Policy Memo & Brief Samples

Updated Spring 2016

MEMOS

Memo Sample 1: recommendations

TO: Peter Stangl, Chairman
FROM: [NYU Wagner Student], Policy Advisor
DATE: July 1, 1983
RE: Recommended Fare Policy Proposal for July 8 Board of Directors Meeting

The purpose of this memorandum is to recommend a series of changes to current MTA fare policies that incorporate the spirit of the original "Fare Deal" plan as well as the findings of the Fare Policy Advisory Task Force (FPATF). Based on a complex modeling analysis relying on thousands of in-person interviews and telephone surveys, the FPATF's findings shows that these recommendations will increase system ridership, grow MTA revenue and improve rider fare equity; all while maximizing system efficiency.

Maintain the current fare of $1.25 for off-peak trips. Adopting all proposals included here is projected to produce a net revenue increase of $67 million. Coupled with potential cost savings from a reduced number of transactions and improved system efficiency, it is unnecessary to adopt additional fare increases at this time, particularly given the substantial increase in capital funds recently secured by MTA.

Implement a peak fare surcharge of $0.50 per trip, bringing the total charge to $1.75 per trip. In line with your previously expressed desire for innovative fare pricing models, a peak fare surcharge of $0.50 per trip will help raise revenue for other fare initiatives without depressing ridership. Peak fare surcharges are also progressive in that they help shift fare costs away from low-income riders, who are more likely to be off-peak riders. Higher peak fare costs will also cause more riders to vary their travel hours to utilize the system during off peak hours, which will spread passengers out across trains, equalizing train exit and entry times as well as providing for a more spacious, pleasant rider experience. Overall, the diffusion of passengers across off- peak hours will raise system efficiency and more accurately match charged fares to user costs.

Introduce an unlimited monthly pass for $82.50 at a charge of 47 peak rides or 66 off-peak rides. A monthly pass is as important symbolically as it is practically. New York's lack of quantity discounts for frequent riders represents a lost opportunity to incentivize ridership and a higher share of costs borne by frequent riders than tourists and non-region residents. Pricing unlimited monthly passes at $82.50 represents a rate of 47 peak rides per month, which is consistent with the spirit of the original Fare Deal plan yet not so cheap as to undercut the potential for bulk fare purchase discounts. The introduction of an unlimited monthly pass will reward frequent local users, reduce transactions and their associated operating costs, and increase system ridership; expanding the direct public benefit provided

by MTA.

Offer a bulk fare 5 percent purchase discount for each fare purchase greater than $8.25. Maintaining a low ceiling for bulk fare discounts is an important part of ensuring frequent riders of low-income are also able to benefit from high ridership discounts. For those frequent riders who will not always have sufficient cash on-hand to purchase a full monthly pass, this policy will offer an important market discount that offsets the potentially regressive impact of the unlimited monthly pass on the poorest riders. Additionally, a five percent discount at a smaller ceiling ensures that the most frequent riders still see value in an unlimited monthly pass, which has a greater impact on increasing general ridership.

Promote a 50% transfer discount for multi-modal users of public transit who are currently getting charged full-price twice. Consolidating payment systems across bus and rail lines has begged legitimate public questions as to why users traveling part of their commute on buses as opposed to only on trains should pay so much more. Multi-modal transit users represent 20% of total system rides but have become a powerful and vocal candidacy. Although multi-modal transit users tend to live in wealthier neighborhoods and have higher incomes, suggesting a higher ability to pay, substantial public pressure has built at the city and state-level to offer transfer discounts to these users. Excluding transfer discounts from the final package of comprehensive fare policy reforms would leave a sizeable constituency unhappy and could endanger the entire fare policy reform package, in addition to potentially endangering the status of MTA leadership. The fifty percent transfer discount recommended offers an equitable solution that aligns with the discount included in MTA's initial Fare Deal proposal.

Please let me know if you have any further questions on these policy recommendations.

Memo Sample 2: recommendations and conclusions

TO: The Honorable Bill de Blasio, Mayor of New York City
FROM: [NYU Wagner Student]
DATE: February 26, 2014
SUBJECT: Wage theft and labor violations in City-funded affordable housing construction

This memo proposes policy alternatives to address worker exploitation resulting from wage theft and labor law violations on publicly funded affordable housing projects. Poor project management and corruption at the Department of Housing Development and Preservation (HPD) contribute to this exploitation. I propose three not mutually exclusive alternatives to redress this issue: (1) partial workforce unionization, (2) procurement reform, and (3) improved project monitoring by HPD.

