterans care system.

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> Peake, a graduate of the U.S. Military Academy at West Point, was awarded the silver star and purple heart for his service in Vietnam as a platoon leader with the 101st Airborne Division. He was wounded twice in battle and received his acceptance letter to Cornell University Medical College while in the hospital recovering from injury. As surgeon general of the U.S. Army, he commanded 50,000 medical personnel and 187 army medical facilities across the world. He also was commanding general of the U.S. Army Medical Department Center and School. From 2004 to 2006, Peake was executive vice president and chief operating officer of Project HOPE, a nonprofit international health foundation. While at HOPE, he helped organize civilian volunteers aboard the Navy hospital ship Mercy as it responded to the tsunami in Indonesia and aboard the hospital ship Comfort which responded to Hurricane Katrina. Joe Davis, a spokesman for Veterans of Foreign Wars, said Peake appeared to be a strong nominee who will nevertheless face many difficult challenges at the VA. "He will inherit a department that continues to face significant challenges, ranging from the influx of a new generation of disabled veterans and an uncontrollable claims backlog, to not having an on-time budget for eight consecutive years," Davis said. "He will walk into tremendous challenges on day one." [Source: Associated Press Deb Riechmann article 30 Oct 07 ++]

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> DOD DISABILITY EVALUATION SYSTEM UPDATE 07: The Defense Department will soon unveil a new, streamlined disability evaluation system that, in tandem with the Department of Veterans Affairs, will replace the current cumbersome process with a single exam and single disability rating. According to a copy of the plan obtained by Military Times and confirmed by Pentagon officials, veterans medically retired from service will be able to apply for, and get, VA benefits immediately. Overall, the time spent in the system, from the point a service member is found unfit for duty until he begins receiving VA disability payments, will be cut "by about half," said to Bill Carr, undersecretary of defense for military personnel policy. The plan is the Pentagon's best effort to make some fixes to the system immediately, without having to seek congressional approval. A broader, longer-range plan unveiled by the White House on 16 OCT, based on recent recommendations from a blue-ribbon commission, will require congressional approval and will take longer to implement. The Pentagon's interim plan will be phased in with a pilot program to be launched in late November at three military hospitals: Walter Reed Army Medical Center in Washington , D.C.; National Naval Medical Center in Bethesda , MD ; and Malcolm Grove Medical Center at Andrews Air Force Base, MD. The plan will expand to other facilities as officials evaluate its effectiveness, with the emphasis on facilities that treat greater numbers of troops wounded in the wars. Carr said expansion will take place as fast as it can.

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> The plan, a top priority of Defense Secretary Robert Gates, is the Pentagon's answer to the Walter Reed scandal earlier this year in which media reports described wounded troops caught in tangle of red tape during their treatment and subsequent medical evaluations. The problems were complicated by the slow-moving VA benefits process and poor coordination between VA and the Pentagon - and exacerbated by the wars in Iraq and Afghanistan, in which more than 28,000 troops have been wounded, more than 13,600 of them seriously. The new program will evaluate all service members equally, regardless of how their condition developed. Each service now does its own physical exam during the process leading to possible separation, and each service member is rated for his condition. A member medically separated or retired who then seeks VA care faces another physical exam and yet another rating. The single exam will be administered to troops as part of the standard Medical Evaluation Board (MEB), which determines a member's fitness for duty. But instead of a military doctor, a VA-qualified provider with access to the member's medical records will perform the exam. In addition to evaluating conditions that could make the member unfit for service, the doctor will also consider problems the member may say have been incurred in or aggravated by military service.

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> If the MEB, which also considers a commanding officer's input, decides the member does not meet retention standards, the case is referred to a Physical Evaluation Board (PEB). This board decides whether to retain, separate or return the member to duty and, under the current system, can determine the nature and amount of military disability benefits. Troops will retain the right to appeal this decision to a formal PEB. But if the original finding is confirmed, the new system will allow troops to have any single condition or rating reconsidered by a VA decision review officer while still on active duty. As it now stands, if a member is rated by the military as at least 30% disabled, he is medically retired. Unless the member served more than 20 years, a rating below 30% calls for medical separation and, under some conditions, a lump-sum, one-time payment. In the new plan, the military no longer will issue ratings; that will be solely the VA's job. But until the law is changed, the military will continue to base its disability ratings decisions only on those conditions that make a member unfit for continued service. For example, if a member is rated as 20% disabled for a knee injury and 10% disabled for hypertension, the military's rating for the purpose of deciding whether to keep or release the member would be 20%, since hypertension is treatable, Carr said. In contrast, VA would use the total rating of 30% to calculate disability compensation for that member, using its own formula.

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> That disparity would vanish if Congress adopts the plan announced 16 OCT by President Bush, Carr said. But while that plan faces competition from separate wounded warrior legislation introduced in the House and Senate, Carr said the essence of the new Pentagon plan likely will stand no matter what happens with follow-on efforts. Carr agreed that the shock of the Walter Reed scandal and Gates' subsequent push to fix the problems sped the process along. But he said three congressionally mandated Pentagon executive groups had been looking at such changes for the past two years. In summary following is a summary of the current, pilot, and future plans:

> . Current plan - DoD & VA run separate disability evaluation and ratings systems, each with its own standards for medical exams and separate processes for setting the level of disability, which in turn determines the

military disability retirement pay or severance pay from the Defense Department and the amount of VA disability compensation.

> . Pilot plan -- An interim program would eliminate the separate military and veterans health exams and separate systems of awarding a disability rating. Injured troops would undergo a single exam and get a single rating based on VA's ratings schedule. DoD would continue paying disability retired pay and severance pay, while the VA would continue paying disability compensation.

> . Future plan -- If Congress approves a White House plan, DoD's role in disability decisions would be reduced to ruling on whether a person is fit to continue military service. Those found unfit would get a pension based on their rank and years of service. VA would then determine the level of disability. Based on that rating, an individual would receive enhanced disability compensation featuring several components - the basic disability payment, plus a transition payment equal to a minimum of three months of basic pay, plus a payment based on an assessment of how the disability has diminished the veteran's quality of life and the potential loss of future income. The exact levels of pay would be determined by a proposed seven-month study.

> [Source: ArmyTimes William McMichael article 29 Oct 07 ++]

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> PENNSYLVANIA VET AGENCY: A comprehensive study issued in OCT 07 supports state Sen. Richard A. Kasunic's bill calling for separate state government departments to serve the needs of Pennsylvania's military personnel and its veterans. Kasunic, who has served as Democratic chairman of the Senate Committee on Veterans Affairs & Emergency Preparedness, estimated the Keystone State is home to 1.3 million veterans. The 154-page Legislative Budget and Finance Committee study's first recommendation calls for a new cabinet-level Department of Veterans Affairs. Kasunic has introduced this measure in every legislative session dating to 1983. According to the study, the federal government annually spends an average of \$545 less on Pennsylvania veterans than on vets who reside in other states. Kasunic said that amounts to \$610 million fewer federal dollars, and \$1.4 billion in lost economic activity. Study recommendations include:

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> . Establishing a separate state Department of Veterans Affairs.

> . Funding the new department with its share of assets from the current DoD & VA, and supplementing the new agency with about \$14 million annually. The study claims that simply separating the department without providing supplemental dollars would do little more than drain already existing program resources.

> . Establishing a state or county Veterans' Service Officer, as well as overseeing the management and funding of the Governor's Veterans Outreach and Assistance Centers.

> . Providing at least \$10 million in the next five years to refurbish the Scotland School for Veterans' Children in Franklin County. The new department would be located at the facility.

> . Increasing monthly benefits in the Educational Gratuity, Blind Veterans' Pension and Paralyzed Veterans' Pension Programs.

> . Changing the law, which excludes veterans younger than 60, to allow any honorably discharged veteran to serve on the State Veterans' Commission.

> . Transferring the Governor's Outreach Assistance Center to the new department.

