Appendix
H

Summary of *A 21st Century System for Evaluating Veterans for Disability Benefits*

The Commission contracted with the Institute of Medicine (IOM) to conduct a comprehensive study of the VA Schedule for Rating Disabilities. IOM convened a committee of experts to perform that task; their final report is titled *A 21st Century System for Evaluating Veterans for Disability Benefits.* This appendix contains the summary from that report. The full report is available from The National Academies Press at www.nap.edu.

Summary

ABSTRACT: *The Department of Veterans Affairs (VA) compensates veterans for injuries and diseases acquired or aggravated during military service. Currently (2007), the amount of monthly compensation to a veteran without dependents ranges from $115 for a 10 percent rating to $2,471 for a 100 percent rating. Approximately 2.8 million veterans are receiving compensation totaling about $30 billion a year (dependents and survivors receive another $5 billion a year). The rating is determined using the VA Schedule for Rating Disabilities (Rating Schedule), which has criteria based mostly on degree of impairment—i.e., loss of body structures and systems. This report recommends that VA comprehensively update the entire Rating Schedule and establish a regular process for keeping it up to date. VA should dedicate staff to maintaining the Rating Schedule and reestablish an external advisory committee of medical and other disability experts to assist in the updating process. The report also recommends that the current statutory purpose of VA's disability compensation program—to compensate for average loss of earning capacity—should be expanded to compensate for nonwork disability and loss of quality of life as well as average loss of earning capacity. VA should investigate how well the rating levels correspond to average loss of earnings and adjust rating criteria to ensure that as ratings increase, average loss of earnings also increases (vertical equity), and that the same ratings are associated with similar average losses of earnings across body systems (horizontal equity). VA should also apply measures of functional limitations, such as activities of daily living and instrumental activities of daily living, and determine if the Rating Schedule accounts for them (i.e., as limitations on ability to engage in usual life activities increase, ratings tend to increase). If not, VA should incorporate functional criteria in rating criteria or develop a separate mechanism for compensating for functional limitations beyond work disability. The methodology for measuring quality of life (QOL) is not as well developed as it is for measuring functional limitations. Accordingly, VA initially should engage in research and development efforts to create measures valid for the veteran population before determining if the Rating Schedule compensates for QOL (i.e., as quality of life diminishes, ratings generally increase) and, if it does not, develop a mechanism for compensating for loss of QOL clearly beyond loss in earnings or limitations in daily life. The report also addresses a number of other top-*

ics, for example, use of computer-based templates to improve disability examinations; better training of examiners and raters; adoption of commonly used diagnostic classification systems; comprehensive needs assessment of veterans separating from military service for health care, vocational rehabilitation, educational, and other benefits and services provided by VA; involvement of vocational expertise in determining individual unemployability; and research to improve the rating process (e.g., analyses of the validity and reliability of the Rating Schedule, evaluate training and certification programs, and assess the extent to which compensation and ancillary benefits meet the needs of veterans).

INTRODUCTION

The Institute of Medicine (IOM) was asked by the Veterans' Disability Benefits Commission to study and recommend improvements in the medical evaluation and rating of veterans for the benefits provided by the Department of Veterans Affairs (VA) to compensate for illnesses or injuries incurred in or aggravated by military service. The main topics examined in this report by the committee formed to undertake the study are VA's "Schedule for Rating Disabilities"—usually referred to as the "Rating Schedule"—and the development of medical information in the evaluation of veterans claiming disability and the use of that information in the rating process.

Compensation for service-connected disability is a monthly cash benefit made to veterans who are disabled due to an illness or injury that occurred during service or was aggravated by service. Raters use the Rating Schedule to determine degree of disability, ranging in 10 percent increments from 0 to 100 percent, and a veteran's benefit level is tied to his or her rating. Benefits in 2007 range from $115 a month for a 10 percent rating to $2,471 for a 100 percent rating (plus additional amounts for dependents of those with 30 percent ratings or higher).