The problem: A recent report by the NYS Attorney General and US Department of Labor (DOL) found over $9 million of back wages due to HPD workers since 2011. Of the DOL wage investigations in New York City initiated in 2009, 78% of back wages findings by dollar value resulted from wage theft on HPD jobsites. Safety and economic risks to workers reporting abuse result in many unreported violations.

Policy Recommendations:
1. **Decrease wage theft by unionizing a segment of the workforce**. Enter a project labor agreement (PLA) with the New York City Building and Construction Trades Council (BCTC) for prevailing wage projects. Limiting the PLA to prevailing wage work negates cost increases and opens affordable housing construction to a group of employers with a demonstrated ability to pay prevailing wages. It shifts the burden of enforcement: unions police their own contractors to ensure their collective bargaining agreements are enforced.

A PLA is practically and politically feasible, but will be viewed unfavorably by real estate interests. Implementation does not require approval beyond your office. Mayor Bloomberg negotiated PLAs for construction under several agencies, including DDC, DCAS, DPR, DOC, and DOHMH. You are well positioned to counter opposition arguments: a prevailing wage PLA would affect only 20% of HPD's projects and the poor compliance record of the current actors in the market speaks for itself.

2. **Pursue procurement reform to close loopholes that reward exploitive employers**. HPD procurement is not subject to sealed competitive bidding, the method preferred by the New York City Procurement Policy Board and New York State General Municipal Law. Instead it relies on discretionary procurement methods, which consolidate power into a small group of agency decision makers, contributing to agency corruption.

Procurement reform will level the playing field for responsible employers. Switching to competitive, sealed bidding helps eliminate corruption while maintaining a market driven solution. Additional restrictions should also be built into the bidding process. Specifically, bidding parties should be required to have a higher standard for past compliance with labor laws. Adopting a formal debarment process is another method of achieving this end. Both methods have been successfully adopted by other City agencies.

3. **Issue a strong directive to improve project-monitoring so as to reduce future violations**. HPD already has the authority and obligation to monitor labor standards; reforming the existing Labor Monitoring Unit (LMU) would catch more violations. While better enforcement does not address the root cause of illegal underpayment, the negative repercussions of getting caught (penalties, back wage payments, criminal charges, etc.) incentivizes employers to ensure labor laws are not violated.

LMU should realign its relationships. HPD should embrace labor law compliance as a function of its operation, rather than something imposed on it from outside. Pursuing relationships with entities monitoring projects, like regulatory agencies and labor unions, will expand LMU's monitoring capabilities. Moving HPD's LMU to the Inspector General's office will reduce opportunities for collusion and diminish the influence of other HPD departments on investigations.

Conclusions:

There is a trade-off between compliance and cost. Paying the legally required wages, workers compensation insurance, and payroll taxes is an additional expense to non-compliant employers, which may result in fewer housing units produced or necessitate more subsidies.

Procurement reform and monitoring are more equitable to workers. A PLA efficiently diminishes wage violations; however, it also potentially displaces Latino workers. Predominately white and black unionized workers would benefit from enforced prevailing wages, while Latino workers would continue to earn lower wages on non-prevailing wage projects.

Monitoring and procurement reform improve more problems at more projects. A PLA would not address serious labor violations on non-prevailing wage projects, such as failure to pay overtime, worker misclassification, and off-the-books work. According to a recent report by the Fiscal Policy Institute, addressing these violations could add up to $60 million per year in tax revenue to the City.

Repercussions from taking no action could result in a loss of funds. Though it is

unlikely, federal and state governments could stop allocating subsidies to HPD and instead manage their own affordable housing projects in New York City.

Your legacy is at stake. An affordable housing program where workers cannot afford to live in the housing they build detracts from your legacy as a champion of income equality. Adopting these policies to resolve exploitation is within your power. You must strike a balance between protecting a vulnerable population of workers, preserving your image as a force in economic equality, and the political realities of the strength of the real estate lobby in New York City.

Please contact me if you or your staff have any questions or require additional information. I look forward to working with you during your first term. Thank you for your attention.