> [Source: The Tribune-Democrat article 21 Oct 07 ++]

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> VA MRSA TESTING UPDATE 01: Lately the news has been saturated with stories on the increasing rates of methicillin-resistant staphylococcus aureus (MRSA) infections in the United States. The VA wants veterans to know they have taken proactive steps to combat the infection at each of its 153 hospitals and are placing greater emphasis on hygiene and screening procedures to help control spread of the disease. The new disease control plan is based on a pilot program that reduced the worrisome staph infection rate by 70% at a VA facility earlier this year. "VA demonstrated that dramatic reductions in MRSA-related infections are possible," said Acting Secretary of Veterans Affairs Gordon H. Mansfield. "VA's completion of our national deployment of these serious prevention measures reinforces VA's stature as one of the safest health care environments nationally." [Source: NAUS Weekly Update 19 Oct 07 ++]

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> MRSA resists many antibiotics and is presently killing more people annually than AIDS, emphysema or homicide, taking an estimated 19,000 lives in 2005, according to a study published in the Journal of the American Medical Association. The best defense against the potentially deadly infection is common sense and cleanliness. Community-acquired staph infections, or CA-MRSA is primarily a skin infection. It often resembles a pimple, boil or spider bite, but it quickly worsens into an abscess or puss-filled blister or sore. Patients who have sores that won't heal or are filled with pus should see a doctor and ask to be tested for staph infection. They should not squeeze the sore or try to drain it - that can spread the infection to other parts of the skin or deeper into the body. The vast majority of MRSA cases happen in hospital settings, but 10 to 15% occur in the community at large among otherwise healthy people. Infections often occur among people who are prone to cuts and scrapes, such as children and athletes. MRSA typically spreads by skin-to-skin contact, crowded conditions and the sharing of contaminated personal items. Others who should be watchful: people who have regular contact with health care workers, those who have recently taken such antibiotics as fluoroquinolones or cephalosporin, homosexual men, military recruits and prisoners. Clusters of infections have appeared in certain ethnic groups, including Pacific Islanders, Alaskan Natives and Native Americans.

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> The risk of contracting MRSA can be lowered by bathing regularly and washing hands before meals as a start. Wash your hands often or use an antibacterial sanitizer after you've been in public places or have touched handrails and other highly trafficked surfaces. Make sure cuts and scrapes are bandaged until they heal. Wash towels and sheets regularly, preferably in hot water, and leave clothes in the dryer until they are completely dry. Remind kids and teenagers that personal items shouldn't be shared with their friends. This includes brushes, combs, razors, towels, makeup and cell phones. The bacteria may be found on the skin and in the noses of nearly 30% of the population without causing harm. Experts believe it survives on surfaces in 2 to 3% of homes, cars and public places. But the bacteria are evolving, and the statistics may already underestimate the prevalence of MRSA. Be especially vigilant in health clubs and gyms - staph grows rapidly in warm, moist environments. The risks of infection and necessary precautions should be explained to student athletes, particularly those in contact sports who often suffer cuts and spend time in locker rooms. When working out at the gym, make sure you wipe down equipment before you use it.

And if you have a scrape or sore, keep it clean and bandaged until it heals. Minor cuts and scrapes are the way MRSA takes hold. For more info on MRSA refer to www.Mayoclinic.com. [Source: NAUS Weekly Update 19 Oct & NY Times article 23 Oct 07 ++]

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> USAF RETIREE FUNERALS: Manpower cuts and a high operations tempo, plus more retiree funerals than ever in Air Force history, mean base honor guards Air Force-wide will change the way they perform retiree funerals starting 1 NOV 07. The formal 10-person funeral will no longer be authorized for retiree funerals. The funeral detail will now consist of seven people who will serve as pall bearers, flag folders, flag presenter, bugler, spare, and firing party. This is to provide a 30% manpower relief for retiree funeral details, and 21% manning relief for overall funeral details, according to Pentagon air staff officials. "The main concern people had in the change of the funeral procedures was that we wouldn't be keeping with past traditions," said Staff Sgt. David Little, U.S. Air Force Honor Guard course supervisor for base honor guards. "Originally, the number of (Airmen) was going to be lowered to five, but we didn't want to lose the pall-bearing aspect so we determined that seven people would still be able to carry on all aspects of the funeral."

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> This new funeral sequence has three major differences: the noncommissioned officer in charge of pall bearers also will be the NCO in charge of the funeral, the number of firing party members will be reduced to three, and a spare position will be added. The new sequence begins with the NCO of pallbearers assuming the position of NCO in charge to ensure the casket and flag are situated properly in the hearse. He or she will then join the pallbearers and call commands to carry the casket to gravesite, and finally present the flag to the family while the other team members assume their roles as either the bugler, spare or firing party. The final sequences are the same. A video was released 24 SEP documenting the new funeral, and is available on the Air Force Honor Guard Web site. Sergeant Little noted, "Another concern we've heard is that people think we're taking away the '21-gun salute' by having only three people fire. But what people don't realize is that we've never done a 21-gun salute during military funeral honors. What we do is fire three volleys in unison. Only the president receives a 21-gun salute, and only the Navy and Army have ever performed this. The three volleys come from an old battlefield custom where the two warring sides would cease hostilities to clear their dead from the battlefield, then would fire three volleys to alert the other side their dead had been properly cared for and they were ready to resume the battle. The fact that we had seven people firing the three volleys was a coincidence."

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> Overall, the reaction has been positive, Sergeant Little said. "Retirees are grateful; they knew the Air Force was going to make changes, so they're happy we kept all aspects," he said. "The bases have been having a hard time supporting the 10-person funeral so this eases their personnel strain, and the base honor guards are happy with the new sequence. Training for the new sequence is not difficult either. We've had a lot of phone calls about the video, but what is important to remember is that all the manuals are the same. It's what you've already been trained on. The only differences are the sequences, and those are narrated to help each person understand (his or her) role. We're not teaching movements, we're teaching

the sequence. The order of events is the same as the 10-person; the only real differences are the addition of the spare and the sequence at the back of the hearse." For more information or questions regarding funeral policy or protocol, call the Pentagon air staff at (703) 604-4928. [Source: Air Force Retiree News Service Madelyn Waychoff article 23 Oct 07 ++]

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> RESERVE GI BILL UPDATE 07: In the 18 OCT hearing before the House Veterans Affairs Economic Opportunity Subcommittee on the Montgomery GI Bill (MGIB) the dominant subject was education benefits for returning combat veterans from the Minnesota National Guard. The 34th Brigade combat team served a grueling 16-month tour in Iraq and a total of 22 months on active duty. More than half of the unit served on two-year orders that qualified them to apply for active duty MGIB benefits. But orders for the rest of the unit were for one year and 364 days - one day short of two years. Based on that one-day orders snafu, the Army denied active-duty-level benefits for the latter group, offering them an option worth about \$8,000 less. After NBC Nightly News and other media highlighted that unfair decision, the Army let the soldiers apply for an administrative correction that would make them eligible for the active duty benefit. In testimony before the Committee MOAA's Deputy Director for Government Relations, COL Bob Norton (USA-Ret) told the panel that the real problem facing mobilized reservists is that they're not allowed to use their GI Bill benefits after leaving service, whereas all other active duty veterans are allowed 10 years' eligibility after separation. Further, reservists aren't allowed to accumulate multiple activations toward more education benefits. All Guard and Reserve members who serve multiple tours in Iraq or Afghanistan of less than two continuous years lose all GI Bill benefits when they leave service. Norton urged Congress to make two key MGIB fixes. First, consolidate reserve and active duty programs under one law, with benefits scaled in proportion to service rendered. Second, allow activated reservists the same 10 years of post-service access their active duty counterparts have. The Senate approved the readjustment benefit in its version of the FY2008 Defense Authorization Act; the House adopted the consolidation provision in its version of the bill. Norton urged legislators to put those fixes into law. For the longer term, MOAA recommends tying MGIB benefits to the average cost of a four-year public college education. [Source: MOAA Leg Up 19 Oct 07 ++]

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> MEDICARE REIMBURSEMENT RULE (NEW): To defuse physicians' and hospitals' opposition to the creation of Medicare back in 1965, the program's congressional architects selected payment mechanisms designed to preserve the status quo. But as Medicare has expanded and problems of affordability and quality of care have grown, such an approach has become untenable. Recently, the Centers for Medicare and Medicaid Services (CMS) announced its decision to cease paying hospitals for some of the care made necessary by "preventable complications" - conditions that result from medical errors or improper care and that can reasonably be expected to be averted. This rule, which implements a congressionally mandated change in hospital reimbursement, is the latest in a series of steps that have rendered Medicare's payment policy far less passive than it once was. The starting point for current Medicare payments for inpatient care is the system based on diagnosis-related groups (DRGs) that was adopted in 1983 by CMS's predecessor, the Health Care Financing Administration. That system is

considered prospective, in that the amount paid to a hospital for a patient is fixed in advance and depends only on the diagnoses and major procedures reported at discharge (which, in turn, map to a specific DRG).

