MEMORANDUM

TO: **SJR 5 Subcommittee on Veterans' Affairs**

FROM: **David S. Niss, Staff Attorney**

RE: **Grievance Procedures Involving Veterans' Health Care and Other Benefits**

DATE: **November 15, 2001**

I
INTRODUCTION

At its meeting on August 6, 2001, the SJR 5 Subcommittee on Veterans' Affairs requested a report from the Committee staff on the grievance procedure available to veterans who feel that a claim for benefits, including health care, was unjustly denied. This memorandum is responsive to that request.

A matter of definition must first be addressed: a "grievance", within the scope of this memorandum, is a veteran's disagreement with a decision by an authorized representative of the U.S. Department of Veterans Affairs (VA) not to provide a benefit that the VA is generally authorized to grant and which the veteran is eligible (or believed by the veteran to be eligible) to receive. Specifically not included within the scope of this memorandum are complaints against the VA by its own employees over such matters as claims of discrimination or employment contract violations.

The grievance procedure outlined in this memorandum is not just one procedure but is several very different procedures authorized or created pursuant to several different sections of law, federal regulations, or policy decisions. The procedures discussed are comprehensive in that they delineate all the various methods available to a veteran to voice a complaint over the denial of benefits or level of benefits. Benefits over which a grievance might arise are those benefits administered by either of two of the three operating divisions of the VA, the Veterans Health Administration (VHA) or the Veterans Benefits Administration (VBA). Benefits provided by the third operating division of the VA, the National Cemetery Administration, are not considered by this memorandum although some of the grievance procedures discussed below might apply to the National Cemetery Administration. Whether a particular grievance procedure applies to benefits available from the VBA, care available from the VHA, or both, is noted at the beginning of each section describing a grievance procedure. In an attempt to be comprehensive, the grievance procedures discussed below also include the methods used by the VA in responding to

"nonverbal" complaints, such as when a veteran in a medical facility attempts or consummates physical disfigurement or suicide in an apparent attempt to complain about the veteran's treatment. Inclusion of these procedures in this memorandum is not intended to indicate that veterans are dissatisfied with health care benefits, but is intended to show that the VHA does have quality control measures that are intended to respond to these types of "grievances".

The grievance procedures discussed in this memorandum were assembled from a review of federal laws, regulations, and policies of the federal government, most of which were read at the Freedom of Information Act (FOIA) electronic reading room maintained on the Internet by the VA pursuant to law. This information was then checked with state and federal employees at the Fort Harrison VA medical center (VAMC). Therefore, the information contained in this memorandum is largely academic in nature and does not, except as otherwise noted, include any assessment of the effectiveness of these grievance procedures as they may be implemented by either the VHA or the VBA; nor is the inclusion of a grievance procedure in this memorandum intended to indicate that the procedure has in fact been used at the Fort Harrison VAMC for the resolution of a grievance. Except where noted, such an assessment is beyond the scope of this memorandum.

A final note of caution regarding the grievance procedures outlined below: in each case the procedure has been only generally described and technical information regarding the detail of a procedure, such as appeals to the Board of Veterans' Appeals, is not included in this memorandum. Persons intending to use one of the grievance procedures outline below should investigate the procedure thoroughly with state or federal officials before using the procedure.

Copies of documents examined regarding some of the most prominent of the VA grievance procedures, including printouts of material available on the Internet, are attached. Documents concerning the lesser-used procedures, and documents more voluminous in nature, such as the VA Office of Inspector General (VAOIG) inspection reports, are on file in the office of the Subcommittee's counsel.

II
DISCUSSION

A. Listing of Grievance Procedures

A listing of the grievance procedures available to a veteran to dispute the denial of benefits includes the following procedures, discussed in no particular order:

1. Veterans Affairs 1-Stop web page (online, provided by the Veterans Affairs Consumer Affairs Service.
2. Patient advocacy program in use at VA medical facilities.
3. Department of Veterans Affairs Office of Inspector General, including the Inspector

General hotline.