Memo Sample 3: recommendations

TO: President of the United States
FROM: [Harvard Kennedy School Student][1]
SUBJECT: **Re-organizing the Government to Combat the WMD Threat**
DATE: xx / xx / xxxx

The proliferation of nuclear, chemical, and biological weapons is the most serious threat to U.S. security today, and will remain so far into the future. Whereas combating proliferation is an inherently government-wide mission, the existing national security architecture has resulted in a series of agency-specific efforts that are often poorly coordinated and fail to take advantage of important synergies. Re-organizing the government to meet the WMD threat therefore requires reforms that strengthen White House management of nonproliferation programs, expand interagency counterproliferation capabilities, and improve WMD-related intelligence.

Strengthen White House Management of Nonproliferation Programs

The Departments of Energy (DOE), State, Defense (DOD), Commerce, and Homeland Security (DHS) all contribute to U.S. nonproliferation efforts, but receive insufficient top-level program guidance and coordination. For example, DOE did not learn of Libya's decision to abandon its nuclear program until it was revealed in the press. Moreover, DOE had no plan in place to dismantle Libya's nuclear assets despite its central role in performing such activities. Finally, proliferation detection R&D projects are currently managed by a community of end users that have overlapping needs but rarely communicate with each other.

To prevent future interagency breakdowns, the White House should designate a new senior- level Nonproliferation Policy and Program Director (NPD) to oversee all U.S. government nonproliferation programs. The NPD will chair a new National Security Council Policy Coordinating Committee on Nonproliferation (PCC) that will set overarching nonproliferation goals and priorities, develop an interagency strategic plan to achieve those goals and priorities, identify and assign missions and responsibilities to appropriate agencies, and coordinate program execution. To improve proliferation detection R&D, the NPD and PCC will also design an interagency technology development plan that will integrate and prioritize the needs of various technology end users across the government with the capabilities of the U.S. national laboratory system, private industry, and top universities. The Office of Management and Budget (OMB) will work with the new NPD and PCC to develop a multi-year interagency nonproliferation program budget, and will apply performance measures to monitor program management and implementation.

Although the NPD and the PCC will require little additional funding, past attempts at White House policy coordination – such as the Office of Homeland Security – have

[1] Memo sample retrieved from: http://www.hks.harvard.edu/content/download/66717/1239678/version/1/file/sample-

sunk into irrelevance because of agency resistance. To avoid suffering a similar fate, the NPD and PCC must possess clearly delineated authority and high level backing. In particular, the NPD should enjoy unambiguous control over nonproliferation policy and program budgets. The PCC should require agency participation at the Under Secretary level. Most important, the NPD and PCC must receive consistent, visible support from the President.

Expand Interagency Counterproliferation Capabilities

The U.S. military and homeland security communities must be able to rapidly respond to proliferation emergencies. To provide this capability, the United States should create and train "Proliferation Risk Mitigation Teams" – akin to the Department of Homeland Security's Nuclear Emergency Search Teams (NEST) – comprised of DOD special operations forces (SOF), CIA operatives, and DOE technical specialists. These teams will be capable of securing nuclear storage facilities and other sensitive infrastructure during combat operations or in response to the collapse of central authority in states that possess nuclear assets that are attractive to terrorists. They will also provide logistical and operational support to the Energy Department's "Global Cleanout" program that seeks to return stockpiles of weapons-usable highly enriched uranium to Russia and the United States. Finally, they will engage in extensive "red-teaming" simulations in order to foster better situation awareness and preparedness.

Operational control of Proliferation Risk Mitigation Teams will pose a major challenge. Congress may object to placing the teams under CIA control in light of the agency's past abuses. Moreover, DOD will be reluctant to assign SOF personnel to the teams if they will be placed under the command authority of a different agency. Given the types of operations in which the teams are likely to engage, DOD operational control would therefore seem most appropriate. The teams will cost approximately $500 million annually to train and equip. To provide the necessary funding, the United States should cancel the Missile Defense Agency's Airborne Laser program, which has been plagued by cost overruns and schedule delays.

Improve WMD Intelligence

The effectiveness of U.S. nonproliferation and counterproliferation efforts ultimately depends on the quality of WMD intelligence. Unfortunately, the U.S. intelligence community has a poor track record of detecting both state-level and sub-state WMD proliferation. It failed to anticipate India's nuclear test in 1998, produced flawed assessments of the threat from Saddam Hussein's Iraq, and only belatedly uncovered the nuclear black market smuggling ring of Pakistani scientist A.Q. Khan. In addition, the intelligence community remains unable to provide reliable information on the status of nuclear programs in North Korea and Iran.