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> In reality, payments under this system have never been completely prospective, being influenced to some degree by what happens to an individual patient during a hospitalization. For example, higher payments are made on behalf of patients in whom clinically significant complications develop after admission than for those with the same diagnosis who have no such complications. There are also so-called outlier payments that partially compensate hospitals for the additional expenses incurred for very-high-cost cases. With regard to preventable complications, these retrospective features of the DRG payment system have harbored a perverse incentive: hospitals that improved patient safety and ameliorated problems such as nosocomial infections saw their Medicare revenues - and sometimes their profits - reduced.

> Believing that this counterproductive incentive should be eliminated, Congress instructed the Secretary of Health and Human Services in 2005 to select at least 2 conditions that are

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> (a) High cost or high volume or both,

> (b) Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and

> (c) Could reasonably have been prevented through the application of evidence-based guidelines.

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> After issuing a proposed set of measures and considering comments from stakeholders and experts, CMS decided to disallow incremental payments associated with eight secondary conditions that it sees as preventable complications of medical care. These conditions, if not present at the time of admission, will no longer be taken into account in calculating payments to hospitals after October 1, 2008.

> The new rule will result in hospitals seeing substantial reductions in payment for the care of individual patients with preventable complications. For example, if a patient were admitted to a Boston-area hospital with pneumonia and developed a urinary tract infection or bed sores during the hospitalization, the hospital would currently be paid \$6,253.58, under DRG 89 ("pneumonia with complications"); under the new rule, if there were no other complications, the hospital would be paid only \$3,705.38, under DRG 90 ("simple pneumonia") - a difference of \$2,548.20 (a reduction of approximately 40%). The policy, however, is unlikely to change the total Medicare payments to hospitals substantially, because the payment will be "reduced" only for instances in which preventable complications were the only factors causing a case to be reclassified under a more expensive DRG.

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> Medicare will continue to make outlier payments for cases with costs substantially exceeding the average for the appropriate DRG, even when these costs are the consequence of preventable complications - and the likelihood of incurring such outlier payments will actually be increased by the new policy, because cases in which there are complications will more easily exceed the threshold associated with the lower-paying DRG. Moreover, preventable complications including the eight that CMS identified for exclusion may continue to result in higher Medicare payments to hospitals, because their downstream consequences may place cases in entirely different and very-high-cost DRGs, such as DRG 483 (tracheostomy with mechanical

ventilation for 96 hours or more). The new approach does not attempt to unravel these more complex clinical scenarios.

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> Conditions for which Medicare will no longer pay more if acquired during an inpatient stay, number of incidents in FY 2006, and average Medicare payment for admissions in which condition was present are:

> . Object left in patient during surgery - 764 - \$61,962

> . Air embolism - 45 - \$66,007

> . Blood incompatibility - 33 - \$46,492

> . Catheter-associated urinary tract infection - 11,780 - \$40,347

> . Pressure ulcer - 322,926 - \$40,81

> . Vasculat-catheter associated infection - Unknown

> . Mediastinitus after coronary-artery bypass grafting - 108 - \$304,747

> . Fall from bed -2,591 - \$24,962

> [Source: The New England Journal of Medicine Meredith B. Rosenthal article 18 Oct 07 ++]

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> programs designed to reduce the reduction in retired pay due to receipt of Veteran Administration compensation, for certain disabled retirees.

Concurrent Retirement and Disability Payments (CRDP) provides a 10-year phase-out of the offset to military retired pay due to receipt of VA

disability compensation for members whose combined disability rating is 50%

or greater . Members retired under disability provisions must have 20 years

of service. Combat-Related Special Compensation (CRSC) pays added benefits

to retirees who receive VA disability compensation for combat-related

disabilities and have 20 years of service. To find out if either of this

programs apply to you and to obtain the appropriate paperwork to apply refer

to the following:

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> . New Retired Benefit Programs general information paper at

http://www.defenselink.mil/prhome/docs/concurrent_retire_07a.pdf

> . CRSC Information paper Updated NOV 06 at

http://www.defenselink.mil/prhome/docs/crsc_nov06.pdf

> . Revised CRSC guidance effective 1 JAN 04 at

http://www.defenselink.mil/prhome/docs/CRSC_Guidance_104.pdf

> . CRSC Application (DD FORM 2860) at

<http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2860.pdf> or

<http://www.dtic.mil/whs/directives/infomgt/forms/forminfo/forminfopage2483.html>

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> Veterans must apply to their own branch of Service for Combat-Related

Special Compensation (CRSC) benefits. Applicants are urged to contact their

own branch of Service for additional information. Link to your Service web

site:

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> . Army at <https://www.hrc.army.mil/site/crsc/index.html>

> . Navy & Marine corps at

<http://www.donhq.navy.mil/corb/crscb/combatrelated.htm>

> . Air force at

http://ask.afpc.randolph.af.mil/crsc/default.asp?prods3=2039&prods2=39&prods1=1&cats1=144&p_cats=144

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> For more info refer to <http://www.defenselink.mil/prhome/mppcrsc.html>.

[Source: Under Secretary of Defense Personnel & Readiness notice 28 Mar 07

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> VA MRSA TESTING UPDATE 01: Lately the news has been saturated with stories on the increasing rates of methicillin-resistant staphylococcus aureus (MRSA) infections in the United States. The VA wants veterans to know they have taken proactive steps to combat the infection at each of its 153 hospitals and are placing greater emphasis on hygiene and screening procedures to help control spread of the disease. The new disease control plan is based on a pilot program that reduced the worrisome staph infection rate by 70% at a VA facility earlier this year. "VA demonstrated that dramatic reductions in MRSA-related infections are possible," said Acting Secretary of Veterans Affairs Gordon H. Mansfield. "VA's completion of our national deployment of these serious prevention measures reinforces VA's stature as one of the safest health care environments nationally." [Source: NAUS Weekly Update 19 Oct 07 ++]

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> VA COMP PAYMENT DISPARITY UPDATE 09: On 17 OCT, the House Veterans' Affairs Subcommittee on Oversight and Investigations held a hearing to review the disability claims rating process and assess the causes of disparities in disability ratings that are administered by the Department of Veterans Affairs. Variances in VA disability compensation rates range from an average of \$12,000 per veteran in New Mexico to less than \$8,000 per veteran in Ohio. Among the actions under review are six recommendations from the Institute for Defense Analyses (IDA) on providing improved consistency in VA disability ratings and claims payments:

- > 1.) Standardize training for rating specialists;
- > 2.) Standardize the medical evaluation reporting process;
- > 3.) Increase oversight and review of rating decisions;
- > 4.) Consolidate rating activities to a central locations;
- > 5.) Develop metrics to monitor consistency in adjudication results; and,
- > 6.) Improve and expand data collection and retention.