4. Complaints to Senators or Congressmen.
5. Quality management programs.
6. Clinical appeals.
7. Board of Veterans' Appeals and United States Court of Appeals for Veterans Claims.
8. Federal Tort Claims Act and the federal Privacy Act.
9. Veterans' service officers of the VA, state, or various veterans service organizations.
10. VA Montana Local Procedure for Handling Patient Complaints ("Report of Contact")

B. Discussion of Individual Grievance Procedures

1. **Veterans Affairs 1-Stop Web Page.** Both VHA and VBA. The Consumer Affairs Service in the Intergovernmental Affairs office of the Office of Public and Intergovernmental Affairs of the VA in Washington, D.C., maintains a web page on the Internet called the "VA 1-Stop Service Inquiry Page", at www.va.gov/customer/conaff.asp. In addition to providing VA forms and answers to frequently asked questions (dealing with such issues as how to determine the status of a pending claim for benefits), this web page also offers links to other offices and services within the VA, including the VAOIG, the FOIA electronic reading room available on the Internet, the VBA regional office, and the Board of Veterans' Appeals. The page also provides electronic information on agent orange, Persian Gulf illness, medical care, non-medical benefits, veterans' preference, women veterans, and service standards for the 1-Stop Service. Many of these informational pages also offer Internet links to offices within the VA, as well as e-mail addresses to specific VA offices. The web page asks the reader to inform the Consumer Affairs Service if the reader has had any "unpleasant experiences with VA personnel" or if the Department's communications with the reader have not been "clear and timely". The page also reminds the reader that the VA accepts compliments if the reader has been satisfied with the actions of the VA. A copy of a printout from the web page of the Consumer Affairs Service is attached as Attachment A.

2. **Patient Advocacy Program.** VHA only. VHA directive 1050.2 (June 12, 2000) requires that each VHA facility and clinic establish a patient advocacy program, replacing the former patient representation program. The program is to consist of at least one individual trained in the handling of patient complaints. More individuals are to be appointed to the position of patient advocate if the facility is so large that each complaint cannot be resolved by the one individual within the time period established by the directive's service standards. The program is to be established at each facility for the benefit of veterans (or their designated representatives) and their family members, in order to resolve complaints in a convenient and timely manner. Resource and performance expectations for the patient advocacy program are also published in the directive. The performance expectations state that responses to patient complaints must be resolved as soon as possible, but in any event no longer than 7 days from the date of the complaint. Other performance standards concerning support services for the patient

advocate, internet access, computer support, etc., are also published.

References to the patient advocacy program are sometimes made in various other VA publications. For example, in the March 1999 issue of a VA publication called the "Agent Orange Review", a description of the patient advocacy program is given under the headline "Patient Advocate Program Helps Many Vietnam Veterans". The description of the patient advocacy program ends with the telephone number and address where additional information on the program may be obtained.

The effectiveness of the patient advocacy program in at least one VA health care facility has been the subject of an investigation conducted and reported by the VAOIG. In a VAOIG report entitled "Multiple Management and Patient Care Issues at the Department of Veterans Affairs Medical Center, Omaha, Nebraska", report number 00-00025-111, dated September 5, 2000, the VAOIG found that "[w]e substantiated multiple patients' allegations regarding the effectiveness of the VAMC's Patient Representative Program. OHI inspectors received numerous complaints regarding the Omaha VAMC's Patient Representative Program. Complainants told inspectors that most patients do not consider the Patient Representative to be their liaison or advocate." The same report notes that there are successful patient representative programs, the forerunner of the patient advocacy program, in other VA medical centers across the country. No VAOIG review of the patient advocacy program at the Fort Harrison VAMC, and certainly none reaching a conclusion similar to that reached above regarding the Omaha VAMC, has been located, which may or may not indicate that the patient advocacy program at the Fort Harrison VAMC is functioning correctly.

Patient advocacy issues reaching the patient advocate are entered into a computer data system known as the national computerized patient complaint data base. The data base is used to produce reports and track issues and trends for use by the patient advocate and VA facility management for all of the VHA facilities. A copy of the most recent report from the data base containing figures for all VHA facilities in Montana is attached as Attachment B.

The patient advocate at the Fort Harrison is Mr. Ed Hollandsworth, whose telephone number is 447-7990. A copy of the directive requiring establishment of the patient advocacy program at each VA facility is attached as Attachment C.