To improve community-wide WMD intelligence collection and analysis, the United States should, per the recommendation of the recent WMD commission, create a new National Counter Proliferation Center (NCPC). The Center would report directly

to the new Director for National Intelligence and set requirements for WMD-related human, imagery, and signals collection for the entire intelligence community. It would also house an analytical division that would provide high-quality, actionable intelligence assessments to customers across the U.S. government, including the new White House NPD.

The NCPC will require approximately $1 billion in annual funding. Given this price tag, Congress may resist creation of the NCPC until it can determine whether recent legislation will effectively address current intelligence community deficiencies. Moreover, CIA already operates an analytical unit devoted to WMD intelligence (WINPAC) that will fiercely resist encroachment upon its turf. The NCPC should therefore function as both a consumer and independent reviewer of WINPAC intelligence products while avoiding disruptive turf battles. Competition between WINPAC and the NCPC could result in higher-quality intelligence products from both.

Briefs

Brief Sample 1: short issue overview, concluding with recommendation

To: Bob Cook-Deegan
From: [Stanford University Student][2]
Date: February 8, 2000
Re: Federal Mandate for Infertility Treatment Coverage by Insurance Providers

Statement of Issue: 6 million Americans currently suffer from a medical disorder resulting in infertility. Because only 14%-17% of insurance companies provide coverage for fertility services, including assisted reproductive technologies, access to treatment is restricted to the affluent who pay high out-of-pocket expenses. Without insurance coverage, costs are spread across a small fraction of the population, increasing per capita rates for treatment and encouraging physicians to favor quicker and cheaper practices that compromise quality of care and raise health care costs.

- **Reproduction is a "major life activity"** according to the Supreme Court. By denying access to effective treatment for most socioeconomic groups, current policy violates the Americans with Disabilities Act.
- **Costs of infertility treatments without insurance coverage are a significant barrier to access**. An infertile couple will pay an average of $59,484 in medical expenses per live delivery with assisted reproductive technologies.
- **Premium increases to provide insurance coverage for infertility treatments are low**. The monthly cost of providing infertility treatment in Massachusetts, which mandates coverage, is approximately $0.26 per person.
- **Exclusion of infertility coverage increases multiple gestation, the main cause of neonatal morbidity in IVF patients**. With financial and time pressure from patients with limited funds, doctors have incentives to maximize pregnancy outcomes that may negatively affect maternal and neonatal health and increase hospital costs.

Policy Options

- A federal mandate for annualized case rate packages, would require all insurance companies to provide infertility treatment. Local provider communities would decide on specific treatment algorithms and base their one-year case rates of unlimited services on these algorithms. Patients would receive treatment at designated centers. Supported by infertility interest groups such as RESOLVE and many women's groups.
    - ***Advantages***: Provides coverage to all patients, reducing per capita costs and allowing insurance companies to negotiate discounts for services. Resolves ethical issue of discrimination under ADA. Eliminates incentives

[2] Brief sample retrieved from: https://web.stanford.edu/class/siw198q/modelppr/amber2.htm

for couples to seek premature ART, reducing the risk of multiple gestation and limiting related health care costs. Eliminates discrepancies between states.
    - ***Disadvantages***: Increases premiums for all payers, most without infertility problems. Encourages more people to seek treatment, increasing costs. Reluctance to increase premiums and payments from providers, who argue that infertility is not a life-threatening disease. Mixed support from reproductive specialists, who will either benefit or lose business through designation of treatment centers.
- A restricted federal mandate, similar to the above option in structure, would limit coverage only to those with higher probability of success, such as younger women with no male-factor infertility. Limits could also be placed on the number of treatment cycles performed.
    - ***Advantages***: Less costly than a full federal mandate. Provides coverage for couples with best chances of success, limiting costs. May encourage couples with little hope of conceiving to consider adoption. Insurance company support more likely for limited mandate.
    - ***Disadvantages***: Limits on treatment will encourage overuse of ART and incidence of multiple gestation. Would not fully resolve discrimination issue, because clear restrictions are difficult to set. Consumer savings from reduced benefits would be small relative to total premiums.
- Optional state mandates, already successful in areas such as Illinois and Massachusetts, would leave discretion to state legislatures. As already reflected in current legislation, the scope and restrictions of the initiatives would vary considerably, and the federal government would make no requirement stipulating mandatory coverage.
    - ***Advantages***: Doctors, providers, and patients could be encouraged to limit costs without government intervention. More individualized policies depending on state demographics. Less opposition from national insurance providers.
    - ***Disadvantages***: Many current state policies have significant restrictions on coverage. Variety in state policies could not address problem of multiple gestation and overuse of ART as effectively. Insurance companies who provide coverage in states without mandate will pay disproportionately high costs as more people enroll in their plans.