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> The hearing marks what will hopefully be the continuation of a more rigorous effort to modernize and improve the way we evaluate disabilities and award compensation for injured service members, exactly as the Veterans' Disability Benefits Commission and a number of other blue-ribbon panels have also recommended. [Source: NAUS Weekly Update 19 Oct 07 ++]

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> GRAYHOUND DISCOUNTS:

> Military Discount: Active duty and retired military personnel and their dependent family members may receive a 10% discount off the Greyhound walk-up (unrestricted) fare. Another option for military personnel is to travel on Greyhound for a maximum fare of \$198 round trip anywhere in the continental United States. The following restrictions apply:

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- > 1. Fares are valid on Greyhound schedules and those of participating interline carriers. Not available on Greyhound Canada routes.
- > 2. This fare applies only to active and retired members of the United States Armed Forces, which includes the U.S. Air Force, Army, Coast Guard, Marines, and Navy; members of the National Guard, reservists and bonafide identifiable spouses and dependents of the above. A valid military picture identification card must be presented upon request.
- > 3. A 40% discount for children of military personnel referenced above is available. Discount not available with \$198 maximum military fare. No other

discounts apply.

> 4. Only totally unused tickets may be refunded to the location of the original purchase. A 15% penalty fee applies upon refund. No refund will be allowed if any portion of the ticket has been used.

> 5. Departure date and time may be changed for a charge of \$10 per ticket provided that the advance purchase requirement is not violated.

> 6. Advance purchase tickets purchased over the phone require a minimum of ten days for delivery by mail and for online orders.

> 7. Casino, commuter, Discovery Pass, student or other special military fares do not qualify for the military discount.

> 8. Fares are subject to change until purchase and may be higher during peak holiday travel periods.

> 9. Ten-percent discount may not be used in conjunction with the \$198 maximum fare.

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> Veterans Discount: With the Veterans Advantage Discount Card, members can save 15% on walk-up fares at the terminal or online. Veterans Advantage is available for U.S. Military Veterans, active duty, National Guard & Reservists, and their family members. Membership is good for discounts on travel, dining, entertainment, clothing, and many more services and products. To become a member and get this discount, apply online at the Veterans Advantage Web site, or call 1(866) 838-7392. A Veterans Advantage 30-day free trial offer is currently available for Greyhound riders to thank you for your service. Full memberships are available for as low as \$59.95 for one year, plus \$4.95 to process enrollment.

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> VA Patient Discount: A 25% discount on applicable one-way fares also is available to patients of U.S. Veterans Administration Hospitals, patients assigned by the U.S. Veterans Administration to Army, Navy, Air Force, or military hospitals, or patients assigned by the U.S. Veterans Administration to civil and state institutions when traveling at their own expense. To qualify, the patient must present a completed original Veterans Administration Request for Reduced Rate Transportation Form (VA-Form 3068) to the ticket agent at time of purchase. No copies, facsimiles, or other forms will be accepted for this discount.

> [Source: Military.com 18 Oct 07 ++]

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> TRICARE UNIFORM FORMULARY UPDATE 22: On 26 OCT DoD officials announced the reclassification of nine additional medications as non-formulary. The nasal corticosteroid Veramyst and growth stimulants Genotropin, Genotropin Miniquick, Humatrope, Saizen and Omnitrope will be changed to non-formulary status on 9 DEC 07. Allergy medications Clarinex, Clarinex-D and the asthma medication Zyflo will be reclassified as non-formulary medications on 19 JAN 08. Medications not on the Uniform Formulary are not available at military treatment facility (MTF) pharmacies unless medical necessity has been established and an MTF provider writes the prescription. Beneficiaries taking non-formulary medications may want to consult with their health care provider about changing to a less costly alternative. Beneficiaries can also ask providers if establishing medical necessity for the third-tier medication is appropriate. If medical necessity is established for a third-tier medication, the co-payment is reduced to \$9. Medical necessity forms and criteria are available at

www.tricare.mil/pharmacy/medical-nonformulary.cfm

<<http://www.tricare.mil/pharmacy/medical-nonformulary.cfm>>. For a complete

list of medications, their formulary status and where they are available
beneficiaries can refer to

> www.tricareformularysearch.org/dod/medicationcenter/default.aspx.

[Source: NAUS Weekly Update 26 Oct 07 ++]

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> COLA 2008 UPDATE 08: The Department of Labor announced that next year's COLA (Cost of Living Adjustment) be 2.3%. The increase will apply to military retirees and their survivors, as well as Social Security annuities and certain other federal payments. Civilian federal retirees will receive a COLA of 2.0%. This is the lowest increase since 2004. The cost of living increase was 2.7 % in 2004, 4.1% in 2005 and 3.3% in 2006. COLAs are set by comparing the change in the consumer price index for wage earners and clerical workers from the third quarter of one year to the third quarter of the next year. The COLA is lower this year than last due to a drop in energy costs in August and September. Counterbalancing the COLA for Medicare beneficiaries will be a rise in Medicare premiums of \$2.50, to \$96.40 a month. The COLA is effective on 1 DEC 07 and will appear in your JAN checks.

[Source: NAUS Weekly Update 19 Oct 07 ++]

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> PNEUMONIA VACCINATION: The Army Medical Department is launching a concerted effort to reduce the needless suffering, death, and waste of medical resources that stem from widespread failure by older beneficiaries to get their pneumonia vaccinations. Military medical facilities are being pressed to stay on their toes about offering the shots to all their older patients. Also known as the pneumococcal shot or Pneumococcal Polysaccharide Vaccine or PPV, the pneumonia vaccine is safe and highly effective, according to medical authorities-provided it gets out of the bottle and inside somebody's body. To encourage that to happen more often, military medical leaders are stressing these facts:

> . Pneumococcal disease can kill you. It is the sixth leading cause of death in the U.S. (40,000 deaths annually).

> . It can make you miserably and expensively ill. There are 100,000 -130,000 hospitalizations annually in the U.S.

> . It can affect your lungs, blood, and brain. It usually causes fever, cough, and shortness of breath.

> . Pneumococcal disease can affect people of all ages, but older adults ages 65 and over are at higher risk for complications from both the flu and pneumococcal disease. The shot can help protect you from getting a serious infection in your lungs, blood and brain.

> . Getting the shot when you're age 65 or older should protect you for the rest of your life. You can get it any time of the year. The shot is safe and most people have no side effects. For maximum safety, medical officials also encourage beneficiaries to take the flu vaccine annually.

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> Anyone can get pneumococcal disease, but some people are at greater risk from the disease. These include people 65 and older, the very young, and people with special health problems. The pneumonia vaccine protects you from getting serious infection in your blood or brain that can cause dangerous health problems, hospitalization, and death. Pneumococcal disease can lead to serious infections of the lungs (pneumonia), the blood (bacteremia), and the covering of the brain (meningitis). About 1 out of every 20 people who get pneumococcal pneumonia dies from it, as do about two people out of 10 who get bacteremia and three people out of 10 who get meningitis. People

with the special health problems are even more likely to die from the disease. Drugs such as penicillin were once effective in treating these infections; but the disease has become more resistant to these drugs, making treatment of pneumococcal infections more difficult. This makes prevention of the disease through vaccination even more important. Those who should get the pneumococcal shot are:

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- > . All adults 65 years of age or older.
- > . Anyone over 2 years of age who has a long term health problem such as: heart disease, lung, disease, sickle cell disease, diabetes, alcoholism, cirrhosis, or leaks of cerebrospinal fluid.
- > . Anyone over 2 years of age who has a disease or condition that lowers the body's resistance to infection, such as: Hodgkin's disease, lymphoma, leukemia, kidney failure, multiple myeloma, nephrotic syndrome, HIV infection or AIDS, damaged spleen, or no spleen, organ transplant.
- > . Anyone over 2 years of age who is taking any drug or treatment that lowers the body's resistance to infection, such as: long-term steroids, certain cancer drugs, radiation therapy.
- > . Alaskan Natives and certain Native American populations.
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- > For more info on immunizations Ask your doctor or nurse, refer to the National Immunization Program
- > website <http://www.cdc.gov/nip/default.htm> (Department of Health And Human Services Centers for Disease Control and Prevention National Immunization Program, or go to <http://www.cdc.gov/nip/vaccine/pneumo/pneumo-pubs.htm#top>. [Source: Army News Service Harry Noyes article 18 Oct 07 ++]
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- > VETERANS DAY FREE MEALS UPDATE 01: In their annual salute to all veterans McCormick & Schmick's Seafood Restaurants will again provide free meals in honor of Veterans Day. All veterans can receive a free lunch or dinner entrée at McCormick & Schmick's Seafood Restaurants nationwide on Sunday, 5 NOV 06. Vets should show proper identification (VA card, VFW card, veterans ID, discharge papers, etc.) Reservations are strongly encouraged! In a show of thanks to our nation's veterans, Bill McCormick and Doug Schmick offer to serve those who've served at their McCormick & Schmick's Seafood Restaurants. Last year the company served nearly 15,000 vets nationwide. This year's event is taking place on the Sunday before Veterans Day so that families can participate. McCormick & Schmick's annual veterans program began as a small effort in just one restaurant in 1999. Due to its overwhelming popularity and positive response received from veterans the program has expanded nationwide. A complete list of participating restaurants may be found at www.McCormickandSchmicks.com .
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- > Also thanking active duty and veterans, the Golden Corral restaurants will be having their annual salute to the military on Monday 13 NOV from 17-2100. Military Appreciation Monday (First Monday after Veteran's Day) is set aside for Golden Corral to honor all active duty and retired military personnel with a free "thank you" dinner and beverage at any Golden Corral restaurant. No identification is required. Since 2001, Golden Corral has served 1,230,960 free meals to active duty and retired military personnel. For more info go to their website <http://www.goldencorral.net/>. [Source: The Veterans Voice <http://www.theveteransvoice.com/Hello.html> Oct 07 ++]
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> WINDOWS VISTA BOYCOTT: The Consumers' Association (Consumentenbond) has called on consumers when purchasing a new computer to explicitly ask for the operating system Windows XP. New PCs come standard with Windows XP's successor Windows Vista but there are many complaints about this system. The organization has also called on shops to provide free Windows XP packages to clients who are having problems with Vista. The Consumers' Association took this decision on 18 OCT after a meeting with Microsoft to discuss the problems with Vista. After a survey conducted by the Consumers' Association showed that the performance of Microsoft's latest operating system was very poor, the Association set up a registration centre for complaints about Vista. In less than five weeks 5,000 users filed complaints about the functioning of the system. "The product has many teething problems, it is just not ready," a spokesperson for the association said. Printers and other hardware reportedly failed in combination with Vista, computers crash regularly and the peripherals are very slow. The association had a meeting about the complaints with Microsoft Nederland on 18 OCT and suggested that Microsoft offer Windows XP as an alternative to clients who are having problems with Vista, but Microsoft refused. "Although they do offer Windows XP to their business clients when they are having problems," the spokesperson for the association said. Microsoft was not available for comment. [Source: Expatica News ANP Oct 07 ++]

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> TRICARE BREAST CANCER MRI'S: Recognizing the importance of early detection, the Tricare Management Activity (TMA) recently changed its policy adding coverage for Magnetic Resonance Imaging (MRI) screening for women at high risk of developing breast cancer. The American Cancer Society has clear guidelines defining high risk which doctors can use to determine who qualifies for the coverage. If any qualified beneficiary receives this care in the near future and it is denied, they can resubmit their claim for reimbursement. "An MRI is a clearly superior tool for screening the highest risk women for breast cancer," said Army Major General Elder Granger, Deputy Director, and Tricare Management Activity. "We want these women to have every chance to detect any cancer at the earliest possible stages."

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> Breast cancer is the third most common cancer among Tricare beneficiaries and the second most common cause of cancer death for women in the United States. An individual's level of risk can be impacted by a number of factors including age, family history and race. Doctors can advise their patients of their individual risk factors, but even women of average or low risk should be vigilant. "The availability of MRI screenings does not reduce the importance of regular examinations," Major General Granger stressed. "All women over 39 years old need to get those annual mammograms. The key to dealing with cancer is early detection." Anyone who meets the criteria for a breast MRI will be covered by Tricare, retroactive to 1 MAR 07. If any qualified beneficiaries received this care on or after March 1, 2007 and it was denied, they can resubmit their claim for reimbursement. For more information about breast cancer refer to http://www.Tricare.mil/pressroom/doctor_is_in.aspx?fid=60. [Source: Tricare Press Release 07-71dtd 17 OCT 07 ++]

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> SALUTING THE FLAG UPDATE 01: S1877, introduced by Senator Inhofe of Oklahoma, to amend Title 4, United States Code, to prescribe those members

of the Armed Forces and veterans out of uniform may render the military salute during hoisting, lowering, or passing of the flag. The bill was sent to the House Judiciary Committee for consideration. The Committee, to date, has not set the bill for review. They have a huge backlog of issues currently under consideration. The staff reports that the concern with this bill is that there is no way to determine when people are in civilian clothes who is and who is not a veteran. The staff also said that there currently is in the law an appropriate method for rendering honors and that is to place one's hand over one's heart. It is not known at this point whether or not this bill will become law, but it is expected to be mired in legal wrangling and constitutional law review for quite some time. The Air Force Association (AFA) in the interim is suggesting that veterans render honors in a way they deem appropriate. If the situation warrants, place your hand over your heart - if you'd rather salute, do that. No law is going to change the way you feel about rendering honors. You earned the privilege to do as you choose. [Source: AFA Update 17 Oct 07 ++]

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> VA CEMETERY TEXAS UPDATE 01: The numbers are deceiving for the Ft. Sam Houston National Cemetery. Since 31 JUL 07 the total internments have reached 116,766 and occupied gravesites number 92,980. Just five years ago, the cemetery added 40 new acres that were expected to give Fort Sam enough gravesites to last through 2010. But that section already is 90% full. There are just 5,256 gravesites left, which could run out in less than a year. Those running the cemetery say they're utilizing the space they have left better, and are mapping plans to open one last section that could keep it in business through 2035. Run by the Veterans Affairs Department, the cemetery acquired 169.8 acres from Fort Sam Houston that is bordered by Salado Creek. Cemetery director William Trower said at least 100,000 veterans and their spouses are to be buried there before space runs out. Burials are done in concrete-lined crypts that can hold both a veteran and his or her spouse. The "lawn crypt," as it's called, allows five graves to be placed in the same space that four once used. The headstone, set in a concrete containment box, won't move the way others do that rest on the earth. All headstones in American veteran's cemeteries stand as soldiers do before mustering to war. But those here won't rise and fall, creating a "wave" of marble in a sea of well-manicured grass. That will spare Fort Sam's maintenance workers from having to occasionally straighten the markers. [Source: San Antonio Express-News 15 Oct 07 ++]

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> VETERANS MENTAL HEALTH BILL: U.S. Senator Daniel K. Akaka (D-HI), Chairman of The Committee on Veterans' Affairs, has introduced comprehensive mental health legislation. The bill, inspired by an 25 APR Committee hearing on mental health care, would address the immediate needs of veterans by ensuring high quality mental health services at VA facilities and in their communities. In testimony at the hearing, veterans and their family members told heart-wrenching stories of substance abuse, PTSD, and suicide, which exposed flaws in the current mental health care system for veterans. "Servicemen and women return from war suffering from invisible wounds that are complicated and wide-ranging," Akaka said. "The solutions put forth in this legislation will help lead to proper mental health care for our veterans." In his floor statement Akaka noted:

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> . A MAR 07 study published in the Archives of Internal Medicine reported

that more than one-third of war veterans who have served in either Iraq or Afghanistan are suffering from various mental ailments including post-traumatic stress disorder, anxiety, depression, substance use disorder and other problems. According to the study, a disproportionate number of young soldiers suffer mental health problems.

> . One in five Iraq War veterans are likely to develop PTSD, as studies have estimated, and this is but one aspect of the mental health challenges faced by veterans.