3. **Veterans Affairs Office of Inspector General and Hotline.** Both VHA and VBA. Established by an act of Congress in 1978 (The Inspector General Act, P.L. 95-452, which created an office of Inspector General in many federal departments and agencies), the VAOIG serves as one of the primary entities to which veterans' grievances may be voiced and by which those grievances are resolved. The VAOIG consists of the (1) office of investigations, which handles targeted investigations, both civil and criminal, and participates in proactive, combined audits of facilities chosen on a random basis, known as the combined assessment program (CAP) inspections; (2) office of audit, which conducts performance and financial audits and participates

in CAP inspections, performs contract reviews and evaluations, and performs other types of audit-like actions; (3) office of healthcare inspections (OHI), which manages CAP inspections, provides some oversight of hotline cases, and does various inspections of VHA facilities and program reviews; and (4) office of management and administration, which manages the VAOIG hotline, conducts follow up on VAOIG reports, and prepares reports on certain unimplemented VAOIG reports.

VAOIG inquiries such as targeted inspections by the OHI and CAP reviews usually follow a series of predetermined steps involving collection of data; entrance conferences; interviews with complainants, VA facility managers and other facility employees; exit conferences; preparation of a draft report containing findings and recommendations; submittal of the draft report to the managers of the facility in question; release of the final report including notations as to whether facility managers agreed with draft recommendations of the VAOIG; and followup to determine compliance with recommendations. Of course, in criminal cases or other situations in which collection of sensitive evidence is involved, different inspection or collection procedures may be used.

The VAOIG issues semiannual reports documenting the activities of the Office during the reporting period in which the IG typically provides figures on the number of complaints investigated. For example, in the report covering the period April 1, 2000, through September 30, 2000, the VAOIG reported the following activities:

	Current 6 Months 4/1/00 – 9/30/00	FY 2000 10/1/99 – 9/30/00
DOLLAR IMPACT	Dollars in Millions	
Funds Put to Better Use	$41.7	$302.2
Dollar Recoveries	$6.0	$11.4
Fines, Penalties, Restitutions, and Civil Judgments	$7.2	$13.8
RETURN ON INVESTMENT		
Dollar Impact ($54.9) / Cost of OIG Operations ($24.6)	2 : 1	
Dollar Impact ($327.4) / Cost of OIG Operations ($45.4)		7 : 1
OTHER IMPACT		
Arrests	174	338
Indictments	156	280
Convictions	122	247
Administrative Sanctions	195	496
ACTIVITIES		
Reports Issued		
Combined Assessment Program	14	18
Audits	19	35
Contract Reviews	24	40
Healthcare Inspections	9	15
Administrative Investigations	8	16

Investigative Cases		
Opened	478	882
Closed	316	545
Hotline Activities		
Contacts	8,319	15,771
Cases Opened	547	985
Cases Closed	461	717

As can be seen from the foregoing data, for the year ending September 30, 2000, the VAOIG hotline ((800) 488-8244) engenders a substantial number of reactive investigations conducted by the VAOIG. The hotline is in operation between 8:30 a.m. and 4:00 p.m. Eastern time. At other times, and even at times when the hotline is answered, complaints to the VAOIG can also be sent by fax, e-mail (VAOIG.HOTLINE@FORUM.VA.GOV), and the USPS. The VAOIG hotline web page contains information on how to use the hotline and how to submit complaints to the VAOIG through the other available means as well. The VAOIG hotline web page also contains information about various types of complaints or cases, such as complaints concerning cases that are in litigation, and information on federal whistleblowing, discussed below. A copy of the print out from the VAOIG Hotline webpage is attached as Attachment D.

Complaints received on the VAOIG hotline follow a predetermined path that generally involves: referral by formal VAOIG memorandum to an appropriate management official (unless the hotline complaint involves that official), typically a facility manager of the facility about which the hotline call is made, with a copy of the referral memorandum to an internal VAOIG manager; action by the facility manager with a formal response to the VAOIG; and case closure. Hotline complaints involving serious allegations against a facility manager are referred by the VAOIG to the chief veterans integrated service network (VISN) officer and appropriate network director. Hotline complaints against high ranking officials or involving other sensitive issues are referred to a special inquiries section of the VAOIG. No information was found explaining whether or how the results of hotline complaints are made available by the VAOIG or the facility manager to the complainant.