The statutory purpose of disability benefits is to compensate veterans for "the average impairments of earning capacity resulting from such injuries in civil occupations." VA program policies clearly reflect a grateful nation. They include deciding in favor of the veteran if there is reasonable doubt; assisting the veteran in gathering evidence; identifying conditions that might be compensable even if the veteran does not claim them; and presumption of service connection for certain conditions. A disability rating also entitles a veteran to ancillary services, such as vocational rehabilitation and employment services, and higher ratings provide access to more benefits, such as free health care. The compensation is tax exempt, and there are annual cost-of-living adjustments.

It is important that the tool used to determine the rating—the Rating Schedule—be as effective as possible in fulfilling the purpose of the compensation program. Is it valid and reliable in determining degree of disability? Is it up to date, and are there adequate arrangements for keeping it up to date? Are there better ways of evaluating disability? This report addresses these and related questions and makes recommendations for improvements.

IMPAIRMENT, DISABILITY, AND QUALITY OF LIFE

The statutory purpose of the cash benefits currently provided to veterans with disabilities is to compensate for the work disability ("average impairment in earning capacity") resulting from service-related injuries and diseases. In practice, Congress and VA have implicitly recognized consequences in addition to work disability of impairments suffered by veterans in the Rating

Schedule and other ways. Modern concepts of disability include work disability, nonwork disability, and quality of life, although not all of the tools used to operationalize the evaluation of this broader concept of disability are well developed. The Rating Schedule currently emphasizes impairment and limitations or loss of specific body structures and functions, which may not predict disability well. However, the Rating Schedule could be revised to include factors that are more directly related to disability, such as activities of daily living and other whole-person-level functional limitations. It also may be possible to develop procedures to measure and compensate for loss of quality of life. Revising the Rating Schedule would be greatly assisted by a clearer definition of the purpose of compensation.

Recommendation 3-1.[1] The purpose of the current veterans disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is, work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life. (Specific recommendations on approaches to evaluating each consequence of service-connected injuries and diseases are in Chapter 4.)

The committee is aware that adopting Recommendation 3-1 would be difficult and costly. Legislative endorsement would be very helpful, if not required. If the recommendation is adopted, the Rating Schedule and the procedures needed to implement it will need to be revised to reflect the expanded purposes for disability benefits endorsed by the committee. This can be done in phases, after appropriate research and analysis and pilot projects to study the feasibility of changes. This issue is addressed in Chapters 4 and 5.

Expanding the bases for veterans disability compensation also has cost implications. There will be start-up costs incurred in developing the instruments for evaluating degree of functional limitation and loss of QOL, transitional costs such as training, and possibly greater compensation costs (if functional or QOL deficits are greater on average than are accounted for using the current impairment ratings). Although the committee was not asked to consider costs in recommending improvements in medical evaluation of veterans for disability benefits, the issue is addressed at the end of Chapter 4.

In addition, if disability compensation is considered in the larger context of veterans benefits, in conjunction with today's views on the rights of individuals with disabilities to live as full a life as possible, it is possible to envision a more comprehensive evaluation of a veteran's needs—including medical, educational, vocational, and compensation. Currently, the assessment process is piecemeal and fragmented. Either the veteran must receive a rating to access related services, such as health care and vocational rehabilitation and employment services, or the other service, such as education, is separate. This issue is addressed in Chapter 6.

[1] Recommendations used throughout the Summary and the rest of the report are numbered according to the chapter in which they appear and the order in which they appear in that chapter. Thus Recommendation 3-1, which is the first recommendation in the report, is the first recommendation to appear in Chapter 3. See Box S-1 for all of the recommendations, categorized according to the committee's specific tasks.

THE RATING SCHEDULE

Updating the Rating Schedule

It is important for the Rating Schedule to be as up to date as possible in current medical approaches and terminology to serve veterans with disabilities most effectively. This ensures that the criteria in the Rating Schedule are based on concepts and terms used by medical personnel who provide medical evidence, and that evolving understanding of, or recognition of, new disabling conditions is reflected.