Policy Recommendation: With rising usage rates of infertility treatment, along with rising rates of multiple gestation, quick reform is necessary to ensure patients have access to cost-effective, quality care. Although state reform has worked in some areas, the time needed for broad implementation in states without current initiatives hurts the health of patients. A federal mandate without significant restrictions, streamlining care and providing consistency between states, will increase access to many people in a short amount of time. While this option costs money, individual burden will be very minimal. Additionally, the costs of infertility

treatments and ART have been steadily falling with rising use, suggesting that infertility treatments will be more affordable as the market grows through expanded insurance coverage.

Sources:

"RESOLVE: Inform Congress about Infertility." http://www.resolve.org/advltr1.htm. Netscape Navigator, Feb. 6, 2000.

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Griffen, Martha and William F. Panak. "The economic cost of infertility-related services: an examination of the Massachusetts infertility insurance mandate." Fertility and Sterility. Vol. 70, No. 1, July 1998.

Faber, Kenneth. "IVF in the US: multiple gestation, economic competition, and the necessity of excess."

Brief Sample 2: issue overview with action plan

Maternal Health in Nepal[3]
From: Laura Chambers, Secretary of Health, Nepal
To: Minister of Finance, Nepal

Introduction:
As one of the world's poorest countries, Nepal faces immense shortcomings in women's health and a infections (STIs)[3] exacerbate maternal complications and contribute to poor women's health. Efforts must be focused on iron, zinc, and folic acid supplementation for immediate improvements in women's health. Access to safe motherhood services and increased education and empowerment of women must be emphasized for sustainable progress.

Nature and Magnitude of the Problem:
Poor women's health remains a pervasive problem in Nepal. Although the reported maternal mortality ratio (MMR) is 281 deaths per 100,000 live births,[4] the actual MMR, adjusted for underreporting and misclassification, is about 830 deaths per 100,000 live births.[1] The lifetime risk of dying a maternal death is 1 in 31.[1] Moreover, every year between 138,000 and 207,000 women and girls suffer from disability due to complications in pregnancy and childbirth.[5] Nepal lacks an adequate system for health surveillance; however, it is known that a significant portion of maternal morbidity and mortality is due to hemorrhage, sepsis, unsafe abortion, and obstetric fistula.[6]

Poor nutrition makes women more susceptible to illness and increases the risk of complications and death during pregnancy and childbirth. Deficiencies in iron, zinc, and folic acid, all crucial for a healthy pregnancy, are widespread; over 62% of pregnant women in Nepal are anemic.[2,7]

Nepal faces an increasing burden of sexually transmitted infections (STIs). Over 200,000 cases of STIs occur annually, including HIV/AIDS, chlamydia, gonorrhea, syphilis, trichomonas, and bacterial vaginosis.[3] Approximately 30% of the 70,000 HIV positive Nepalis are women.[8,9] Access to STI health services in Nepal is inadequate, especially for women.[3]

Affected Populations:
The poor, rural populations in Nepal have the most dismal women's health circumstances. Approximately 89% of Nepalis live in rural areas, indicating that virtually all women face extreme barriers to good health and safe health services. Overall, Nepal received a rating of 30 out of 100 for access to safe maternal health care services; with a rating of 13 in rural areas versus 46 in urban areas. Moreover,

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[3] Policy brief sample retrieved from: http://www.jbpub.com/essentialpublichealth/skolnik/sampleFiles.aspx

27% of rural areas, compared with 72% of urban areas, have access to 24-hour hospitalization.[10]

Risk Factors:
Women have exceptional and serious health problems due to biological differences from men and unique social circumstances. Crucial micronutrients are lacking from Nepali women's daily diets, largely due to food scarcity, lack of dietary diversity, and the growing population.

Nepal's high MMR is deeply rooted in the lack of access to safe motherhood services. Nepal received a rating of 35 out of 100 for its ability to provide emergency obstetric care, and only 11% of deliveries have a skilled attendant present. Only 34% of health centers have the capacity to deal with postpartum hemorrhage, and only 18% of health centers are able to quickly transport a woman with obstructed labor to a hospital. Even if a hospital is accessible, only 46% of district hospitals can perform cesarean-sections, and only 45% can provide blood transfusions.[10]

Nepali women's lack of empowerment contributes to substantial disparities in access to education. The female literacy rate in Nepal is about 35% compared to 63% for males.[11] Such disparities deeply influences the health status of women, their children, and entire families.