An important part of VAOIG hotline complaints, as well as some other types of complaints to the VAOIG, is the issue of the identification of the complainant. The VAOIG offers anonymity or confidentiality to any complainant. The identification of a complainant is an especially important issue, because of the possibility of reprisals against the employee, when the complainant is a VA employee at the facility or job site that is the subject of the inquiry. Reprisals for whistleblowing against employees of the VA are prohibited and protected against by The Inspector General Act and, as they are for all federal employees, by the Whistle Blower Protection Act of 1989 (Whistle blower Act), 5 U.S.C. 1213, et seq., administered by the Office of Special Counsel of the Merit System Protections Board. The Inspector General Act prohibits the disclosure of the identity of employees of an agency who bring complaints about their agency to the attention of the agency Inspector General without the consent of the complainant.

4. **Complaints to Members of Congress**. Both VBA and VHA. A time-honored service performed by members of Congress is to resolve constituent complaints about their dealings with federal executive branch agencies. The tradition is alive and well in the offices of the Montana congressional delegation in the services performed for Montana veterans. Each of the members of the Montana congressional delegation has a staff specialist assigned to casework veterans' issues with the VA. Those veterans' affairs specialists are: for Senator Conrad Burns: Mr. Mike Brown (Great Falls - (406) 452-9585); for Senator Max Baucus: Ms. Andrea Merrill (Missoula - (406) 329-3123); and for Representative Dennis Rehburg: Mr. Jeff Garrard (Helena - (406) 443-7878) .

The VA Office of Congressional and Legislative Affairs (OCLA) exists to help veterans and congressional caseworkers deal with veterans' complaints and inquiries regarding veterans' benefits and services available from the VA. The OCLA has a web page for use by veterans and congressional caseworkers that includes VA forms, laws and regulations, links to members of Congress and Congressional committees, information on how to contact the OCLA, and a caseworkers resource page. The caseworkers resource page includes a link to another web page by which a caseworker can forward a complaint or inquiry to the VA. The complaint page requires specific information concerning the nature of the complaint, the person filing the complaint form, etc.

Most VA facilities have on their staff a person designated to deal with inquiries from members of Congress. At the VA medical facility at Fort Harrison, that person is Ms. Cindy Stenger ((406) 442-7979). As congressional liaison, it's Ms. Stenger's job to respond to or coordinate the response to inquiries by congressional caseworkers. As necessary, the congressional staffs also deal with other officials of the VA, up to and including the Secretary of the Department of Veterans Affairs. Mr. Mike Brown of Senator Burns' office has explained that he deals with about 300 to 350 veterans' cases per year, about 75 % of which are for Montana veterans. To what degree these may be "complaints" or "grievances" is partly a matter of definition. It's probable that no records are kept that would distinguish an "inquiry", or a "problem", from a "grievance".

5. **Attempted or Consummated Injury or Suicide as a "Complaint" – Quality Management at VAMCs.** VHA only. This is a delicate subject. The VAOIG has documented at least one instance, not at the VAMC at Fort Harrison, in which a veteran allegedly committed suicide over the quality of his care. In the VAOIG Semiannual Report to Congress for the period April 1, 2000 through September 30, 2000, at page 57, the report states, regarding the Carl Vinson Department of Veterans Affairs Medical Center, Dublin, GA: "[w]e reviewed allegations that a patient committed suicide because VAMC employees had not properly managed his care and that the availability of unsecured weapons on VA property provided for an unsafe environment....We could not confirm that the patient received improper care."

Clearly, no one knows for sure whether this occurrence at the Dublin, GA, VAMC was intended

as a "complaint" by the veteran who took his own life, whether the death occurred because of the quality of the veteran's care without being intended by the veteran, or whether the death was totally unrelated to the veteran's care. The inclusion of this subject in this memorandum is not intended to imply that any patients at the Fort Harrison VAMC have taken or will take their own lives or have intentionally injured or will intentionally injure themselves as a protest against the care received. However, in an attempt to be comprehensive in the inclusion of channels for grievances and the VA systems for dealing with those grievances, it may be instructive to take note of the VA quality management (QM) systems that are intended to be responsive to such an occurrence as took place at the Dublin VAMC.

As part of the VA QM program, each VISN and VAMC operates a patient safety improvement program, which is an umbrella program covering many different MC activities. VHA handbook 1051/1 requires that each facility report sentinel events (loss of life or limb or permanent loss of function), unplanned clinical occurrences, and certain other events electronically, or on a VA form to the VISN, within a specified period after the event or occurrence. The VISN then reports the event to VHA headquarters. A review or investigation of the event or occurrence must then be initiated by the facility within 10 working days after the report is made. The investigation may or may not involve sworn testimony of health care providers, depending upon the nature of the event and kind of investigation conducted. Reports are then used cumulatively to identify lessons learned, which are shared with the VISN, and identify necessary system redesigns. The Office of Medical Inspector within the VAOIG monitors the reviews or investigations resulting from the initial reports.