Currently, the Rating Schedule is out of date medically. It has been more than 10 years since many body systems were comprehensively updated, and some have not been updated for much longer. The Rating Schedule should be revised to remove ambiguous criteria and obsolete conditions and language, reflect current medical practice, and include medical advances in diagnosis and classification of new conditions.

VA should expeditiously undertake a comprehensive revision of the Rating Schedule and establish a formal process to revise it approximately every 10 years. Several body systems could be revised each year on a staggered basis to make this feasible. VA will need to increase its staff capacity to update and revise the Rating Schedule. The process would also benefit from external advice from medical, rehabilitation, and vocational experts, and the veteran community.

Recommendation 4-1. VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update, and devise a system for keeping it up to date. VA should reestablish a disability advisory committee to advise on changes in the Rating Schedule.

Revising the Rating Schedule to Improve the Relationship Between Ratings and Earnings Losses

The formal purpose of the Rating Schedule is to compensate for loss of earning capacity. Loss of earning capacity is more a legal or economic than a medical concept. In practice, the best proxy for earning capacity is actual earnings. There is no current evidence on the relationship between the Rating Schedule's severity ratings and average loss of earnings of veterans with disabilities. Findings were mixed when VA last looked at this in 1971. Since that time, substantial social and technological changes have occurred (e.g., passage of the Americans with Disabilities Act, advances in assistive devices) that make it easier for people with disabilities to work. A comparison study should be done using a nationally representative sample of veterans with and without disabilities. The rating criteria could be adjusted accordingly to achieve vertical equity (i.e., the higher the rating, the lower the earnings on average) and horizontal equity (i.e., average earnings at any given rating level are the same across conditions).

Recommendation 4-2. VA should regularly conduct research on the ability of the Rating Schedule to predict actual loss in earnings. The accuracy of the Rating Schedule to predict such losses should be evaluated using the criteria of horizontal and vertical equity.

Recommendation 4-3. VA should conduct research to determine if inclusion of factors in addition to medical impairment, such as age, education, and work experience, improves the ability of the Rating Schedule to predict actual losses in earnings.

Recommendation 4-4. VA should regularly use the results from research on the ability of the Rating Schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the Rating Schedule or by adjusting the amounts of compensation associated with each rating degree.

Revising the Rating Schedule to Improve the Relationship Between Ratings and Limitations on Ability to Engage in Usual Life Activities

The lives of veterans with service-connected injuries and diseases can be changed in many ways from what their lives might have been had they not become limited by the effects of those injuries or diseases, which can affect even those veterans who can work. It is possible that the Rating Schedule, when updated, will compensate for consequences in addition to work disability even though it is intended to compensate for loss of earning capacity. This is an empirical question that VA should address by developing a functional limitation scale (or adapting an existing scale) to a sample of veterans with and without disabilities, and determining if it would lead to different ratings than would the Rating Schedule. If it is found that functional measures capture disability not captured by the Rating Schedule, VA should decide how to compensate for it.

Recommendation 4-5. VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism.

Revising the Rating Schedule to Improve the Relationship Between Ratings and Losses in Quality of Life

The purpose of the current Rating Schedule is to compensate for work disability, not for losses in quality of life. Therefore, it is likely that the relationship between ratings under the current Rating Schedule and the QOL measures are not particularly close, which creates an empirical question that should be addressed. If research shows a disparity between the Rating Schedule and loss of QOL measures, VA should develop a way to compensate for the loss not compensated by the Rating Schedule. This could be done by adapting the Rating Schedule to be used for both work disability and loss in quality of life, or there could be separate Rating Schedules for these two consequences of service-related injuries and diseases.

Recommendation 4-6. VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and if it does not, developing a procedure for evaluating and rating loss of quality of life of veterans with disabilities.