> . We also know that veterans suffering from physical and mental wounds use drugs and alcohol to assuage their pain. Experts believe that stress is the number one cause of drug abuse, and of relapse to drug abuse. Sixty to eighty percent of Vietnam veterans who have sought PTSD treatment have alcohol use disorders. VA has been dealing with substance abuse issues for decades, but much remains to be done.

> . This bill addresses the immediate needs of veterans by ensuring high quality mental health services at VA facilities and in their communities.

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> The bill also looks to the future through a number core provisions. The legislation would:

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> . Require VA medical centers to offer a minimum range of services for veterans in need of help to overcome their substance use disorders.

> . Require programs to prevent relapse and to provide medical treatments to reduce cravings for alcohol and drugs, among others.

> . Require that the confluence of substance use disorders and other mental health disorders be treated by a well-qualified team of health professionals who would treat the disorders concurrently.

> . Create grants to enhance programs and fill holes. VA facilities would compete for grants for various purposes, from increasing weekend and evening hours to creating programs which encourage urgent care physicians - who are often gateways for new patients - to quickly refer those whom they believe may have a mental health disorder.

> . Require the VA Secretary to designate six inpatient facilities to provide recovery services for veterans with comorbid PTSD and substance use disorders.

> . Require a comprehensive review of VA's residential mental health facilities.

> . Restate an existing law which allows families to have access to care which will aid in the effective treatment and rehabilitation of a veteran by clarifying the type of services to which family members should have access.

> . Set up a mental health research program based on the successful pediatric oncology model. It proposes a network of sites with adequate patient flow and clinical and research expertise with a goal of promoting rapid progress from research to therapeutic advancement and effective treatments for PTSD and PTSD in the presence of a substance use disorder.

> . Authorize the creation of new programs and expansion of existing ones.

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> The Veterans Affairs Department on 24 OCT announced its opposition to the mental health care legislation, contending that it duplicates efforts already under way. Dr. Michael J. Kussman, the VA's undersecretary for health, "said the substance abuse segment of the bill was 'overly prescriptive and attempts to mandate the type of treatments to be provided to covered veterans, the treatment settings and the composition of treatment teams.' Kussman also said the contracted care sections of the bill are duplicative of currently existing authorities. [Source: SCVA News Release

15 Oct 07 ++]

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> VA PAIN CARE: On 15 OCT Senator Daniel K. Akaka (D-HI), Chairman of the Veterans' Affairs Committee, and fellow Committee member Senator Sherrod Brown (D-OH), introduced legislation that would enhance the Department of Veterans Affairs' pain management program. The Veterans Pain Care Act of 2007 would assist in focusing attention on pain management as a new generation of veterans suffering from pain enter VA's health care system. This legislation seeks to significantly bolster VA's existing pain management efforts and bring them up to par at a national, system-wide level. This bill, among others, is scheduled to be reviewed at the Committee's 24 OCT 07 hearing on pending legislation. It has been endorsed by the Pain Care Forum, a consortium representing over 75 health care and health advocacy organizations from across the country. Sen. Akaka noted in introducing the legislation that:

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> . It is estimated that nearly 30% of Americans - that's some 86 million people - suffer from chronic or acute pain every year. A recent study conducted by VA researchers in Connecticut found that nearly 50% of veteran patients that are seen at VA facilities reported that they experience pain regularly.

> . While pain increases in severity with age, it is also a growing problem among younger veterans who have been injured in the wars in Iraq and Afghanistan. Many of these veterans are coming home with severe injuries - often traumatic brain injuries - that require intensive rehabilitation. In some cases, these younger veterans will have to live with the long-term effects of their injuries, of which pain is a large and debilitating part.

> . Pain management is an area of health care that by many accounts is not yet to up to par, in both the private and public sectors. The legislation being introduced would enhance VA's pain management program on a national, system-wide level, by requiring VA to establish a pain care initiative at every VA health care facility. Every hospital and clinic would be required to employ a professionally recognized pain assessment tool or process, and ensure that every patient who is determined to be in chronic or acute pain is treated appropriately.

> . The profile of a veteran in pain is often times different than that of his or her counterpart in the private sector. For example, veterans suffering from chronic pain are more likely to be receiving treatment for other problems including depression, substance abuse, alcoholism, or post traumatic stress disorder. Understanding and treating their pain must be a priority, and this bill will help VA enhance the department's existing pain management program.

> . VA's current pain management efforts are worthwhile, but are unfortunately not adequate to meet all of the needs of veterans. Pain management in VA continues to be relatively decentralized and unstandardized. Some VA medical centers have adopted successful approaches and procedures to deal with pain, while others have been less active. Fortunately, VA has begun the work of identifying professional talent and developing ideas that provide the groundwork of an effective pain management program. This bill would build upon that foundation and help ensure that these ideas become practice.

> [Source: SCVA News Release 15 Oct 07 ++]

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> VA CLAIM BACKLOG UPDATE 12: On 9 OCT at a field hearing of the House Veterans Affairs Subcommittee on Disability Assistance and Memorial Affairs, Chairman John Hall (D-NY-19) called on the VA to reduce the waiting time for veterans stuck in its overwhelming claims backlog by two-thirds. He pointed out that these veterans have mortgages, medical bills, and tuition bills for their children's education and that bill collectors don't wait 6 months, 2 years, or 5 years to collect-you have to pay them every month. The VA must meet the same standard. He is asking that the VA cut the waiting time from six months to two months, and someday even be able to turn around a claim in 30 days. The VA currently maintains a backlog of over 600,000 cases. Due to funding shortfalls over the past five years, the backlog and waiting times became exacerbated to the point of unmanageability. The current average waiting periods at all levels in the VA disability benefits system are staggering:

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- > . 177 days at the Regional Office
- > . 751 days at the Board of Veterans Appeals
- > . 240 days at the Court of Appeals for Veterans Claims

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> Hal said, "This backlog is simply unacceptable and the VA has shown little ability or interest in reducing the number of claims pending a decision. These veterans stood up for our country when asked, and now it's our turn to stand up for them." The backlog New York veterans face is even worse than that suffered by the average veteran in the U.S. The New York City VA Regional Office's performance on processing claims is far behind the national average. Currently, it averages 255 days to complete a claim and has a pending backlog of 9,638 claims (20% higher than its goal of 7,952). Hall pointed out that the New York VA is working with one arm tied behind its back due to a hiring freeze that began in 2001 through JAN 06 to comply with federal cuts to VA funding. The New York office's accuracy rating is 83%, meaning 17% of veterans are getting thrown into the hamster wheel of the appeals process which can take years to complete.

> The New York Regional Office has said it needs at least a third more employees (40-50) to deal with the number of claims it currently has and the number of claims anticipated. Hall was joined by other Members of the Subcommittee and by U.S. Rep. Maurice Hinchey at the rare field hearing held at New Windsor Town Hall in Orange County. Testimony was heard from local veterans who suffered financial and other problems as a result of delays in receiving their veterans claim decision, from a representative of the Veterans Administration, and representatives from a number of Veterans Service Organizations. [Source: Congressman Hall Press Release 9 Oct 07 ++]

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> ARMY COMBAT ACTION BADGE: The Army Combat Action Badge (CAB) may be awarded to any soldier performing assigned duties in an area where hostile fire pay or imminent danger pay is authorized; must have engaged the enemy; and must not be assigned/attached to a unit that would qualify the soldier for the CIB/CMB. Award of the CAB is authorized from 18 SEP 01 to a date to be determined. Retroactive awards for the CAB are not presently authorized. Second and third awards of the CAB for subsequent qualifying periods are indicated by superimposing one and two stars respectively, centered at the top of the badge between the points of the oak wreath. To expand retroactive eligibility of the Army CAB to include members of the Army who participated in combat during which they personally engaged, or were

personally engaged by, the enemy at any time on or after 7 DEC 41, H.R.2267 was introduced by Ms. Ginny Brown-Waite (FL-05) on 10 MAY 07. The bill would authorize the Secretary of the Army to make arrangements with suppliers of the Army Combat Action Badge so that eligible recipients of the Army Combat Action Badge may procure the badge directly from suppliers, thereby eliminating or at least substantially reducing administrative costs for the Army. This bill has been referred to the House Subcommittee on Military Personnel and will most likely die in committee unless enough veterans contact their legislators and convince them to bring the bill to the house floor for a vote. Although the bill would cost the government only a minimal amount since veterans would be authorized to purchase their own badges it does not seem to be getting much attention by the subcommittee. This could be because the Army is not in favor due to what they claim would be problems verifying who was eligible. They also cite funding. Veterans are encouraged to contact their legislators and convince them to aid in getting this bill out of committee. [Source: Various Oct 07 ++]