The VA Montana health care system reports that in addition to review of critical events, such as suicide, missing patients, and patient mishaps as part of its local quality management assurance program, it conducts internal peer reviews of certain cases. The Montana system also contracts with Mountain Pacific Foundation to review individual health care cases and compare those cases to accepted community standards for health care.

6. **Clinical Appeals.** VHA only. VHA Directive 2001-033 (May 23, 2001) establishes a process by which a veteran or the veteran's representative may appeal a clinical decision regarding the veteran's care or the denial of a certain type of care that could result in a different or improved clinical outcome for the veteran. The directive notes that the clinical appeal process was established based upon the policy that patients at a VA facilities have access to a fair and impartial review process to review disputes or impasses regarding clinical determinations or services that are not resolved at the VAMC level. Patients wishing to pursue a clinical appeal must be assisted by the patient's advocate, who must enter the appeal and its resolution in the national computerized patient complaint database.

Clinical appeals may be either internal or external to the VISN. In either case, an appeal is begun at the facility level by a final written response to a patient's requests or grievances concerning clinical aspects of the patient's care. The written response to the patient by the VA facility must

include information on the clinical appeals process. In an internal appeal, a veteran provides a statement of appeal to the VISN, which then requests documentation and supporting arguments from both the veteran and the VA facility. The VISN must itself review the documentation or convene a independent network clinical panel to do the review and make a recommendation to the VISN. The network director must make a decision on the appeal within 30 days of receipt of an appeal from a patient.

At any stage of the appeal process, the VISN may request an external review of the veteran's appeal. The decision whether to request an external review appears to be discretionary with the VISN. If such a review is requested, the documentation involving the appeal is coordinated by the Office of Quality and Performance in the VA central office and is sent to a contracting board of medical professionals outside of the VA. The board must make written findings and a report within 10 days of its receipt of a completed request for review from the VISN. If an external review is requested by the VISN, the network director must make a final decision on the appeal within 45 days of receipt of the veteran's appeal. The outcome of the appeal is also entered in the national computerized patient complaint database. Copies of VHA Directive 2001-033 and the VISN directive implementing that national directive within VISN 19 are on file with the committee counsel.

7. **Board of Veterans' Appeals and United States Court of Appeals for Veterans Claims.** VBA and, to a limited extent, VHA. The Board of Veterans' Appeals (BVA or "the Board") is a panel created by federal statute (38 U.S.C. 7101) to resolve disputes between a veteran and the government regarding a veteran's benefit to which the veteran believes he or she is entitled but has been denied by the action of a VA regional office. The board is composed of attorneys experienced in veterans' law and benefits. The BVA meets principally in Washington, D.C., but also travels on a limited basis throughout the country to hear appeals.

A VA publication entitled "Understanding the Appeal Process" notes that about 90 % of the veterans appealing a denial of veterans' benefits to the BVA do so with the help of a representative, not necessarily an attorney. About 85 % of the veterans appealing get the help of a veterans' service organization or their state veterans' department (such as, in Montana, the Montana Veterans Affairs Division). An appeal is filed by submitting a statement called a notice of disagreement (NOD) to the local VA office that helped process the claim. A standardized VA form must then also be filed with that office. Issues that are typically appealed are disability compensation, pension benefits, education benefits, waiver of recovery of overpayments, waiver of medication copayment debts, and reimbursement for unauthorized medical services.

After the submission of the form required by the BVA, the Board assigns a docket number to the case, and it is scheduled for decision by the Board in the order in which it was received. A veteran also has a right to request a hearing before the Board, either at the local Regional Office or before the Board at its headquarters in Washington, D.C., in order to present argument to the Board. As of the fall of 1999, it took the Board, on average, 2 years from the time a veteran filed

the NOD to decide an appeal before the Board. A schematic of the BVA appeal process is attached as Attachment E.