THE MEDICAL EXAMINATION AND DISABILITY RATING PROCESS

Medical Evaluation Process

Nearly every veteran applying for disability compensation is examined by a physician or other clinician (e.g., audiologist) working for or under contract to VA. Investigations of the claims process in the 1990s showed that incompleteness and lateness of such compensation and pension (C&P) examinations were a serious problem. The Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA) have worked to improve this process, but more needs to be done and stronger measures need to be taken to implement the improved procedures that have been developed.

Need for Regular Updating of Examination Worksheets/Templates

VA does not systematically update the C&P examination worksheets and some—developed as long ago as 10 years—are seriously out of date.

Recommendation 5-1. VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability advisory committee recommended above (see Recommendation 4-1).

Requiring the Use of the Examination Templates

Use of the worksheets is not required and many examiners do not use them. Use of the online templates has increased rapidly, presumably because of their ease of use. VA is considering a mandate that the latter be used, although that is not the case currently.

Recommendation 5-2. VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations.

Assessing and Improving Quality and Consistency of Examinations

Quality assurance of medical examinations and ratings currently is process oriented—meaning, focused on whether the information provided on the examination form was complete and timely, not whether it was correct. A sample of ratings is reviewed substantively, but the results are not systematically analyzed for general problems or consistency.

Recommendation 5-3. VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, for example, by revising the templates, changing the training, or adjusting the performance standards for examiners.

The Rating Process

Quality of Rating Decisions

VBA's quality assurance program, STAR, implemented in 1998, has improved the accuracy rate from 80 percent in FY 2002 to 88 percent in FY 2006. The sample is only large enough to determine the aggregate accuracy rate of regional offices. It does not assess accuracy at the body system or diagnostic code level, and it does not measure consistency across regional offices.

There are many sources of variability in decision making that, if not addressed and reduced to the extent possible, make it unlikely that veterans with similar disabilities are being treated similarly. Variability cannot be totally eliminated, but sources of variability that can be controlled, such as training, guidelines, and rater qualifications, should be addressed.

Recommendation 5-4. The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions.

Better Access to Medical Expertise

Few raters have medical backgrounds. They are required to review and assess medical evidence provided by treating physicians and VHA examining physicians and determine percentage of disability, but VBA does not have medical consultants or advisers to support the raters. Medical advisers would also improve the process of deciding what medical examinations and tests are needed to sufficiently prepare a case for rating.

Recommendation 5-5. VA raters should have ready access to qualified health-care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence or assessing the need for additional examinations or diagnostic tests).

Medical consultants to adjudicators could come from VHA or outside contractors, or VBA could hire health-care providers as part of its own staff.

Training of Examiners and Adjudicators

VBA has a training program and is implementing a certification program for raters and, with VHA, is implementing a training and certification program for medical examiners. The training should be more intensive, and the training program should be rigorously evaluated.

Recommendation 5-6. Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs.

MEDICAL CRITERIA FOR ANCILLARY BENEFITS

Currently, VA requires a disability rating for access to other benefits that are meant to help a veteran realize his or her potential in civilian life. The process is not ideal, because it requires the veteran to establish his or her disability, which may take months or sometimes years, before he or she is eligible for benefits from available services—such as health care, vocational rehabilitation, and adaptive vehicles and housing—that could improve his or her economic situation and quality of life. There are also practical advantages to conducting a comprehensive evaluation of newly separating servicemembers that includes a determination of rehabilitation and vocational needs as well as compensation needs.

Recommendation 6-1. VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychosocial, and vocational evaluation of each veteran applying for disability compensation at the time of service separation.

VA does not systematically assess the needs of veterans or evaluate its ancillary service programs. Many ancillary benefits, such as clothing allowances, automobile grants, and adaptive housing, arose piecemeal in response to circumstances of the time they were adopted. It could be that these programs could be changed to better serve veterans or that there are unaddressed needs. However, it is not possible to judge their appropriateness because the thresholds that have been set for ancillary benefits requirements were not based on research on who benefits or who benefits most from the services in terms of rating level.