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> VA BUDGET 2008 UPDATE 08: A war of words over veterans spending intensified 16 OCT, as Democrats went on offense after taking repeated hits from the GOP in recent days for not moving ahead on a \$109.2 billion measure funding military construction and veterans' benefits. Democrats pointed out that the last time a veterans spending bill was approved before the end of the fiscal year was during the Clinton administration in fiscal 1997, when the Veterans Affairs Department was funded under the former VA-Housing and Urban Development measure. Last year, the VA budget did not pass until Democrats enacted a continuing resolution this February for the entire fiscal year, and during President Bush's tenure, the earliest Congress has sent him a final bill was 26 NOV. In each of fiscal 2003-2005, veterans spending was included as part of an omnibus appropriations package -- the earliest being 8 DEC -- which Republicans now criticize Democrats for moving toward.

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> Earlier, House Minority Leader John Boehner (R-OH) had criticized House Democrats for not naming conferees on the Military Construction-VA bill, which he called inexcusable and evidence the majority was holding it back as a vehicle for more pork. "Mr. Boehner seems to have conveniently forgotten that last year, under his leadership, the Congress let down veterans and our troops by never passing the VA-Military Construction bill," replied House Military Construction-VA Appropriations Subcommittee Chairman Chet Edwards (D-TX). A Boehner spokesman said ignoring basic facts is becoming an all-too-common tack for House Democrats and laid last year's mess at the feet of the then-Senate leadership, as the House had passed its version. "This year the burden is on House Democrats, and their unwillingness to move forward represents a failure of leadership and demonstrates their inability to govern," he said. Both chambers have passed the measure, and Bush has indicated he would sign it despite a price tag \$4 billion above his request. Bush has also demanded corresponding offsets in other areas of the budget, and Democrats have been reluctant to send him the bill and put domestic programs at risk.

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> The Senate has already appointed conferees. But the House generally does not name conferees until right before a formal conference is ready to convene because the minority party can use that opportunity to offer procedural motions that are political in nature. Edwards said informal

conference negotiations have already begun and that it is his hope that Democratic leaders would send Bush the bill by Veterans Day, 11 NOV. But senior Democratic aides said there was not yet a decision on timing or whether the measure would become part of a larger package. House Appropriations ranking member Jerry Lewis (R-CA) argued that the delays in getting the bill signed mean the VA cannot begin programs such as 450 claims processing units, addition of clinics and improvement of existing facilities. Democrats note that the White House and GOP leaders in recent years fought efforts to add spending on veterans programs, even stripping former House Veterans Affairs Chairman Christopher Smith, (R-NJ) of his chairmanship in 2005 after he had regularly spoken out against Republican budgets for not including more veteran's funds. Edwards added that under Democratic leadership in Congress this year, we will pass the largest increase in veteran's healthcare funding in the 77-year history of the Veterans Administration.

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> Veterans are a crucial voting bloc for both parties, and earlier this year Bush touted his budget's increase as the largest in the agency's history. As veterans programs remain mired in the larger budget fight, Bush and Democratic leaders traded barbs over delays in passing any of the fiscal 2008 appropriations bills. In a speech in Rogers, Ark., Bush reiterated his pledge to veto Democratic spending bills, which are, overall, \$23 billion above his \$933 billion discretionary budget request. House Majority Leader Steny Hoyer (D-MD) shot back that the worst kept secret in Washington this fall is that Bush has taken a newfound hard line on spending in a vain attempt to establish his bona fides with his conservative base. Bush signed into law farm, highway and prescription drug legislation, as well as a number of appropriations bills that exceeded his requests when Republicans were in control.

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> The House has passed all 12 fiscal 2008 appropriations bills. The Senate was moving toward passage of its sixth, a \$55 billion Commerce-Justice-Science measure. Senate Commerce-Justice-Science (C-J-S) Appropriations Subcommittee Chairwoman Barbara Mikulski (D-MD) told colleagues it was time to fish or cut bait if they wanted to offer amendments. Following passage of the C-J-S measure, Senate Majority Leader Harry Reid (D-NV) said he would keep the chamber in session through the weekend if necessary to complete work on the \$150 billion Labor-Health and Human Services bill, as Senate Labor-HHS Appropriations Subcommittee Chairman Tom Harkin (D-IA) -- also chairman of the Senate Agriculture Committee -- needs to turn his attention to next week's farm bill markup. Senate Minority Leader Mitch McConnell (R-KY) pledged significant cooperation on our end in working through the bills, calling them the basic work of government and we need to try and complete it as rapidly as possible. Bottom line, Politics as Usual. [Source: Congress Daily Peter Cohn article 16 Oct 07 ++]

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> CELL-PHONE SCARE MESSAGE: The FTC has again stated that despite the claims made in e-mails circulating on the Internet, consumers should not be concerned that their cell phone numbers will be released to telemarketers in the near future, and that it is not necessary to register cell phone numbers on the National Do Not Call Registry to be protected from most telemarketing calls to cell phones. Federal Communications Commission regulations prohibit telemarketers from using automated dialers to call cell phone numbers. No

cell phone directory is imminent. Because automated dialers are standard in the industry, most telemarketers would be barred from calling consumers on their cell phones without their consent even if a directory were issued.

For more info on the subject refer to

<http://www.ftc.gov/opa/2007/10/dnccellphones.shtm>. [Source: FTC news release 12 Oct 07 ++]

> Consumer Health Digest #07-39, October 9, 2007

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> REMOTE INFRARED AUDIBLE SIGNS (RIAS): The VA has installed their first Remote Infrared Audible Signs (RIAS) at San Francisco VA Hospital and the Audie Murphy hospital in San Antonio has decided to also. RIAS is a wireless communication system that employs permanently installed transmitters and hand-held receivers. Human voice or text to speech messages that identify landmarks and provide information are heard through a receiver carried by the traveler. People who are visually or print reading disabled scan for directional transmissions and find their way without asking for help. Talking Signs transmitters are used in buildings, to identify approaching buses, on bus stops, at cross-walks, in hospitals, museums, malls, etc. Using the Talking Signs system, users are provided wayfinding, orientation and information access in the built environment.

[Source: BVA Ward Dond input 16 Oct 07 ++]

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> ALZHEIMER'S UPDATE 04: Scientists reported progress 14 OCT toward one of medicine's long-sought goals: the development of a blood test that can accurately diagnose Alzheimer's disease, and even do so years before truly debilitating memory loss. A team of scientists, based mainly at Stanford University, developed a test that was about 90% accurate in distinguishing the blood of people with Alzheimer's from the blood of those without the disease. The test was about 80% accurate in predicting which patients with mild memory loss would go on to develop Alzheimer's disease two to six years later. Outside experts called the results, published online by Nature Medicine, promising but preliminary. They cautioned that the work needed to be validated by others and in much larger studies, because there have been many disappointments in the past. Right now, Alzheimer's disease is diagnosed by a battery of mental and other tests, and even that diagnosis rests on the judgment of the physician. Doctors say it would be useful to have something like a pregnancy test for Alzheimer's - one that is simple and definitive and can pick up the disease early, maybe even before symptoms appear.

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> At present, treatments for Alzheimer's disease are not very effective. The real usefulness of an early diagnostic test would come when drugs are developed that slow or halt the progression of the disease. Several therapies that might be able to do that are now being tested. The drugs would be most valuable if they could be used before cognitive ability had declined too much. Numerous efforts have been made to find an early marker in blood, urine, spinal fluid and eye movements, as well as through brain imaging using PET scans and MRI. A Norwegian company, DiaGenic, has presented some early results of a blood test that analyzes gene activity. Researchers at Cornell published early results last December using a pattern of 23 proteins in the spinal fluid. But no test has gained universal acceptance.