If a veteran is dissatisfied with the decision rendered by the Board, the veteran may appeal the decision of the Board to the U.S. Court of Appeals for Veterans Claims (CAVC or "the Court"), located in Washington, D.C. The CAVC was created in 1988, although under a different name, and is an independent judicial body, not part of the VA. The Court consists of seven justices, one chief justice and six associate justices, appointed by the President for 15-year terms and confirmed by the U.S. Senate. As an appellate court, the Court does not hold trials or receive any evidence other than what was presented to the BVA and as may be submitted in the briefs of the parties before the Court. The Court hears live, oral argument in about 1% of its cases heard in Washington, D.C., but sometimes hears argument in a conference call. An appeal from a decision of the BVA must be filed directly in the form of a notice of appeal with the Court within 120 days of the decision by the Board. Either party may appeal a decision of the Court to the U.S. Court of Appeals for the Federal Circuit, located in Washington, D.C. From that court, parties may seek review by the U.S. Supreme Court. Information about filing an appeal with the Court can be obtained from either the Court's website at www.vetapp.uscourts.gov/ or from the Court at (800) 869-8654.

The CAVC has heard a steadily increasing number of appeals from the BVA. In 1995, there were 1279 appeals filed with the Court. In 2000, 2442 appeals were filed with the Court. In 1995, just 68 of the decisions by the CAVC were appealed to the Federal Circuit Court. In 2000, 189 of the decisions of the Court were appealed to the Federal Circuit Court.

Both attorneys and non-attorneys may be admitted to practice before the CAVC. The Court publishes a list of both attorneys and non-attorneys that are admitted to practice from each state. The are seven attorneys, but no non-attorneys, in Montana who are admitted to practice before the Court. Attorneys and non-attorneys alike may be admitted to practice on a temporary basis for the purposes of one particular case ("pro hac vice" admission) before the Court. Veterans may also represent themselves before the Court. The instances in which a person appearing before the Court on behalf of a veteran may charge a fee are regulated by the Court, as is the size of the fee.

8. <u>Federal Tort Claims Act and Privacy Act.</u> Federal Tort Claims Act VIIA only; federal Privacy Act both VHA and VBA. Prior to 1946, a person injured by the negligence of the United States could not sue the federal government for the injuries resulting from that negligence because the United States, as one of the aspects of its sovereignty, was held to be immune from suit. In 1946, the Congress enacted the Federal Tort Claims Act (FTCA) (28 U.S.C. 2671, et seq.), effectively waiving the sovereign immunity of the United States to the extent provided for in the Act. The FTCA provides that the United States is liable "in the same manner as a private individual under like circumstances". While the focus of this explanation of the FTCA will be medical malpractice claims for injuries or death arising from treatment or lack of treatment at a

VA health facility, much of the discussion applies to any form of negligence, such as an automobile accident, in which a person is injured by the negligence of an individual employed by the United States.

The waiver of sovereign immunity enacted by the FTCA is conditioned upon presentment of the claim first to the agency that caused the harm. Under the FTCA procedural requirements, the administrative claim must state a specific dollar amount, or "sum certain", in which the claimant has been harmed. The administrative claim must be presented to the agency, in this case the VA, within 2 years after the claimant learns of the injury and the cause of the injury or, through the exercise of due diligence, should have known of the injury and its cause. Various persons within the VA are authorized to settle claims of varying amounts. If the claim is paid by the agency, the federal regulations implementing the FTCA provide that acceptance of the settlement bars any subsequent legal action by the claimant arising from the negligence for which the payment is made. If the claim is denied by the agency, the injured claimant then has 6 months from the date of the denial of the claim by the VA to bring a legal action under the FTCA against the United States. Failure to bring suit within the 6-month time period results in the barring of the law suit, forever. Failure of the agency to act on the claim within the 6-month time period constitutes a denial of the claim.

Under the FTCA and more recent amendments to that Act, a physician or other health care professional who was acting within the scope of the professional's employment but acting, or neglecting to act, negligently cannot, with certain very limited exceptions, be sued in an individual capacity for damages caused by their negligence. Under the FTCA, if a health care professional is individually sued, an investigation is undertaken by the VA regional counsel and the U.S. Attorney's office in the district in which the suit was filed to determine whether the person was acting within the scope of employment. If the investigation shows that the person was acting within the scope of employment and the U.S. Attorney General certifies to that effect, the individual health care professional must be dismissed from the suit, the United States must be substituted by the court as the defendant, and the U.S. Department of Justice and the U.S. Attorney for the district in which the suit is brought defend the agency with the direct assistance of attorneys for the federal agency.