Economic and Social Consequences:
Maternal death and disability have a direct and indirect economic burden for Nepal. Although the cost of emergency care for preventable conditions is high, the lack of availability of health care services causes an astronomical indirect economic loss due to decreased productivity.[6]

The social consequences for the families of women with poor health are profound. Nepali women are responsible for household maintenance and family caregiving, so a woman's health deeply impacts family functionality and the future of her children. When a mother dies, her young children frequently die soon after. Moreover, maternal complications, such as obstetric fistula, can lead to extreme disability and cause women to be ostracized from their families and communities.[6]

Priority Action Steps:
The immediate and long-term needs of women in Nepal must be met, and there exist cost effective methods for improving women's health. Widespread, community-based micronutrient supplementation must begin immediately to reduce iron, zinc, and folic acid deficiency in adolescent girls and women of childbearing age. Supervised weekly iron and folic acid supplementation of adolescent girls at school has been shown to reduce the prevalence of anemia.[12]

For long-term women's health improvements, Nepal must focus on midwifery and increased access to high-level health services. As demonstrated in Sri Lanka,

midwives can be a critical link between communities and health care providers in poor countries; Sri Lanka cut maternal deaths in half with such improvements to the health system.[6] Increasing the proportion of births with a skilled birth attendant present, while promoting access to safe health facilities, will greatly reduce the MMR in Nepal.

In order to make sustainable improvements, the education of women must be dramatically improved upon. Conditional cash transfers, similar to those utilized in Chile, Mexico, and Brazil, should incentivize attendance and performance in primary and secondary education, specifically for females. Such programs have been shown to reduce inequality and promote growth, leading to improved empowerment of women, which is crucial for improved maternal and child health.

Endnotes:

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2. Kvale, G. et al. The prevalence of anemia in pregnant Nepali women – a study in Kathmandu. May 2000. Acta Obstet Gynecol Scand; 79(5):341-9.
3. Nepal: STI/HIV/AIDS. Chapter 8. United Nations Educational, Scientific, and Cultural Organization: Bangkok Office. http://www.unescobkk.org/fileadmin/user_upload/arsh/Country_Profiles/Nepal/Chapter_8.pdf
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13. Soares, Sergei et al. Conditional cash Transfers in Brazil, Chile and Mexico: Impacts Upon Inequality. International Poverty Centre of UNDP. 2007.

Brief Sample 3: call-to-action issue overview

DATE: October 11, 2014
TO: Robert A. McDonald, Secretary of the Department of Veterans Affairs; Jeff Miller, Chairman of the United States House of Representatives Committee on Veterans' Affairs Chairman; Bernie Sanders, Chairman of the United States Senate Committee on Veterans' Affairs Chairman; Paul Light, Professor of Public Policy at New York University
FROM: Jacob Shiflett, Vice President of Outreach for WagVets at New York University
SUBJECT: Addressing Neglect of United States Veterans

The purpose of this memo is to raise awareness of critical issues facing veterans returning from Post-9/11 military operations and make the case for immediate action to reform the Department of Veterans Affairs. This memorandum argues the Department of Veterans Affairs continues to fail its mission to honorably serve veterans. Post-9/11 veterans face a number of disturbing trends. These veterans community trends include growing unemployment, underemployment, and poverty. Veterans also face higher risk to homelessness, substance abuse, and suicide. The Veterans Affairs Inspector General, Government Accountability Office, and Pew Research Center identified a number of causes for this crisis. Causes include disability claims processed inaccurately, widespread inaccessibility of care, excessive wait times, fragmentation of care, stigmatization of assistance, lack of specialists, and insufficient performance measurements and management.

Size of Neglect

I urge you to take immediate action on reforming benefits for military veterans of the United States of America. Approximately 2 million servicemen and servicewomen returned home since the beginning of the War on Terror.[4] The Department of Veterans Affairs reported over 1 million veterans used health care services provided by the VA for service-connected injuries that commonly involve "joint and back disorders, mental disorders, and 'symptoms, signs, and ill-defined condition.'"[5] Only half of returning veterans utilized their medical benefits. This is a critical failure of public service. However, even greater issues exist the VA continues to ignore.