Recommendation 6-2. VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increased functional capacity and enhanced health-related quality of life.

The current 12-year limit on eligibility for vocational rehabilitation services is a policy decision with no medical basis, although there may be administrative convenience or fiscal control reasons. There are types of employment and training requirements that do not realistically adhere to a 12-year deadline. For example, emerging assistive and workplace technologies (e.g., computing) may provide training or retraining opportunities for veterans with disabilities through continuing education of various kinds. New types of work may also emerge for which veterans with disabilities could be trained.

Recommendation 6-3. The concept underlying the extant 12-year limitation for vocational rehabilitation for service-connected veterans should be reviewed and, when appropriate, revised on the basis of current employment data, functional requirements, and individual vocational rehabilitation and medical needs.

The percentage of entitled veterans applying for vocational rehabilitation and employment (VR&E) services is relatively low. In FY 2005, about 40,000 veterans applied for VR&E services and were accepted. Of those deemed eligible, between a quarter and a third have not completed the program in recent years. VA should explore ways to increase participation in this program.

Recommendation 6-4. VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal.

INDIVIDUAL UNEMPLOYABILITY

Individual unemployability (IU) is a way for VA to compensate veterans at the 100 percent rate who are unable to work because of their service-connected disability, although their rating according to the Rating Schedule does not reach 100 percent. IU is based on an evaluation of the individual veteran's capacity to engage in a substantially gainful occupation, which is defined as the inability to earn more than the federal poverty level, rather than on the schedular evaluation, which is based on the average impairment of earnings concept.

Vocational Assessment in IU Evaluation

Currently, VA's policy is to consider vocational and other factors, but the process for obtaining and assessing vocational evaluations is weak. Raters have disability evaluation reports from medical professionals and other medical records to analyze, but they do not have comparable functional capacity or vocational evaluations from vocational experts. Raters must determine the veteran's ability to engage in normal work activities from medical reports and from information in the two-page application for IU and the one-page report from employers, neither of which asks about functional limitations. Raters do not receive training in vocational assessment.

Recommendation 7-1. In addition to medical evaluations by medical professionals, VA should require vocational assessment in the determination of eligibility for individual unemployability benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of individual unemployability claims.

IU Eligibility Thresholds

Currently, to be eligible for IU, a veteran must have a rating of 60 percent for one impairment or 70 percent for more than one impairment, as long as one of them is rated 40 percent. The basis for these threshold percentages is not known; they were adopted in 1941. Having a threshold makes obvious administrative sense, as long as it is not so high that many people with lower ratings who are legitimately unemployable are excluded. What that threshold should be, and the extent to which the current threshold requirements reflect actual unemployability, are not known.

Recommendation 7-2. VA should monitor and evaluate trends in its disability program and conduct research on employment among veterans with disabilities.

Age of IU Recipients

As noted in the discussion of ancillary benefits, VA does not systematically assess the economic situation of the veteran population and its needs. VA does not know, therefore, the reasons

for the rapid increase in the number of IU beneficiaries, and whether it indicates a need to address special employment or medical needs of older veterans.

Recommendation 7-3. VA should conduct research on the earnings histories of veterans who initially applied for individual unemployability benefits past the normal age of retirement for benefits under the Old Age, Survivors, and Disability Insurance Program under the Social Security Act.

Factors Considered in IU Evaluation

Congress has made a policy decision not to put an age limit on eligibility for IU. It is true that individuals are able and willing to work, and do work, into their 70s and 80s, and they should not be barred from receiving IU if disability forces them to quit. But age should still be considered a factor contributing to unemployability, in conjunction with other vocational factors that also reduce an individual's likelihood of getting or keeping a job, such as minimal education, lack of skills, and employment history (e.g., manual labor).

Recommendation 7-4. Eligibility for individual unemployability should be based on the impacts of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on his or her potential employability.