Under the federal Privacy Act of 1974 (5 U.S.C. 552a et seq.), a federal agency such as the VA may only maintain in its records that information on an individual that is relevant and necessary for the agency to accomplish its purpose, as established in statute, and must maintain the security and privacy of the records within the agency's system. The person on whom a record is maintained must be given access to the record and must be provided with an opportunity to object to any record maintained on the person that the individual feels is being kept contrary to law. If an agency maintains a record contrary to law, fails to amend its record in a way requested by the person who is the subject of the record, or maintains a record with such poor accuracy that the record is not fair to the person about whom the record is kept, that person may bring a civil action against the agency to require the record to be eliminated or changed. The person bringing the suit may collect attorney fees and, in some cases, statutory penalties.

9. **Veterans' Service Officers.** Both VHA and VBA. Veteran service officers are those individuals employed by the VA, the Montana Veterans Affairs Division, and certain veterans service organizations (VSOs) who are recognized pursuant to federal regulation as trained in veterans' benefits and whose job it is to assist veterans with filing claims for those benefits. If a benefit is denied after the filing of a claim, it is usually the veterans service officer who assisted the veteran in filing the original claim who is the first to be notified of denial of the claim. If the veteran then wants to request reconsideration of the claim or an appeal to the BVA, the veteran normally would request the assistance of the veterans service officer who assisted with the original claim. Certain veterans service officers are authorized to appear with the veteran at any hearing granted by the BVA (see paragraph 7 of this section). Several VSO's employ full-time service officers to assist veterans with claims.

10. **VA Montana Local Procedure for Handling Patient Complaints ("Report of Contact").** VHA only. The Fort Harrison VAMC has formalized in Center Circular 11C-0103 (October 6, 2001) a local procedure for handling patient complaints, at all VHA facilities in Montana, that specifies the relationship between and among the health care consumer (the veteran or the veteran's family or representative), the VA medical staff, the VA patient advocate, the VA congressional liaison, and private sector health care providers providing health care services to veterans under a contract with the VA. This procedure requires the use of a written form (Report of Contact) for documenting health care complaints or concerns raised by the veteran and resolving those complaints or concerns within the facility or with the VA contractor. The report of contact is completed by the patient advocate or other VA employee receiving the complaint and then is used to record subsequent efforts to resolve the complaint. The patient advocate is directed to prepare quarterly reports of patient complaints or concerns for the governing board executive committee that is to include recommendations for improvements to services or changes to current policy to reduce complaints or concerns and better serve veterans. A copy of Center Circular 11C-01-03 is attached as Attachment F.

III
CONCLUSION

Whether or not a particular service, office, or procedure within or without the VA constitutes a "grievance procedure" available to veterans for the filing of grievances concerning veterans benefits (including health care) is a matter of definition. If the term is construed most broadly, this memorandum has detailed no less than 10 procedures or avenues that a veteran might use to voice dissatisfaction with the denial of benefits (including health care), denial of a particular benefit, or denial of a level of benefits sought by the veteran. Each of those procedures discussed above may often be utilized in conjunction with one or more other applicable grievance procedures also discussed, because there is generally no statute, rule, or policy that prohibits a veteran from seeking redress by using as many of the procedures as are applicable to the veteran's

particular circumstance.

Except in several limited areas previously noted, no attempt has been made to discuss how well the grievance procedures reviewed in this memorandum work. Such a determination cannot be made without examination of information that might be publicly available, reviewing documents that could only be released with the approval of the veterans who are the subject of the documents, or accepting testimony from those veterans who have used the procedures and from persons at the Fort Harrison VAMC and others who are in charge of or operate the various grievance systems discussed. An accurate assessment by the Veterans' Affairs Subcommittee of the degree to which any of the grievance procedures are or are not functioning in the manner in which they were intended will likely have to rely on all of those forms of assessment. Before any legislation can be accurately drafted creating or altering state agencies or employee positions to interface with any of the grievance systems or procedures reviewed in this memorandum, the subcommittee will likely need to know such matters as the number of grievances made in a particular system, the subject of those grievances, the time and manner in which those grievances are resolved, and generally how the grievance procedure or system in question is functioning. Those lines of inquiry and others are suggested by the grievance structure examined in this memorandum.