Developing Trends

The US Congress Joint Economic Committee revealed 1.4 million veterans live under the poverty line.[6] This figure accounts for over half of all returning veterans. The VA continues to fail these individuals by not providing them with the programs

[4] Sanford J. Mall, *The Future of Veterans' Benefits*, 9 Vol. (2013).
[5] United States Department of Veterans Affairs. Veterans Health Administration. *Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn* (Washington: GPO, 2014) 11.
[6] United States Congress, Joint Economic Committee, *Broken Promises: The Need to Improve Economic Security for Veterans* (Washington: GPO, 2011) 2.

necessary to combat extreme poverty. In addition, the Pew Research Center reported 49% of wounded veterans are unemployed, 33% of not wounded veterans are unemployed and, of the veterans who are employed, only 28% of the wounded work full-time whereas only 40% of the not wounded work full-time.[7] These veterans live in extreme poverty due to their inability to secure sufficient employment. This gives rise to more even more serious issues.

The National Center for Veterans Analysis and Statistics discovered over 140,000 veterans live on the streets.[8] If veterans cannot sufficiently provide for themselves, then it logically follows many will end up homeless since they will not have the means to meet their financial obligations. Some of these individuals suffer from Post Traumatic Stress Disorder. Over 300,000 of Post-9/11 veterans sought treatment for PTSD.[9] This disease makes them vulnerable to alcohol and substance abuse. Approximately 20% of veterans diagnosed with PTSD also suffer from substance abuse.[10] Veterans, as you can see, face a great deal of uncertainty when transitioning from the military to civilian life. For some the stress of living hand-to-mouth and mental illness become too unbearable. Some resort to suicide. Approximately 22 veterans per day commit suicide.[11] How many can be prevented? Where does the fault lie?

Causes of Injustice

Veterans face an unforgiving transition from the military back into civilian life. In the military, these men and women receive specific instruction on everything. Anything they need is provided by the military in a timely manner and free of charge. Then, when they leave the military, these institutionalized individuals stare down the harsh reality of self-reliance with no discernible skill-sets, nor clear support network to rely on. We assume this was the intended role of the Department of Veterans Affairs—to fill the void by setting up able-bodied veterans for success while acting as a reliable crutch for disabled veterans. However, not everything works out the way we intend.

A significant gap exists between the care provided to military men and women by the Department of Defense and the care they receive once out of the military from the Department of Veterans Affairs. This "fragmentation of care" creates discontinuity in the context of records and treatment for veterans since the Department of Defense and Department of Veterans Affairs do not communicate, nor coordinate their efforts.[12] This allows many veterans to fall through the cracks.

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[7] Pew Research Center, *For Many Injured Veterans, A lifetime of Consequences* 8 Nov. 11: 8.
[8] United States Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Sheltered Veterans for Fiscal Year 2009 and 2010* (Washington: GPO, 2012) 4.
[9] *Profile of Sheltered Veterans for Fiscal Year 2009 and 2010* 10.
[10] Department of Veterans Affairs, *PTSD and Substance Abuse in Veterans*, Internet, 10 Oct. 2014. Available: http://www.ptsd.va.gov/public/problems/ptsd_substance_abuse_veterans.asp
[11] Department of Veteran Affairs, Mental Health Services Suicide Prevention Program, *Suicide Data Report* (Washington: GPO,2012) 15.
[12] National Academy of Sciences, Committee on the Assessment of the Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine, *Returning Home from Iraq and*

Even more go unassisted since the VA inaccurately processed a significant amount of claims. The VA Office of Inspector General discovered an estimated 23% of disability claims get processed incorrectly.[13] The same investigation found these claims had "data processing errors, medical exam notifications not processed, rating decision inaccuracies, and decisions not finalized".[14] These errors further complicated care since many veterans do not know their benefits, rights, or processes to appeal denied claims.[15]

The National Academy of Sciences found several other deficiencies in the delivery of services to veterans. Recently, the VA seems plagued by excessive wait times that can range up to 9 months.[16] Veterans found themselves languishing, feeling helpless, with nothing to occupy their idle time except intense episodes of PTSD. Aside from wait times, the National Academy of Sciences also identified accessibility of facilities as another barrier to veterans receiving the care they seek. This primarily affects veterans living in rural areas.[17] However, some veterans live in regions where geographic accessibility is simply not feasible.[18]