Employment of IU Recipients

Under the current system, a veteran on IU is permitted to engage in substantially gainful employment for up to 12 months before IU benefits are terminated, after which his or her payments drop back to their scheduler rating of 60, 70, 80, or 90 percent. Disability compensation amounts do not increase in direct proportion to disability rating percentages. The largest dollar increase in payment is between the 90 percent ($1,483 per month) and 100 percent ($2,471 per month) rating, which means that a veteran terminated from IU after working a year will have his or her monthly payments drop by 40 to 64 percent, depending on the scheduler rating. This poses a sudden "cash cliff" that may deter some veterans from trying to reenter the workforce. Most cash support programs try to provide incentives to work by using some sort of sliding scale to ease the transition from being a beneficiary to being ineligible.

Recommendation 7-5. VA should implement a gradual reduction in compensation to individual unemployability recipients who are able to return to substantial gainful employment rather than abruptly terminate their disability payments at an arbitrary level of earnings.

OTHER DIAGNOSTIC CLASSIFICATION SYSTEMS AND RATING SCHEDULES

Alternative Diagnostic Classification Codes

Having the same diagnostic categories for the disability compensation program as VHA and other health-care providers—*International Classification of Diseases* (ICD) and *Diagnostic and Statistical Manual for Mental Disorders* (DSM)—would facilitate communication and understanding of a veteran's health problems. The rater would be better able to relate information in medical records to the Rating Schedule if the diagnostic categories were the same. It would also help the program keep up with advances in medical understanding, because the ICD and the DSM undergo regular revision and periodic comprehensive revisions. This would help avoid the present situation in which some currently identified conditions are not in the Rating Schedule. Another advantage of using ICD codes would be the reduction in the rate of use of analogous codes.

Use of common diagnostic categories also would allow VA program managers and researchers to compare populations and trends that would help in program planning and in epidemiological and health services research. VA's diagnostic codes are unique and do not allow comparisons of trends in disabilities in populations served by VHA or the Department of Defense or research normed to the veteran population.

Recommendation 8-1. VA should adopt a new classification system using the *International Classification of Disease* (ICD) and the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) codes. This system should apply to all applications, including those that are denied. During the transition to ICD and DSM codes, VA can continue to use its own diagnostic codes, and subsequently track and analyze them comparatively for trends affecting veterans and for program planning purposes. Knowledge of an applicant's ICD or DSM codes should help raters, especially with the task of properly categorizing conditions.

AMA Guides Impairment Rating System

The AMA *Guides to the Evaluation of Permanent Impairment* is superior to the current Rating Schedule in two important respects. The *Guides* uses current medical concepts, terminology, and tests, and is updated regularly; however, it is not designed to measure disability, only impairment, and it is also designed for use by physicians. The *Guides*, designed to measure degree of permanent impairment, not degree of ability to work (which is to be determined by government agencies or insurance companies), tends to have lower ratings than the Rating Schedule. The *Guides* do not determine percentage of impairment from mental disorders.

Recommendation 8-2. Considering some of the unique conditions relevant for disability following military activities, it would be preferable for VA to update and improve the Rating Schedule on a regular basis rather than adopt an impairment schedule developed for other purposes.

SERVICE CONNECTION ON AGGRAVATION AND SECONDARY BASES

Compensation for Aggravation of Preservice Disability and Allen Aggravation Claims

Determination of aggravation is an individualized clinical judgment.

Recommendation 9-1. VA should seek the judgment of qualified experts, supported by findings from current peer-reviewed literature, as guidance for adjudicating both aggravation of preservice disability and Allen aggravation claims. Judgment could be provided by VHA examiners, perhaps from VA centers of excellence, who have the appropriate expertise for evaluating the condition(s) in question in individual claims.

Secondary Service Connection

Like aggravation, secondary service connection involves individualized clinical judgment, but clinical judgment should be informed by the state of knowledge of causation in the condition being evaluated.