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> Dr. Tony Wyss-Coray, an associate professor of neurology at Stanford and the senior author of the new paper, said there was evidence from animal studies that brains affected by Alzheimer's sent out signals to the body's immune system. So his team decided that rather than looking at all proteins in the blood, it would focus on those involved in communication between cells, hoping to eavesdrop, as it were, on dialogue related to Alzheimer's. The researchers gathered more than 200 blood samples from people with Alzheimer's and those without. Using 83 of the samples, they measured the abundance of 120 proteins involved in cell signaling and found they could distinguish the Alzheimer's samples from the controls using 18 of the proteins. They then tested their 18-protein signature on an additional 92 samples. The tests agreed with the clinical diagnosis about 90% of the time. Perhaps most intriguing were the results of the test on 47 blood samples taken from people with mild cognitive impairment, a minor loss of memory that can be a precursor of Alzheimer's. The test was able to predict with about 80% accuracy whether a patient went on to develop Alzheimer's two to six years after the blood sample had been collected.

> Dr. Wyss-Coray, who is also at the Veterans Affairs Palo Alto Health System, said that monitoring communications between cells might be a way to develop diagnostic tests for other diseases. And understanding why the levels of the 18 proteins are different in Alzheimer's patients might provide a better understanding of the disease. The study was paid for by the National Institute on Aging, the John Douglas French Alzheimer's Foundation, the Alzheimer's Association and Satoris, a company co-founded by Dr. Wyss-Coray to commercialize the test. The company said in a news release that it hoped to have a test available for research purposes next year. But even if the preliminary results are validated, it is likely to be a few years before a test is approved and ready for use by doctors. [Source: New York Times Andrew Pollack article 15 Oct 07 ++]

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> VA FRAUD UPDATE 02: U.S. Attorney Mary Beth Buchanan announced a federal grand jury indicted a McKeesport PA woman for allegedly defrauding the Department of Veterans Affairs. The two-count indictment alleges Jacqueline Byrd, 58, had concealed evidence of her second marriage from authorities since 1977 in order to continue receiving veterans benefits. The Department of Veterans Affairs Inspector General conducted the investigation that led to Byrd. If convicted, Byrd faces 20 years in prison and a fine of \$500,000. [Source: Pittsburgh Tribune-Review article 15 Oct 07 ++]

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> VA CANCER REPORTING POLICY: Until recently, the nation's cancer surveillance program was humming along. In every state, investigators were getting reports from every hospital describing every cancer patient they had seen. The data, which include the name, address, age, race and medical history of patients, are used to compile cancer rates. They also are used to investigate survival and other issues, like unusual cancer clusters and whether patients' experiences are different depending on their racial or economic group. While other hospitals are required by state laws to submit data, Veterans Affairs hospitals are not. And now, for the first time, veterans hospitals have stopped providing information on their cancer patients. The concern, the VA says, is protecting patient privacy. The department has set up a new national directive setting conditions for using patients' personal information and has said it cannot provide data unless and until states sign it. At issue, says Dr. Joel Kupersmith, chief of the

department's research and development office, is "the dynamic tension between patient privacy and the desire to use patients' private information to do research."

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> Only a handful of states have signed the directive so far, and the VA is just starting to send some of them data. Other states, including California, whose population includes more veterans than any other state's, have not signed and say the department's conditions are almost impossible to meet. In the meantime, when the National Cancer Institute publishes its latest national cancer statistics next summer, they will be missing data from VA patients. And that will make them hard to interpret. For example, if prostate cancer rates fall is that because VA patients were excluded. Dr. Brenda K. Edwards, associate director of the cancer institute's surveillance research program said, "Cancer research will be severely impacted" and added that the situation was so complicated that investigators could not even find a good way to estimate what the new rates would have been if the veterans' data had been provided. The Centers for Disease control & Prevention (CDC) also relies on data from the state registries. Acting chief for the CDC's cancer surveillance branch says they been talking to VA administrators, trying to resolve the situation. But the veterans agency says there is a limit to how much it can compromise. "The VA has come down clearly," Dr. Kupersmith said. "The paramount issue for us is the protection of patient privacy and the protection of patient information." He added that the department was especially sensitive to privacy concerns in light of incidents like the theft by teenagers last year of a laptop computer containing personal information on 26.5 million veterans.

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> The VA had been providing its patient data since 1972 without incident. However, in response to California's cancer registry chief request for clarification on VA policy the department replied with a directive on 22 AUG that applied to every veterans hospital. And the agency told its hospitals to stop providing information on cancer patients unless and until the states signed its new directive. Among other things, it says that anyone who wants to use personal data involving Veterans Affairs patients must either get permission from the VA's under secretary of health or find an agency researcher to collaborate with and get permission from the hospital's ethics board. The directive also says that patient information must be encoded so that unauthorized people cannot read it. Cancer researchers say they have no idea how they will meet the conditions. Senator Daniel K. Akaka, the Hawaii Democrat who is chairman of the Senate Veterans Affairs oversight committee, expressed sympathy for the VA's position. Now, states are asking: Is it better to go along with the VA and get the data, even if the restrictions make it almost impossible to use the patient information in research? Or is it better to hold firm and not sign? It is especially difficult now to compile national statistics, said Dr. Edwards of the cancer institute. In some states, VA hospitals reported data until last month. In others, limited amounts are being reported, and in still other states, no data have been reported for a year or more. [Source: New York Times Gina Kolata article 10 Oct 07 ++]

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> FTC FRAUD SURVEY: The Federal Trade Commission (FTC) has released its second survey of frauds among American adults. The data were gathered from 3,888 interviews with a representative sample of adults. The survey found that 30.2 million adults-13.5% of the adult population-were defrauded during

a 1-year period that began in late 2004. More people were victims of fraudulent weight-loss products than of any of the other frauds covered by the survey. The products included nonprescription drugs, dietary supplements, skin patches, creams, wraps, or earrings, where the seller promised that by using the product losing a substantial amount of weight would be easy or could be achieved without diet and/or exercise and where consumers who purchased the product lost little or none of the weight they had expected to lose. An estimated 2.1% of consumers-4.8 million U.S. adults-purchased and used such fraudulent weight-loss products during the one year period preceding the survey. An additional 700,000 adults purchased an alleged weight-loss product and didn't use it. The estimated total number of purchases was 8.3 million. Among purchasers, 6% said that they had lost as much or more weight than expected, 10% said that they lost about half of what they expected, 28% said that they only lost a little weight, 34% said that they did not lose any weight or gained weight, and 20% said that they had not used the product. One reason these scams are so prevalent is that the Postal Service no longer pays attention to them. They will continue to be prevalent as long as they remain profitable for media outlets that carry their ads and credit card companies that facilitate the purchases. [Source: Consumer Health Digest #07-42 30 Oct 07 ++]

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> VETERAN LEGISLATION STATUS 29 OCT 07: For a listing of Congressional bills of interest to the veteran community that have been introduced in the 110th Congress refer to the Bulletin's House & Senate attachments. By clicking on the bill number indicated you can access the actual legislative language of the bill and see if your representative has signed on as a cosponsor. 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. A cosponsor is a member of Congress who has joined one or more other members in his/her chamber (i.e. House or Senate) to sponsor a bill or amendment. The member who introduces the bill is considered the sponsor. Members subsequently signing on are called cosponsors. Any number of members may cosponsor a bill in the House or Senate. At <http://thomas.loc.gov> you can also 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/d110/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. At the end of some listed bills is a web link that can be used to do that. Otherwise, you can locate on <http://thomas.loc.gov> who your representative is and his/her phone number, mailing address, or email/website to communicate with a message or letter of your own making. [Source: RAO Bulletin Attachment 29 Oct 07 ++]

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