Moreover, veterans have been increasingly in need of services offered by a limited number of specialists.[19] The demand for specialized treatment outnumbers the amount of practicing specialists in their respective fields. Furthermore, some veterans simply do not want to seek care. Some veterans see any kind of assistance as a sign of weakness. Changing the mentality of veterans regarding the stigmatization of care may be the greatest challenge the VA faces in reforming its practices.[20] One thing remains certain, the Department of Veterans Affairs needs a better strategy concerning performance measurement and management in order to monitor and improve the quality of care provided to veterans.[21]

Consequences

Over 2 million veterans returned home since the beginning of the War on Terror. These veterans face many obstacles when attempting to reintegrate into society. Currently, 6.3 million veterans rely on services provided by the Department of Veterans Affairs.[22] This number grows by the day as more veterans return from areas of conflict. The quality of services offered does not align with the Department

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Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families (Washington: National Academies, 2013) 424.

[13] Department of Veterans Affairs, VA Office of Inspector General, *Systemic Issues Reported During Inspections at VA Regional Offices* (Washington: GPO, 2011) i.

[14] *Systemic Issues Reported During Inspections at the VA Regional Offices* 4.

[15] Storms.

[16] National Academy of Sciences 435 – 436.

[17] National Academy of Sciences 430 – 432.

[18] National Academy of Sciences 437.

[19] National Academy of Sciences 436 – 437.

[20] National Academy of Sciences 432 – 434.

[21] Government Accountability Office, Testimony Before the Committee on Veterans' Affairs, US Senate, Statement of Debra A. Draper, Director, Health Care, VA Health Care: VA Lacks Accurate Information about Outpatient Medical Appointment Wait Times Including Specialty Care Consults (Washington: GPO, 2014) 1 -2

[22] Government Accountability Office i

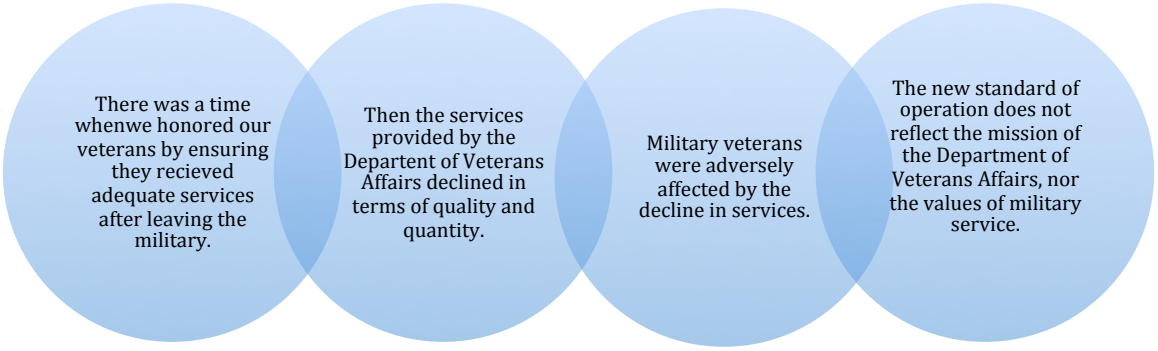
of Veterans Affairs mission, nor does their treatment reflect the military values they embodied while serving in uniform.

Former President George W. Bush acknowledges the need for change and our obligation to honor our veterans.[23] President Barack Obama even considers the current quality of service provided to veterans as "dishonorable".[24] The indifference of government employees to individual circumstance and the inaction of policy makers to improve the situation just add insult to injury. Therefore it is safe to assume some veterans might say the Department of Veterans Affairs, as a provider of veterans' services, exists in name only. Some might even go further as to say the Department of Veterans Affairs only exists to create jobs for college graduates who are willing to service government red-tape and actively seek to deny legitimate claims, in order to save the government a dollar, in exchange for a salary while veterans die by the dozens every day in waiting rooms or in dark alleys.

This problem will not be solved by lip service or even by a blank check.[25] These men and women deserve our utmost respect. Their service and sacrifices warrant immediate action. If you do not take action now, veterans will continue to fall through the cracks. They will continue to transition from the military to civilian life unaware of their rights and benefits. Still more will remain chronically unemployed and immobilized by poverty with nowhere to turn to except substance abuse, criminal activity, or the end of a rope.[26] Have some integrity. Do the right thing. Move this issue to the top of your agenda and let us have a serious discussion on solutions so we can save lives.

[23] Fitzgerald.
[24] Milligan.
[25] Dillinger.
[26] Browm, Stanulis, Theis, Farnworth, Daniels.

Appendix: Logic Model



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