Recommendation 9-2. VA should guide clinical evaluation and rating of claims for secondary service connection by adopting specific criteria for determining causation, such as those cited above (e.g., temporal relationship, consistency of research findings, strength of association, specificity, plausible biological mechanism). VA should also provide and regularly update information to C&P examiners about the findings of epidemiological, biostatistical, and disease mechanism research concerning the secondary consequences of disabilities prevalent among veterans.

CONCLUSION

Some important cross-cutting themes emerged from the study. VA does not devote adequate resources to systematic analysis of how well it is providing its services (process analysis) or how much the lives of veterans are being improved (outcome analysis), the knowledge of which, in turn, would enable VA to improve the effectiveness and impacts of its benefit programs and services.

VBA does not have a program of research oriented toward understanding and improving the effectiveness of its benefit programs. Research efforts in the areas of applied process research, clinical outcomes, and economic outcomes should be undertaken.

VA is missing the opportunity to take a more veteran-centered approach to service provision across its benefits programs. VA has the services needed to maximize the potential of veterans with disabilities, but they are not actively coordinated and thus are not as effective as they could be. The disability compensation evaluation process provides an opportunity to assess the needs of veterans with disabilities for the other services VA provides, such as vocational rehabilitation, employment services, and specialized medical services. This process would coordinate VA's programs for each veteran and make it a more veteran-centered agency.

BOX S-1 Summary of Tasks and Associated Recommendations

TASK 1. *How well do the medical criteria in the VA Rating Schedule and VA rating regulations enable assessment and adjudication of the proper levels of disability to compensate both for the impact on quality of life and impairment in earnings capacity? Provide an analysis of the descriptions associated with each condition's rating level that considers progression of severity of condition as it relates to quality-of-life impairment and impairment in average earnings capacity.*

Recommendation 3-1. The purpose of the current veterans disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is, work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life. (Specific recommendations on approaches to evaluating each consequence of service-connected injuries and diseases are in Chapter 4.)

Recommendation 4-1. VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update, and devise a system for keeping it up to date. VA should reestablish a disability advisory committee to advise on changes in the Rating Schedule.

Recommendation 4-2. VA should regularly conduct research on the ability of the Rating Schedule to predict actual loss in earnings. The accuracy of the Rating Schedule to predict such losses should be evaluated using the criteria of horizontal and vertical equity.

Recommendation 4-3. VA should conduct research to determine if inclusion of factors in addition to medical impairment, such as age, education, and work experience, improves the ability of the Rating Schedule to predict actual losses in earnings.

Recommendation 4-4. VA should regularly use the results from research on the ability of the Rating Schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the Rating Schedule or by adjusting the amounts of compensation associated with each rating degree.

Recommendation 4-5. VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism.

Recommendation 4-6. VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and if it does not, developing a procedure for evaluating and rating loss of quality of life of veterans with disabilities.

TASK 2. *Certain criteria and/or levels of disability are required for entitlement to ancillary and special purpose benefits. To what extent, if any, do the required thresholds need to change? Determine from a medical perspective at what disability rating level a veteran's medical or vocational impairment caused by disability could be improved by various special benefits such as adapted housing, automobile grants, clothing allowance, and vocational rehabilitation. Consideration should be given to existing and additional benefits.*

Recommendation 6-1. VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychosocial, and vocational evaluation of each veteran applying for disability compensation at the time of service separation.

Recommendation 6-2. VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increased functional capacity and enhanced health-related quality of life.

Recommendation 6-3. The concept underlying the extant 12-year limitation for vocational rehabilitation for service-connected veterans should be reviewed and, when appropriate, revised on the basis of current employment data, functional requirements, and individual vocational rehabilitation and medical needs.

Recommendation 6-4. VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal.

TASK 3. *Analyze the current application of the Individual Unemployability (IU) extra-schedular benefit to determine whether the VASRD descriptions need to more accurately reflect a veteran's ability to participate in the economic marketplace. Propose alternative medical approaches, if any, to IU that would more appropriately reflect individual circumstances in the determination of benefits. For the population of disabled veterans, analyze the cohort of IU recipients. Examine the base rating level to identify patterns. Determine if the VASRD description of conditions provide a barrier to assigning the base disability rating level commensurate with the veteran's vocational impairment.*

Recommendation 7-1. In addition to medical evaluations by medical professionals, VA should require vocational assessment in the determination of eligibility for individual unemployability benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of individual unemployability claims.

Recommendation 7-2. VA should monitor and evaluate trends in its disability program and conduct research on employment among veterans with disabilities.

Recommendation 7-3. VA should conduct research on the earnings histories of veterans who initially applied for individual unemployability benefits past the normal age of retirement for benefits under the Old Age, Survivors, and Disability Insurance Program under the Social Security Act.

Recommendation 7-4. Eligibility for individual unemployability should be based on the impacts of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on his or her potential employability.

Recommendation 7-5. VA should implement a gradual reduction in compensation to individual unemployability recipients who are able to return to substantial gainful employment rather than abruptly terminate their disability payments at an arbitrary level of earnings.

TASK 4. *What are the advantages and disadvantages of adopting universal medical diagnostic codes rather than using a unique system? Compare and contrast the advantages/disadvantages of VA Schedule for Rating Disabilities and the American Medical Association Guides to the Evaluation of Permanent Impairment.*

Recommendation 8-1. VA should adopt a new classification system using the *International Classification of Disease* (ICD) and the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) codes. This system should apply to all applications, including those that are denied. During the transition to ICD and DSM codes, VA can continue to use its own diagnostic codes, and subsequently track and analyze them comparatively for trends affecting veterans and for program planning purposes. Knowledge of an applicant's ICD or DSM codes should help raters, especially with the task of properly categorizing conditions.

Recommendation 8-2. Considering some of the unique conditions relevant for disability following military activities, it would be preferable for VA to update and improve the Rating Schedule on a regular basis rather than adopt an impairment schedule developed for other purposes.

TASK 5. *From a medical perspective, analyze the current VA practice of assigning service connection on "secondary" and "aggravation" bases. In "secondary" claims, determine what medical principles and practices should be applied in determining whether a causal relationship exists between two conditions. In "aggravation" claims, determine what medical principles and practices should be applied in determining whether a preexisting disease was increased due to military service or was increased due to the natural process of the disease.*

Recommendation 9-1. VA should seek the judgment of qualified experts, supported by findings from current peer-reviewed literature, as guidance for adjudicating both aggravation of preservice disability and Allen aggravation claims. Judgment could be provided by VHA examiners, perhaps from VA centers of excellence, who have the appropriate expertise for evaluating the condition(s) in question in individual claims.

Recommendation 9-2. VA should guide clinical evaluation and rating of claims for secondary service connection by adopting specific criteria for determining causation, such as those cited above (e.g., temporal relationship, consistency of research findings, strength of association, specificity, plausible biological mechanism). VA should also provide and regularly update information to C&P examiners about the findings of epidemiological, biostatistical, and disease mechanism research concerning the secondary consequences of disabilities prevalent among veterans.

TASK 6. *Compare and contrast the role of healthcare professionals in the claims/appeals process in VA and DoD, Social Security, and federal employee disability benefits programs. What skills, knowledge, training, and certification are required of the persons performing the examinations and assigning the ratings?*

Recommendation 5-1. VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability advisory committee recommended above (see Recommendation 4-1).

Recommendation 5-2. VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations.

Recommendation 5-3. VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, for example, by revising the templates, changing the training, or adjusting the performance standards for examiners.

Recommendation 5-4. The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions.

Recommendation 5-5. VA raters should have ready access to qualified health-care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence or assessing the need for additional examinations or diagnostic tests).

Recommendation 5-6. Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs.

Appendix D. The Role of Medical Personnel in Selected Disability Benefit Programs.